



Joint Guidelines for Dental Core Training in Hospitals
British Association of Oral and Maxillofacial Surgeons (BAOMS) and the
Committee of Postgraduate Dental Deans and Directors (COPDEND) on
Training of Dental Core Trainees (DCT) in OMFS Units

- 1. These guidelines should be considered and used in the context of the General Dental Councils – Standards for the Dental Team, and the General Medical Council’s Promoting Excellence – Standards for Medical Education and Training.**
- 2. These guidelines are neither comprehensive nor definitive but represent a ‘living document’ where COPDEND and BAOMS try to define ‘what good looks like’ for Dental Core Trainees working in hospital practice. COPDEND and BAOMS would ask for feedback on the content and value of these guidelines.**
- 3. Summary of Guidelines on DCTs working in Hospitals.**
 - a. Safe patient care is the top priority.
 - b. It is expected that all GDC and GMC requirements, including any that specifically relate to clinical and educational supervision will be met.
 - c. Dental Core Trainees (DCTs) must practice within the clinical governance structures of the Trusts in which they work. The DCTs should understand these structures and comply with their requirements.
 - d. Contractual and other requirements of Dental Core Training (DCT) differ significantly from those of Dental Foundation Training including the role of a lead or trust employer. DCTs should understand these differences.
 - e. DCTs working in hospitals will be part of multi-disciplinary teams. They must both understand their role within these teams and ensure that those with whom they work understand that they are dentists regulated by the General Dental Council.
 - f. Clinical training will always be a combination of training and service and neither can be considered independent of the other.
 - g. The key components of DCT within OMFS departments are.
 - i. Patients should be aware that postgraduate dentists are involved in their care.
 - ii. Training should be in the context of the DCT Curricula.
 - iii. Ideally, in an average week, DCTs should have access to appropriate training opportunities.
 - iv. Induction and formal training courses should be provided.
 - v. DCTs should have a Learning and Development Plan.
 - vi. Trainees should keep a Record of Training – Portfolio and eLogbook
 - vii. The role of Educational and clinical supervision (Trainers) should be clear.
 - viii. Delegated consent and delegated duties should be defined and documented.
 - ix. Supervision and training for ‘non-dental’ procedures should be documented and signed off by a competent person.
 - x. All on-call and out-of-hours work should be safe and appropriate.
 - xi. There must be a balance between training and service delivery.
 - xii. Changes in Service and Training must be consensual.
 - h. Each of these key components will be further explained below.
- 4. Patients should be aware that postgraduate dentists are involved in their care.**
 - a. Clear communication with patients and staff is a key issue and any identification badge should comprise the following three elements – the individual’s name, department, and position within the team, namely dentist (e.g., Dental Core Trainee). Patients should

be provided with written information advising them that they will be looked after by a team comprising dentists, doctors, and nurses. To help avoid confusion with medical colleagues, DCT badges will not use the honorary title of Dr.

5. Training should be in the context of the DCT Curriculum.

- a. Dental training should be planned in accordance with the requirement of approved dental core training curricula and delivered by trainers who have undergone appropriate training for their training role.
- b. DCTs should have a structured teaching and training programme. Where possible, formal teaching should be 'bleep-free'.
- c. Where there is a regional training programme, DCTs should have access to this.
- d. Training should be progressive and include experiential learning in an environment that permits the development of patient management and surgical skills, by permitting the trainee to repeatedly practice those skills that have been acquired at an appropriate level of competence.
- e. Training should include:
 - i. exposure to emergency care, including appropriately supervised on-call if required.
 - ii. exposure to the surgical removal of teeth and retained roots as well as minor hard and soft tissue surgery (in line with DCT Curriculum).
 - iii. involvement in the management of patients with complex medical co-morbidities.
 - iv. exposure to the management of patients on surgical wards and in the emergency department. Appropriate supervision must always be available, and an escalation policy should be agreed and clearly documented.
- f. BAOMS will support COPDEND, through the DCT Advisory Group, in any curricula redesign.

6. Ideally, in an average week, DCTs should have access to:

- a. Outpatient clinic
- b. Minor oral surgery under local anaesthetic
- c. Minor oral surgery in a day surgery unit
- d. Managing inpatients
- e. Working in theatres, including emergency theatres
- f. Managing emergency and urgent referrals/patients
- g. Work with other dental specialties where available e.g., orthodontics, restorative, Special Care Dentistry
- h. Formal education/teaching/study time

7. Induction and Formal Training Courses should be provided.

- a. All trainees should receive both Trust and Departmental Induction on starting at a Trust before taking up duties.
- b. A period of shadowing prior to taking up a hospital post is ideal.
- c. An initial assessment of competence should occur at the start of the training period to ensure patient safety and inform personal development.
- d. Appropriate courses are recommended for preparing trainees to manage trauma and other cases in the ward. Suitability of courses may differ between DCT1, DCT2, and DCT3 and local arrangements.
 - i. ALERT (Acute Life-Threatening Events Recognition and Treatment).
 - ii. ILS (Intermediate Life Support).
 - iii. ALS and Advanced Trauma Life Support (ATLS) may be appropriate for DCT Year 2/3 trainees.

- iv. Ideally courses should be undertaken early in the training and before trainees take up duties which need the skills and knowledge delivered by those courses. This could be before the post starts, during induction, or before a rotation that involves those skills and knowledge.
- v. Where possible Postgraduate Dental Deans will support and facilitate the release of trainees from their preceding posts to allow shadowing and to attend courses that support DCTs in hospital practice for example visiting hospitals at weekend(s) or during study session(s).

