

RECORD OF COMPETENCE

PART B

EXPANDED CASE STUDIES

Notes for Guidance

1. Case studies of between 1800 and 2200 form part of the RoC for this qualification. The patients may be selected from those for whom PCAS have already been completed.
2. The case Study requirements are:

Case Studies	DSN	IHSN	IVSN
Inhalation Sedation Procedure	✓	✓	
Intravenous Sedation Procedure	✓		✓

Although Inhalation sedation procedures are usually completed on children and intravenous procedures on adults, you should choose cases that reflect your usual area of practice.

3. Each case study should demonstrate a breadth and depth of knowledge about a range of sedation issues. **It must reflect your involvement within the procedure.**
4. Patients selected for the studies should remain anonymous
5. The Guidelines on the following page demonstrate an appropriate structure for your case studies. You must use the subheadings that have been listed.
6. Appropriate illustrations and photographs may be incorporated but are **not** essential. Patients must not be identifiable in any photographs. Written consent must be obtained using the form included in Appendix 1 of this Record of Competence. Once completed this should be retained within the patient clinical records.
7. Each study should be typed in a regular font, size 12, and double line spaced.
8. References/information sources should be attached in an appendix in the order in which they are referred to in the text. Appendices should only be included if they usefully support the content of your case study. References should be in a standard format. e.g.,

For Journal articles:

Lewis MA and Newton JT (2006) "An evaluation of the quality of commercially produced patient information leaflets" *British Dental Journal*; **201**: 114 – 117.

For websites:

Author's name, title of item in double quote marks, title of complete work or site in italics, date of publication or last revision date, the full URL, in angle brackets, date accessed in square brackets.

Example:

Nelson Hilton, *Blake Digital Text Project*, University of Georgia, 1996
<<http://virtual.park.uga.edu/~wblake/home1.html>> [accessed 18 January 2004].

GUIDELINES FOR CASE STUDIES

Sub Headings to be used in Case Studies		Relevant Syllabus section
1.	Introduction	1.1.5, 2.2
2.	Source of patient referral	1.1.4, 2.4
3.	Patient's presenting complaint	1.1.4, 2.4
4.	History of the presenting complaint	1.1.4, 2.1, 2.4
5.	Relevant medical history	1.1.4, 2.2, 2.4
6.	Past dental history	1.1.4, 2.1, 2.4
7.	General and social circumstances to include: Patient's age Gender Smoking history Alcohol history	1.1.4, 2.2, 2.4
8.	Contacts with other disciplines	1.1.1, 1.1.11, 2.4
9.	Patient assessment (Treatment plan)	1.1.3, 1.1.4, 1.1.5, 2.1, 2.2, 2.4, 2.6
10.	Why the patient requires sedation	1.1.3, 1.1.10, 2.1, 2.4, 2.6
11.	Possible difficulties to be considered before providing treatment including medico-legal	1.1.1, 1.1.5, 1.1.7, 1.2.1, 1.2.3, 2.4, 2.6
12.	Which sedation technique is being used	2.1, 2.2, 2.4, 2.6
13.	Preparation of the patient and environment	1.1.1, 2.5
14.	Monitoring and support provided during administration of sedation	1.1.1, 2.2, 2.5, 2.6
15.	Pharmacology / drugs administered and their properties	2.3
16.	Recovery of patient	1.1.1, 2.4, 2.5
17.	Difficulties incurred (if any)	1.1.4, 1.1.6, 1.1.7, 1.1.11, 2.5
18.	Arrangements for follow up care	1.1.8, 1.1.10, 2.4, 2.5
19.	Conclusion with reflective practice	1.1.2, 1.1.3, 1.1.7, 1.1.8, 2.7