BDJ Team
FEBRUARY 2019

STRESS IN DENTISTRY, A TRUE STORY

BDA
British Dental Association

February 2019

CORE CPD: ONE HOUR

Highlights

Regulars

In this issue

Ed's letter

Stress at work p13

Long service recognition p31

Debbie's ambitions p23

Could you use an AED? p8

Stress is a terrible thing. It undermines our health, takes its toll on relationships and makes our working lives fraught. We know all this and yet sometimes it's hard not to fall victim to it. Cary Cray-Webb, who inspired our cover for February, gives (page 13) a very good overview of the pernicious nature of stress and how it can gradually overwhelm you.

With the results of a major study on stress among dentists, Cary's article is timely. Dental nurses are often the buffer between a dentist and the practice reception. Without an enlightened management or practice owner, you are at the sharp end. If your dentist is stressed, the patients are anxious and the reception team operating under pressure, stress can be inescapable.

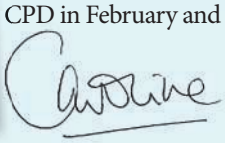
I hope the right people read Cary's article and sit up and take notice. Staff recruitment is a big issue in dentistry and creating the right conditions for all employees to thrive is imperative.

My feature on the BADN long service awards (page 31) as well as the news story about Hazel Coey (page 6) throw a light on the amazing work that dental nurses do and how it's possible to keep advancing your career with the right aptitude and determination. Maureen Stone (page 33) is a perfect example of the caring and courageous qualities that dental nurses have. Another article in this issue which I hope gains some traction is Debbie McGovern's piece (page 23) about her ambitions while she is President of the British Association of Dental Therapists. She predicts that change is on the way but first there needs to be greater understanding of the work that dental therapists can undertake.

Our February issue launches (page 25) a series dedicated to research. The first article is written by two academic trainees and explains how to get ethical approval for research. Coming up in future issues we have contributions from a dental nurse and a dental hygienist, both working in research.

Of course, we try and give consideration to your training and CPD needs. Claire Berry reviews a perio update course she attended while Mark Foster outlines the training required for safeguarding, now essential in dental practices.

In her third article (page 8), Emma Hammett supplies detailed advice on how to operate in an emergency and this month she writes about defibrillation. She tells the inspiring story of how footballer Fabrice Muamba's life was saved thanks to the team at White Hart Lane being trained in the use of an AED and in CPR. Emma's practical guide is the basis for your CPD in February and I predict you will find it most useful!



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Claire Stevens with her dental nurse colleagues

ADVOCATE FOR CHILDREN'S ORAL HEALTH **AWARDED CBE**

Claire Stevens – aka the Toothfairy – has been appointed a CBE – Commander of the British Empire– in the Queen's New Year's Honours List in recognition of her commitment to improving children's oral health. The British Society of Paediatric Dentistry, for whom she is official spokesperson and immediate past President, says it is 'proud beyond measure.'

She is to be awarded the highest of the three orders of the British Empire, recognising the importance of children's dentistry, her work for BSPD and the commitment she has shown to being an advocate for children's oral health.

In her day job, working as a Consultant in Paediatric Dentistry in Greater Manchester's Health and Social Care Partnership, she has made her mark. Jon Rouse, Chief Officer of GMHSCP, supported her nomination for recognition in the Honours List. She is the chair of the Managed Clinical Network for Paediatric Dentistry in Greater Manchester and an expert advisor to the Brush DJ app.

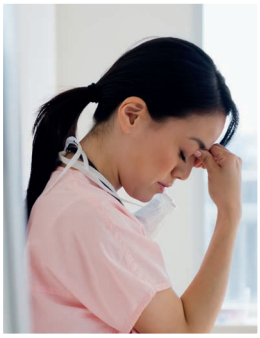
In her day job, Claire has taken a lead role in ensuring that the whole child is assessed, not just the teeth, working with her team to signpost families onto other services. She has been instrumental in connecting her hospital with a programme designed to reduce obesity in Greater Manchester's children. As a result, many of those working with children in the city and beyond are sharing important key messages in relation to diet and oral hygiene.

A mother to two young children and the founder of the Toothfairy blog (www.toothfairyblog.org), she has thrown herself both personally and professionally into reversing the tide of general anaesthetics for multiple extractions in children.

Claire commented: 'This award feels momentous because it has been made for services to children's oral health. At last we are recognising the importance of supporting every child to grow up free of dental disease.'

'I am the public face of the campaign to improve children's oral health, but this isn't just about me. Others have smoothed the way, and I am privileged to work alongside many people who continue to dedicate their lives to improving children's health. My advocacy has only worked thanks to all those who collaborate and work with me, in BSPD, in Greater Manchester and within the profession. To them I pay tribute.'

STRESS IN DENTISTRY



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More than half of dentists say stress is affecting their practice according to a study undertaken by the BDA and published in the BDJ (https://www.nature.com/articles/sj.bdj.2019.6). Around 2000 dentists enrolled in the study of whom 44% said they could not cope with the level of stress and more than 17% said they had seriously considered suicide. One of the authors, Dr Vicki Collins, a BDA Research Analyst said that some aspects of regulation and fear of litigation were key concerns.

Stress at work is not limited to dentists. In this issue of *BDJ Team* we feature an article by Cary Cray-Webb who handed in her resignation at her workplace due to intolerable stress. Among the steps that could be taken to reduce stress in the dental workplace, she suggests, would be allowing more breaks and shorter shifts. To read Cary's article, turn to page 13.

Greater MANCHESTER DOING IT DIFFERENTLY

Thousands of young children are to benefit from a new £1.5m programme aimed at transforming the dental health of under-fives across Greater Manchester. Launched last month by Greater Manchester Health and Social Care Partnership, the body overseeing devolution of health and care services, the fresh initiative will see supervised toothbrushing introduced in schools and nurseries plus dental care incorporated into health visitor checks in areas where particularly large numbers of young children suffer from tooth decay.

NHS 10 YEAR PLAN *UNVEILED*

The new 10-year Long Term Plan for the NHS was launched in Liverpool last month by Prime Minister Theresa May. The plan is good news for those working in Community Dental Services, whose work will be essential to meet the priorities that are identified, while being disappointing for those in general dental services whose work went completely unrecognised. Among hospital dental teams, only those working with paediatric services were referenced.

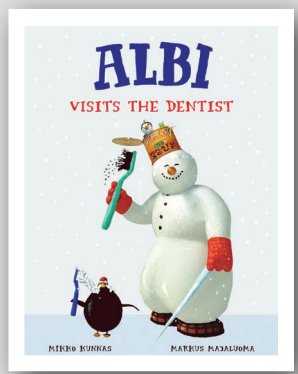
According to the plan, access to care in the community is to be improved with dental services for young people with learning difficulties and autism a priority in addition to improved services for older people in care homes. Services for children with long-term conditions such as asthma, epilepsy and diabetes were also identified as being an area of investment.

The British Dental Association in its press release responding to the plan said dentistry had been overlooked : 'Since taking office Health Secretary Matt Hancock has consistently pledged to put prevention at the heart of NHS strategy – but has failed to invest in public health activity or make any tangible commitment to dentistry.

'The PM launched her plan in Liverpool's famed Alder Hey paediatric hospital. Tooth decay remains the number one reason for child hospital admissions, with official data showing that in Liverpool alone 4,000 children have undergone hospital extractions in the last 5 years, costing up to £1 million a year.'

Finally, the BDA release mentioned Starting Well which the plan said supported 24,000 dentists across England to see more children but which, in fact, is limited to no more than about 100 dentists in a handful of wards in 13 local authority areas in England.

Albi visits the dentist



A popular children's book character from Scandinavia is now making appearances in dental practices around the UK. Albi is a snowman who lives in a land where the snow never melts. His best friends are a bird and a worm who accompany him on his adventures. In the latest book, Albi has a dream about going to the dentist.

The book is now on sale in the Oral Health Foundation bookshop. Alternatively, to benefit from a 20% discount and free postage and packing, email your order to the UK publisher: elena@sapsfordmail.net.

HAZEL COEY RECEIVES SPECIAL RECOGNITION AWARD

BADN President Hazel Coey received a Special Recognition Award, presented by Chief Dental Officer Sara Hurley, at the NEBDN 75th Anniversary Reception. The Award, presented to individuals who have demonstrated dedication, outstanding service and commitment to the education and training of dental nurses through involvement and achievement at a national level, was presented to Hazel for her 25 years as a NEBDN examiner and dental nurse tutor.

Hazel has had a varied career, which began as a dental nurse in a small village practice. She then went on to work in the perio research team at RAF Halton for the late Graham Smart. Her real passion was Oral Health Education and she was Senior Oral Health Promoter in Buckinghamshire for some years, working for Bucks Priority Dental Service. She also worked for Aylesbury College of Further Education, teaching dental nurses, and to date has taught several hundred dental nurses!

