BDJ Team
FEBRUARY 2016

# INFECTION CONTROL

## In your practice

BDA
British Dental Association

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# February 2016

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## Highlights



## Regulars



## In this issue






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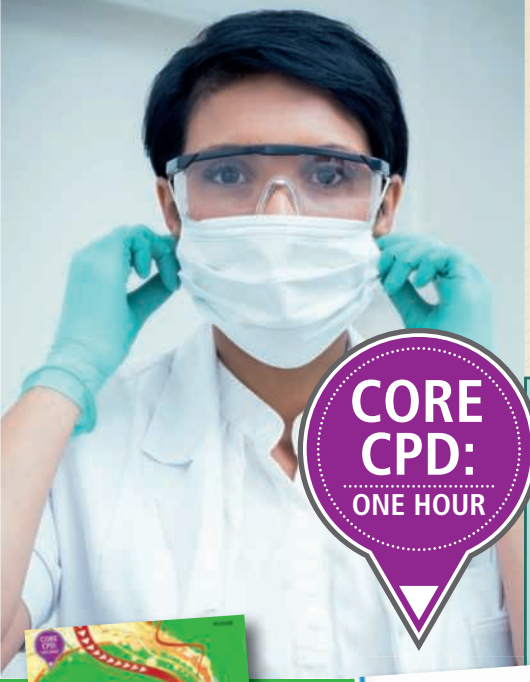


CORE CPD: ONE HOUR

# Ed's letter

Hello readers! It's great to be back editing your favourite dental team magazine once again. I would like to thank David Westgarth who has done a cracking job (in the northern vernacular) of managing *BDJ Team* while I was on maternity leave.

David has even paved the way for this February issue and I am delighted to bring you the second article from one of our reader panel members, **Rachael England**, who describes life as a hygienist in Dubai. 'It's not unusual to meet people who have lions as pets and just a few weeks ago Jackie Chan was in a helicopter outside my apartment!' says Rachael. Read more on page 12.

In our **free CPD** article this month, we look at infection prevention and control in your practice, a core topic for all dental care professionals (DCPs). Speaking of CPD, all CPD questions published on our site from this year are available for six months, so don't hang around if you want to get your free hours! www.nature.com/bdjteamcpd

Reader panel p7

In our presidential column this month we meet **Janet Goodwin**, President of the British Dental Health Foundation. Janet tells us about the Foundation's annual campaigns and how she hopes to use her role to influence the state of the nation's oral health.

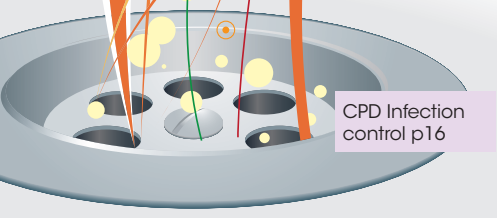
Janet Goodwin p12

Are you a **social media** addict? Sharing photos of your dinner, the weather and the lovely bouquet of flowers you've received for Valentine's may be fun, but when you're using social media to promote your practice, make sure you read our top ten tips that every dental practice should know, on page 13.

How does the multi-disciplinary team contribute where prosthodontics is concerned? Read the original article from speciality trainee Raj Dubal and core trainee Shabana Buth on page 8.

Social media p13

If you are thinking of submitting an original article to *BDJ Team*, please do! I am always thrilled to hear from potential contributors, whether you're writing a personal account, summarising research, or you think you would make a good interviewee. I look forward to hearing from you, so **drop me a line**.



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## THE TEAM

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# 'WE MUST LEARN FROM MEXICO'S **SUGARY DRINKS TAX**'

The UK needs to follow Mexico in introducing a tax on sugary drinks if it is to ensure the dental health of future generations.

That's according to Fiona Sandom, president of the British Association of Dental Therapists, who has welcomed a new report – published in the *British Medical Journal* this week – that illustrates how a 10% tax on sugar-sweetened drinks in Mexico has slashed sales of tooth-rotting beverages by 12%.

As a result, sales of untaxed – and healthier – drinks have increased by 4% – all this, one year after implementation. Researchers now suggest these findings have important implications for health policy makers.

Fiona Sandom commented: 'Mexico has set a precedent with its commitment to improving the health of its population and it is now imperative that the UK government looks at the findings of this significant research and considers the evidence before it.

'The research coincides with two other studies that highlight the potential health risks of consuming sugary foods and must surely add to the mounting pressure on MPs and health experts to seriously consider a similar sugar tax here.'

A report in *The Lancet Diabetes & Endocrinology* shows that reducing free sugars content in sugar-sweetened drinks (including fruit juices) in the UK by 40% over five years – without replacing them with any non-nutritive sweeteners – could prevent around 300,000 cases of type 2 diabetes over two decades.

And, research from the University of Leeds' Department of Cardiovascular Sciences, shows that foods high in sugar could affect the heart's recovery following a heart attack.

Fiona added: 'Health promotion is an essential component of health policy, too. Education is key to improving the wellbeing of our population as well as cost saving for the NHS. As the New Year starts, it was heartening to see the launch of Public Health England's Change4Life Sugar Smart campaign – including the app that scans food and drink for sugar content.

'But, as dental professionals, we all need to put ourselves at the forefront of this drive to enlighten patients – especially in view of the fact that they come to see us when seemingly healthy. Given the links between systemic diseases and dental health, we must make every contact matter and seize the time spent in the chair to discuss diet and dental health habits. Only with an all-encompassing approach to health can preventive measures be successful.'

The average child in the UK consumes three times the annual amount recommended by the Specialist Advisory Committee on Nutrition.

Meanwhile, Mexico implemented its excise tax of 1 peso per litre on sugar-sweetened beverages in January 2014. With some of the highest levels of diabetes, overweight, and obesity in the world, reducing the consumption of sugar-sweetened beverages was paramount in achieving an important target for obesity and diabetes prevention.

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# NEW YEAR'S RESOLUTIONS FOR OUR LEADERS

If Claire Stevens, BSPD's media spokesperson, could influence the New Year's resolutions of the UK's Health ministers, she knows exactly what she would like them to ask for. Her over-arching wish is for the next generation to be completely free from dental disease. In order to achieve this, she believes the following New Year's resolutions should be made by the Health Ministers in England, Ireland, Scotland and Wales:

1. Clear and consistent labeling of foods and drinks should be made mandatory to benefit consumers of all ages. New rules should make labeling completely simple – nothing half-baked or cloaked in jargon – so it's possible to understand immediately the amount of sugar in any given product. For instance, nine teaspoons in a standard can of Coke.
2. Introduction of a tax on food and drink with high sugar content but implemented in such a way that healthy food and drinks are incentivised. Currently, says Claire, her young patients tell her that a bottle of water in a vending machine is the same price as a bottle of sweetened, carbonated drink. Not only should the latter be more expensive but the water should be cheaper.
3. A clear plan of action is the third and last resolution that Claire would like our leaders to have. A report called *Sugar Reduction The evidence for **Action*** was published by Public Health England in October but BSPD has heard nothing since. She would like to be kept informed of developments and to see an implementation plan for the report's recommendations. Finally, says Claire, as more money is accrued by the UK's governments through higher taxation on sugar, it should fund programmes of prevention to reduce inequalities and meet the needs of local populations.

# JUNIOR DENTISTS JOIN MEDICS IN **INDUSTRIAL ACTION**

The British Dental Association (BDA) announced on 4 January that hospital dentists would take part in their first ever industrial action on 12 January, joining their medical colleagues following government failure to address concerns on safe working and unsocial hours.


An overwhelming majority of BDA voters had backed moves to take part in industrial action. Plans were postponed to give negotiations at the conciliation service ACAS a chance.

The BDA then wrote to NHS trusts in England to inform them of the following planned industrial action:

- 8am, Tuesday 12 January to 8am, Wednesday 13 January – emergency care only
- 8am, Tuesday 26 January to 8am, Thursday 28 January – emergency care only
- 8am to 5pm, Wednesday 10 February – full withdrawal of labour.

BDA Chair Mick Armstrong said: 'We wanted to see real progress towards a contract that could work for patients and practitioners. Regrettably the Department of Health has been unwilling to compromise on the fundamentals, on safe working and unsocial hours.

'Next week will see colleagues take industrial action for the very first time. These hospital dentists form a small but vital part of our NHS, but their dispute matters to every healthcare professional. Dentists and doctors will not stand by and see patients and practitioners put at risk.

'Industrial action is always a last resort, and one we sincerely hoped could have been avoided. We have been left with little choice but to take this step in the face of government intransigence.'

The industrial action planned for 26 January was later suspended in support of the British Medical Association (BMA) as it sought to rekindle talks to resolve the differences over the proposed new contract.

The BDA hoped to take a group of trainees to the Houses of Parliament in London to lobby their MPs in person on 10 February as *BDJ Team* goes to press.

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# NEW **NICE GUIDELINES** AIM TO IMPROVE QUALITY OF DENTISTRY PROVISION IN THE UK

The British Dental Health Foundation has welcomed the focus on giving patients the ability to make an informed decision about their care in the new NICE guidelines on oral health promotion in general dental practice.

