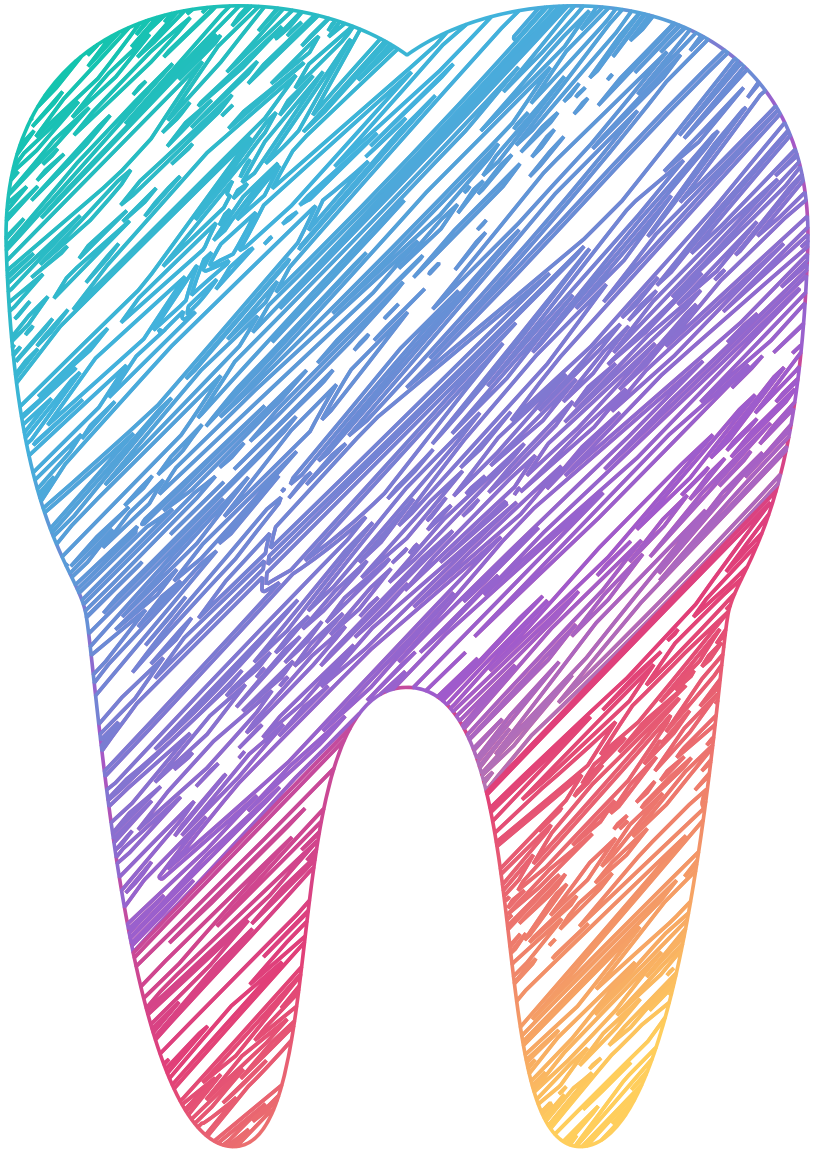
HEALTH MATTERS

Health Consumers' Council (WA) Inc. Magazine
Bumper Issue 1 2017



Contents

Features

Regulars

Foreword

Teeth and Patient Experience. Obvious, huh?

We recognise it is now well into the year, with our first Health Matters magazine finally making its way to your inbox or letter box. We had every intention of getting the dental edition out before Patient Experience Week and then... well it got too hectic.

So, this bumper issue brings you all the articles and stories we have gathered with a dental theme, as well as Patient Experience news. Enjoy!

Patient Experience is the Human Experience ... Community Conversation

On Thursday 27th April HCC convened a Patient Experience Community Conversation. This built on Patient Experience Events held in 2016, where one of the global leaders on patient experience, the US's Jason Wolf addressed the launch event virtually. I looked at him on the screen in 2016, and vowed to make him part of the event in 2017. This wish came true in part because the NSW Centre for Clinical Excellence flew Jason out for events in May 2017, and we flew Jason to Perth for our events.

He was every bit as inspiring as we had hoped. A video of his presentation is available to view here www.hconc.org.au/hccpxw

The Community Conversation was about getting together health providers, not-for-profit organisations and the community to talk about 'what matters to you?' about patient experience, and to develop patient experience improvement priorities. A longer report of the event and the Leadership Breakfast held on the following day, is available on page 3.

Health Consumer Excellence Awards

After the Community Conversation, we held HCC's Health Consumer Excellence Awards which aims to honour the everyday heroes in health and raise awareness of consumers doing excellent work. The Honourable Alanna Clohesy MLC, Parliamentary Secretary to the Deputy Premier; Health; Mental Health, attended the event and presided over the award presentations. You can read more about the Awards on page 6.

Extraordinary General Meeting - New Rules for HCC

On 22nd March, HCC convened an Extraordinary General Meeting to vote on the adoption of proposed new Rules to replace HCC's Constitution. This was to ensure we are compliant with the new Incorporations Act which requires all not-for-profit organisations incorporated in Western Australia to review and update the way they operate. The new Rules were unanimously voted in, and have been endorsed by the Department of Communities. For more information please visit http://www.hconc.org.au/egm-2017/ or contact us if you have any questions.

Staff and Students

Bronte Duncan has joined the HCC Advocacy Team after a stellar student placement at HCC. We have also welcomed Kate Bullow and Ashleigh Rossicano to the team. Kate and Ashleigh are working on two six-month projects supporting consumer engagement in primary care, funded by the WA Primary Health Alliance. In May we farewelled Stephanie Newell, who has left to take up opportunities elsewhere. We wish Steph all the best for whatever's next.

Student placements have continued to be a great resource for HCC, with Nadeen Curran working on Position Papers, Jasmine Teo supporting the Consumer and Community Engagement Project and providing invaluable help during Patient Experience Week.

Pip Brennan
Executive Director
Health Consumers' Council

Message from the Editor... & Letters to the Editor...

Lucy Palermo Marketing & Communications Coordinator / Health Matters Editor | HCC

Message from the Health Matters Editor

Dear Members,

While researching this issue I had a conversation with my parents about the disabled daughter of a family friend. She is in her early thirties and has an intellectual impairment. She can't cope with a routine dental check up, let alone a filling without a general anesthetic.

Just recently she was going in for a filling. The doctors had prescribed a Vallium to calm her down before coming to hospital. Unfortunately this didn't work. By the time they reached the hospital she became hysterical. She bit her carer and the police had to be called for insurance purposes.

She then also hit an innocent bystander with her handbag and bit her twice on the face. The lady who had just been discharged and was waiting for her bus, had to be treated for her wounds.

Needless to say the woman's mother who witnessed the incident (she is recovering from a hip operation) was horrified and offered to pay for any medical expenses. She also visited the lady the following day to make sure she was alright.

The surgery didn't go ahead. Following this, the doctors who had previously dismissed this process as overkill, are now taking the needs of the daughter with a disability more seriously.

Unfortunately this story is also eccoed in the article 'Peter's long trip to the Dentist' on page 22.

Visiting the dentist might appear a straight forward procedure, but for those with an intellectual impairement or acquired brain injury, it is anything but.

If you having difficulty accessing dental health services for your family member, or someone you care for with a disability, call Health Consumers' Council on (08) 9221 3422 and ask to speak to an advocate.

Kind regards,

Lucy Palermo
Health Matters Editor

Letters to the Editor aims to capture your feedback. We welcome your letters & messages. You can leave messages on Twitter and Facebook using hashtag #hconcwa_editor, email info@hconc.org.au or post GPO Box C134, PERTH WA 6839. Please include your name, suburb and phone number. Letters may be edited for legal issues, space or clarity.

Patient Experience Week 2017

Lucy Palermo Marketing & Communications Coordinator/ Health Matters Editor | HCC

Pictured: Pip Brennan Executive Director HCC, Jason Wolf President Beryl Institute & Steph Newell

In 2016, Health Consumers' Council (HCC) held our inaugural Patient Experience events and shifted the presentation of our Health Consumer Excellence Awards to coincide with Patient Experience Week.

In 2017, HCC and the Australasian College of Health Service Management (ACHSM) partnered to start a new conversation about patient experience!

PXW Community Conversation

On Thursday April 27, 100 people representing consumers/carers, not-for-profits and health professionals in WA worked together to improve the patient experience by exploring the question 'What matters to you?' about our health system.

The HCC event was opened by the Director General of WA Health, Dr David Russell-Weisz who assured the audience they were in the right place "to make the patient experience better", and this is the most important work we need to do together.

Our keynote speaker was Jason Wolf, President of the Beryl Institute and international patient experience expert. The Beryl Institute spearheads the international patient experience movement, with a membership of 50,000 spanning more than 50 countries. Jason Wolf speaks at Patient Experience Week events across the world, and yet he noted WA's event was unique as it was convened by a consumer organisation, not a service provider organisation.

