Chasing a dream
Sharon Holmes gets back to reality...

Going home on the train one evening a fellow passenger sitting opposite me was engrossed in his book entitled *Mastering The Art Of Running*. I thought to myself how nice it would be to read such a book! Why is there no such book called *Mastering the Art of Dental Practice Management*? I only...

So I felt compelled to write an article of encouragement for all practice managers or principal dentists who manage practices. If I have moments of fatigue surely there must be others who feel just like me at times.

I have come to surmise much to my dismay that there is no such thing as a "perfectly run dental practice". If you think there is you are going to drive yourself crazy; I have been chasing that dream for years.

The one process in practice management that I find I am most sensitive to is untoward incidences, because normally these are due to negligence. Accidents are manmade; they don’t just happen although they most certainly are not planned. However no matter how many practice protocols you have in place you cannot predict what could go wrong in the future.

When a major incident occurs you have got to carry out an investigation to get a full picture of what actually occurred and where the turning point was when it all went wrong.

Too many times I have found staff battle to be honest for fear of blame or retribution for being a grass or a snitch. I don’t look at an untoward incident as blame. I look at it objectively to establish why it happened even though there are practice policies and procedures in place. It’s normally a chain of events that will lead to failure.

Once I have all the necessary information in front of me I work out what went wrong, who was accountable and establish whether negligence was involved or a weak practice procedure which was not concise enough. Once I have all those involved made clear to me I meet with each one to understand their thinking of what went wrong. Through this I am able to determine what the ‘cause’ was. Sometimes it is a lack of understanding or just plain negligence due to not taking responsibility for what appears to be wrong. It’s the scenario of anybody’s, somebody’s and nobody’s job. When the explanation starts ‘but I thought’, I know I’m in for tool box talk with the whole team.

We therefore call an urgent staff meeting where a ‘tool box’ talk takes place openly. We discuss what went wrong, what we have learned from the incident and then re-write a policy if it was not concise enough and if a policy does not exist for the incident that occurred we create one by agreement as to what should be expected. This should be done as a team effort then those who created the policy could be held accountable and establish whether negligence was involved or a weak practice procedure which was not concise enough. Once we have all those involved made clear to me I meet with each one to understand what went wrong. Through this I have all those involved made accountable and establish what went wrong.

In such an incident we then re-write a policy if it is a lack of understanding or just plain negligence due to not taking responsibility for what appears to be wrong. It’s the scenario of anybody’s, somebody’s and nobody’s job. When the explanation starts ‘but I thought’, I know I’m in for tool box talk with the whole team.

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You have to keep all records for CQC as all regulated activities must be evidence based. If it is a serious incident, such as a death, you need to report this to them immediately. All staff are required to sign an attendance list stating that they have attend a meeting and that they now understand what is required of them in the future. Your policies should be discussed frequently to keep them on your teams’ agenda because if they remember a policy that was written sometime back hopefully untoward incidences won’t happen often at all.

As Winston Churchill once said: However beautiful the strategy, you should occasionally look at the results.