Following on from this she worked for the Oxford Deanery teaching the dental nurse apprenticeship programme. She became an NEBDN Examiner in 1994, and was on the NEBDN Committee for Oral Health Education for many years, as well as being a Presiding Examiner.

Her most recent post was as Dental Tutor at Milton Keynes University Hospital, working for Health Education England, where she arranged CPD courses for the whole dental team. Hazel's own CPD includes obtaining her Further Adult Education Teaching Certificate, Certificate of Education, Certificate in Oral Health Education and a BA (Hons) in Post Compulsory Education.

Chief Dental Officer, England Sara Hurley, presents Hazel Coey with her award.

Dates for your diary

If you have an event you want featured in 2019, email the Editor: caroline.holland@nature.com

The Orthodontic National Group Spring Study Day
March 2, Birmingham, RCS (Ed) Regional Centre, 85-89 Colmore Row, B3 2BB
9am-4pm, 5 hours verifiable CPD
Speakers include Marwa Maarouf, George Jones, Sheena Kotecha and Jane Bonehill.
Facebook.com/orthodonticnationalgroup or www.orthodontic-ong.org.

BSP 2019
The 2019 BSP Conference takes place in Brighton 24-26th April
Details here http://www.bsperio.org.uk/events/info/bsp-conference-2019.

The ADI Team Congress 2019
*M*ay 2-4, the Edinburgh International Conference Centre (EICC)
The Future of Dental Implantology: Techniques-Technology – Teamwork.
An event for experienced dental professionals as well as those who have just started out with dental implants, the Congress gives the chance to gain up-to-date knowledge, make new discoveries, network with like-minded individuals and make new contacts. The event will see a major trade exhibition hosting a wide selection of stands where professionals can experience new products and discover the latest advancements. For more information, please visit www.adi.org.uk.
https://www.adi.org.uk/events/events.php.

National Orthodontic Therapist Day
May 17, Mandec, Manchester.
Speakers: David Waring, Steve Chadwick, Simon Littlewood, Amy Gallacher, Richard Needham, Badri Thiruvenkatachari, Ovais Malik.
Limited spaces, book early: www.bos.org.uk.

EVERYTHING I DO, **I DO FOR YOU**

An inspirational talk by Dr Rosie Tope on the topic of caring for patients with dementia was one of the highlights of the most recent meeting of the British Society of Gerodontology entitled: ***The future's bright for older people and oral care in the UK?***

A trustee of Carers UK, a nurse, an academic researcher and a campaigner for people living with dementia and their families, Dr Tope gave an outline of the resources she is developing to assist communications with dementia patients.

'At least 25% of you will become a long-term carer,' she said, urging her audience to understand that dementia is an umbrella term. There are many different kinds with Alzheimers being the most common.

When discussing the challenges faced by carers, she speaks from experience. Poignantly, but with great humour, she told the story of living with her late husband Roy, who suffered with dementia for 13 years.

'I used to think I was empathetic. Until you are looking after someone 24/7, you have no idea of what it's like to be a carer.' For nine of the 13 years of his illness, she was able to care for him at home, she said, as he would have done for her, until he became too unwell and difficult to care for when he went into a secure unit in hospital.

Roy self-diagnosed in 2001. He had been getting increasingly muddled and then one day he said to his grand-child: 'I have absolute compliments in you.' The three-year-old child did not understand, while for Roy, recognition dawned that it was the onset of 'the long good-bye.' He asked Rosie to do what she could to highlight the impact of the disease.

At the time, she said they were both physically fit, but this is not always the case, especially with later onset or patients who may need medical interventions. Dr Tope suggested that at the point of diagnosis, all patients and their carers should be given a health MOT to ensure that they are in good health, especially their teeth, sight and hearing, before other challenges develop.

Roy's teeth were not a problem throughout his illness, she said as she paid tribute to Special Care Dentist Dr Janet Griffiths and dental hygienist Dawn Hooper. His eyes were a different matter and he needed a cataract operation, which she had to push for.

With Roy, communication gradually became more difficult. She found he wanted to express himself through sign language, such as a thumbs up or thumbs down. Other carers she spoke to had similar experiences of their loved ones using hand signs. She is now leading on the development of a project called 'Watch my needs.' In 2014 she won a Big Lottery Fund grant of £46,590 to support the project.

Dr Rosie Tope

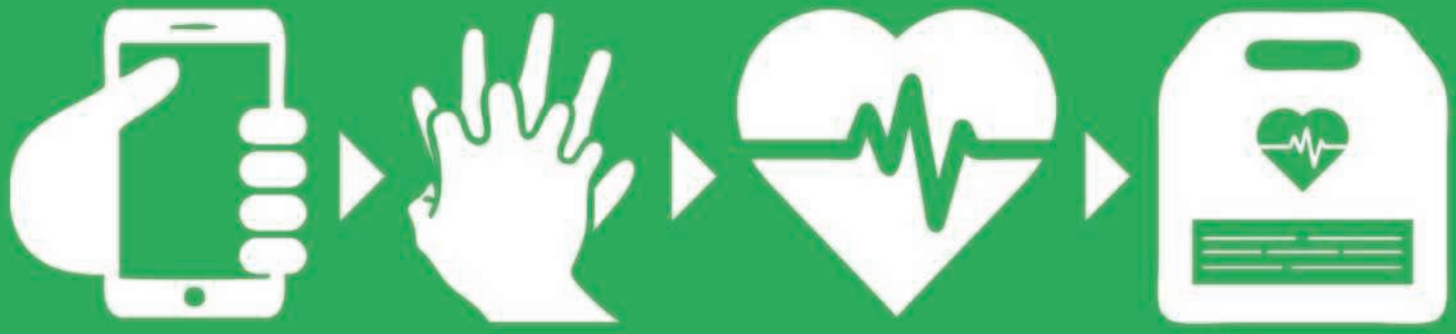
Through a Cardiff based organisation she is working with the Makaton Charity to train people with dementia and their carers to use sign language. Dr Tope said: 'It's been extraordinary. 200 people with dementia and their carers have attended the *Watch My Needs* course and we are now delivering it in care homes.'

A further development has been the creation of 'choice boards' which dementia sufferers can be given so they can indicate their preferences and needs. 'The last thing I want to get across to you is that someone with dementia, no matter how far along their journey they are, they understand what is said but cannot compute or communicate back to you.'

Dr Tope was full of optimism for the difference the new Makaton sign language and Choice Boards will make for dementia sufferers and their carers and predicted the resources should be ready to go nationwide in 2019.

'Everything I do for Carers UK and as Chair of Carers Wales I do for Roy,' she said, 'and I would not have it any other way. I will champion this issue until I take my last breath.'

Mili Doshi, President of BSG, said the Society is keen to work with DCPs who can join as members. For more information: https://www.gerodontology.com.



A guide to How to save a life with CPR and an AED

CORE CPD: ONE HOUR

CPD questions

This article has four CPD questions attached to it which will earn you one hour of verifiable CPD. To access the free BDA CPD hub, go to ***https://cpd.bda.org/login/index.php***

Emma Hammett of First Aid for Life outlines how to use a defibrillator in the event of a patient going into cardiac arrest.

Around 30,000 people in Britain every year suffer a sudden cardiac arrest in the community. They can affect anyone at any time – from young children at school, to adults when they are at work, at home or out and about.

It is vital that anyone experiencing a cardiac arrest receives immediate and appropriate treatment using cardiopulmonary resuscitation (CPR) – covered in our January edition - and an automatic external defibrillator (AED) defibrillator.

Of the 30,000 out-of-hospital cardiac arrests, 80 per cent happen at home and 20 per cent occur in public places – this includes dental practices. Being prepared for such an eventuality is covered in the General Dental Council's Scope of Practice (2013).

'A patient could collapse on any premises at any time, whether they have received treatment or not. It is therefore essential that ALL registrants are trained in dealing with medical emergencies, ***including resuscitation***, and possess up to date evidence of capability'.

Importance of the AED

Research[1,2] has been shown that administering defibrillation within 3–5 minutes of collapse can produce survival rates as high as 50–70%. Dental practices are therefore encouraged to have an AED on the premises. In the event of a cardiac arrest in a dental practice, when calling 999 for an ambulance, send a colleague to fetch the AED (and resuscitation equipment) whilst starting chest compressions. Each minute of delay to defibrillation reduces the probability of survival by 10%.

Hundreds of people are alive today entirely due to the prompt and appropriate use of a defibrillator. AEDs are now easily accessible at numerous locations; train and tube stations, shopping centres, dental and GP practices, sports grounds, leisure centres… and are available for the general public to use. They can be semi-automatic (you still need to press the shock button when indicated) or fully automatic (the machine shocks automatically when a shock is advised).

Defibrillators are absolutely vital to be able to bring someone back following a cardiac arrest. CPR keeps the heart and brain full of oxygenated blood and acts as a life support machine; however, it is the AED that enables the heart to be shocked back into sinus rhythm. These two interventions together give the casualty the very best chance of survival.