Jason flew all the way from the USA to address and inspire our community about what works and what's next in the global patient experience movement. And inspire he did! Jason highlighted that "Patient Experience is the Human Experience". He emphasied that Patient Experience is a movement – not a specific set of activities with an end date. A video of his powerful presentation and slides are available here: www.hconc.org.au/hccpxw

Following Jason's presentation, the whole room set to work at their tables, exploring the question 'What matters to you?' and even though we responded from our different perspectives, the themes we identified were the same. We then worked together to identify practical patient experience improvement priorities using the interactive platform, Group Map. We could see priorities identified by other groups and 'like' them in real time. You can read the priorities developed on page 5.

A special thank you to LotteryWest, our sponsor for this event, the members of the Steering Committee and our Table Champions for your valuable contribution. We would also like to thank the hospitals and health services who provided a poster on the Patient Improvement Priorities they are currently working on. You can read about the projects and initiatives that are making a difference in WA Health here: www.hconc.org.au/pxposters

Pictured: Dr David Russell-Weisz, Director General of WA Health

Pictured: Antonella Segre, Dianne Bianchini, BK Tan & Ruth Lopex

PXW Health Leadership Breakfast

Our 2017 Patient Experience Community Conversation was designed with the end in mind. The aim was to create an event to deliver the patient experience improvement priorities identified at the 'Conversation' to the WA health leaders.

To do this Health Consumers' Council (HCC) partnered with the Australasian College of Health Service Management (ACHSM) to hold a Health Leadership Breakfast on Friday April 28, 2017. Jason Wolf, our keynote speaker and President of the Beryl Institute presented the patient experience priorities to a packed room of WA health leaders. At this event, Jason Wolf presented the findings from the Community Conversation and, again highlighted the important message that patient experience is a movement, something that we continue to build. We never "get" there.

Jason co-presented with WA's Dr Simon Towler who provided a moving and grounding testimonial of his own lived experience of the moment he went from being Chief Medical Officer to cancer patient. His presentation highlighted the consumer perspective, both the negative and positive moments and highlighted the importance of keeping the patient at the centre.

Between now and Patient Experience 2018, HCC will be talking to as many clinicians and health service providers as we can about the event to help build momentum. We are actively seeking clinician/consumer partnerships that we know are out there, when those at either end of the stethoscope focus on what would make things work better for patients and families.

A special thank you goes out to HESTA, our sponsor for this event, and to the ACHSM, who were both such wonderful and supportive partners in putting this event together.

Pictured: Dianne Bianchini, Dr Simon Towler, Pip Brennan & Jason Wolf at the Health Leadership Breakfast

WORKSHOP SESSION

Participants worked in small groups to complete the sentence...

The thing that matters most to me about patient experience is ...

The key Priority Areas are below.

TRANSPARENCY

What is happening? Individually, at the service level, at the system level

PARTNERSHIP

Patients, consumers & carers included in decision making, service & system design

BEING HEARD

Being listened to, time for conversations and to asking questions, developing positive change from being heard

EQUITY

Avoiding stereotypes, respecting individuality and culture

SAFETY

That I and my carers feel that I'm safe, that I'm treated by competent clinicians, that I know my patients feel safe

CHOICE

I know the options and I'm empowered to make informed choices

PERSON CENTRED

That I feel like a person not a number, that a holistic and family focused approach is taken

Health Consumer Excellence Awards 2017

Lucy Palermo Marketing & Communications Coordinator/ Health Matters Editor | HCC

Pictured: Pip Brennan, Alanna Clohesy MLC & Jason Wolf at the Health Consumer Excellence Awards

The Health Consumers' Council and the Western Australian Department of Health are pleased to present the winners and finalists for the 'Health Consumer Excellence Awards' 2017!

Following the Community Conversation on April 27, the Awards were opened by the Hon Alanna Clohesy MLC Parliamentary Secretary to the Deputy Premier; Health; Mental Health, standing in for Roger Cook MLA, Deputy Premier.

These awards were created to honour the everyday heroes in health in WA, from the administrator to the clinician and to recognise health consumers that go out of their way to make a difference.

Jason Wolf President of the Beryl Institute was also there to congratulate the award winners.

A special thank you to our sponsors LotteryWest and the Western Australia Department of Health and our judges; Cheryl Holland, HCC Chair; Richard Brightwell; Karen Bradley, Chief Nurse; Dr Bernadette Wright, Clinical Psychologist; And Yvonne Parnell, South Metropolitan Health Service Board Member.

Congratulations to our winners!...

And the winners are...

Health Organisation Award – Moorditj Djena (pictured pg 7 top left)

Health Professional Award – Elaine (Ellie) Newman (pictured pg 7 top right)

Health Consumer Award – Carolyn (Caz) Chisholm (Pictured pg 7 second row)

Health Consumer Award, Highly Commended – Petrina Lawrence

Rosemary Caithness Award – Carolyn (Caz) Chisholm

Rosemary Caithness Award, Highly Commended – Janice (Jan) Thair

Aboriginal/Torres Strait Islander Health Award – Aboriginal Health Liaison Service – Royal Perth Bentley Group (Pictured pg 7 third row, left)

Aboriginal/Torres Strait Islander Health Award, Highly Commended – Boodjari Yorgas Family Care Program – Armadale Health Service

Compassionate Care Award – Fatima Edward (Pictured pg 7 fourth row, right)

More information about the winners is available at: www.hconc.org.au/hceawards

Pictured: Hon. Alanna Clohesy MLC, Team from Moorditji Djena: Renae Hilder, Nicole Bell, Susan Jetta, David Burns-Wallace & Jason Wolf

Pictured: Hon. Alanna Clohesy MLC, Ellie Newman & Jason Wolf

Pictured: Pip Brennan, Hon. Alanna Clohesy MLA, Carolyn Chisholm & Jason Wolf

Pictured: Pip Brennan, Hon. Alanna Clohesy, Carolyn Chisholm & Robyn Nolan

Pictured: Hon. Alanna Clohesy MLA, Aboriginal Health Liaison Service Team: Sacha Andrew, Crystal Clarke & Janita Solvberg

Pictured: Hon. Alanna Clohesy, Fatima Edward & Karen Bradley

Pictured: Dr Bernadette Wright & Jane Harwood

Pictured: Jason Wolf, Dr Aesen Thambiran & Dianne Bianchini

Statewide News

Pip Brennan Executive Director | **HCC**

New State Government

In March 2017 the WA Labor Party was elected to the State Government with these election promises:

1. Introduce a patient feedback mechanism to drive improvements in our health system.

   Specifically, this refers to Patient Opinion, a moderated platform which provides real-time, transparent feedback from patients. Visit: www.patientopinion.org.au.

   The website is nation-wide and has been established for some years by an Australian not for profit organisation, and it mirrors the same website in the UK which has been in place for a decade.

   The Health Consumers' Council has long been a supporter of this platform and is pleased that WA Country Health Service, Child and Adolescent Health Service and East Metropolitan Health Service have already signed up as subscribers. We are looking forward to North and South Metropolitan Health Service joining them. WA Primary Health Alliance has also been an early adopter to facilitate GPs and primary care services accessing this patient feedback mechanism.

2. Conduct a new review of health services to put WA Health on a sustainable footing into the future.

3. Introduce Urgent Care Clinics at major hospitals in the community.

   HCC has requested a meeting with the Minister for Health (but this hasn't happened yet) to continue to explore consumer and the HCC's role in how these initiatives are to be implemented. Stay tuned...

Clinical Senate News, After the Reform...

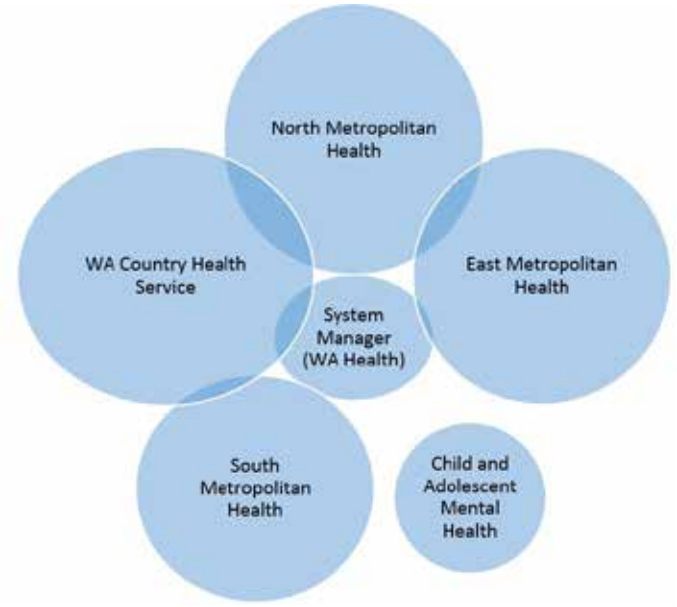
The September 2016 Clinical Senate Debate on Clinician Engagement in the Brave New World of Health Service Boards developed three recommendations, all of which were endorsed:

1. Within 12 months the System Manager (i.e. the Health Department at Royal Street) develops a policy framework on clinician engagement that incorporates:
   - Key Performance Indicators (KPIs) as part of Health Service Performance Reporting.
   - An expectation that Health Service Boards will have a clinical engagement strategy.