The guidelines cover how general dental practice teams can communicate advice about oral hygiene, the use of fluoride, as well as how areas such as diet, smoking, smokeless tobacco and alcohol intake affect oral health in order to help patients make informed decisions on their own care and encourage preventive treatments.

Dr Ben Atkins, a dentist and Trustee of the British Dental Health Foundation, was a member of the committee for the NICE guidelines.

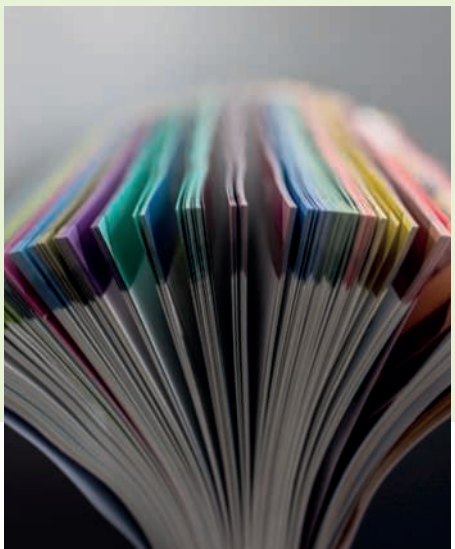
Dr Atkins said: 'These guidelines have been developed with the patient firmly in mind; they outline a patient-centred approach to ensure patients who are using the services are actively involved in discussions and able to make informed decisions about their care.

'Throughout the consultation stage it was recognised that interventions need to provide patients with support to help them change their behaviour in order to effectively change how they look after their oral health at all times.

'By focusing on providing staff in dental practices with the means to do this by following these guidelines we are hoping to see the quality of dental provision in the UK improve in the future.'

The NICE guidelines include lots of helpful information for dental professionals to help communicate with patients, such as how they can use appropriate words to discuss the strength of their recommendations.

They also include information about prescribing medicines, professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding to help improve patient support.



Dr Nigel Carter OBE, Chief Executive of the British Dental Health Foundation, said of the guidelines: 'Although the landscape of oral health in the UK has improved significantly over recent years, there remain significant regional disparities. We welcome the new NICE guidelines, which can help to address these socio-economic variances and inequalities which still exist in oral health.

'Putting the patient front and centre and giving them all the information they need to make an informed decision can educate them and tackle these inequalities.

'By developing a more preventive approach to their treatment dental professionals can help to stop problems before they even exist.

The new guidelines recognise how oral health is vitally important to general health and wellbeing too and acknowledged how it can affect people's ability to eat, speak and socialise normally.

Poor oral health can also lead to absences from school and workplaces as well as affecting the ability of children to learn, thrive and develop.'

Read the full NICE guidelines here.

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# A NEW ROUTE INTO DENTAL CARE

More young people are getting the chance to start careers in dental care in Scotland with a new course at Edinburgh College that is widening access to the industry.

The Dental Care Assistant course is the first of its kind in East Scotland and offers an introductory course at a level suited to a wide range of abilities and backgrounds. Previously, applicants who were interested in working in the dental care profession would have to be turned away from the existing courses due to a lack of experience or qualifications. The new course gives them a route into further study and valuable experience for the workplace.

Tom MacGregor, curriculum manager for Health and Veterinary at Edinburgh College, said: 'The college sector is committed to providing opportunities for learners across all ages, backgrounds and academic abilities. This course fits perfectly with our vision and the current cohort of learners is now ready for work experience in dental practices across Edinburgh and the Lothians'.

Students on the Dental Care Assistant course learn about the importance of caring for their own teeth, an awareness of the dental environment, the instruments and equipment used and the importance of effective infection control. The programme is designed to be an excellent foundation for them to progress onto to the college's SVQ Level 3 in Dental Nursing, National Diploma in Dental Nursing or further study whilst in practice.

There are no formal entry requirements but applicants are expected to be well-presented with an interest in oral health and good interpersonal skills.

Tom said: 'Many of our Dental Care Assistant students joined the course in August with a lack of confidence and found teamwork and interacting with others a challenge. This course has developed them into confident individuals who can make positive contributions to their team as well as working well independently. The dental nursing team and I are very pleased with their progress. They now show self-belief, have more job-ready skills and feel comfortable presenting themselves and their work'.

The students wear smart raspberry coloured scrubs in college, and are going out to engage with other college students and college staff to offer simple oral health messages in the wider college community. They are currently working on an awareness project to highlight the dangers of hidden sugar found in every day drinks and foods.

The next Dental Care Assistant course started in January and runs for 18 weeks. www.edinburghcollege.ac.uk

Dental Care Assistant students in raspberry uniforms, with Dental Nursing students in turquoise and teaching staff in blue

# NEBDN LAUNCHES ITS '**GUIDE TO SUCCESS**' ONLINE SUPPORT FOR DIPLOMA STUDENTS

To support all candidates studying for the NEBDN National Diploma in Dental Nursing qualification, the National Examining Board for Dental Nurses has joined forces with Healthcare Learning to create an online examination guidance programme entitled 'Guide to Success'.

This innovative and easy to follow programme offers step by step guidance to students to help them prepare for both the Written section and the Practical Objective Structured Clinical Examination (OSCE).

In a simple staged format, the NEBDN Guide to Success offers robust advice on a range of topics from how to prepare for an examination, and what to expect in the examination room, to techniques for remaining calm under stress and creating an effective revision plan.

Although the programme is rich in educational content and offers a mine of valuable information for candidates it is not intended as a learning resource. The content of the National Diploma curriculum can only be learned through accredited training providers.

The programme, which is delivered through Healthcare Learning's online platform, is available direct to students and dental nurses who are interested in refining their skills.

To view a trailer of the Guide to Success visit http://clients.healthcare-learning.com.s3.amazonaws.com/nebdn/student/trailer/nebdn_student_trailer_edit.mp4.

To purchase the Guide to Success click http://www.healthcare-learning.com/elearning/detail/view/productId/88.

# British Dental Health Foundation – Better oral health for all

President of the British Dental Health Foundation, **Janet Goodwin**

The role of president of the British Dental Health Foundation comes with some amazing opportunities and responsibilities to help influence the state of everyone's oral health, all of which I am excited and eager to face head on.

At the very top of the agenda for my term as the charity's president is to try and make good quality, trustworthy and accurate dental health information available to anyone who wants it. I believe this will help to relieve some of the dental anxiety that still is far too widespread in society and go a long way to address the level of tooth decay in the UK.

I want to help make visiting the dentist something people don't worry about and feel safe and comfortable doing by increasing their own knowledge.

The Foundation works tirelessly to provide reliable and trusted information to all through the Dental Helpline, social media, press and campaigns. For decades they have helped countless people and organisations to improve the quality of their oral health and that is what I am hoping to build upon. One of the most exciting areas that I will oversee during my presidency is to explore new possibilities to increase and improve our global identity to try and help more people than ever before.

Our globally renowned 'Tell Me About' information is now available online in ten languages, making our information accessible to millions more globally, and this is just the beginning of something very special.

## National Smile Month

This year (16 May–16 June) marks a landmark for National Smile Month as the campaign celebrates its 40th birthday. The campaign has grown and developed into its own global brand and is now one of the key landmarks of the dental industry calendar.

This year the campaign will be larger than ever and we hope it will facilitate thousands of grassroots activities such as fun days, talks, sponsored events, road-shows, displays, open sessions and competitions – all which have the ultimate goal of engaging people in the importance of oral health.

At the British Dental Health Foundation we are extremely proud of what National Smile Month has achieved while the number of individuals and organisations that get involved is amazing. With their support we are able to spread good oral health messages to millions of people.

But we want to go even further. This year, with the industry's support, we want to celebrate the campaign's birthday with a huge party and engage more people, helping to show that the campaign really does make a significant difference by improving the oral health of those most at need.

## Mouth Cancer Action Month

In November our other major campaign takes centre stage. Mouth Cancer Action Month will once again take over dental practices across the country to help raise awareness of mouth cancer and make a difference by saving thousands of lives through early detection and prevention.

As long-time campaigners for mouth cancer, I am delighted to say that everybody at the Foundation remains passionate and committed to increasing awareness of the disease and reducing the number of lives lost to it every year.

In 2015, the campaign was the biggest ever and cemented itself as an influential springboard for making a difference in the fight against mouth cancer. But with recent statistics showing cases of mouth cancer are still seeing a significant increase there is a greater need than ever to bring the whole industry together to spread awareness even further.

## Better oral health for all

One of the main problems which I see today is a shortage of NHS dentistry in certain areas of the country. Some people are not able to access quality care which is convenient and affordable to them; this can put them off visiting the dentist altogether and means those who may need it the most are not getting the care and support they require. This is something that I hope to highlight as a matter of urgency.

The availability of drinks and confectionery with high sugar content is also a major problem; this is especially the case when it comes to children's dental health where nearly half of eight year olds have visible signs of decay in their teeth. This is a major health issue in the UK that needs to be addressed urgently; I believe that the introduction of a 'sugar-tax' would be a hugely beneficial step

For many people there is still a lot of fear attached to the prospect of going to the dentist, which within modern dentistry is unnecessary. Too many people relate going to the dentist with being in pain which is a lot of the problem. Modern dentistry is in fact pain free and there is far more of a focus on preventative treatments to stop pain occurring in the first instance. I want to help people to understand this.