8. DCTs should have a Learning and Development Plan

- a. All trainees should have a written Learning and Development Plan agreed with and signed by them and a nominated Educational Supervisor within two weeks of commencement in post.
- b. All Trainees should have a minimum of three review meetings per year where the content of their Portfolio can be discussed, progress monitored and documented, and education and training objectives confirmed.
- c. The process should be quality managed by the Postgraduate Dental Dean.

9. Trainee must keep a 'Record of Training' – Portfolio and e Logbook.

- a. Educational portfolio
 - i. measures progress in attaining the curriculum competences including workplace-based assessments.
 - ii. Records attendance at teaching and learning events within and outside the department.
 - iii. Records and show analysis and reflection of significant events.
- b. eLogbook
 - i. the eLogbook at www.elogbook.org should be used to record activity.
 - ii. trainees should register using their GDC number as Senior House Officer (DCT is not available).
 - iii. records should be:
 - 1. contemporaneous.
 - 2. validated.

10. The roles of Educational and Clinical Supervisor should be clear.

- a. Staff involved in delivery of training should comply with HEE/Deanery - the 'educational commissioners' requirements for clinical and educational supervisors in line with COPDEND Standards for Dental Educators.
 - i. Includes completion of an appropriate Training the Trainer /Educational/Clinical Supervision course (at least every three-five years to comply with local recommendations).
 - ii. These requirements apply to all grades of medical and dental staff supervising trainees (not just Consultants).
 - iii. GMC registered trainers must comply with GMC requirements for Educational Supervisors.
- b. The local guidelines about the time allocation within SPA's as an educational supervisor will be followed until such time as national guidelines are available.
- c. Trainers must have sufficient time in their job plans to undertake training work-based assessments, completion of portfolios ensuring provision of weekly tutorials/bleep free teaching to meet trainees' learning needs.

11. Delegated consent and delegated duties should be clearly defined and documented.

- a. Employing authorities' policies for delegated consent should be followed:
 - i. Delegated consent is where consent is obtained by an individual who does not have the necessary knowledge, skills, and competence to undertake the procedure themselves.
 - ii. Employing authorities record and audit delegated consent training and competence.
 - iii. Dentally qualified trainees should not be expected to obtain informed consent for complex surgery or cases where they do not understand the surgery and possible complications.
- b. Consultant and other trainers must only delegate duties where they have satisfied themselves that a trainee has acquired an appropriate level of competence to perform specific tasks as demonstrated by satisfactory certified assessment.

12. Supervision and training for specific 'non-dental' procedures should be documented.

- a. All Employing authorities should have clear documentation of training and competencies obtained during induction training and during the development of the trainee.
- b. The Employing authorities should make clear to the DCT the medical and dental support and clinical supervision structures within the Trust.
 - i. Employing authorities must ensure that a suitably qualified medical member of staff is always available on site to provide advice to trainees in situations which require expertise beyond that of a singly dentally qualified trainee. This should apply to both elective and emergency situations.
 - ii. Within the escalation plan for DCTs, a dentally qualified supervisor should always be involved.
 - iii. Specific arrangements will be a matter for individual employing authorities, but Trusts should be directed to produce a protocol tailored to local circumstances. Dentists should only be expected or asked to carry out tasks for which they have been appropriately trained, except under close direct supervision as part of a structured teaching session.
 - iv. Where medical procedures such as arterial blood gas sampling, insertion of nasogastric tubes, insertion of urinary catheters etc. are required to be undertaken by a singly qualified dental trainee then the trainee should have undergone appropriate accredited training and have certificated competence for such procedures.

13. On-call and Out of Hours work should be safe and appropriate.

- a. Good training flows from well-organized and delivered surgical services.
- b. Ideally, on-call/out of hours' time should avoid the period from 10pm until 8am where this does not provide access to supervised exposure to emergency care. Where trainees are working overnight it is expected that the learning is captured within the training portfolio in the form of WPBAs, reflective log and feedback from senior clinicians. It is encouraged that DCTs engage with other clinical teams for this feedback.
- c. Where there is a 'Hospital at Night' team, trainees may benefit from exposure to this team's management of acute problems in the hospital.
- d. When DCTs are not directly supervised by someone with a dental qualification (e.g., ED Team), there should be a clear escalation plan to a dentally qualified supervisor.
- e. Wherever possible direct supervision of on-call/out of hours cover should be provided from within the medical specialty of OMFS, but it is recognised that this may not be possible in small or geographically isolated units.

- f. Where shift patterns are worked, best practice must be applied with appropriate hand-over and supervision.
- g. DCTs should not work in poor work patterns which fragment team structure and lose contact between trainers and trainees to the detriment of continuity of patient care. Badly organized shift patterns represent the highest risk of this unsatisfactory practice.

14. There must be a balance between training and service delivery.

- a. Trainees should be encouraged, as part of the team, to contribute to service delivery and improvement as well as develop professional attributes.
- b. Trainees should not be expected to deliver service commitments to the exclusion of their training, but rather as part of a planned and balanced programme within OMFS/dental teams.

15. Changes to Service Configuration and Training must be consensual.

- a. Changes to service configurations and training programmes should be developed and implemented jointly by HEE/Deaneries and Trusts/NHS Boards to ensure both service continuity and effective training.
- b. Where conflict arises between the needs of training and service that cannot be resolved locally, support should be sought from Deaneries / HEE and BAOMS to allow an agreement to take place.
- c. Service configuration can permit the development of out of hours care that does not need Dental Core Trainees being on-call throughout the night. This is desirable when the low density of out of hours activity means daytime training is compromised without balancing training benefits. However, reconfiguration without alternative provision of out of hours care will have a deleterious effect upon the quality and safety of patient care and is therefore undesirable.
- d. As reconfiguration of services occurs the impact on dental training should be reviewed.