   Elements of a clinical engagement strategy should include:
   - Measuring clinical engagement (using the KPI tool in Recommendation 2).
   - Shared values across the system.
   - Common principles.
   - Transparency.
   - Investment in leadership e.g. Institute for Health Leadership programs.

2. Adopt a 'measurable KPI' (using an identical tool across all Health Service Boards) for clinical engagement and include it in safety and quality outputs within Health Service Board agreements, linking the score to a performance bonus/penalty. Results (after an introduction phase of one to two years) must be transparent and published so all internal and external stakeholders can see and compare outcomes across WA Health.

3. That the System Manager, when considering or developing a direction or policy that has operational impacts, ensure a broad range of clinicians from all Health Service Providers are consulted, engaged and recorded.



Pictured: WA Area Health Services

What do you think?

Would you like to have your say on the new Health Service Boards? HCC has developed a short survey to gather your feedback: www.surveymonkey.com/r/HSPBoards WA Health's Review of Safety and Quality

WA Health's Review of Safety and Quality

A Review of Safety and Quality in the WA Health System has been recently commissioned by the WA Director General of Health. The review is to proactively identify areas to improve system-wide arrangements for safety and quality and to make sure the transition to the five new Boards, hasn't impacted patient safety and quality negatively.

The Review is being assisted by Professor Hugo Mascie-Taylor who, among other things, worked on the Mid-Staffs Review of the Stafford Hospital in the UK. It is estimated that between 400 and 1,200 patients died as a result of poor care over the 50 months between January 2005 and March 2009.

Professor Mascie-Taylor has conducted consultations across the WA health system since February. On March 3 a group conversation and discussion with Professor Mascie-Taylor was convened, with very short notice, with invited attendees. The discussion covered:

- The current environment and culture of safety and quality across the system as whole.
- Priorities for safety and quality at a system level which may include topics such as:
    - Patient experience, patient transfer, service planning and consistency.
    - Ways to support a culture of innovation and improvement across the system.

The Review Report is still being finalised and will form part of the next Clinical Senate Debate on Safety and Quality, scheduled for July 2017.

Clinical Senate Debate – Homelessness, Family and Domestic Violence

Interestingly the debates held in November 2016 and in March 2017 have been discussing topics where most of the services are delivered from the not for profit sector rather than from hospitals and health services. Both topics highlight the gap between community and hospital services, and how the presentation of people affected by homelessness or domestic violence (who can sometimes be the same person, domestic violence being a risk factor for homelessness) in our emergency services can be an ongoing sign that services are not meeting needs.

Royal Perth Hospital's Homeless Healthcare strategy has been working effectively across the hospital, primary and not for profit sectors through a partnership approach. The Fifty Lives Fifty Homes project that supports people to be housed is spearheaded by the not for profit organisation RUAH. They are the lead agency of a consortium of more than 40 not for profit agencies working with RPH to support people who present at Emergency Department often because there is nowhere else for them to go. Lead clinician at RPH Amanda Stafford was a stand-out presenter and passionate advocate for her patients.

At this stage, there is no final report for either of the debates. Clinical Senate Recommendations are finding their feet in the new World Order of Health Service Boards too.

Further information can be found on the Health Department's website here: ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia/Clinical-Senate-debates-and-publications

Contact the office if you would like further information or have difficulty accessing a computer.

What is the Clinical Senate?

The Clinical Senate is a forum established in 2003 where collective knowledge on clinical issues can be shared and provided to the Director General and State Health Executive Forum (SHEF). SHEF is a key body, promoting action within WA Health.

The debate involves presentations on the topic of the day, including a consumer presentation, a general discussion of the issues raised, ending with resolutions.

The resolutions from the Clinical Senate Debate are presented to the DG and SHEF for formal adoption and ultimately actioning.

The website notes; "Matters discussed will include the coordination and development of clinical planning; clinical and resource decision making; other relevant clinical issues in health service delivery in Western Australia; and issues of key concern to the Director General".

For more information visit: www.clinicalsenate.health.wa.gov.au/about/index.cfm

National News

Pip Brennan Executive Director | HCC

Choosing Wisely

In May HCC attended a National Meeting for the Choosing Wisely campaign. It was an interesting day of presentations from service providers who are driving system improvements to eliminate the many wasteful, low cost practices throughout our health system. You can view all the presentations here: www.choosingwisely.org.au/members/choosing-wisely-australia-national-meeting-2017

Five Questions to Ask Your Doctor

This simple, effective tool is designed to empower you in your next consultation. It was suggested during the Choosing Wisley National Meeting that the 'five questions to ask your doctor' is included on My Health Record. If it happens, you heard it here first... (See the questions below)

Launch of the Question Builder Tool

The Australian Commission on Safety and Quality in Health Care has partnered with Healthdirect Australia to bring you the Question Builder. A free web-based tool to help you prepare for your next medical appointment will ensure you make the best use of time with your doctor.

The Question Builder helps you create a list of questions to ask your doctor, prepare for the questions your doctor may ask you, and allows you to print out or email the question list so you can bring them to your appointment. It encourages you to ask questions, participate in the appointment and share decisions about your healthcare with your doctor.

You will find the tool at: www.healthdirect.gov.au/question-builder. Additional supporting resources and information about the Question Builder can be found on the Commission's website: www.safetyandquality.gov.au/questionbuilder.

Choosing Wisely Australia
An initiative of NPS MedicineWise

NPS MEDICINEWISE

5 QUESTIONS

TO ASK YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER BEFORE YOU GET ANY TEST, TREATMENT OR PROCEDURE

Some tests, treatments, and procedures provide little benefit. And in some cases, they may even cause harm.

Use the 5 questions to make sure you end up with the right amount of care — not too much and not too little.

1

DO I REALLY NEED THIS TEST OR PROCEDURE? Tests may help you and your doctor or other health care provider determine the problem. Procedures may help to treat it.

2

WHAT ARE THE RISKS? Will there be side effects? What are the chances of getting results that aren't accurate? Could that lead to more testing or another procedure?

3

ARE THERE SIMPLER, SAFER OPTIONS? Sometimes all you need to do is make lifestyle changes, such as eating healthier foods or exercising more.

4

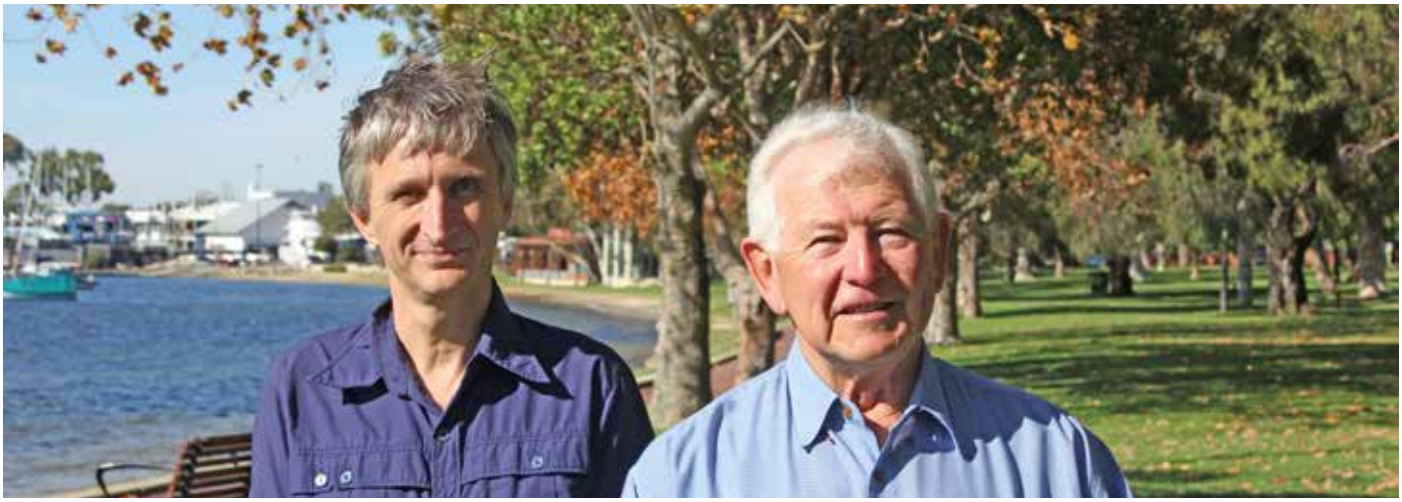
WHAT HAPPENS IF I DON'T DO ANYTHING? Ask if your condition might get worse — or better — if you don't have the test or procedure right away.