I would also like the public to recognise the importance of their teeth for eating and speaking rather than wanting perfect brilliant white teeth to look like celebrities.

Finally, in my role as president I hope to use my experience and knowledge to help steer the trustees of the British Dental Health Foundation to make informed decisions on the direction of the charity, and show how they can use their influence to help further enhance public experiences, information and knowledge of dental issues and best practices.

We as a charity will continue tirelessly in our role in helping to provide better oral health for all.

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# Practical prosthodontics for the dental team

By **R.Dubal**,[1] **S.Buth**[2]

## Introduction

Teamwork is an essential aspect of good clinical practice, clinical governance and for ensuring optimal patient care. An effective patient pathway involves interaction with a number of different members of the dental team, all aimed at providing the best possible outcome for the patient. Each member of the team has an influential role to play in making the care pathway as efficient and as smooth as possible, not only for the patient but also for the dental team. Poor teamwork can lead to breakdown in communication and deterioration in working relationships, ultimately leading to sub-standard patient care and a loss of patient trust and confidence.

The General Dental Council (GDC) have stated in their guidance document *'Principles of dental team working'*[1] that a good team includes the following components:

1. Good leadership[1]
2. Clear, shared aims, and work together to achieve them[1]
3. Different roles and responsibilities, and understand those roles and responsibilities.[1]

The most recent figures from the GDC report that 40,721 dentists are currently registered to practise in the United Kingdom.[2] As the workforce increases in size, care teams increase in number and diversify in function. This is reflected in the emergence of dental therapists, orthodontic therapists, clinical dental technicians and oral and maxillofacial clinical scientists. With increasingly more diverse skills available and a multitude of roles to be fulfilled, the pillars of effective communication, teamwork and patient-centred outcomes become even more important. Prosthodontic procedures involve a wide array of individuals with a variety of skills, who come together to ensure high quality rehabilitation for patients.

## Prosthodontics

Prosthodontic procedures are the commonest treatment modality undertaken by dental surgeons. Prosthodontic care includes decision-making, planning and the provision of fixed, removable and implant-retained prostheses. Fixed prostheses include restorations such as crowns, bridges, inlays and onlays. Removable prostheses include acrylic and cobalt chromium dentures. Implant retained prostheses can be fixed or removable including crowns, bridges and dentures.

Twenty-first century prosthodontics has moved a long way from conventional treatments and treatment planning. The emphasis is now very much on the preservation of natural tooth tissue and the use of enamel and dentine bonding wherever possible. The modern prosthodontist is more aware of the implications of failure cycling and is keener to buy biological time.

The Adult Dental Health Survey (2009) revealed that in England, Wales and Northern Ireland, 94% of the combined population were dentate, meaning that they had one or more natural teeth.[3] With the current population of the previously mentioned countries estimated to be 57.9 million people, this leaves just under 3.5 million people with no teeth at all. Further to this, 13% of adults in England had natural teeth with dentures.[3] The survey also revealed that in England 8% of dentate adults had one or more carious or unrestorable teeth.[3] The statistics, when considered in real terms, provide us with the sombre conclusion that the need for care, by means of prevention, restoration and maintenance, is as important now as it has ever been.

The recent revolution in our understanding and provision of conservative and more adhesive clinical prosthodontic treatment has also led to the evolution of roles within the dental team. There has been a change in the way in which we manage dental disease and rehabilitate patients with missing teeth. Each member of the team has an increasingly more valuable part to play with an emphasis on communication, prevention and the patient being at the centre of the care process. This is reflective of the quality of life and 'patient-centred' approach which we should all be embracing today. With a co-operative and focused patient, it is more likely that our direct and indirect restorations will perform better with less associated biological damage at the time of failure.

There has been a move towards the whole dental team being involved in patient care. For most patients, the care pathway begins from the moment they enter the practice reception area, before they even see a dentist.

The receptionist, oral health educator, hygiene and therapy team, dental nurse, dentist and technician, are all responsible in ensuring that the patient is cared for optimally. This is facilitated by good communication and organisation within the team. The roles of each team member are distinct and valuable, and all contribute to the patient's summative experience. In this article we will consider the various roles of each member.

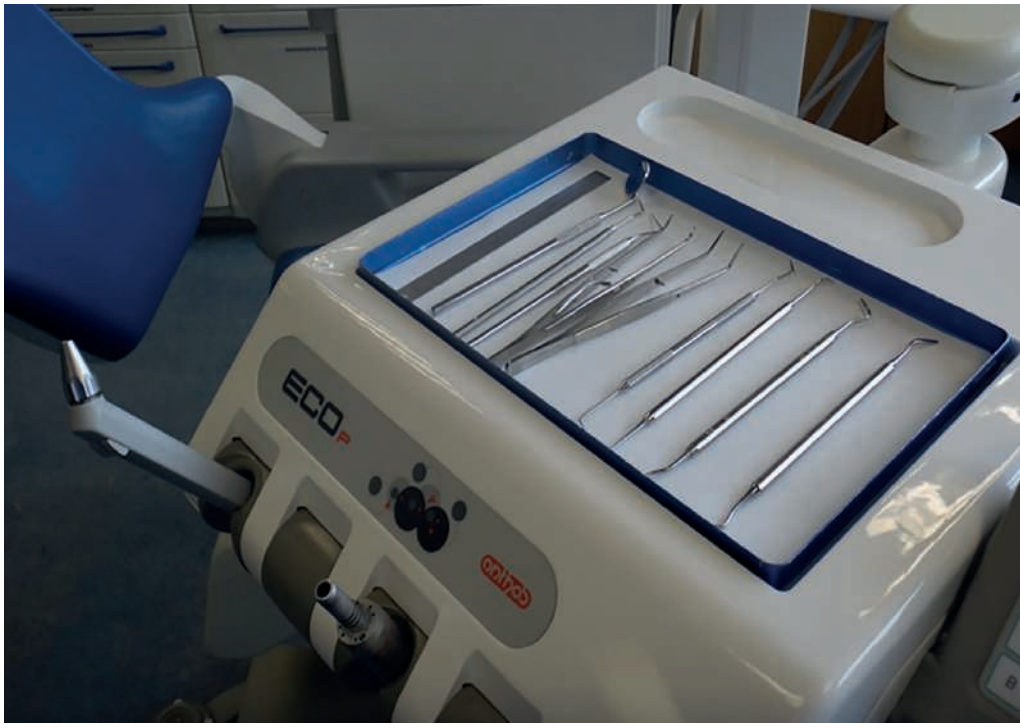
## The role of the clinician

Prosthodontic treatment requires a healthy and stable periodontal foundation. A successful approach and response to oral health promotion requires engagement and involvement between the patient and the dental team. Whilst dentists lead, guide and coordinate clinical pathways, input from all

[1] *Raj Dubal is a specialty trainee in restorative dentistry;* [2]*Shabana Buth is a dental core trainee year 3*

members of the multidisciplinary team is crucial. Clinicians have the responsibility of ensuring clear management plans and effective utilisation of the multidisciplinary approach to optimise patient outcomes. The team (dentist, therapist, oral health advisor, dental hygienist and dental nurse) must all share a common philosophy towards optimising patient care. Patients with gingival inflammation are rarely good candidates for prosthodontic treatment. Gingival inflammation can give rise to problems with impression taking, the cementation of adhesive restorations such as veneers and the use of composite resin restorations. Many patients believe that the easiest way to solve this problem is to ask for scaling from a hygienist or therapist on a regular basis rather than take responsibility for their own ongoing care. This would be by means of more aggressive daily home-cleaning, ensuring that the bristles of their toothbrush and interdental brushes remove debris from the gingival margin and pass sub-gingivally where inflammation or pocketing may be present. This may mean both pain and gingival bleeding for the patient in the first few weeks of using a more aggressive approach. The whole team must be united with a common message that patients must take responsibility for their own periodontal health and clean themselves, despite discomfort and bleeding, in order to establish and maintain periodontal health. Although the dentist has the role of leading and coordinating care, they must also help build confidence and empower and encourage all members of the team to promote excellent communication and care when interacting with patients. They will also need to reassure and support team members when patients question key beliefs of the practice, particularly if they are new to them. Utilising the full skillset of all members of the team will promote confidence, reflect team cohesiveness and allow more freedom and autonomy as well as provide a better model of care for patients.

All clinical dental team members should be mindful of monitoring and advising on the causes of dental diseases, which include an increasing frequency of consumption of sugars, oral hygiene advice, a reduction in alcohol consumption and encouraging smoking cessation activities. Where preventative measures fail, ongoing patient maintenance and support should be provided. This ensures that both successes and failures are shared, with the needs of the patient always put first. Such principles can be taught and encouraged through group training, practice meetings to include team-building sessions and access to relevant CPD.