One of the most high-profile cases surrounding defibrillators involved footballer Fabrice Muamba, who suffered a cardiac arrest in 2012. He was incredibly lucky that his Tottenham Hotspur FC, at White Hart Lane had both appropriately trained people and a defibrillator.

Fabrice Muamba required a total of 15 defibrillation shocks between his collapse and arriving at the London Chest Hospital (LCH). His heart was highly unstable and he repeatedly reverted back to a shockable rythm.

Any casualty is likely to remain in a highly unstable state and may well require further shocks – never be tempted to remove the defibrillator pads if the casualty appears to recover, as you may need the defibrillator again and you only have a limited number of pads .

After arriving at hospital, it took a further 30 minutes of delivering shocks and medication to stabilise Fabrice. Despite undergoing CPR for an astonishing 80 minutes, Fabrice Muamba went on to make a full recovery and is now an ardent campaigner for the importance of the AED.

The sooner you recognise there is a problem, get help on the way, start CPR, use a defibrillator and then transfer the casualty to advanced medical care – the better the outcome.

How a defibrillator works

The defibrillator administers a shock to stop the heart. Enabling the heart's own system to reboot and hopefully restart in sinus rhythm. It should only be used when someone is unconscious and not breathing.

The machine analyses the casualty's heart rhythm and will only allow a shock to be given if they are in a shockable rhythm. It is not possible to override this with an AED and if a shock is not advised you should continue to give CPR until the ambulance arrives.

Ensure the team are all competent and confident in performing the best possible CPR – pushing down 5-6 cms on the centre of the chest at a rate of about 2 compressions per second and ensuring a release from pressure in between compressions - to enable the heart to refill.

Shockable rhythms

An AED will only allow you to administer a shock when someone is in ventricular fibrillation (VF) or ventricular tachycardia (VT).

VF – ventricular fibrillation (Figure 1) causes the casualty to become unconscious and stop breathing. VF is a shockable rhythm and if a defibrillator is used promptly on someone in VF there is a strong chance that stopping the heart with the shock will allow the heart to restart in a normal rhythm. The longer someone remains in VF the less likely it is that their heart will restart normally.

If an area of heart muscle is damaged due to a heart attack, the casualty may well survive, depending where the damage occurs and how much heart muscle is lost.

Because the heart has so many back-up systems, even if one of the pacemakers is damaged, the heart itself may still be able to generate sufficient electrical impulses to contract. The heart is an amazing organ comprising cells capable of independently generating impulses; the 2 pacemakers work together and act like the conductor of an orchestra initiating the correct impulses and ensuring that the heart beats to a fairly regular rhythm.

When an area of heart muscle is damaged it becomes unstable and often fires off its own impulses independently and this interferes with the co-ordinated rhythm generated by the pacemakers.

This misfiring affects the rhythm of the heart and causes it to become irregular. If the heart experiences a 'misfiring' beat at the point when the cells are re-charging, this can upset the whole system and the different cells fire independently of each other causing the heart to quiver erratically and chaotically. This is known as ventricular fibrillation and whilst the heart is shaking instead of pumping, it is incapable of effectively circulating the blood around the body.

VT – Ventricular tachycardia (Figure 2) is another shockable rhythm. The heart rate has become so fast that the chambers are incapable of refilling and so there is little or no blood being pumped around the body. If the casualty is unconscious and not breathing, you can use a defibrillator, which will stop the heart and hopefully restart it in a normal rhythm.

Asystole – Flat-lining (Figure 3) – This is too late for an automated external defibrillator (AED) in the community, as the heart has run out of oxygen and is now still.

Fig. 1 Ventricular fibrillation (VF)

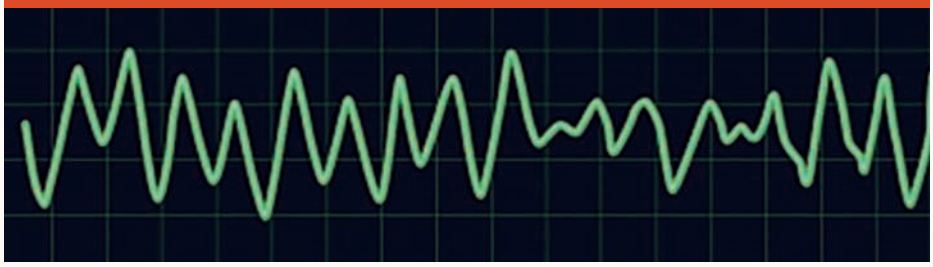


Fig. 2 Ventricular tachycardia (VT)

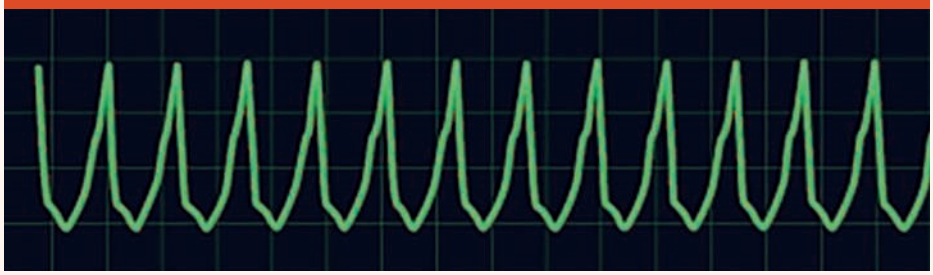
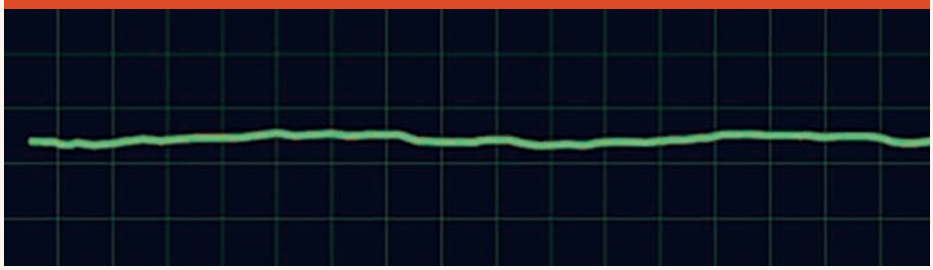


Fig. 3 Asystole – Flat-lining



Your checklist

- *Danger* – do not put yourself in danger
- *Response* – if no response, shout for help and if possible get a bystander to call for an ambulance and locate a defibrillator if there is one
- *Airway* – open the airway and check for breathing
- *Breathing* – If the casualty does not appear to be breathing normally and there are less than 2 breaths in a 10 second period you will need to start CPR
- *If you are on your own* – call 999/112 and get the AED as quickly as possible
- *If you have help* – the bystander will need to let the emergency services know that the casualty is unconscious and not breathing and bring the AED as quickly as possible. Continue CPR whilst waiting for the defibrillator.

Fig. 4 Your checklist

Fig. 5 When the AED arrives

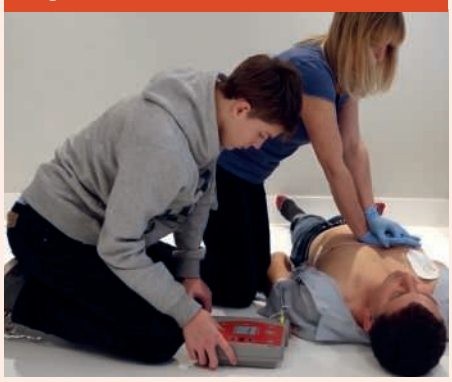
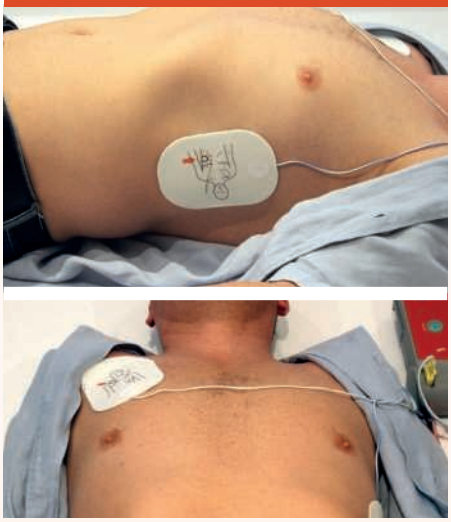


Fig. 6 Placing the pads



When the AED arrives

As soon as the AED arrives it should be activated (usually done just by opening the lid, or pressing an obvious button)(Figure 5). It will then start speaking to you. If there are two of you, one should continue with the CPR, whilst the other, attaches the leads to the AED (if necessary) dries the chest (and shaves them if necessary) and places the pads on the chest as per the diagrams (Figure 6).