5

WHAT ARE THE COSTS? Costs can be financial, emotional or a cost of your time. Where there is a cost to the community, is the cost reasonable or is there a cheaper alternative?

Dental Education in Australia: Stopping the disaster

Winthrop Professor Marc Tennant School of Human Sciences | UWA
Emeritus Professor John McGeachie OAM School of Human Sciences | UWA



Pictured: Marc Tennant & John McGeachie

In the late 1990s we wrote an academic paper* about dental education in Australia and the stresses it faced. Nearly 20 years later it is fantastic to look back at the essence of that original work and how it has impacted on the national agenda for dentistry. We knew the ideas were controversial and were clearly told so at the time. Today, re-reading our paper makes the changes we proposed look relatively "pedestrian".

So, let us cast our mind back to the late 1990s and the genesis of arguably the greatest change in dental education in Australian history. It is fascinating to reflect on how this has advanced the dental health of all Australians for generations to come.

In the 1990s Australia had reached the situation where fewer dentists were being trained than had been the case for decades. It was so expensive to train dentists that universities and governments had cut-back, and were threatening to close-down Schools. Academics in Dental Schools were often considered to be 'has beens', or as undertaking 'less than productive' positions by the practicing profession. Very minimal new blood was attracted to research and development in dentistry; in short dental education and academic dentistry was at a low ebb. Consequently, Australia faced a real workforce crisis in dentistry. At its essence, the problem was a lack of investment, both financial and intellectual, in dental education over decades.
A lack of training led to a lack of dentists. Workforce shortages hit the government safety-net services first and hardest; the poor and marginalised were suffering. Shortages of dentists led to growing waitlists and a real crisis, at first for those in need and then as the crisis deepened, for all Australians.

The real circuit breaker was a two-fold breakthrough:

- A realisation by governments that they were facing a real and present danger of disaster in access to dental care; and
- The development of a new viable model for dental education in Australia.

In retrospect, the model at its core was simple, pedestrian and obvious, but at the time is was regarded by some as 'outrageous'. The model proposed at the time was based upon the principle of dental schools being integral elements of society with a strong focus on an outplacement-based educational model. The main thrust of this reform was its academic staff profile being constituted by a growing number of highly experienced dental practitioners willing to give a proportion of their time (on a sessional basis) to support education, aided a small group of dedicated academics to manage and provide core educational services.

The innovation started here in Western Australia. The closure of the old Perth Dental Hospital and the opening of the Oral Health Centre of Western Australia (OHCWA) was based on the new model of dental education that continues today some 15-20 years later. Western Australia led the way!

The 20th century broken model of dental education was replaced with a 21st century tailored model, which revolutionised the system.

The OHCWA continues through an integrated service, education and research model to provide care at the rate of over 50,000 patient visits per year. At the same time students move around metropolitan clinics (and to the rural regions) to learn about society, and as a bi-product of that learning provide direct, supervised care to patients. Over the 15+years the model has evolved on various pathways but the fundamental underpinning principles remain and have been replicated across the nation.

Western Australia can take great pride as the innovation hub that led to the real rescue of dental education in Australia.

In the 1990s, and for the 50 odd years previously, Australia had just 5 dental schools each based in one of the larger national capitals. These Schools were producing about 200-250 dentists in total each year; a number at the time that was clearly way too low for the Australian population's future needs.

From that initiation of a more community-centric model of dental education in Western Australia, new universities considered it viable to start dental schools. This was extra-ordinarily controversial at the time. Many alumni of the traditional schools saw this as in a very negative perspective: "why not give more money to our old established School". But, what was really missing was the essence of diversity and risk distribution. New schools based in regional Australia and some in rural and remote Australia developed a real focus on the poorest Australians and most needy, and brought a real community focus to dental education.

So, over the first decade of this millennium we saw new schools start in Queensland, New South Wales and Victoria. A total of four new schools; an enormous capital investment by governments and universities (hundreds of millions of dollars). All were of the 'open walls model' where community placements and clinics based in needy areas provided a mix of education, service and research. This was direct investment in rural and remote Australia that rested on two important factors. It is well-established fact that students trained in rural areas are more likely to return to work in rural areas; and people of rural origin are more likely to work in rural areas after training. Fifteen years later, this has been proven to be effective in Australian dentistry.

The essence of modern dental education in Australia is rooted in three fundamental domains: a sound clinical training program; programs based on a strong science background; and coupling these with a social responsibility element. Achieving the balance between these domains is challenging to achieve, but ongoing efforts of Schools to adjust the balance as society expectations and educational imperatives change is vital to our future. The differences across the nine schools in the balance between these domains are a highlight of the diversity that was a core of the original push to grow School numbers.

We have now increased dental graduate numbers to around 500-550 per year. A number that places Australia on a more sustainable foundation for the future as the country continues to grow and the population ages.

The 'traditional schools' have followed in the footsteps of the new 21st century 'open-wall' model. It remains a slow and painful journey. For many, these journeys are not over yet but it is happening. Dental students spend a good deal of their time based in communities-in-need, providing care (as a bi-product of best-practice learning). Student experience diversity and learning from a wide variety of community experiences; this is way beyond the traditional model of 20th Century dental education.

What is going to be the focus of the next decade of dental education?

In Australia, dental education must come to grips with an ageing academic staff. That period through the 1980s and 90s saw few new academics start careers in the field. I remember the animosity shown towards the idea of becoming an academic in dentistry: - "you ain't a real dentist - only wet-fingered dentists can run dental schools." Derogatory and discouraging comments like that were common in that period.

So now we reap the reward of that 'gap'. To train a high level academic takes decades. To remedy this issue is going to take years-and-years, and in the interim we are going to have shortages of suitably trained academics in dental schools. The important outcome of the greater diversity in dental schools is we have doubled academic opportunities so positions now exist and we already see a flow of academics between schools. Life is brighter for academics in dentistry today than in the last 20 years.

The second big issue that dental education faces in Australia for the next decade is dispelling the old ways of education. Education, especially at the university level, has progressed from the oppressive days of old. Modern education is about building strong staff-student relations and fostering positive learning environments. This is going to be a tough course for dental education to face, but it must! The level of

educational dissatisfaction, as measured by asking students/graduates (e.g. the Good Universities Guide Survey) is substantial in parts of dental education in Australia. We must address this as a matter of urgency. Positive student experience is a vital part of growing a positive next generation of dentists who will support and grow their relationships with schools and give back their expertise to their school. Australia needs its dental graduates to be positively disposed to education. The ways of old must finish.

To conclude, Western Australia can be proud of its place in moving dental education into the 21st Century in Australia. A number of people took great risk and paid very heavy prices to drive innovation and reform. The rest of Australia watched, learned and grew from the base formed in Western Australia. We have built a tremendous foundation for the future security of our population giving access to good dental care. Many challenges remain in the service side of dentistry, in this State, nationally and internationally; which is for later discussion, but we can be proud, and thankful, that local effort, innovation and action saved WA dental education from falling off the cliff.

* Marc Tennant John K. McGeachie Australian dental schools: Moving towards the 21st century. Australian Dental Journal 1999:44;238-242.

Prevention better than drill & fill at the dentists

Frank Smith | Health Matters Contributor

Drilling and filling will become largely obsolete if recent research findings from the University of Sydney are widely adopted. "It's unnecessary for patients to have fillings because they're not required in many cases of dental decay," said Associate Professor Wendell Evans. "Dental practise in Australia needs to change.

"This research signals the need for a major shift in the way tooth decay is managed by dentists. Our study shows that a preventative approach has major benefits compared to current practice.

"For a long time it was believed that tooth decay was a rapidly progressive phenomenon and the best way to manage it was to identify early decay and remove it immediately in order to prevent a tooth surface from breaking up into cavities. After removing the decay, the affected tooth is then restored with a filling material - this process is sometimes referred to as 'drilling and filling."

"However, 50 years of research studies have shown that decay is not always progressive and develops more slowly than was previously believed. For example, it takes an average of four to eight years for decay to progress from the tooth's outer layer (enamel) to the inner layer (dentine)."

"That is plenty of time for the decay to be detected and treated before it becomes a cavity and requires a filling." The study found that the need for fillings could be reduced by 30%-50% through preventative oral care.

Professor Wendell Evans and his team have developed the Caries Management System (CMS) – a set of protocols which cover the assessment of decay risk, the interpretation of dental X-rays and specific treatment of early decay (decay that is not yet a cavity).

Under the protocol dentists apply a high concentration fluoride varnish to the sites of early decay. Patients are taught better at-home brushing skills and not to snack or consume sugar-loaded drinks between meals. Dentists are taught to monitor signs of decay and assess the risk of caries developing.

"The CMS was first tested on high risk patients at Westmead Hospital with great success," said Professor Evans. "It showed that early decay could be stopped and reversed and that the need for drilling and filling was reduced dramatically. "A tooth should only be drilled and filled where an actual hole-in-the-tooth (cavity) is already evident," he said.