## Oral health educators, reception staff and practice managers

The patient journey begins when an appointment is first booked by the receptionist. It is the responsibility of the dentist to assess the patient's suitability for treatment and to gain informed consent. Once a diagnosis is made, a treatment plan can be formulated and treatment options discussed and agreed. It can be very helpful for the oral health educator to contribute to these discussions, particularly when they fully understand the treatment modalities concerned. Sometimes patients are more reluctant to discuss their queries with the dentist, and more comfortable with another member of the team; it is not unusual for a patient to have queries and a discussion with the receptionist first as a result of confusion or misunderstanding. Information leaflets allow the patient to gather information and develop an understanding in their own time and at their own pace. This can help to provide clarity, raise questions and reinforce consent.

Where oral hygiene is inadequate, it may be appropriate to refer the patient to an oral health advisor, dental therapist or hygienist for periodontal treatment and oral hygiene instructions. Ultimately, good oral hygiene and periodontal health is essential for satisfactory prosthodontic care and long term success.

## Dental nurses

The involvement and opinion of the dental nurse can help validate subjective decisions such as choice of tooth shade, or offering an opinion on overall appearance of fixed or removable prosthodontic restorations. It is important that all team members are encouraged to bring their own genuine opinion when giving such advice. In general, two views are better than one, and a more inclusive dimension to patient care is delivered.

Following successful completion of the procedure, dental nurses are fundamental in ensuring that the patient is well, and can provide any post-operative advice, as well as reassurance that may be necessary. They can then direct the patient towards the reception area.

The dental nurse's role also includes adherence to infection control policies, whilst the surgery is cleared, cleaned and disinfected, ready for the next patient. Impressions and any other laboratory work should be disinfected, and packaged according to recommended guidelines prior to dispatch. The nurse is responsible for ensuring the completion of

> 'The involvement and opinion of the dental nurse can help validate subjective decisions...'

appropriate patient identifying labels and disinfection of the laboratory work including the clinician's laboratory instructions. They are also instrumental in ensuring that the correct return dates are noted on the correct laboratory prescription form. There is an intricately efficient inter-play between clinician, nurse, patient, technician and receptionist, and this can be reflective of teamwork at its best. It is clear that when we work together everyone benefits.

## The role of dental technicians

Dental technicians are registered dental professionals[4,5] who construct devices to a prescription from a dentist or clinical dental technician.[4,5]

They are very important members of the prosthodontic team. Depending on their training and registration they either construct restorations (dental technician) or additionally provide the clinical stages involved in the provision of removable prostheses (clinical dental technician). Dental technicians are involved in the construction of dentures, crowns, bridges and orthodontic appliances aimed at improving the patient's appearance, speech and masticatory function. Dental technicians are divided into four key groups: prosthodontic, conservation, orthodontic and maxillofacial technicians, depending on the type of devices they are trained to fabricate. High standards of care must be shared by all members of the team. Technicians must feel able to inform dentists if they are unhappy with clinical quality issues (eg tooth preparation, denture design, impression quality) and *vice versa*.

A good relationship between the clinician and dental technician is fundamental in order to achieve prosthodontic success and contributes to optimal treatment outcomes. Poor communication can lead to inadequately constructed or ill-fitting prostheses as well as laboratory work not arriving in time for a patient's appointment. Thus it is highly important, for clinicians to develop a good working relationship with their dental technician colleagues, so that they can freely and clearly communicate the type of appliance desired, material of choice as well as any additional information such as marginal position, type of marginal finish and any specific features pertinent to the case.

### Clinical dental technicians

Clinical dental technicians (CDTs) are registered dental professionals who provide complete dentures directly to patients and other dental devices on prescription from a dentist.[5] They are also qualified as dental technicians. The key difference is that they are trained to undertake a detailed dental history and relevant medical history[5] and perform any technical and clinical procedures related to providing removable dental appliances.[5] They are also able to prescribe, provide and fit removable prostheses to patients directly.

The number of qualified CDTs emerging is increasing and some may argue that they are now a separate entity to clinicians when it comes to prescribing, fabricating and fitting certain types of removable prostheses. However, it is also important to note that although CDTs may be able to set up their own independent practice, they must have adequate protocols in place to enable appropriate patient referrals when faced with a patient whose needs are out of their scope of practice.[4,5] This is critical in order to ensure an efficient and successful patient care pathway, which is also robust and comprehensive.

Many technicians have valuable insight and experience regarding recording tooth shade for a prosthesis, and the management of challenging cases. In some cases it is valuable to call the lab or even visit them so that the case can be discussed and a combined plan of action be established. Careful planning and the combination of skill sets can ensure optimal treatment outcomes.

Overall, a sound working relationship and clear communication between the prescribing clinician and the dental or clinical dental technician is of paramount importance to ensure both accurate and efficient patient treatment with successful outcomes. This is an integral part of the patient care pathway.

## Summary

There has been a paradigm shift towards a patient-centred approach to delivering high quality prosthodontic care. As a function of this, the patient-care pathway should be supportive, engaging and informed at all points of the journey. The calming effect of a considerate receptionist is often the first and last point of contact for patients, and the psycho-social and emotional dimension of the care experience is what patients often judge us on.

As the roles and responsibilities of team members continue to evolve, the overlap of each team member's duties become wider, and this should allow us to create a more comprehensive care network. Irrespective of individual roles, there should be a focus on empathetic and effective communication with the patient, which should be honest, comprehensive and comprehendible. All team members should be knowledgeable and be able to answer or redirect common questions asked by patients.

In consideration of the GDC and Care Quality Commission aspirations to set and ensure well outlined standards for the profession, there is a shared and implicit duty on the part of all members of the team to ensure that these are met and that relevant policies and best practice guidelines are adhered to. Now is an exciting time for evolution of the dental team, and never has there been greater access to opportunities for professional growth and development. Continuing training and education for all members of the team and regular audit will help to ensure that we are all doing what we are supposed to be doing, and this will equip us to improve our services further.

In the twenty-first century, with a greater number of more complex prosthodontics treatments available, it is increasingly important that treatment planning, explanations of treatment options and the provision of successful prosthodontic care are provided by a high quality dental team. As a result, we must work together with a common goal and ideologies, which place our patients at the centre of our focus. As they say, there is no I in team…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# Working abroad – to do or not to do

Life as a dental hygienist in the UK is pretty well-documented. Direct access in 2013 was a major step forward in this country, but what is it like overseas? We ask *BDJ Team* reader panellist **Rachael England** that very question.

I decided to move to Dubai in June 2013, the thought had been in my mind for some time and after four years living in the South-East of England and an hour's commute each way to the clinic I applied for a job with a well-established business. Following an embarrassing Skype interview I was offered a position and they organised my visa and licence while I packed up the house!

The visa and licensing process was my first experience of Dubai bureaucracy. The whole process took three months, which is quite quick. A huge amount of paperwork was needed and involved me writing to every practice I had worked for over the previous five years, good standing certificate from the GDC, proof of my indemnity and a transcript from hygiene school; just to name a few things. When I arrived in Dubai I also had to take a viva style exam at the Dubai Health Authority and while I waited for the results took some time to find an apartment and start getting acquainted with life.

## Life in Dubai

Most personal administrative tasks take a huge amount of patience and visiting of various departments, each giving conflicting advice. Luckily after the first two year visa is up and it's time to renew it becomes slightly less painful because you're used to the 'Dubai way'.

I stayed here for Christmas this year and I really missed my family and friends; friendships in Dubai remind me a lot of those I have from military life, close bonds because you're all experiencing life away from home. My social life is great, despite myths about life here we are allowed to drink and women can drive (although not at the same time), I am treated with the utmost respect as a woman and feel very safe around the city.

I've even fostered a rescue dog, so life here still reflects how it was at home, although it's not unusual to meet people who have lions as pets and just a few weeks ago Jackie Chan was in a helicopter outside my apartment!

## Working life

I started work at the clinic fairly soon and after a while noticed patterns in the types of problems or dentistry people have depending on their country of origin, for example lots of gold crowns in Central Asia, huge composites from Eastern Europe. The dental knowledge of some patients is extremely poor and can prove a real challenge to introduce new health behaviours. Smoking is still very much acceptable here. Shisha is popular and smoking in restaurants and bars is still going on, despite there being laws against it.

It is fascinating meeting patients from such diverse countries and backgrounds, from billionaires to housemaids. The language barrier can really pose a challenge too and I often worry about the understanding of the medical history and lifestyle factor discussions being fully understood. You may experience this in the UK, but only in certain pockets of the country – and more so in London. I'm quite a visual artistic person; using good old pictures and videos which say a thousand words and help with the language barrier. Experiencing so many cultural differences and sensitivities have given me such a new rich education and made me aware of taking extra care when recommending products or making suggestions to people about diet and lifestyle. That's something you don't really think about at home.

Health care primarily relies on insurance in Dubai, and quite often dentistry isn't covered or is severely limited. It also creates a gulf of inequity between the service workers and labourers who only have very basic access to emergency medicine. I also find that unless a patient's insurance will cover their work, people will decline treatment more often than not.

> ***'IT IS FASCINATING MEETING PATIENTS FROM SUCH DIVERSE COUNTRIES AND BACKGROUNDS, FROM BILLIONAIRES TO HOUSEMAIDS'***

My patient base is quite narrow, expatriates cannot retire here, so we rarely treat people much older than 50-55, and I've only seen one denture in the last 28 months!