- Peel the pad off the backing one at a time and place onto the dry chest according to the diagram.
- Place one pad below the casualty's right collar bone
- Place the other on the casualty's left hand side, over their lower ribs.

If you realise you have put the pads on the wrong way round – do not remove them as the AED will still work fine. If the AED offers a trace, this may appear upside down – but this will not affect the functioning of the AED.

- The AED will analyse the heart rhythm. Stop CPR when instructed and ensure no one is touching the casualty (Figure 7).

Fig. 7 Stop CPR when instructed

If a shock is advised:

- Check the whole length of the casualty to ensure no one is touching them. Loudly shout 'stand clear'
- Press the flashing shock button as directed (fully automated AEDs will do this automatically once a shock is advised)
- Continue with CPR as directed
- Keep going with 30 compressions to 2 breaths

  Keep any time off the chest to an absolute minimum
- Do not stop to check them unless they begin to regain consciousness and start breathing normally
- The machine will reassess their heart rhythm every 2 minutes and advise another shock if indicated

If no shock is advised:

- Continue with CPR (Figure 8) and follow prompts
- Keep going until help arrives, you are too exhausted to continue, or the casualty begins to regain consciousness and starts to breathe normally
- The machine will reassess their heart rhythm every 2 minutes and advise a shock if indicated
- If there is more than one rescuer swap every couple of minutes

Fig. 8 CPR

30 compressions

2 rescue breaths

'DEFIBRILLATORS ARE ABSOLUTELY VITAL TO BE ABLE TO BRING SOMEONE BACK FOLLOWING A CARDIAC ARREST... IT IS THE AED THAT ENABLES THE HEART TO BE SHOCKED BACK INTO SINUS RHYTHM.'

When the paramedics arrive

The paramedics will need to know what happened, how long you have been doing CPR, whether a shock was advised by the AED and if so, how many shocks have been given (Figure 9).

Items to keep with your defibrillator

- Spare pads
- Paediatric pads
- Resuscitation mask
- Tough scissors to cut through clothes
- Gloves
- A towel
- A razor to remove excessive chest hair

Safety Considerations when using an AED (Figure 10)

- Electric Shock – The risk of electric shock from an AED is extremely small. Providing the chest is dry and the pads are well stuck, there is little chance of the charge arcing and causing a problem. However it is always sensible to check no one is touching the casualty when the shock is given
- Jewellery – avoid placing the pads over metal jewellery as it can conduct electricity and burn the casualty. Jewellery does not need to be removed
- Ensure the casualty is still when the AED is analysing the rhythm, to avoid

Fig. 9 AED flowchart

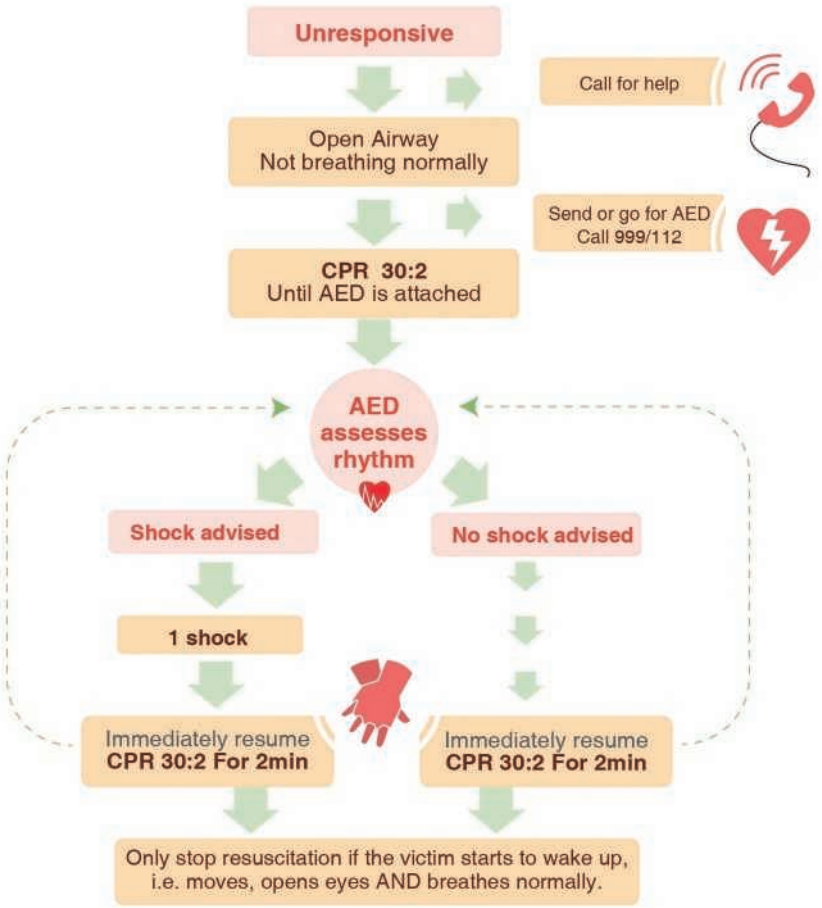
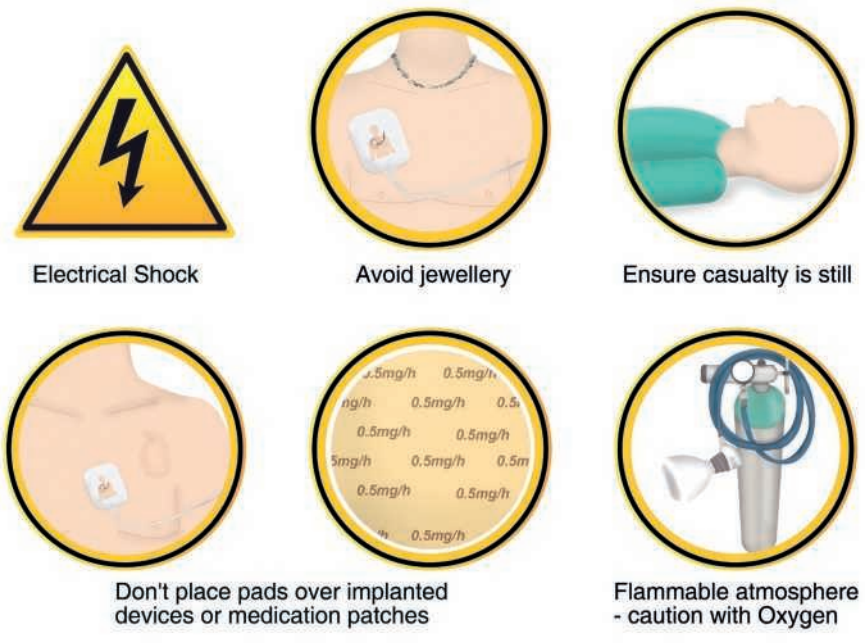


Fig. 10 Safety considerations when using an AED



an inappropriate rhythm assessment. Switch off vehicle engines and vibrating machinery if possible

- Medication patches – Remove any obvious patches on the casualty's chest and do not place pads over them. Some heart patients wear GTN (glyceryl tri-nitrate) patches and these would explode if a shock was passed over them
- Implanted devices – most pacemakers are on the left hand side of the chest. Don't place pads over strange bumps or scars
- Flammable atmosphere – turn off oxygen when giving the shock, do not use in the presence of petrol fumes.

Using a defibrillator on a child

Some defibrillators have a switch or key that adapts it for child use. If you have a child over the age of 1 who needs a defibrillator, but only have adult pads available – adult pads can be used with one on the front of the child's chest and the other placed directly opposite, on the centre of their back. If it is a baby that needs resuscitating, you must use paediatric pads or the paediatric capability (Figure 11).

AED signage

All clinical dental areas should have immediate access (within the first minutes of a cardiorespiratory arrest) to oxygen, resuscitation equipment for airway management including suction, and an automated external defibrillator (AED). The standard AED sign (Figure 12) should be used in order to reduce delay in using a defibrillator in an emergency (www.resus.org.uk/defibrillators/standard-sign-for-aeds/).

Maintenance of the AED

Follow the manufacturer's recommendations for the maintenance of the AED. It should be kept in a prominent place and everyone in the building should have easy access to it and know where it is kept.