The CMS treatment was then tested in general dental practices in New South Wales and the Australian Capital Territory. After seven years, decay risk was substantially reduced among the CMS patients and their need for fillings was reduced by 30 to 50 per cent compared to the control group.

"The reduced decay risk and reduced need for fillings was understandably welcomed by patients," Professor Evans said. "However, patients play an important role in their treatment. This treatment will need a partnership between dentists and patients to be most successful."

The results of the study, were published in *Community Dentistry and Oral Epidemiology.*

Diabetes & Oral Health

Office of the Chief Dental Officer

Diabetes is Australia's fastest growing chronic disease. Approximately 280 Australians develop the condition every day. In Western Australia, more than 112,000 people have been diagnosed with diabetes and for every person diagnosed, it is estimated that there is another person who is unaware they have the disease.

People living with diabetes are usually aware that the condition can affect their whole body including the eyes, nerves, kidneys, heart and other important body systems. But many may not know that diabetes can also cause complications in the mouth. Knowledge of which oral diseases can develop and how to minimise or even prevent them is an important first step.

Why do people with diabetes have a higher risk of oral disease?

Oral disease in people with diabetes may occur due to one or more factors including poor blood glucose control, poor circulation (which reduces the body's ability to heal) and certain medications. Smoking, sweet food and drinks will also increase the likelihood and severity of oral disease.

What are oral diseases?

People with diabetes, regardless of age, are prone to several oral diseases including tooth decay, fungal infections and gum disease (gingivitis and periodontal disease). In addition, people may also experience slow healing after extractions or oral surgery due to the thickening of blood vessels, which delays the delivery of nutrients to tissues caused by diabetes.

Tooth decay

People with diabetes can also experience reduced saliva flow resulting in a dry mouth. A dry mouth encourages dental plaque to form on teeth which may lead to tooth decay. Untreated tooth decay can lead to toothache; tooth nerve infections, abscesses and possible tooth removal.

Fungal infections

Diabetes lowers the body's resistance to infection, with people more likely to experience oral infections including fungal infections such as thrush. Oral thrush grows on the soft tissues within the mouth and may present as white bumps on the tongue, inner cheeks, tonsils and/or gums, along with redness and cracks at the corners of the mouth. Oral thrush may also cause difficulty in swallowing and may cause people to choose foods that are easier to eat, which may not be suitable for their diabetes.

Gum disease

Gum disease is caused by bacteria which produce toxins and create gum inflammation. Mild gum disease (gingivitis) may result in inflamed and/or bleeding gums and bad breath; while moderate to advanced gum disease (periodontal disease) may result in the presence of pus from the gums or loose teeth. People with diabetes may also feel changes in their bite or notice spaces developing between their teeth, sometimes encouraging food to stick between teeth. Most Australians will experience some level of gum disease, however it is usually more pronounced in people with diabetes.

Why is the management of gum disease especially important for people with diabetes?

Over the past 10 years, research has been conducted on the link between diabetes and periodontal disease. People with diabetes are 3-4 times more likely to develop periodontal disease.

The management of periodontal disease is extremely important for people with diabetes as research suggests the relationship between periodontal disease and diabetes is two-way. Not only are people with diabetes more susceptible to periodontal disease, it also has the potential to affect blood glucose control and contribute to the progression of diabetes.

How can you improve your oral health and help prevent oral diseases?

Oral disease can be prevented with a few healthy habits.

Oral Hygiene

- Brush your teeth twice daily with fluoridated toothpaste and a soft brush, removing all plaque on and between your teeth and at the gum line. Gently brush your tongue daily to remove bacteria to keep your mouth fresh and healthy.
- Use dental floss or interdental cleaners daily to clean plaque from between your teeth.
- People with dentures (full or partial) should remove them overnight and clean them daily.
- Avoid a dry mouth by drinking plenty of fluoridated tap water and chewing sugar-free

gum to stimulate saliva production.
- It is important to brush your teeth 30 minutes after eating sugary foods . If you can't brush at that time, chew sugar-free gum to help stimulate saliva.
- Visit your oral health professional regularly even if you wear dentures and book appointments for mornings when insulin levels are more stable.

Diabetes management
- Keep blood glucose levels within target.
- Take all medications prescribed by your family GP.

Overall health
- Quit smoking. Smokers with diabetes have an even greater chance of having severe gum problems than non-smokers and non-diabetics.
- Follow a healthy diet.

Where to get help
Oral health
- Your dentist or oral health professional.
- For your nearest private dentist, visit www.ada.org.au/Find-a-Dentist
- For your nearest public dentist, if you have a health care or pensioner concession card or if your child is aged 5 – 17 years visit www.dental.wa.gov.au/ or (08) 9313 0555

Diabetes management
- Your family GP
- Diabetes educator
- Diabetes Information and Advice Line (DIAL) 1300 136 588

Quitting smoking
- Quitline 13 7848
- "My QuitBuddy": Free personalised quit smoking app

Dietary advice
- See an accredited dietitian for dietary advice. For more information visit www.nutritionaustralia.org/wa

CCE: Oral health & people from refugee backgrounds living in WA

Louise Ford Consumer & Community Engagement Manger | HCC

Image Source: Borderless Dentists (http://www.borderlessdentists.org/background.html)

'Oral health', what does it mean when you? It is terminology like this that can impact on people from refugee backgrounds when accessing oral healthcare. A good start when working with people from refugee backgrounds, (particularly those who have arrived in the last five years) would be to make sure the term 'oral health' is explained in a way they can understand. So, they know it's not only about teeth, but also the health of their gums and mouth, and why those things are important for dental and oral health.

'Those who heal are right: One day in the refugee camp Melkadida' by Johannes Kortmann, provides some background on a day in the life of a coordinator in a remote refugee camp in Ethiopia. It also reveals a dentist may be seen as, 'someone who extracts teeth', so the notion of 'oral health' is probably not a familiar one. This reinforces the need to explain the concept to people who may not be familar with the western system. Dental health services vary greatly from one part of the world to another and it can be useful to ask patients what services they are familiar with. This will assist in establishing their understanding and experience of dental care and oral health.

It is heartening to see research focusing on oral health and refugee communities is being undertaken by the UWA Dental School. Their 'Oral Health Inequalities' Research Program:

> *'is to undertake mixed methods of research to provide high quality evidence which will assist in improving services, outcomes and reduce oral health inequalities. This work centres around the use of epidemiological approaches that are largely new or unexplored in dental research – it has become evident in this research that high quality epidemiological research requires understanding of existing evidence, understanding variables and contexts, and translating research.' (Slack-Smith*

n.d.).

Another body of work, also undertaken by the UWA Dental School is the 'Informing a culturally appropriate approach to oral health and dental care for pre-school refugee children: a community participatory study'. I strongly encourage those with an interest in oral health and general health to read the publication in its entirety. It brings community and individual perspectives and experiences to the fore and highlights the need for cultural awareness and community consultation in the work we do. The Journal Article concludes:

> *'The participatory approach of this study has enabled a comprehensive description of the issues involved in the current failure to provide adequate dental/oral health for a cohort of preschool children that suffer high morbidity and are particularly vulnerable. The involvement of refugees themselves, as well as health care professionals provides a basis of cross-cultural understanding and hence an opportunity for all the groups to work together for the future of these vulnerable children. Action now will prevent increasing oral health problems in the future, and consequently long term saving of scarce resources will occur.*
>
> *Change is already occurring with the inclusion of a dental professional in the Western Australian health care screening team for refugees. In addition, options for improved delivery of dental treatment for this group are being explored which will be inclusive of dental students; thus providing awareness of refugee issues to the next generation of dental practitioners.*
>
> *Nationally, resourcing at government level and broad "higher level" issues are being addressed through recommendations to the development of the next Oral Health Plan for Australia. These issues, however, will remain challenging.' (Nicol,P, et. Al 2014)*

It is very refreshing (not to mention exciting!) to see local content in the area of research around health and healthcare, particularly for this potentially vulnerable group. I encourage readers to have a look at the references below to gain further knowledge and understanding on the topic.

In closing I would like to mention 'Fact Sheet 11 The Oral Health of Refugees – for dental professionals' produced by the NSW Refugee Health Service (see references below). I have mentioned this because the Fact Sheet contains useful and relevant information, including why some individuals who arrived as refugees may have lower rates of oral health than

Image Source: Children watch military dentists provide care in Puerto Barrios (https://commons.wikimedia.org)

many mainstream Australians as well as things to be aware of if you are a practitioner.

Some reasons are painful even to think about. However, they have been a reality for members of our community and from a healthcare perspective it is important to be aware of them. Remember that people from refugee backgrounds who are accessing oral health services may have been subject to torture including tooth extractions, beatings to the face and head, and electric shock treatment to the mouth. The implication of this, apart from physical damage and injury, is ongoing Post Traumatic Stress Disorder (PTSD) and a great fear of having dental treatment. Recognising these factors is useful and relevant and will assist with developing strategies that support people with such experiences to begin to improve their oral health condition.