Children's dental health on the other hand appears to be neglected. The decayed, missing, filled teeth (DMFT) is 3.8, above the standards set by the World Health Organisation, who state DMFT should be no more than 3 in a population, while 80% have unhealthy gums. It's an area I'm planning to research for my dissertation in Master of Public Health this year. A future Oral Health Strategy in Dubai needs to be aware of the knowledge, attitudes and practices of different cultures when making its recommendations.

Would I recommend working abroad? Absolutely!

Connect with Rachael via https://ae.linkedin.com/in/rachael-england-84b1493a.

bdjteam201630

# 10 top things every dental practice should know about social media

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Ten top tips from **Gemma Breeze**, a dental nurse/marketing manager at Smile Essential in Leicester. Gemma has been at her practice since 2008 and keeps the practice's blog and social media pages up to date.

## 1 What's the point – will I get patients?

Ok so you more than likely won't be able to track tons of phone calls from social media but posting regularly can help drive potential patients through to your website and improve how high you rank on a Google search.

Social media works amazingly well for cementing the bonds in existing patient relationships. It can be hard to shake off the dark dentist image of yesteryear; connecting with patients in a twenty-first century way shows that dentistry has moved out of the dark ages.

## 2 It's time to step onto your own stage

When was the last time you posted a personal status or uploaded a photo? Before you plan to start posting on your dental practice's Facebook page it can help to share the odd status or post a pic of something of interest on your own Facebook account.

Facebook didn't come naturally to me and before I would launch a campaign I used to try and improve my social confidence by sharing pictures of my family or events and I found when the likes started to tot up so too did my confidence.

It's important to be your authentic self on social media but remember it is classed as a public domain, so aim to be personal but professional.

## 3 Silence can be deadly

Don't be a silent snooper! We're all guilty of looking and not liking or commenting but being social is a two way transaction. So if you like it give a thumbs up; after a week of doing this stretch yourself a little further and write a comment.

This applies to both your personal and dental practice accounts. Following other dental organisations such as the BDJ, BDHF, Colgate, BDA and other dental organisations will help to keep you in the know and help that organisation to keep the information coming your way. Interact regularly and you'll get noticed and they could start interacting with your stuff!

**'IT'S IMPORTANT TO BE YOUR AUTHENTIC SELF ON SOCIAL MEDIA, SO AIM TO BE PERSONAL BUT PROFESSIONAL.'**

## 4 Facebook is not the social world

I'll be honest and admit I hated Twitter- who used it, why would they use it, it's too complicated, I can't keep up. When I actually took some time and learned how to do Twitter, it brought us in a lucrative patient. He recommended other patients and raved about us on Twitter and it was so easy!

So once you're comfortable using Facebook spend some time looking at other successful dental practices on Twitter. Already mastered these? Lucky you! There are so many to try and you might be surprised that it really works for you. You could try Instagram, Pinterest or try and help your Google ranking with Google+ posts.

## 5 Keeping it real

Think about what people like to see when they flick through social media. Reminding people to brush twice daily for two minutes with a fluoride toothpaste is important in surgery and perhaps during a dental campaign or oral health month but it's unlikely to be a social media hit with your patients if it's otherwise.

People love to see a bit of personality and information that's only really shared on social media whether that be a weird dental fact, a look behind the scenes at your practice or seeing your practice in a new light because you've shared a picture of yourself with the latest gadget, a team award or even being naughty treating yourself to a chocolate biscuit that a patient brought in for you.

We all love finding out more about people and creating mini profiles of all the dental team with the odd fun questions thrown in; this can strike a chord with your patients. Too often practices seem to separate their online and practice activities. This will help the team to feel connected. It will also have the added benefit of your team being online and offline branding being kept in sync.

## 6 Book yourself an appointment

Finding the time to post to social media is tricky- Mrs Jones has lost a crown, Timmy has broken his tooth falling from his bike and Mr Smith forgot he had a mouth full of metal and treated himself to a toffee with a surprise lost filling! Now to write up the notes for the day and hmmm let's do a fun engaging post to Facebook.

Facebook easily lets you schedule your posts months in advance, so try and find an hour somewhere in the week when you're relaxed and plan 2-3 posts for that week. Perhaps a photo of the team on a course or work outing, a tip for fresh breath and a patient testimonial. Just remember to schedule them at a good and convenient time. I find 1pm and 6pm work well because this is when people have a break from work and if someone comments I will be able to respond back quickly.

There are also websites which allow you to post Facebook and other social media sites such as Twitter in advance. Once you're comfortable scheduling why not give them a go? The most popular are Hootsuite and Buffer.

## 7 If you don't ask you don't get

Patients will rarely look you up on social media. Advertising your social media sites in the practice is a good start, incentivising it with a simple competition is better but by far the best way is to ask them directly.

Talk to your team about how to ask and acknowledge when someone they have asked has taken action.

'Joan we are currently growing our Facebook page and would love you to connect with us on there I'll send you a link or you can search us INSERT PRACTICE NAME.' Or 'John are you on Facebook? Yes. Great we love connecting with patients and would appreciate it next time you're online to give us a like.'

Keep trying different wording on patients until you find something your whole team feel comfortable saying and is working to get your patients following you.

## 8 Don't go it alone

The saying it takes a village to raise a child can be heard as it takes a whole dental team to make your dental practice a success. This is true for the social media part as well. It can be difficult constantly coming up with ideas or an event that has happened at work when you weren't there. Encourage everyone to share ideas and if something happens in your absence to take and send you a picture.

If you have someone creative and trustworthy in your team who is a brand advocate for your practice then why not let them do some of the social media. You could let them do all or just part of it. Be clear what the guidelines are and work together for the first few weeks to ensure the message you give is what you really want.

Sometimes it's necessary to get a little extra help and if you've come to a dead end or are finding it stressful don't give up! There are lots of social media workshops and dental companies providing personalised analysis and training. Investing a little could help a lot.

## 9 A picture says a thousand words

I would go as far as saying at least 70% of the time you should be sharing a picture with your social media posts.

By sharing a picture with your social media posts you will significantly increase the chance of people engaging with it. This is for two reasons: firstly a picture will of course make your post stand out more and secondly social media sites such as Facebook know that its audiences prefer to see imagery so it will favour showing your post.

When I said share a picture at least 70% of the time what I really meant was 100% time on Facebook, Instagram, Google+ and Pinterest and 70% on Twitter.

Don't let the 160 word capacity of Twitter fool you. The small capacity of space on Twitter can mean that it has a tendency to be text heavy. A Twitter audience wants news, information, facts and it wants them fast. So try and incorporate some imagery in Twitter, it could be picture, a video or the fun use of an emoji or two.

## 10 GDC: the rules

This may be the final point and it's one that lots of dental professionals agonise over and ultimately puts dental professionals off social media- but it shouldn't. I find the General Dental Council (GDC) rules are fairly straightforward and easy to follow- it's the not knowing what's-what that's most worrying.

The GDC standards set out the standards of conduct, performance and ethics that govern you as a dental professional and this includes social media.

I recommend to read section 9 in particular in regards to social media 'Make sure your personal behaviour maintains patients' confidence in you and the dental profession.' Also the additional guidance sheet on using social media (which mainly refers to your own personal social media) and the guidance on advertising (which apply more so to your dental practice's social media) is very important.

All of the sections and guidance sheets I've recommended are short and easy to understand. I'd recommend printing them and having a read; it should only take about 30 minutes to read the lot and you can highlight any areas you need to pay particular attention to.

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# Infection prevention and control *in your practice*

By **Martha Walker**, a medical management consultant specialising in CQC registration and compliance.

## Infection prevention and control

When it comes to Care Quality Commission (CQC) inspection and compliance, probably the one essential outcome that most dental practices say gives them greatest concern is Outcome 8: Cleanliness and infection control.

As a provider of dental care you want to ensure that you, your staff and your patients are not exposed to the risk of infection. The most effective way to achieve this is through a comprehensive infection control policy and process that forms part of your surgery's overall Health and Safety Policy.

Your infection prevention and control policy will be a mixture of processes that are national, such as following the decontamination steps as in HTM 01-05 (2013) and local to your practice such as how you arrange staff training and responsibilities. Your policy will use a variety of advice and guidelines available with careful planning and delegation of responsibilities, ensuring that your practice is infection free should not be all time-consuming and fraught.

There are four CPD questions based on this article. To take part, visit www.nature.com/bdjteamcpd.

**Table 1 Criteria used by the CQC to assess compliance with Outcome 8**

| Criteria | The 10 Criterion in the Code of Practice that the CQC judge dental practice compliance by |
|---|---|
| 01 | Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them. |
| 02 | Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. |
| 03 | Provide suitable accurate information on infections to service users and their visitors. |
| 04 | Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion. |
| 05 | Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people. |
| 06 | Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection. |
| 07 | Provide or secure adequate isolation facilities.<br>Note: this criteria would not normally be required in a dental setting. |
| 08 | Secure adequate access to laboratory support as appropriate. |
| 09 | Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections. |
| 10 | Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care. |

**Table 2 Policy outline**

**Things to think about when writing your Infection Prevention Control Policy and Processes**

An effective infection control policy should include a range of processes that cover all the areas within your practice that require a procedure.