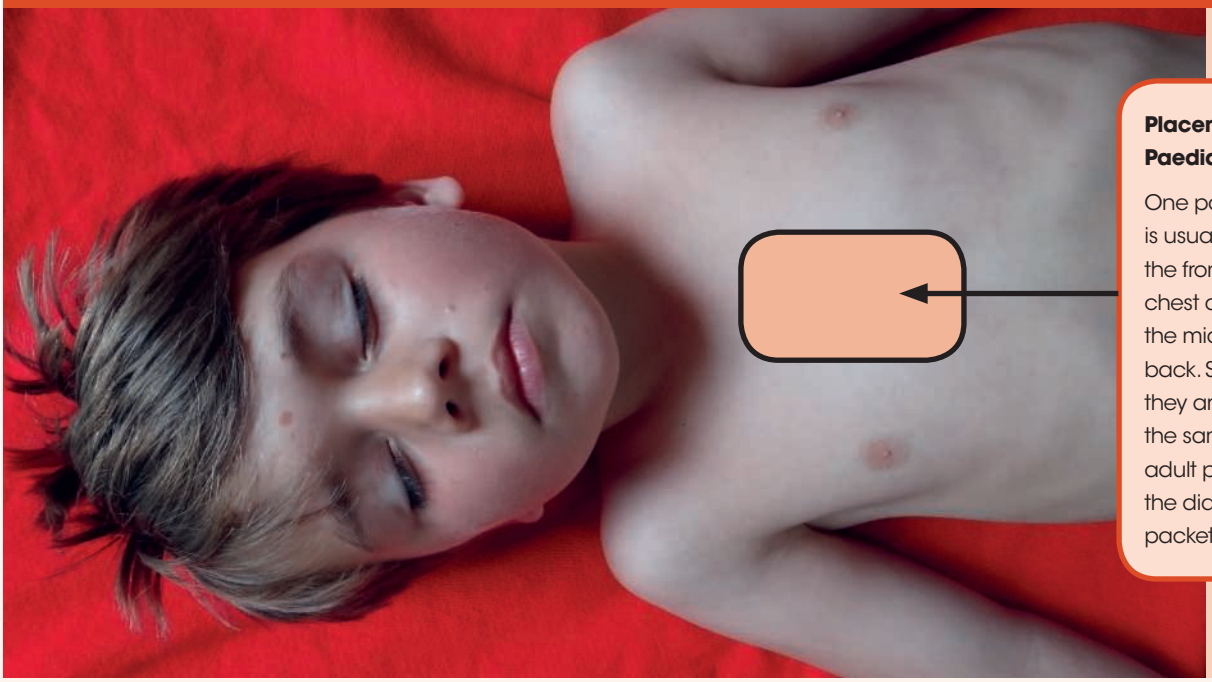
Check the expiry date for the battery and pads and order replacements in good time. Spare pads and a battery are highly recommended.

Most AEDs have warning lights and alarms to alert you if there is a malfunction or if the battery is running low. Some have a gauge that indicates battery charge. Ideally the AED should be briefly checked daily to ensure it is in good working order in case you need it. Most units have a battery life of around 5 years.

After the emergency – THE AFTERMATH

- Ensure appropriate paperwork and

Fig. 11 Using a defibrillator on a child



Placement of Paediatric Pads

One paediatric pad is usually placed on the front of the child's chest and one in the middle of their back. Sometimes they are placed in the same location as adult pads – look at the diagram on the packet.

Fig. 12 AED signage

accident forms are completed and that there is a written log of all the emergency treatment and any drugs given (including oxygen)

- Restock anything that has been used
- Ensure that everyone is ok afterwards and make time to talk things through
- Dealing with a medical emergency can be extremely stressful and some people need professional help and counselling following such an episode. It is perfectly normal to feel any of the following;
  a. A feeling of elation and an adrenaline buzz,
  b. Anger
  c. Confusion
  d. Flashbacks and bad dreams
  e. Depression.

'THE SOONER YOU RECOGNISE THERE IS A PROBLEM, GET HELP ON THE WAY, START CPR, USE A DEFIBRILLATOR AND THEN TRANSFER THE CASUALTY TO ADVANCED MEDICAL CARE – THE BETTER THE OUTCOME.'

Finally, the British Heart Foundation and Association of Ambulance Medical Directors in partnership with the University of Warwick have a national out-of-hospital database of community cardiac arrests and would welcome your input: https://warwick.ac.uk/fac/sci/med/research/ctu/trials/ohcao/.

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Emma Hammett is a qualified nurse and award-winning first aid trainer with over 30 years' healthcare and teaching experience. She is the Founder and CEO of First Aid for Life, a multi-award-winning, fully regulated first aid training provider specialising in first aid and medical emergency training for Dental Practices.

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bdjteam201937

Dentistry can be **harmful** to your (mental) health

Workplace stress is a serious business, says **Cary Cray-Webb**, who describes how and why she took a break from her job as a dental nurse.

A year ago I resigned from my post as a dental nurse. I'd had enough of the pressures associated with working in a business – a corporate chain of dental practices - where the over-riding priority was UDA completions. The final straw came when I was asked by my manager to carry out a time-saving short-cut that I felt jeopardised our compliance record. I refused and was censured.

I decided to find a job that wouldn't force me to sacrifice the quality of my work in favour of simply doing more. I wanted to reduce the mental and emotional stress to which I constantly found myself subjected and which prevented me from doing my best for my patient (or my employer, for that matter).

I'm in the fortunate position of being a co-director of a small PR consultancy run by my husband, so I was able to be more involved while I looked for a new job. And that's when it dawned on me. As well as being a full-time nurse, just like everyone else, I have other stresses and responsibilities. I am a company director, a student, a full-time Mum and a grandmother. Added to the sheer fatigue of commuting, no-wonder I was stressed out. I was in the fortunate position of being able to walk away for a while. I chose to take a break from nursing to save my mental heath.

Causes of stress in dentistry

The structure of UK dentistry (independent businesses, small chains and a few big chains) makes it hard to gather good quality evidence. So this is my own overview of the top five causes of stress for dental nurses, based on my experience and that of my friends in the profession;

Poor management. Too few practice managers and principal dentists have any qualification, training or wider experience of people management, operations management or financial management. The result is often, from the perspective of a chair-side nurse, chaos. We are frequently asked to work without basic items, or deal with defective equipment and instruments. And if we raise a problem it is too often deemed our fault by managers who won't listen.

Clinical compromise. We are asked to take short-cuts that make our actions non-compliant with best practice and regulations. Yet, very often, especially when something goes wrong, we are left to take responsibility for our actions, even when it wasn't our choice. But it's hard to speak up – see point 1.

Grumpy colleagues. Dentistry is a people business, and dental treatments require a team effort. Being rude, snappy, sullen and bullying towards colleagues is simply not acceptable and surely damages patient care as much as working relationship. But, when the pressure builds, it happens.

Bad time keeping. Every nurse I know complains that their dentist starts late, over-runs lunch breaks or brings patients into surgery before everything has been cleaned down and readied. Some dentists are even guilty of all of these things. As a diabetic, maybe I need a predictable lunch break more than most; but we all get hungry and tired, we all need time to make calls to schools, garages, and loved ones. Those of us with small children and long journeys home need to get

to child minders on time. On top of this, once we're running behind we have to constantly deal with (understandably) annoyed patients, stressed reception staff (who are dealing with annoyed patients) and angry practice managers who blame nurses because they clearly don't fancy 'having a word' with an equally stressed and tired dentist!

Pace and volume of work. The number of patients seen in a day in one surgery in general practice can be as high as 40. This is just too many. We are required to watch for signs of problems and abuse, particularly in children, but with this volume of patients, how do you spot an issue, let alone deal with it? Mental health conditions, diabetic hypoglycaemia, and even asthma attacks turn into 'problems' when they should be patients we are caring for.

Given that so many practices are short staffed and that it takes so long to recruit, problems like these are magnified when someone goes sick or leaves the practice, and this rapidly ramps up the pressure and stress felt by the other staff members.

Respect for human dignity

I have a close friend who is a dentist. I nursed for him when we worked at a big corporate. My friend often sees 30 or 40 patients a day. He is in his surgery for up to 5 hours at a time without a break. So is his nurse. He is highly qualified and very experienced. He does an extremely delicate and skilled job. It requires concentration, physical and mental dexterity, and is often highly stressful.

Yet when it comes to breaks, he and his nurse get the absolute legal minimum – assuming they don't over-run. In his early 40s, he has developed Carpal Tunnel Syndrome so badly that at one point he couldn't hold a pen. Although he was able to get treatment, he still wears a brace, a physical reminder of the pressure he faced.

I think it's time that corporate practice managers (and probably principal dentists) gave some thought to the commercial risks which they are exposing their business to. An overworked clinician is an expensive loss. Another factor, of course, is a respect for human dignity which we should all be able to take for granted.

Associate dentists are becoming harder and harder to recruit. Likewise, qualified nurses are becoming increasingly difficult to retain. While many nurses move to another practice or to roles that use their qualifications and skills, many find easier and better paid work at supermarket checkout tills. It's not just the money – workplace stress plays a very large part in the decision to leave a profession that most of us love.

I believe practice managers need to think about better rotation of nurses and providing cover for shorter shifts and more breaks. They could perhaps look at three appointment sessions with two breaks. Or else a proper, old-fashioned 'tea break' for their dentists and hygienists.