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Dentistry from an international perspective

Leila Zandi Dentist

Australia as a country of immigration, annually hosts many immigrants and refugees from different backgrounds. In order to achieve long-term health goals, it is important to have the right policy for providing education on preventive methods and treatment of these groups.

While a lot of immigrants, especially skilled workers come from the average level of their society and have acceptable knowledge of health issues, others are from a vast spectrum of social classes. Their understanding of the importance of oral health is very limited. Despite developing countries' recent efforts to improve oral heath, there are still deficiencies in people's awareness of dental healthcare significance. For example, oral hygiene (brushing and using dental floss) which is taken for granted in Australia as a regular habit, is far ahead of the world's dental health standards. Moreover, the significance of simple dental treatments to prevent later complicated issues is still ignored. A lot of parents are not aware of the importance of keeping baby teeth as they have a critical role in children's future dental health.

Besides, dentistry as an expensive treatment is not insured in many developing countries. However good steps have been taken recently to promote oral health. For example, in my country, Iran, a lot of health centres have been established in rural areas to provide preventive education and dental treatment but the services are very basic, so people are referred to the private sector where they must pay for dental treatment and a lot of them can't afford it. As a result, people try to postpone their dentist visits as much as possible.

Furthermore, nutrition knowledge as an important factor in oral health is basic in developing countries and sugar consumption is much higher in those areas. Also, nutritional behaviour usually is affected during immigrants and refugees' resettlement in the new society. This issue in addition to neglecting oral hygiene can lead to higher occurrence of dental cavities and gum diseases among immigrants. Therefore, one of the most effective ways to have a better perspective is to identify immigrant's knowledge and attitude to oral care and preventive health procedures. This can be done through research and surveys on their arrival, or when registering for health services. Limitations can then be effectively targeted by distribution of related pamphlets and brochures.

Another big issue is a lot of immigrants are not aware of Australian regulations and rules regarding health consumer's rights such as access to healthcare and being treated with respect. This may not be normal in their countries, and as a resident of Australia, they should be informed of the 'Australian Charter of Healthcare Rights' to avoid discrimination happening or the repeating of it.

Immigrants and their children are important to the future Australian society. Their oral health as an aspect of general wellbeing is critical for having a healthy population in future as well as saving Australian health resources. In my opinion as a dentist who has seen both environments, informing immigrants and refugees about available dental health facilities and providing educational information and workshops are very helpful ways to improve their oral and dental health and knowledge of their healthcare rights.

Leila is a Dentist and recent immigrant to Australia. Originally from Iran she is currently undertaking her training certificates so she can practice in Australia. Leila contacted the HCC because she is passionate about patient-centred care and wanted to give back to the community. She has volunteered for HCC at events and supported the Marketing Communications Coordinator.

Oral health, the community & the Fairy Croc Father

Linda Slack-Smith Oral Health Inequities Research Group | UWA

Pictured: Fairy Croc Father Rethink your drink Poster

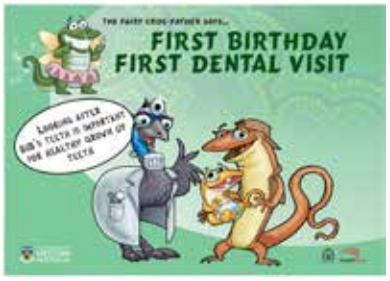
Oral health is an essential part of overall health for people across their lifespan and it is often those who are most marginalised that miss out on dental care and have poor oral health outcomes. There are poorer outcomes in Aboriginal children and families, refugee children, people having mental health issues, the disabled and the aged. All too often poor and disadvantaged do not attend dental care when they are in pain – thus requiring more extensive treatment or losing teeth. We often say "dental disease is almost entirely preventable" yet the problems remain significant in our community. So what is wrong??

We often talk about engaging consumers in research but "wicked or intractable" problems such as poor oral health require even more than consumer input; they require partnerships across sectors and stakeholders and reciprocity. Reciprocity in oral health research is about health providers – policy makers, practitioners and researchers - learning from the consumers (and the non-consumers of dental services!!) about what works and what doesn't and being able to translate research findings into providing better care for the community. The more we can conduct research in multidisciplinary teams engaging all stakeholders the more we can learn from each other and the richer and more useful our research can be.

The Oral Health Inequities Research Group have undertaken a number of studies investigating perceptions about oral health in particular community groups including health professionals and those who care for children and older relatives. While we have learnt that many people just desperately need some basic dental care we have also heard how the lack of regular care leads to pain and poor outcomes.

In one example we worked with African communities linking with those working in aged care to understand their perspective on oral health (Culturally and Linguistically Diverse (CALD) Carers' Perceptions of Oral Care in Residential Aged Care Settings in Perth, Western Australia, www.ncbi.nlm.nih.gov/pubmed/26763582). Despite many of those we interviewed having significant education we found that many carers had little information on the dental system and did not receive regular care themselves – making it difficult to advise families on dental care for their older family members.

In another series of studies we investigated perceptions of oral health of children and adults in the Aboriginal Community. This provided significant insight and will be useful in designing services and models of care and has already assisted in developing policy. While undertaking interviews we realised that community members really wanted more resources about oral health. Working with the Aboriginal Health Team at South Metro Health Service and with support from Healthway, we developed some posters with oral health messages inspired by posters dental students produce as part of their course. We developed a character called the Fairy Croc Father, toothbrush, tutu and all!!



So how do we beat this "intractable wicked" problem?? We have to decide whether good oral health is a luxury or a right and find a way to fund it appropriately. We need to avoid focusing on blame and look at broader ways we can make changes. Better canteen food and preventive dental care would assist. Translating the evidence we have about oral health is also critically important and this sharing of evidence is often poor.

I want to acknowledge all of those who participate or assist our research and those in my team – past and present who have contributed to our research and its translation.

Dental Health Services in WA

WA Dental Health Service

Pictured: Interior of New Mobile DTC

Funded by the State Government, Dental Health Services (DHS) is the largest public dental health service provider in Western Australia. Our Vision is to improve the health of Western Australians through access to quality oral health services.

Access to oral health services is important as it has long been recognised that oral health plays a vital role in general health and well-being. There is a growing body of evidence linking poor oral health with a range of chronic diseases, such as diabetes and respiratory illnesses.

DHS provides oral health services to the public of Western Australia by the following:

School Dental Service

Since 1973 the School Dental Service has provided free general dental care to Western Australia's school children. Using a combination of fixed and mobile dental clinics, a dedicated team of dental practitioners deliver services throughout the State to ensure our 5-16 year olds receive the care they need.

It is essential that children attend our Service in the early years so we can teach children the importance of looking after their teeth and gums every day, and instil lifelong positive habits.

Mobile clinics travel to remote locations

The SDS is upgrading its fleet of mobile DTCs and has received positive feedback from consumers.
The School Dental Service has 28 mobile units that travel to Western Australia's most remote locations to service school children. Children love coming to see our dental staff in the mobile units. They ask lots of questions and are curious about the equipment – it's a fun adventure for them.

Although the service provides children with free dental care, the emphasis is on prevention and oral health promotion.

DHS has a range of age appropriate materials designed to teach children about good oral hygiene and the hidden dangers and damage sweet snacks can do to growing teeth.

Pictured: New Mobile DTC

Pictured: Student receiving oral hygiene instructions

One of the most important contributors to good oral health is the addition of fluoride to the State's drinking water. Current research indicates that in the 50 years Western Australia has had fluoridated water, the probability of a 12 year old having one or more decayed, missing or filled permanent teeth has reduced by 82 per cent.

Since the inception of the School Dental Service the oral health outcomes of enrolled children as measured by caries (decay) experience has improved exponentially. In 1977, a 12 year old child enrolled in the School Dental Service had on average 4 decayed, missing or filled teeth. This has reduced to 0.6 in 2016.

Each dental therapy centre is staffed by Dental Therapists, Dental Clinic Assistants and a visiting Dental Officer. Students are provided with an initial course of care during the first year of enrolment in the school dental program. Depending on their clinical needs, students are then placed on a recall waiting list to undergo periodic examinations. In 2015-16, 364,801 students were enrolled in the school dental program, with over 163,591 receiving care through 280,604 occasions of service. For further information about the school dental program call 9313 0555 during office hours or visit www.dental.wa.gov.au/.

General Dental Service

General Dental Clinics operate throughout the metropolitan area and in rural and remote Western Australia, providing subsidised general and emergency dental care for financially and geographically disadvantaged Western Australians aged 17 plus who hold a current Health Care or Pension Concession card. Children aged between 0 and 4 years whose name appears on their parent's Health Care or Pension Concession Card, are also eligible to attend a general dental clinic for care.