Below are headings for the areas, but they are just that: you must populate them with relevant information to ensure the processes will work in your practice. The Code of Practice and HTM 01-05 (2013) will guide you as to what the processes are and how they can be achieved. You may consider using photographs to support the written processes.

Consider the following when writing each process:
Who will be responsible for this area?
Who will carry out the process (not always the same person)?
What will the process be?
How will the process be checked to ensure it is effective in delivering its objective?

**Aim of this policy**
The aim of this policy is to ensure that the risk of infection within this dental practice is reduced to a minimum. All members of staff will work to demonstrate compliance with Outcome 8 of the Essential Standards of Quality and Safety in accordance with the Code of Practice and HTM 01-05 (2013).

The processes by which this aim is achieved is through the following procedures:

**Patients** Whilst we would not refuse a patient on medical grounds we must take precautions to minimise risk of cross infection. Therefore a detailed medical history is taken at the first appointment. Because a patient may not disclose if they have an infectious disease we will ensure that universal precautions are taken with every patient. If a patient does disclose they have an infectious disease or we suspect they do it is advisable that we take specialist advice from our local health protection unit.

**Staff** Administration as well as clinical staff must be aware of the need to minimise infection within the practice:
- Induction
- Training
- Immunisation
- PPE (gloves, goggles, aprons etc)
- Uniform/dress/appearance (hair, makeup, jewellery etc)
- Hand hygiene
- Needle stick injury

(Tip: All of the above staff information could be incorporated into the staff hand-book.)

**Infection Prevention and Control** within the surgeries and decontamination room – this process will be supported by a comprehensive Check List (see Table 4). Create a Tick Box Check List for each surgery and decontamination room of what to do and by whom. These Check Lists will provide evidence that you are doing what you say you do and can be used in audit.
- Daily (At the start of the day and end of each day)
- Weekly
- Monthly.

Note: Similar checklists can also be drawn up for non-clinical cleaners to follow (this is particularly useful if these cleaners are from an agency or not on-site when you are).

**Decontamination room** Consider if you have the most effective layout in the decontamination room. Does the journey of 'dirty in' and 'clean out' flow without the two crossing over? (See Table 3) HTM 01-05 (2013 version) recommends that access to the decontamination room is restricted to relevant staff.

**Instruments** If you use *single use* instruments ensure they are clearly labelled and disposed of promptly in clinical waste.

*Re-usable* instruments go through a four stage process – each process needs guidance on how to complete and a designated area to carry out the task:
- Decontamination
- Sterilisation
- Packing
- Storing.

**Transferring to the laboratory** All impressions and appliances must be disinfected before being sent to the laboratory. Explain how they are to be handled and labelled.

**X-ray films** Ensure that X-rays are handled carefully using gloves.

**Equipment** Ensure all equipment is operated, sited, cleaned and serviced in accordance with the manufacturers' guidelines.

**Dental unit waterlines** Explain how infective agents are prevented from being introduced into the water supply.

**Treatment areas** Keep these areas clutter free (keep the whole surgery clutter free; it makes for easier cleaning). Decide which areas are at greatest risk of contamination; keep these areas to a minimum and ensure they are decontaminated after each patient. Keep the administrative/computer area separate from the clinical area.

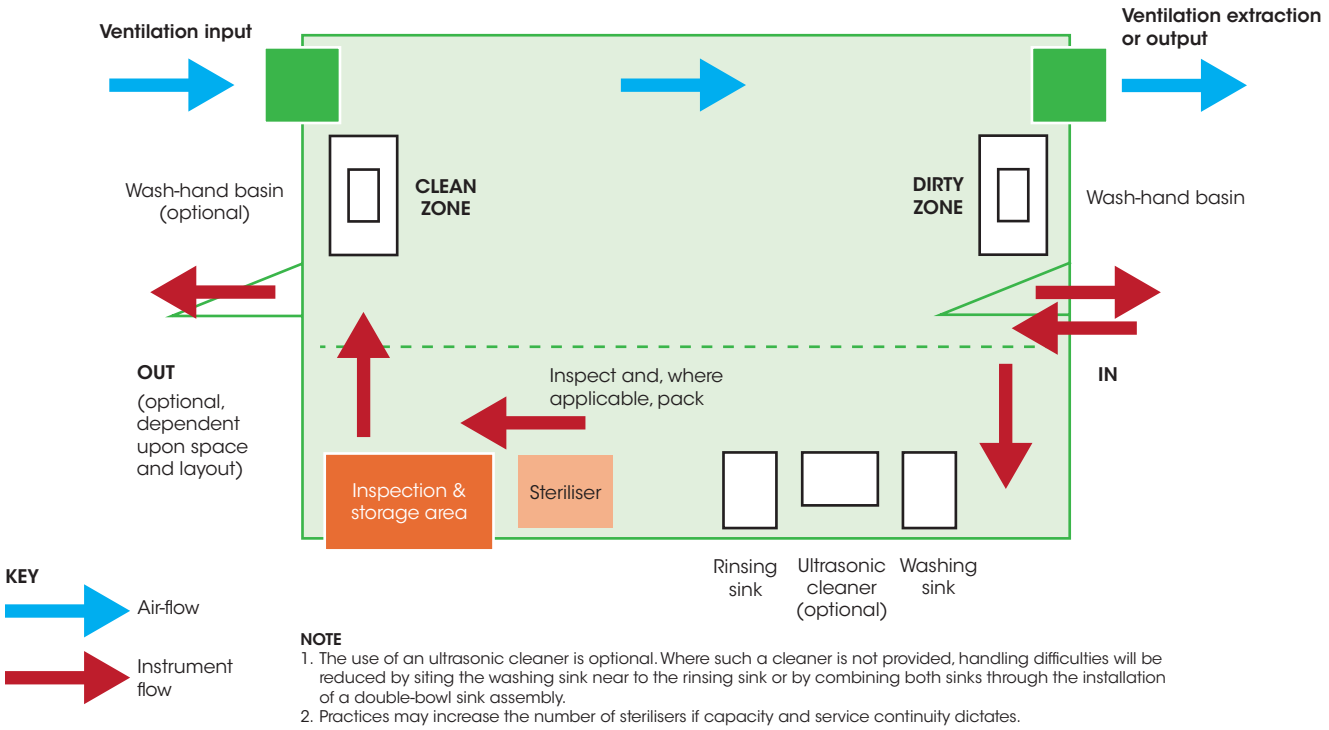
**Ventilation** Explain how the practice is ventilated; are there any special precautions to be observed?

**Clinical waste** Consider the following:
- Siting and labelling of clinical waste bins in surgery
- Removal of clinical waste from surgery and secure storage until collection
- Siting and labeling of sharps boxes in surgery
- Removal of sharps boxes from surgery and secure storage until collection.

The above list is not exhaustive and following discussion within the practice you may wish to add other procedures. Once you have written the policy and processes it must be distributed amongst the staff. The IPC lead may decide to introduce it during a staff training session or email it to everyone. However it is distributed, the IPC lead must be satisfied that it is understood by all staff.

**Table 3 Plan for decontamination room**

**Example layout for essential quality requirements as recommended in HTM 01-05 (2013)**




**NOTE**
1. The use of an ultrasonic cleaner is optional. Where such a cleaner is not provided, handling difficulties will be reduced by siting the washing sink near to the rinsing sink or by combining both sinks through the installation of a double-bowl sink assembly.
2. Practices may increase the number of sterilisers if capacity and service continuity dictates.

## Getting started

Before you begin developing your infection prevention and control policy you must ensure that your dental practice has an effective infection control team in place. In a small practice the team may just be the lead dentist or dental nurse and one or two others; in larger establishments the workload can be shared across the whole team.

## Appoint an Infection Prevention and Control Lead (IPC lead)

The IPC lead will report to the registered provider or registered manager.

The IPC lead will oversee and monitor staff as they carry out various tasks relating to infection control in different departments within the dental practice. Make your IPC lead responsible for the cleaning standards throughout the practice, including the non-clinical areas. The CQC inspect the whole establishment and your patients will give their opinion on what they see and understand. They won't know if the ultrasonic cleaner's surfaces or the aspirator is cleaned at the end of each day, but they will be able to say if the toilets are dirty or there are bags of rubbish in the corridor.

Allocate appropriate staff to be responsible for undertaking infection control cleaning in the various departments such as:

- Decontamination room(s)
- Hygienist room(s)
- Surgery(ies)
- Waiting/reception areas
- Administration areas
- Toilet and cloakroom facilities.

## The role of the IPC lead

An effective IPC lead will be responsible for the management and structure of infection prevention and control in the practice and oversee the delivery of local policies and their implementation. The IPC lead will be report directly to the registered provider or registered manager.

> 'Does the journey of "dirty in" and "clean out" flow without the two crossing over?'

The IPC lead must:

- Have the authority to challenge, assess and make recommendations
- Be part of the practice governance team
- Produce an annual statement regarding compliance and make it available both internally and externally (eg CQC if required).

## Allocate resources to infection control

Ensure a budget and time is allocated to allow sufficient resources to be made available for staff training, purchase of equipment or maintenance (of building and equipment) to be planned.