> ***'THE NUMBER OF PATIENTS SEEN IN A DAY IN ONE SURGERY IN GENERAL PRACTICE CAN BE AS HIGH AS 40. THIS IS JUST TOO MANY.'***

By reducing the physical stress on staff in this way they will also reduce the mental stress. By reducing over-all stress they may well find that they also reduce levels of illness and 'industrial injury' (such as Carpal Tunnel Syndrome) and make their practice a happier and more enjoyable place to work, leading to better staff retention.

Ideas to reduce workplace stress

I think that our professional bodies and the CQC owe it to all dental professionals, the businesses we work for (independents and corporates), and our patients, to run (and act upon) a proper study on workplace stress. If we all wore heart-rate monitors in the way that many people wear dosimeters, the CQC could review the data to check stress levels of staff during their regular inspections.

Meantime, some practical steps dental practices could take include;

1. *Management training.* Our leaders should take business management, marketing and HR courses and qualifications. Maybe designate (and train) a member of staff to act as HR manager and impartially manage 'differences' between staff and management.
2. *Respect everyone's professional integrity equally.* If someone feels something is non-compliant, work through the process and check the appropriate standards. A new nurse might be inexperienced, but may have recently studied legislation that you haven't looked at in years. And remember that everyone who works in a non-compliant manner is risking sanctions from the regulators, so don't simply shout them down.
3. *Deal with unacceptable behaviour in a positive manner.* Bullying is now a business risk and is harshly dealt with by industrial tribunals. It is the responsibility of the practice manager and principal dentist to eliminate bad behaviour. But address it in a thoughtful and conciliatory manner. A heavy-handed approach just makes things worse. Develop a positive, team-based culture through being fair to all and open to everyone.
4. *Deal with bad time keeping.* If someone is late, address the issue with that person – don't ask the nurse to 'hurry them up'. That is not our job.
5. *Proactively manage workloads and staffing.* Time is a finite resource, so if you don't have the staff, don't book the patients. If you can't find a locum you simply have to reduce the number of patients until you do.

Finally, remember that flexibility is a two-way thing, and if your staff put themselves out to help, make sure you do something meaningful to them by way of compensation.

Cary Cray-Webb is a director of Precision PR Limited, a specialist marketing company whose clients include the Pearl Dental Software brand. Cary is also a registered dental nurse. She qualified in 2015 and has worked for both of the 'big-two' corporate chains. She has gained experience at four very different practices and currently works as a locum nurse and a marketing consultant.

bdjteam201938

Singing from the same *(perio)* hymnsheet

As the dental profession faces a rising tide of negligence cases, **Claire Berry** reviews a Masterclass in Perio run by **Deepak Simkhada** in Sheffield and encourages dentists to attend.

Dental negligence claims are on the rise and there are solicitors actively encouraging patients to make a claim against their dental professional. Periodontal disease, according to Dental Protection, accounts for 47% of claims made, the highest total value of claims (Figure 1). Why then do a significant proportion of clinicians still not attach greater importance to carrying out CPD in periodontal disease?

In a poll I carried out on a dental forum, 28% of clinicians said they haven't been on a perio specific course in the last 3 years and

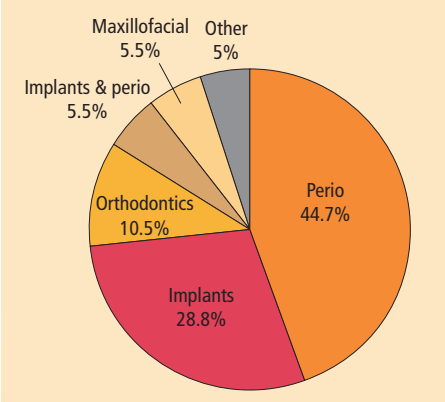


Fig.1 Top 20 UK dental negligence claims by value

have no immediate plans to do so. A further 28% hadn't been on a perio specific course but wanted to, they simply didn't know which one to attend. With recent changes in periodontal and peri implant disease classifications we should now more than ever be trying to get our heads around how to best treat these conditions so we are singing off the same song sheet as a profession and protecting ourselves as individuals.

A dentist I know asked recently: 'Why do I need to go on a perio course when I have a hygienist working with me'? My answer is we are all responsible for our own registration and the treatment of periodontal disease and peri implant diseases is part of general dentistry. Isn't it much better that we are all giving our patients the same consistent advice? And what if the patient chooses to have treatment with the dentist and not the hygienist/therapist? The treatment should be the same, whoever provides it.

So, in the interest of the 28% of people who haven't been on a perio specific course in the last 3 years, but expressed an interest in wanting to, these are my thoughts on the Masterclass in Perio run by Deepak Simkhada. I'd heard that his was a good course but I didn't know what the 3 days entailed. I approached Deepak to see if I could critically review the course. It enhanced the value of my investment to know I could help inform colleagues looking for a good clinical update.

Before attending I believed that this course was developed by a hygienist for hygienists. Although it is perfect for myself and my colleagues, it is open for dentists to attend too. It's a 'must' if you want to see your business grow generally, but in particular on the periodontal front. Not only will patients benefit greatly from the way you will go about treating their periodontal issues, you will have a happier hygienist and a more profitable periodontal treatment plan (and that is just an incidental bonus as a consequence of treating perio more effectively). It is a win win.

Day 1 is an intense day of research, studies and all the information that will set you up for days 2 and 3. Don't let this put you off though. It was all very interesting stuff and a re-cap on a lot of things you will have learnt at Uni. It gives you a base for why perio is taught the way it is. You will delve into studies so you can apply evidence based treatment for your patients, focusing on why they are in control of treatment outcomes and how to get this across to them.

Day 2 is a hands on day. This is a brilliant opportunity for clinicians to learn about all the different instruments that can be used in the non surgical periodontal therapy (NSPT) phase of treatment and representatives from Swallows dental suppliers are on hand to help with advice on sharpening instruments and general maintenance and care. Deepak provided us with quail's eggs which are small and delicate. We had to make sure we applied just the right amount of pressure using the scalers in order to scale the eggs without causing any damage.

We were exposed to different ultrasonic scaling units and taught how to adapt the settings in order to suit the kind of treatment we carry out. Think you know how to do all of this well? I did before I went, but I have taken away so much that will further improve my skills.

Day 3 is the game changer. How to treat perio in the NHS was broken down and we learned the best way to treat perio privately, which could incidentally also improve profitability greatly. Deepak explained how to refer patients to your hygienist and how to appropriately sell the private hygienist treatment as an option. Periodontal disease cases in front of the GDC were discussed and then followed by advice on how to best protect yourself against these claims. Since completing the course I am managing my patients in a much better way. As a result, I am earning more while treating and managing perio better! I came back to work and asked for a business meeting with my boss, who after hearing all I had to say has changed the way we run things and the business in general is seeing results.

As a profession we are seeing more and more claims against perio and peri implant diseases, so we should be putting more emphasis on increasing our knowledge in this treatment area. We should be striving to make sure we are all working effectively so as to protect ourselves and help our patients. I know I am just one hygienist trying to change your mindset, but if I have swayed you into thinking that in 2019 you are wanting to choose a course to embark on, please consider a perio one and better still, choose perio with Deepak.

https://www.periowithdeepak.com/

'SINCE COMPLETING THE COURSE I AM MANAGING MY PATIENTS IN A MUCH BETTER WAY. AS A RESULT, I AM EARNING MORE WHILE TREATING AND MANAGING PERIO BETTER!'

Claire qualified as a Dental Hygienist in 2009, training with the Army. She now works in practices in Doncaster and York.

bdjteam201939

Eat well, keep gums healthy, live longer

Dental hygienist **Juliette Reeves** was among the delegates at the recent British Society of Periodontology (BSP) conference and provides *BDJ Team* readers with a summary of the latest thinking on nutrition and systemic diseases as risk factors in the aetiology of periodontal disease.

An emerging body of evidence suggests poor nutrition is associated with chronic diseases and inflammation of the periodontal tissues. At the same time, at least 1 in 10 people aged 65 and over are malnourished or at risk of malnutrition. The theme of **Longevity** for the 2018 BSP annual conference in Edinburgh was the platform for examining how the dental profession can raise awareness of the importance of nutrition to health generally and periodontal health in particular.

Several presentations focused on the link between diet, health and disease with particular reference to the role of nutrition, lifestyle patterns and systemic diseases (including obesity and diabetes) as risk factors in the aetiology of periodontal disease. These factors can help explain why chronic inflammatory diseases may manifest and progress differently in some individuals and may indicate a role for nutritional intervention strategies.