There are over 30 General Dental Clinics ranging from large clinics in the metropolitan area to one chair clinics in remote locations providing emergency and general dental care to eligible patients. Staff in remote locations also provide outreach services to Communities in the Pilbara, Kimberley and Goldfields.

In 2015/16 74,000 adults received care at a general dental clinic through 142,206 occasions of service.

National Partnership Agreement on reducing Public Dental Waitlists

Since 2013, DHS has been the leading service provider in a Commonwealth government funded program to reduce the number of adult patients waiting for dental services on public waitlists. The program has been extremely successful in delivering dental services to thousands of extra patients.

Dental Care for Special Groups

DHS also provides care for people with special dental needs including:

- Aged care facilities – visiting program to screen consenting residents;
- Prisoners in metropolitan and major rural Department of Corrective Services facilities mainly in prison based clinics;
- Eligible Disability Services Commission clients;
- Medically compromised general dental care to eligible patients in Royal Perth and Graylands Hospitals.

Pictured: Dentists chair

Teeth & gums misunderstood & forgotten in residential care

Frank Smith | Health Matters Contributor

Image Source: Stock Photos

Clive Rogers, The Visiting Dentist, is saddened by the continued poor quality daily dental care provided by many residential care facilities.

He gave the example of one person who developed a disability, which prevented him from managing his own care:

"He thought that his teeth, which he had maintained fairly well, and had spent thousands of dollars on, would be maintained and cared for him after he became unable to care for himself.

"He was wrong. His 'teeth for life' actually became 'teeth for pain' and 'teeth for infection'."

"Generally resident's teeth and gums are not cleaned at all, nor is their tooth decay controlled," he said.

In care facilities people don't control their own diet. "A high frequency sugar diet is the main problem with tooth decay. There is a constant stream of things going in the mouth: sugared tea, sugared breakfast, sugared medication, then sugared cakes and biscuits. Constant sugar in the mouth is converted by bacteria into acid that eats into teeth. Eventually the teeth decay down to the gums."

He said every person entering residential care in Australia has a high risk of developing poor oral health. Even dentists and residential facility directors who become old and disabled are not immune to this threat.

He is concerned by the lack of oral health education of the public in general and for residents in care.

There is one simple question which shows the huge lack of understanding about preventing tooth decay and gum diseases. Should people put the fluoride containing toothpaste on the toothbrush before or after cleaning their teeth and gums? The surprising but correct answer is after.

"Put fluoride toothpaste on the brush after you have cleaned your teeth and gums. Then coat the teeth with topical fluoride. You only need a tiny amount. And don't wash it out by rinsing, just spit, spit, spit."

"Daily tooth brushing (really gum-brushing) is about stopping gum disease not stopping tooth decay."

He said dentists need to prepare patients for the future, for time spent in care when they cannot look after their own teeth.

Even people with dentures need to prepare in case they need to enter residential care.

"If you wear dentures get them permanently name-labelled. If you go into a hospital or nursing home there is a high chance that they will be lost. Then it is like solving a jigsaw puzzle sorting out whose is whose," he said. "A dental technician should be able to label most dentures for around $25 - $40."

"It is also a good idea to duplicate your dentures if they are fitting well as an insurance policy. It is much cheaper than having to pay for a new set when they are lost."

"We need to change the residential health care system from the top down. It all comes down to education. We must educate facility directors, nurses and right down to carers. Training carers alone is made difficult, because of lack of support from above, and high staff turnover.

Mr Rogers says much of the oral and dental pain and suffering in residential care could be avoided if proper attention was paid to residents' daily oral hygiene, and decay prevention care.

"This starts with real education and training," he said.

Peter's long trip to the Dentist

Fiona Panagoulias | HCC Consumer Contibutor

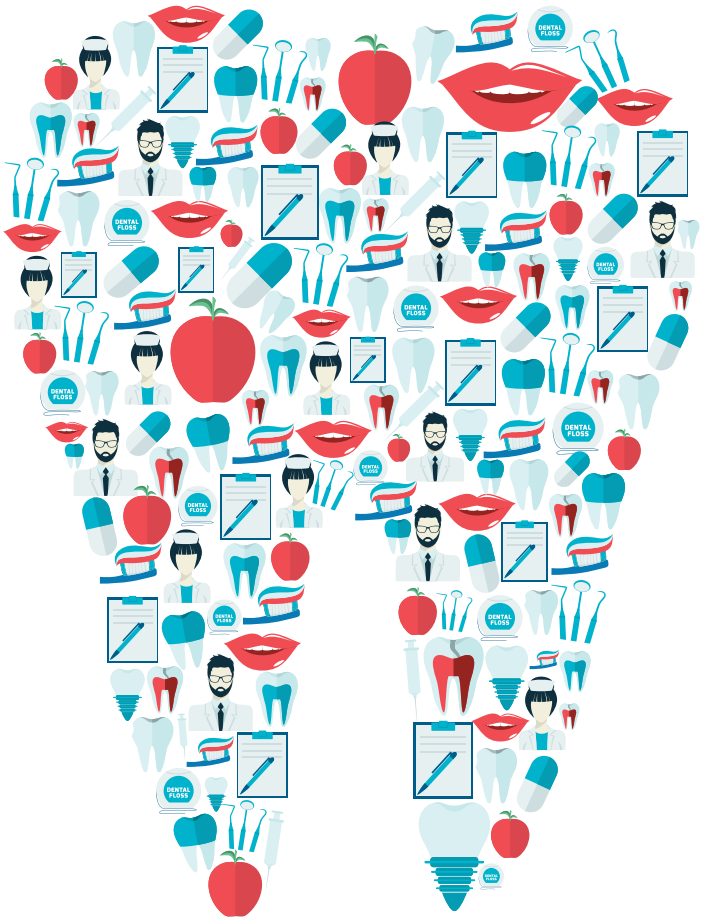


Image Source: depositphotos

Peter needs to see a dentist

The last time I was at the dentist with my husband, Peter, in 2009, I witnessed him trying to bite the Dentist's hand. You may think that sounds unbelievable but if you knew Peter you would know that it is entirely possible. Since Peter acquired his brain injury nine years ago, I have witnessed more unbelievable things than I would ever have wanted to. Peter is not a bad person or even a badly behaved person (well sometimes he can be) but he is a person with an Acquired Brain Injury (ABI). Where do you draw the line between the brain injury and the bad behaviour? It is a question we (his Support Team) are constantly asking. Nevertheless, regardless of his behavioural issues he still requires dental treatment and over a year ago it was time to tackle the issue. There had been some reports when he went out with his Support Workers into the community that his breath smelt, which was impacting on his ability to socialise. To resolve the halitosis, his Residential Care Facility (RCF) felt that his dental needs needed to be addressed.

Peter has complex health issues – his barrier to accessing services

Peter has been seeing a dentist for a couple of years but due to Peter's behavioural issues the Dentist has not been able to complete any treatment. He needs two fillings, a scale and polish but all attempts to accomplish these tasks have been, to be blunt, a waste of time. After the biting incident, the Dentist's advice was that any treatment other than an exam will need to be carried out under anaesthetic. This advice was also provided by another Dentist in December 2015 when Peter attended an appointment whilst visiting family in Melbourne who confirmed that he needed to be sedated for treatment to occur.

Not such a big deal you might think, but it is for Peter. Going under an anaesthetic is a big deal as the drugs the Anaesthetists use have only ever been tested on 'well' people, or should I say 'people who do not have a brain injury'. Anaesthetists know that once a person has a brain injury, the way they respond to the anaesthetic drugs can be unpredictable. Peter

also has diabetes insipidus, a rare form of diabetes caused by a deficiency of the pituitary hormone vasopressin, which regulates kidney function. Before his brain injury he was able to monitor this condition independently but now he requires his Support Team to monitor it on his behalf. This requires his fluid intake to be measured every day according to his Endocrinologist's protocol and together with his blood tests, adjustments are made to his fluid intake and/or medication as required. If he has anaesthetic, he needs to fast and then if he took a long time to wake up post operatively, there may not be enough hours left in the day for him to be able to physically consume the required amount of fluid. If this was the case, his Medical Team would need to intervene and give him fluid via a drip. From past experience this is quite a tricky thing for them to do and he has required emergency transfer to the nearest ICU facility.

He has a couple of other issues too but I think you get the picture. The bottom line is he is defined as being a 'high risk patient with complex medical needs'. This seems to mean that he is put in the "too hard" basket and falls through the gaps within the current public and private dental systems.