## Adhere to regulations and essential standards of compliance

The CQC gives no guidance within the Essential Standards of Quality & Safety relating to Outcome 8, Cleanliness and Infection Control. They refer all providers (including dentists) to the Department of Health publication *The Code of Practice for health and adult social care on the prevention and control of infections and related guidance.*

The Code of Practice itself is comprehensive and easy to follow and its ten criterions are used by the CQC to assess compliance with Outcome 8 (Table 1).

Table 4 Check List template

Example of **Check List for a daily cleaning schedule in the decontamination room** (this is not exhaustive, but merely for guidance; go around the decontamination room to compile your list)

| **Week starting** ...../...../..... | | **Decontamination Room** | | | **Usually carried out by** | | | |
|---|---|---|---|---|---|---|---|---|
| ✔ | Item | Carried out at start/end each day by dental nurse initials | | | | | Monitored by IPC lead weekly following visual inspection | Comments |
| ✔ | Autoclave surfaces | *07/10/13 08hrs AB 17hrs AB* | *08/10/13* | *09/10/13* | *10/10/13* | *11/10/13* | | |
| | Work surfaces | | | | | | | |
| | Sinks | | | | | | | |
| | Ultra sonic cleaner surfaces | | | | | | | |
| | Autoclave surfaces | | | | | | | |
| | Trolleys and boxes used for carrying dirty instruments | | | | | | | |
| | Stool | | | | | | | |
| | Computer equipment | | | | | | | |
| | Telephone | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Dental practices must adhere to the *Health Technical Memoranda (HTM) 01-05, 2013 edition*. When writing or reviewing your Infection Prevention and Control policy (Table 2) and processes use both The Code of Practice and HTM 01-05 (2013) as the main references. For example HTM 01-05 (2013) recommends a layout for a decontamination room to meet essential quality requirements (Table 3).

## Build up a support network

Your practice does not have to work in isolation. There are some excellent resources available for dental practices to use in developing an effective infection control policy that will lead to best practice including:

- The local deanery
- The MHRA and local health protection agency
- The British Dental Association (BDA)
- The local CCG (clinical commissioning group)
- Equipment manufacturers
- Local colleagues to share ideas.

Don't forget that the Internet has many examples of helpful policies, guidelines and hints and tips on audit that have been posted by dental practices and health trusts to give you ideas on how others are delivering effective infection prevention and control.

## Preparing your infection prevention and control policy

Once you have appointed the IPC lead, identified specific staff to be responsible for different areas in the practice and familiarised yourself with the requirements of the Code of Practice and HTM 01-05 (2013), you can now write your policy (together with the IPC lead).

The policy outline given here (Table 2) shows the different areas that need to have clear instructions explaining how infection will be minimised. A range of appendices showing how you will achieve its aims and objectives should support your policy. For example, the cleaning regime of the decontamination room and surgeries can be created and recorded on Check Lists (Table 4).

Once you have completed your infection prevention and control policy and processes, circulate it to all staff.

## Ongoing compliance

An effective policy is one that can be used as a working tool. The policy should be available for reference. The successful delivery of a policy is demonstrated through observation:

- Does the practice look and smell clean?
- Are staff dressed appropriately (is there protective clothing available)?
- Do staff know what to do when asked, for example about a needlestick injury or clearing up body fluids?

*Written evidence – results of audits*

- Minutes from staff meetings
- Annual report from the IPC lead
- Completed Check Lists

> 'Once you have written the policy and processes it must be distributed amongst the staff. The IPC lead must be satisfied that it is understood by all staff.'

*Staff training - training matrix*

- Individual staff training records
- Appraisal records.

Patient input - questionnaires/feedbacks should include something about the cleanliness of the practice.

## In summary

Appoint a competent IPC lead and support them to develop the infection prevention and control policy. Allow time and budget to train staff and implement changes and systems as required. Develop a network for support and advice. Allow staff to take responsibility for specific areas. Work through the IPC lead to monitor, assess and adjust the infection prevention and control processes put in place.

Working as a team will help develop and deliver an effective infection prevention and control culture within your dental practice.

## Useful resources to help you achieve best practice in infection prevention and control in your practice


- Department of Health. The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. 14 December 2010. Available at: www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance.
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To contact Martha, email info@cqcconsultancy.co.uk or visit www.cqcconsultancy.co.uk

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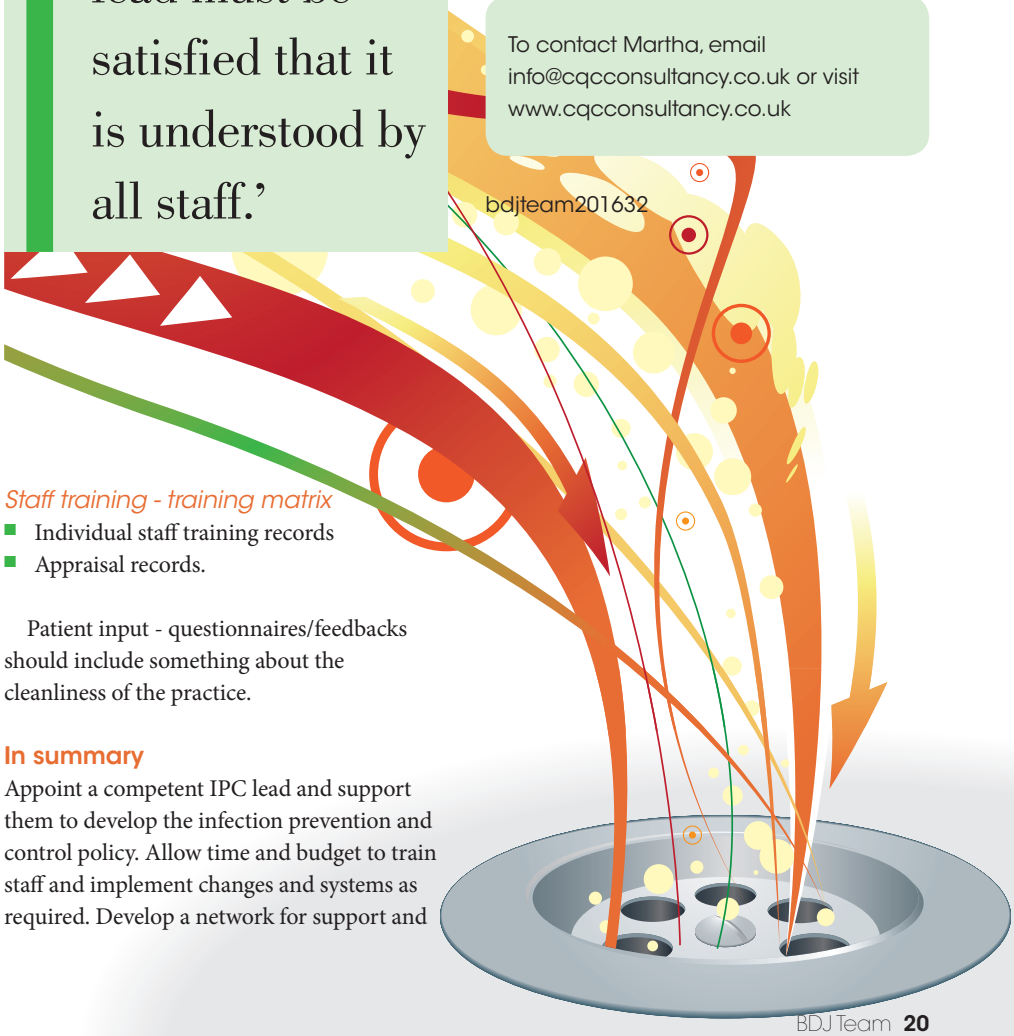


# Product news

Product news is provided as a service to readers using text and images from the manufacturer, supplier or distributor and does not imply endorsement by *BDJ Team*. Normal and prudent research should be exercised before purchase or use of any product mentioned.

## EVERYONE CAN HAVE FRESH BREATH IN 2016


Bring confidence to your patients in 2016 by recommending CB12.

Many people lose their self-esteem either worrying about their breath or suffering with the embarrassment of oral malodour. A daily shot of CB12 mouthwash could change their lives for the better.

CB12 mouthwash works instantly by targeting and neutralising the volatile sulphur compounds that cause unpleasant breath. The active ingredients in CB12 also chemically bind to the tissues in the oral cavity to prevent bad breath for 12 hours.

CB12 contains 0.05% sodium fluoride to further encourage good oral health, and is available in mint menthol and mild mint menthol flavours to give your patients fresh breath confidence every day.

CB12 also offer sugar-free Boost chewing gum with a pleasant mint flavour that can be used to boost breath confidence anywhere.

Help your patients make a new start this New Year by recommending CB12. To become a stockist or receive an information pack contact the team now on 01279 873 449 or visit www.cb12.co.uk.

## CUT DOWN ON PAPER FORM FILLING


With more and more patients having access to smart phones and emails, it makes sense to extend your paperless system directly to your patient's mobile device. Patient Portal by iSmile allows your patients to fill out medical history forms and patient questionnaires on their mobile phones, tablets or desktop computers.

Forms are automatically emailed to patients, allowing them to securely fill them out online prior or post appointment. Not only does this give your patients a more connected experience, it also means less hassle filling out forms at reception.