Nutrition

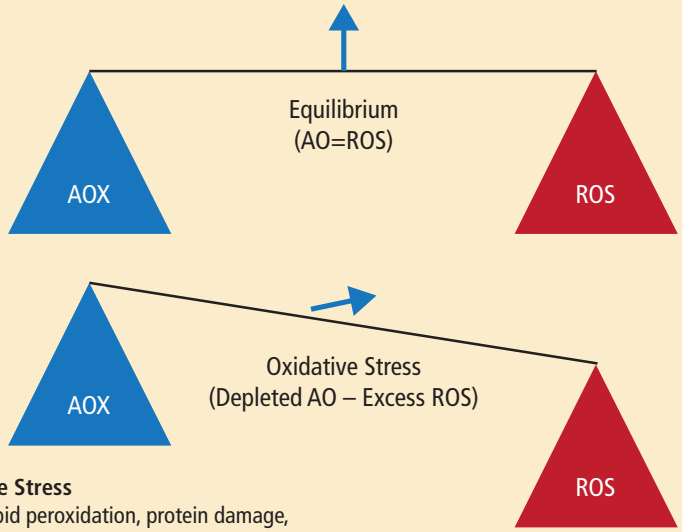
Dr Mike Milward quoted the WHO definition of nutrition as 'an adequate, well balanced diet combined with regular physical activity. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity.'[1] A balanced diet is made up macronutrients (fats, carbohydrates and proteins) and micronutrients (vitamins, minerals and trace elements) all of which are involved in human growth and development, including metabolic regulation and other biological processes. Deficiency therefore results in a wide variety of systemic and chronic inflammatory diseases.

The role of oxidative stress was highlighted by Dr Milward as playing a central role in the pathogenesis of chronic inflammatory diseases[2] and has also been proposed as a common factor in the association of periodontitis and systemic diseases.[3,4] Oxidative stress is thought to make a significant contribution to all inflammatory diseases, including inflammatory periodontal disease. An increasing body of evidence is emerging to implicate free radical activity in the pathogenesis of periodontal breakdown.[5]

In susceptible individuals, periodontal disease is characterised by a dysregulated host response to pathogenic bacteria, resulting in a heightened inflammatory response. It is thought that 20% of the tissue response is mediated by bacterial burden and 80% of tissue destruction is mediated by the host response.[4]

Oxidative stress can be defined as an imbalance between damaging reactive oxygen species (ROS) and protective antioxidant (AOX) compounds. (**Fig1**) Antioxidants are

Fig 1. Oxidative stress



Oxidative Stress
Causes lipid peroxidation, protein damage, DNA damage and cell death

substances that protect other cells in the body from damaging oxidation reactions which occur primarily as part of the inflammatory response.

Oxidative burst is part of the inflammatory response and the physiological function of polymorphonuclear leukocytes (PMLs), which, during phagocytosis, results in massive production and release of reactive oxygen species (ROS). This response is needed to destroy invading micro-organisms, but, over a prolonged period, exerts oxidative stress on otherwise healthy tissues. Research has suggested that low levels of antioxidants may be implicated in the susceptibility and progression of chronic periodontal disease and that high concentrations of antioxidants in health may represent an important anti-inflammatory defence system in the progression of inflammatory periodontal disease.[6] Earlier research has also suggested that lowered local and systemic antioxidant capacity is a feature of periodontal disease.[7]

The optimal function of the host defence system depends, therefore, on an adequate supply of antioxidant micronutrients.[8] The antioxidant micronutrients are important not only for limiting oxidative damage and tissue damage, but also in preventing increased cytokine production, which is a result of prolonged activation of the immune response. Adequate host defence activity critically depends upon the micronutrient status of an individual, particularly the oxidant-antioxidant balance.[8] Food sources that contain antioxidants including vitamin A, C, E, selenium and zinc are found in fruits and vegetables, nuts, seeds, oily fish and wholegrains.

Diabetes and obesity

There are a number of systemic diseases associated with an increased risk for periodontal disease. Professor Philip Preshaw presented the latest statistics and evidence of the relationship between obesity, diabetes and periodontal disease.

Antioxidant rich foods

Vegetables: sweet potato, carrots, red and yellow peppers, leeks, courgettes, tomatoes

Fruits: apricots, mango, cantaloupe melon, pink grapefruit, avocados

Nuts: brazil nuts, almonds, cashews, mixed nuts and raisins, hazelnuts

Seeds: sunflower, sesame, pumpkin, tahini paste

Oily fish: salmon, mackerel, herring, tuna, sardines, trout

Meat: Beef, chicken, pork

Nutrition risk factor check list:

Medical history: check for risk of diabetes, cardio-vascular disease, digestion and absorption issues such as Crohn's, diverticulitis and IBS

Dietary habits: reduce/avoid: refined foods, sugars, saturated fats. Increase: fruit, vegetables, lean protein, nuts, seeds, oily fish and wholegrains

Lifestyle: smoking, alcohol consumption, sedentary lifestyle, exposure to sunlight, isolation/ loneliness in older people

The World Health Organisation (WHO) reports that rates of obesity worldwide have tripled since 1975 with 39% of adults aged 18 and over being classified as overweight and 13% of adults being obese.[9] 28% of the UK adult population has been classified as obese.[10] The cause was identified as increased energy intake from foods dense in fat, sugar and salt. This coupled with a decrease in physical activity and the sedentary nature of many forms of work, has led to the statistics seen today.

The relationship with periodontal disease is associated with shared factors in the immuno-inflammatory cascade. The association is mediated by adipose tissue which acts like an endocrine organ producing leptin and contributing to elevated levels of pro-inflammatory cytokines, such as tumour necrosis factor (TNF) and interleukin-6 (IL-6).[11] Being overweight has been positively associated with periodontitis in adults[12] with a 35% increased risk in obese patients[13] and a three fold increased risk in type 2 diabetes patients.[14] Diabetes impacts on the 'whole person' and research shows that patients with diabetes and severe periodontal disease are three times more likely to develop end stage renal failure[15] and have a higher risk of death from ischaemic heart disease.[16]

The treatment of periodontal disease is associated with a reduction in HbA1c.[17] Each 1% reduction in HbA1c is associated with a 21% reduction in deaths related to diabetes and a 37% reduction for myocardial complications.[18] This reinforces the European Federation of Periodontology (EFP) manifesto call to all dental professionals to act in the prevention, early diagnosis and effective treatment of periodontal disease in order to combat the devastating oral and general health effects for the individual and society.[19] The Joint EFP-IDF workshop on perio diabetes[20] highlighted the role the dental team can play in treating the diabetes patient and the advantages of interdisciplinary care amongst the dental and medical professions.[21]

Vitamin D and periodontal disease

Vitamin D has long been associated with bone health and along with calcium benefits all population groups. As one of the authors of the 2016 Scientific Advisory Committee on Nutrition (SACN) Vitamin D and Health report, Professor Kevin Cashman considered the role of dietary sources of Vitamin D and recommended intake levels.

Vitamin D deficiency, based on bone health research outcomes, is set at a serum 25(OH) D threshold of <25nmol/L - 30nmol/L[22] as a population based recommendation. It is recognised however, that at risk groups such as those with dark skin and those with health issues, are likely to require a threshold of 50nmol/L. A review of standardised data show that across Europe, 13% of the population fall below the 25nmol/L threshold with 16% of adults in the UK showing serum levels of 25(OH)D below 25nmol/L and 20% below 30nmol/L respectively.[23,24] Worldwide, the data shows 120 million individuals fall below the 30nmol/L threshold.[25]

Vitamin D food sources

Oily fish: salmon, herring, tuna, sardines, mackerel

Egg yolks, butter, beef

Cheese, mushrooms/fungi

Fortified foods, margarines, cereals, milk, yoghurts

The major source of Vitamin D is the conversion of 7-dehydrocholesterol to Vitamin D3 via exposure of skin to UVB radiation (sunlight). In some parts of the globe availability to UVB is limited to 2-8 months of the year resulting in some populations being unable to synthesise Vitamin D for over half of the year.[26]

The 2016 SACN report on Vitamin D and Health recommends a daily intake of 10ug/d. [22]

'AN INCREASING BODY OF EVIDENCE IS EMERGING TO IMPLICATE FREE RADICAL ACTIVITY IN THE PATHOGENESIS OF PERIODONTAL BREAKDOWN.[5]'

Data shows that the mean UK intake of Vitamin D is 2-3 ug/d,[22] indicating that the majority of the UK population is receiving intakes below the Estimated Average Requirement (EAR). The importance of dietary intake and food sources cannot be underestimated, however. Food sources of Vitamin D are limited and whist population statistics show improved Vitamin D status with supplementation,[27,28] data collected from the National Health and Nutrition Examination Survey (NHANES) in the US show that only 30% of the population take vitamin supplementation, leaving two thirds of the population with an intake below the recommended EAR.[29] Based on randomised controlled trials in population studies, the way forward, therefore, may be to increase the diversity of food products fortified with Vitamin D.[30-33]

Professor Thomas Dietrich considered the effects of Vitamin D deficiency on the periodontium, looking at health outcomes beyond bone tissue, including inflammatory diseases such as periodontal disease. In the first study carried out in 2004 using NHANES data, Dietrich *et al*[34] found no difference in attachment loss (AL) between Vitamin D sufficient and Vitamin D deficient groups in men and women aged 20-50 years. However in men and women aged over 50 years, AL was significantly associated with serum 25(OH)D3 concentrations independently of bone mineral density (BMD). The question of whether these clinical findings could be attributed to immune-modulatory effects was considered.