The journey we have been on – systems issues galore. Back to the 'Peter needs two fillings and a scale and polish' story. Even though Peter resides in a Residential Care Facility (RCF) there is no mechanism for them to arrange his required dental treatment, they can only direct me on what to do. In June 2015, I was given a form from the Oral Health Centre WA (OCWA). I phoned OCWA and I was told they would make an appointment for him to see one of their dentists who is 'very good with people like Peter' but I need to complete the paperwork first. I complete all the necessary paperwork and I made sure to write on the form that Peter has an Acquired Brain Injury. In June 2015, I took the paperwork to OCWA and personally handed it in. About a month later, I received a letter letting me know that Peter is on the wait list. In a little over four months, I received a call from OCWA offering him an appointment in early December 2015 which I accepted. The woman on the phone appeared to be having a bad day and a few minutes later she called me back and said that she did not realise that Peter had an ABI (even though it was clearly marked on the form) and as such, he cannot attend the Centre. The appointment was cancelled and I was not offered another avenue to follow. I approached Peter's RCF for help. The Social Worker contacted OCWA, who stated they cannot help her and referred her to Disability Services. She called the Special Needs Clinic in North Perth and explained to them that he needed to be seen on site at SCGH but they weren't able to assist. She then rang the Domiciliary Dental Service, which is a service that comes out to the RCF, explained to them the issues: that Peter will most likely refuse to open his mouth for the dentist; that he will need to be sedated; that sedation could cause major medical issues; and for these reasons that any dental treatment would need to be done at SCGH. The Domiciliary Service said that they can refer Peter directly into the surgical clinic at SCGH and in March 2016, Peter was registered with the Domiciliary Service.

In February 2016 Peter attended an appointment at SCGH Endocrinology Unit and given Peter's issues with his diabetes insipidus, we discussed with his Endocrinologist the possibility of him having dental treatment at SCGH and her availability to monitor him during the dental process. His Endocrinologist was unclear whether or not she was able to have any input to the process but she advised that she would look into it. I followed up with an email to her in April 2016 but I did not hear back.

In July 2016 I was offered help from a Wellbeing Advocate to support Peter and myself and as the dental appointments had not yet been confirmed, she started making enquiries on our behalf. To find the best option for Peter, she contacted the General Manager of the Oral Health Centre WA (OCWA); the CEO of the Australian Dental Association (WA); the Director of WA Dental Health Services; Peter's treating Dentist; his Endocrinologist, the Day Surgery where Peter's Dentist might undertake work under an anaesthetic, the Anaesthetist and his Residential Care Facility.

Public or Private?

There were two distinct routes outlined by these health providers – the private route vs the public route. The advice the Wellbeing Advocate received was that it might be faster to go via the private route as Peter has private insurance. This did not guarantee him treatment, as he still need approval from both his Endocrinologist and the Anaesthetist to proceed. Both Specialists needed to assess his suitability to be seen at a private hospital without an ICU because he could be in a position where he has an adverse reaction to the anaesthetic or slow recovery time after the anaesthetic and he would need to be transferred via ambulance to an ICU at a public hospital to obtain the level of care he requires. Given the risk to his life, emergency transfer between facilities is obviously not an option we would choose. To investigate whether or not treatment in a private hospital would be an option, Peter and I attended at the Anaesthetist's rooms in September 2016. Unfortunately, the Anaesthetist felt that Peter has "a reasonably significant risk of requiring transfer", based on his history of delayed wakeup following anaesthesia, his surgical and medical history, and

Pictured: Oral Health Centre WA

the fact that independent of an anaesthetic he occasionally requires emergency transfer to SCGH's ICU for management of hypothermia and/or electrolyte disturbances.

With the private option not being available to Peter, we were left with the public options to explore:

1. Oral Health Centre WA. This service had previously advised that it does not currently have the capacity to treat Peter as they do not have a Special Needs Dentist. They are employing a Special Needs Dentist, who will work two days a week and should start in early 2017. He would need to get back on their waiting list, which would mean waiting 18 months or more.
2. Special Needs Clinic, North Perth. The Wellbeing Advocate had been previously advised that the Clinic had recently gained access to some theatre sessions in the Midland St John of God Hospital, which might be an option for Peter.
3. Royal Perth Dental Clinic. The WA Oral Health Director had previously advised that the Royal Perth Dental Clinic can do dental work under a general anaesthetic.

In early October 2016, I called the North Perth Clinic and I was again told that they only deal with Intellectual Disabilities and not ABIs. I was told that people with ABIs fall through the cracks, as do people with Cerebral Palsy and Low Level Autism. I was advised to call their Head Office. I called the Head Office and was put through to the Director. He listened to me and joined the dots to the conversation he had had previously with the Wellbeing Advocate, asked whether Peter had been a previous patient at RPH and because he had, he said that he could possibly be seen at the RPH Clinic. He asked me to email him some details and he forwarded those to the RPH Dental Clinic.

The Director's action resulted in a call from the Dentist at RPH who after some discussion felt that Peter would meet her criteria for patients. There are only a couple of sessions a week and there is quite a long list ahead of him but we will get there eventually. Peter needs a referral from his doctor, which we are in the process of obtaining. We are also trying to get a copy of his x-ray taken by the dentist in Melbourne, which will inform the dental treatment in Perth and avoid another X-ray appointment for Peter, which could cause him distress.

In mid-October 2016, I saw the Domiciliary Dentist at Peter's RCF and I asked her if she had Peter's name on her list, but he wasn't. I explained that we are in the process of trying to get him into the clinic at RPH. They were very understanding and said they would follow up with the RPH dentist and see if they could get him on the list for next time they are at Peter's RCF, even if it is just to have a quick look so that they could let the RPH dentist know what to expect.

Image Source: depositphotos

Still waiting

And here we are in October 2016 and still no dental treatment for Peter, but we are on the right list now, well we think so anyway! At this point it would be remiss of me not to mention the time wasted for all people involved, remembering Peter is only one person.

In the event of none of the above results in dental treatment for Peter, there are a number of systemic advocacy and complaint options to pursue. In the meantime, Peter still requires dental care, he still has halitosis and it is still impacting on his day to day life.

Possible Solutions:

- Automatic referral to the Special Dental Service once a person is diagnosed with an ABI.
- A system in the WA Dental Health patient records for flagging a person with complex health needs
- Collaborative approach between all the Special Needs Dentists in WA to manage patients with complex health needs

Advocacy: What matters to you? Peter's Story

Carly Parry Senior Advocate | HCC

Image Source: Stockphotos

12 months ago, Peter started experiencing tooth ache and sought treatment from a dentist. He was advised he required a dental plate and some tooth extractions.

During treatment, the dentist caused severe damage to Peter's jaw and gums. In addition, the dentist cut through Peter's sinus sack which resulted in sinus fluid leaking into his mouth and lungs, leading to illness and multiple infections.

He was left with a hole in the roof of his mouth and the dentist charged Peter for the extractions!

As the primary carer for his disabled adult daughter Peter found himself unable to manage, his wife was forced to leave her job as a tenancy advocate to take over the carer role.

During one visit to the dentist, the receptionist discreetly passed Peter the number for the Dental Cases Panel (DCP). Peter had previously been unaware of the panel but was soon overjoyed to realise they could help.

Peter sought the advice of the panel who agreed to carry out a remedial attempt.

Peter has so far undergone two highly invasive surgeries which have included treatment to stop the sinus flow and a graft from his palate to close the hole left from the botch job.

Peter said "if the receptionist hadn't signposted me to the DCP then I would've been none the wiser and incurred massive expense in a bid to fix the mess."

Peter also accessed our Advocacy Service. If you need assistance call (08) 9221 3422 and ask to speak to an Advocate.

The Dental Case Panel

The Dental Cases Panel (DCP), is a standalone body designed to investigate complaints from patients where they feel they have not had a good outcome from dental treatment. The DCP is not part of the Dental Association (ADA) and is not directed in any way by the ADA.

Patients may write, email or telephone the DCP (9211 5627) and contact Cherie our secretary on cases@dentalcases.com.au who will provide them with a complaint form and a brochure explaining how the DCP works and what the various steps are to launch a claim.

Generally, a patient will complete the form which will be assessed by one of three experienced case managers and with the permission of the patient will seek the treatment records of the dentist in question and their version of the events. If there is a matter which requires attention, the DCP will authorise an expert to provide a report along with a proposed treatment plan to repair the problem. Should this be accepted by the DCP, another senior dentist will be authorised to make these repairs at no cost to the patient. Very occasionally where additional previously existing dental problems may be involved the DCP can authorise a settlement which can be applied to the whole dental problem to produce a better outcome for the patient.

The DCP has no capacity to order damages to be paid as it is not a Court and if a patient believes they are entitled to damages they should take their matter to an alternate venue. Should a patient wish to take their issue to AHPRA (Australian Health Practitioner Regulation Agency) the DCP cannot act until the matter is heard by that body. The DCP has been in operation for 25 years and during that time has assisted many patients remediating their problems. It remains a free service.

Dental Cases Panel Pty Ltd
PO Box 34 West Perth WA 6872
Ph: (08) 9211 5627 Fax: (08) 9321 1757
Email: cases@dentalcases.com.au

(The above information was provided by the Dental Cases Panel)

HEALTH CONSUMERS' COUNCIL

YOUR VOICE ON HEALTH

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Monday to Friday 9:00am - 4:30pm | Closed Public Holidays