Once the online forms are back in your practice management system they can be verified and signed by the patient using a digital signature pad. Patient Portal further allows you to use your own choice of tablet (iOS or Android) for form filling at the practice, in case there are patients that don't have access to a mobile device.

iSmile's powerful reporting system allows you to display data from patient feedback forms in a range of formats so you can analyse trends across different time.

www.ismiledental.co.uk

## SWIFT, EFFECTIVE WHITENING AT HOME


The Philips Zoom! QuickPro 6% is the latest addition to the Philips Zoom! EU portfolio of whitening products and addresses the concerns voiced by many dental professionals as it offers convenience to the patient, without taking up valuable practice chair time or requiring custom made trays. It also fills the void left by the removal of over-the-counter tooth whitening products from the market. Philips Zoom! QuickPro 6% is clinically proven to whiten up to four shades in as little as four days (average shade reduction; actual results may vary).

No trays are needed and, provided the patient is judged suitable for treatment by a dentist, a dental professional simply walks through the first application with the patient and dispenses the product, saving valuable chair time.

Philips Zoom! QuickPro can be used as a stand-alone procedure; following a chairside treatment; or to 'top up' previous whitening. A general appointment can become a whitening appointment, thanks to the convenience of the five-minute application, making it easy and cost effective to add whitening to any appointment, especially routine hygiene sessions.

Many patients who used to buy OTC whitening products still want to whiten with the convenience of a home-use kit. Philips Zoom! QuickPro provides an affordable but professional whitening solution with that convenience.

More information is available from www.philips-tsp.co.uk/bdia.

## CALLING ALL STAR TECHNICIANS

Ivoclar Vivadent are inviting teams of dentists and dental technicians to enter the new IPS e.max Smile Award 2016 with the aim of finding the world's most aesthetic and impressive dental restoration cases using the IPS e.max system.

IPS e.max is the world's most popular and successful all-ceramic system. These users are now being invited to showcase their most impressive dental work.

To be in with a chance of winning, dentists and technicians must register as a team at ipsemax.com/smileaward. Entrants must submit their project online to showcase their finest IPS e.max work, using pictures and videos to successfully demonstrate standards such as high quality aesthetics and excellent dentist and technician collaboration.

A panel of experts will evaluate entries based on aesthetics, complexity and harmony. As aesthetic perception varies across different continents and regions there will be 12 winners. The best three teams of the four regions, Europe/Middle East/Africa, North America/Oceania, Latin America and Asia will be awarded the IPS e.max Smile Award 2016.

The closing date for submissions is 28 February 2016.

For more information on how to enter visit www.ipsemax.com/smileaward or call Ivoclar Vivadent on 0116 284 7880.

## IF PANDAS USED TOOTHBRUSHES…

The Humble Brush toothbrush is made out of 100% biodegradable bamboo which provides a naturally non-slip surface. It has an ergonomic grip and soft, BPA-free bristles made from nylon, a durable material that degrades over time and can be processed through regular waste channels. There is no other plant-based material that would allow you to use your toothbrush for the recommended three months.

The makers of the Humble Brush care about the environment; it is packed in a transparent, biodegradable wrapper made completely out of plants and the box is made from 100% recycled materials.

Bamboo is the fastest growing plant on earth and is naturally antibacterial which means there is no need to use fertilisers or pesticides during its cultivation.

For every Humble Brush sold, one toothbrush is donated to people in need of oral care.

Ultra-soft kids' toothbrushes are also available. For more information on the Humble Brush or to purchase Humble Brushes with free shipping, visit www.humblebrush.co.uk.

## ACT NOW TO AVOID HEFTY PENSION CHARGES

Employers who have delayed setting up their workplace pension scheme may now be subject to hefty initial or monthly charges. Two of the main workplace pension scheme providers have recently imposed a charge to employers.

The People's Pension added a £500+VAT set-up charge for employers signing up after 23 November 2015, reduced to £300+VAT if they sign up through a financial adviser.

NOW: Pensions has a monthly service charge ranging from £12.50+VAT to £36.00+VAT depending on the number of employees and whether the employer has a scheme administered by a payroll bureau using the NOW: Pensions' microsite.

Jon Drysdale, an independent financial adviser from Chartered Financial planners PFM Dental, says: 'Even though your 'staging date' – when you start making contributions to a pension scheme – may be many months away, it makes sense to get your scheme set up as soon as possible to reduce the risk of future set-up or service charges being imposed. It is hard for pension providers to add charges where employers have already signed terms and conditions, so my advice is act now.'

For more information visit www.pfmdental.co.uk

## THE IMPACT OF DENTINE HYPERSENSITIVITY

GSK Consumer Healthcare, manufacturers of Sensodyne, hosted a special symposium at the FDI conference, Bangkok to share results of research into the impact of dentine hypersensitivity (DH).

The research used the Dentine Hypersensitivity Evaluation Questionnaire (DHEQ), a validated tool, in order to demonstrate the impact of DH.[1,2] Through a new pooled analysis of DHEQ data, Sensodyne revealed some surprising findings about how people who experience the condition will compensate, cope and alter their social activities when living with dentine hypersensitivity:[3,4]

- Nine out of ten sufferers had been experiencing the condition for longer than one year
- 70.4% of DH sufferers considered their sensitivity takes a lot of pleasure out of eating and drinking
- 59.4% of DH sufferers try to avoid the sensations by biting food into small pieces.

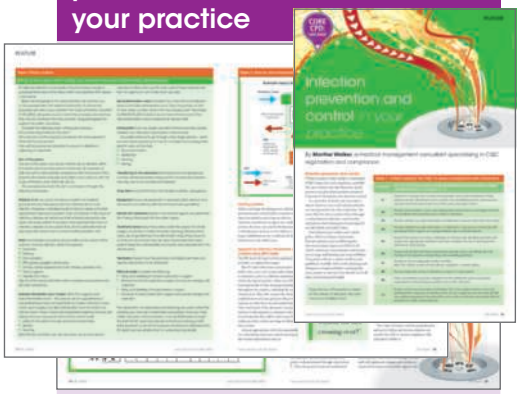
Research also confirmed the clinical benefits of continuous twice-daily use of sensitivity toothpaste.[3,4]


1. Boiko O V, Baker S R, Gibson B J *et al*. Construction and validation of the quality of life measure for dentine hypersensitivity (DHEQ). *J Clin Periodontol* 2010; **37:** 973-980.
2. Baker S R, Gibson B J, Sufi F, Barlow A, Robinson P G. The Dentine Hypersensitivity Experience Questionnaire: a longitudinal validation study. *J Clin Periodontol* 2014; **41:** 52-59.
3. GSK Data on File RH02026
4. Sufi F, Baker S. *The subjective experience of dentine hypersensitivity – a pooled analysis*. Presented at the 93rd General Session & Exhibition of the IADR. 2015.


If you would like to promote your products or services direct to the dental industry in *BDJ Team*, call Andy May on 020 7843 4785 or email a.may@nature.com.

# CPD questions February 2016

**CPD ARTICLE: Infection prevention and control in your practice**




1. A dental practice's IPC lead **does not**:

a) mop the whole practice every night

b) report to the registered provider or registered manager

c) oversee and monitor staff as they carry out various tasks relating to infection control

d) have the authority to challenge, assess and make recommendations

2. Which of the following **is not** a recommended document to use when writing or reviewing your Infection Prevention and Control policy?

a) The Code of Practice on the prevention and control of infections and related guidance

b) HTM 01-05 (2013)

c) Standards for the dental team

d) Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

3. When an ultrasonic cleaner is not provided in a practice, how might handling difficulties be reduced?

a) by installing a double-bowl sink

b) by using the sink in the staff toilet

c) by siting the washing sink near to the rinsing sink

4. Select the **correct** statement:

a) single use instruments go through a four stage process

b) administrative staff are exempt from the need to minimise infection within the practice

c) the administrative/computer area of the practice should be kept separate from the clinical area

d) the dental laboratory has full responsibility for disinfecting impressions and appliances

# *BDJ Team* CPD

CPD: ONE HOUR

## Missed **CPD**?

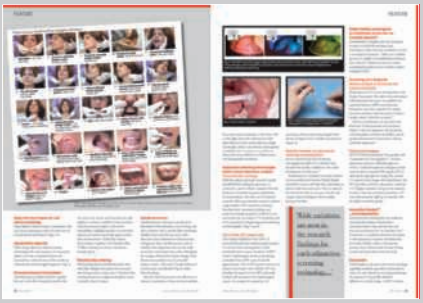
Don't worry! We know you can't always do our CPD when it arrives! That's why we make the last six CPD articles available for you to complete. Visit www.nature.com/bdjteam/cpd to get your verifiable CPD.

➤ January 2016: **The knowledge of dental nurses at one institution of the scope of practice of the dental team member**


➤ November 2015: **No turning back: posture in dental practice**


*BDJ Team* is offering all readers **10 hours of free** CPD throughout 2016. Simply visit **www.nature.com/bdjteam/cpd** to take part!

➤ October 2015: **Making oral cancer screening a routine part of your patient care – Part 2**

➤ September 2015: **Saliva: A review of its role in maintaining oral health and preventing dental disease**


➤ July 2015: **Patients with pacemakers**