Further studies showed an association between serum concentrations of 25(OH)D and gingival inflammation,[35] and when considering tooth loss, subjects were 20% less likely to lose teeth with sufficient 25(OH)D serum concentrations.[36] Zahn was also able to show subjects 14% less likely to lose teeth over a 5 year period with serum 25(OH)D concentrations greater than 30nmol/L.[37] However, a recently published[38] systematic review of Vitamin D intake and the risk of periodontal disease was unable to support or refute the association pending more longitudinal clinical studies and standardised periodontal and Vitamin D data.

The dental profession, in taking an holistic approach to care, can play an important role in helping to determine those at risk of Vitamin D deficiency and recommending adequate dietary or supplemental Vitamin D intake, thereby offsetting any oral health or systemic seqeuelae.

Lifestyle patterns

Professor Jayne Woodside presented data concerning diet and lifestyle patterns and chronic disease risk. The Global Burden of Disease[39] study cites diet and lifestyle factors as being leading risk factors causing early death and disability. These include smoking as the number one factor, alcohol intake, high blood pressure and high blood sugar levels – all of which are attributable to diet and lifestyle. Over the last two years the Eat Well Guide[40] has been revised and updated, reducing the recommended intake of free sugars to no more than 5% of dietary energy and increasing fibre intake to 30g a day for adults. There has been a shift in research patterns over the last few years looking at dietary patterns instead of studying individual nutrients as it is recognised that food and nutrient intakes are synergistic in the effect on health and disease.

Key points

- Free radical activity is implicated in the pathogenesis of periodontal breakdown
- In individuals susceptible to periodontal disease, it is thought that 20% of the tissue response is mediated by bacterial burden and 80% of tissue destruction is mediated by the host response
- A diet lacking in sufficient macronutrients (fats, carbohydrates and protein) and micronutrients such as vitamins, minerals and trace elements results in a wide variety of systemic and chronic inflammatory diseases
- The majority of the UK population does not consume enough Vitamin D – the way forward may be to increase the diversity of food products fortified with Vitamin D
- The dental profession can play an important role in determining those at risk of Vitamin D deficiency and recommending strategies to boost intake

It is now recognised that physical activity also plays a part in health and disease and this is being incorporated into food pyramid graphics.[41] The Mediterranean Diet (TMD) has recently been updated to reflect cultural and socio-economic variations.[42] There is an increasing body of high quality evidence to support the effects of TMD in decreasing cardiovascular disease and diabetes in high risk groups.[43,44] Sofi *et al*[45] report that for each two point increase in TMD score, a 5% decrease in overall cancer statistics was observed.

The discussion surrounding the question of how to encourage dietary changes at a population level included raising awareness of the health benefits, educating the public, increasing the availability of healthy options outside of the home and working with government to encourage change. More studies are needed to encourage behaviour change in 'at risk' populations.

When addressing the needs of our elderly population, Professor Marion Hetherington discussed the importance of orosensory exposure and its influence on satiety. The 2013 Malnutrition Taskforce[46] reports 1 in 10 people aged 65 and over living in the community are malnourished or at risk of malnutrition and one in three older adults in care homes are at risk of malnutrition.[47] Launa *et al*[48] demonstrated that increasing age is associated with reduced capabilities and that grip showed a strong correlation to orofacial muscle strength. The perceived difficulties with eating certain foods resulted in these foods being avoided in older adults with the lowest eating capability scores.

Appetite decreases with increasing age along with a diminished sense of taste and smell. Other factors including dry mouth, poverty, loneliness and depression all impact on the nutritional habits of older people. Presenting foods in an easy to access format such as soft foods, serving foods with sauces and in smaller more frequent portions and enriching foods with high protein products to aid in tissue growth and repair are some of the methods recommended to encourage nutrient intake in older adults. The ultimate goal being to enhance the health, wellbeing and quality of life of older adults.

As a profession we are in a prime position to encourage healthy lifestyle practices in our patients, not only in an effort to improve their periodontal health but also to enhance their overall health, wellbeing and quality of life.

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'THERE IS AN INCREASING BODY OF HIGH QUALITY EVIDENCE TO SUPPORT THE EFFECTS OF THE MEDITERRANEAN DIET (TMD) IN DECREASING CARDIOVASCULAR DISEASE AND DIABETES IN HIGH RISK GROUPS.[44,45]'

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She is Clinical Director of Perio-Nutrition and an elected executive committee member to the British Society of Dental Hygiene and Therapy.

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We have the *skills*, now let us use them!

Debbie McGovern's passion for patient care is matched by a gritty determination to improve the status of dental therapists while she is BADT President.

A few weeks ago, a young child was brought into the Liverpool Dental Spa practice where Debbie McGovern was working. There was no dentist on the premises so, officially, Debbie was not allowed to get the child out of pain. As all therapists know only too well, the rules of the current GDS contact only allow a dentist to diagnose; without a dentist's diagnosis, notwithstanding Debbie's knowledge and competence, treatment was not permissible.

Ironically, Debbie also works in a private practice – the Dental Spa is a small group of four practices established by Debbie and her dentist husband, Marius -where, under the rules of direct access, she would have been allowed to diagnose and treat the child there and then. Where is the sense, or humanity Debbie asks, in allowing those who can most afford dental care easiest access?

The disparity between the freedoms afforded to dental care professionals in the NHS compared to private dentistry is a regular frustration for Debbie. But she is hopeful that she can continue to drive change over the course of the two years in which she is President of the British Association of Dental Therapists.

She has big ambitions. 'I would love it,' she said, 'if during my presidency I can build a profile around what therapists can do.' Even within dentistry, there are people who think therapists can only provide small fillings to children. But, she says, they can provide all

sorts of fillings from an amalgam to a large composite on patients of all ages.

Says Debbie: 'Dentists' skills are so much better employed elsewhere. We should be encouraged to get on with the routine restorative work.' She is aware that some general practices have introduced therapists to their team but it hasn't worked because the right systems aren't in place.

It's much easier, she says, to set up a practice from scratch with dental therapists at the heart of dental provision. 'All the dentists who work at our Dental Spa practices say they could not work without their dental therapists.'

She believes the contract is a barrier to successfully using dental therapists and she is keen to draw attention to this. On the list of people she wants to meet is public health minister Steve Brine who she heard speak at the All Party Parliamentary Group for Dentistry in the House of Commons. She believes he will be sympathetic to her cause due to the emphasis he placed on prevention.

She is also planning to engage with student dental therapists. She wants each university to have a dental therapy student representative so therapists of the future are thoroughly invested in. BADT was established 57 years ago and during her Presidency she wants to build a strong agenda and committed membership.

Never in a million years, she says, did she think that she would end up as President of her professional organisation. There was a brief time as a teenager when she wasn't sure about her career. But then she got a part-time job as a dental receptionist and there was no turning back.

'From the second I stepped into a dental practice, I loved it. I think it was just in me.'

In her family, healthcare is in the genes. Her mother is a nurse, her aunty a health visitor and another aunty a midwife. From there she decided she wanted to be a dental nurse and trained at the hospital and then went on to Manchester University to study for a BSc in Oral Health Sciences.

It was at Manchester that she met her husband, Marius, and when they got together, a dental dynasty was born!

There are seven dentists in the family, including her husband, her brother-in-law, her nephew and three nieces. She and Marius have four children aged between 26 and 13 and one of them is already training to be a dental therapist.

'You can imagine what it's like when we get around a table and we all talk about teeth! We really are a family who live and breathe dentistry.'

At work, Debbie enjoys mentoring therapists doing their vocational training. She is always happy when she can spend time providing oral health prevention. 'I love educating patients, I am a bit of a gabby Annie. I get great job satisfaction out of seeing patients change their habits and start to look after their teeth.'

She and Marius also get great satisfaction out of their charitable work. The Liverpool Dental Spa organised a ball and raised £25k to fund the team going to Morocco to provide dental care to children. They have been twice, she says, and it's very moving to have young children walk for four hours to come and see you.

'YOU CAN IMAGINE WHAT IT'S LIKE WHEN WE GET AROUND A TABLE AND WE ALL TALK ABOUT TEETH! WE REALLY ARE A FAMILY WHO LIVE AND BREATHE DENTISTRY.'

They are very conscious, too, of the enormous dental need in the UK. 'When we retire, we want to get a dental van and treat the homeless. Our attitude is that God gave us these skills so why should we not put them to good use helping others as well as earning a living.'

In the meantime, for the next two years, she is committed to BADT and advancing its cause. Big organisations are starting to realise, she says, that dental therapists will be central to the new dental contract.

'It's a very interesting time to be President and I intend to make the most of it.'

'I LOVE EDUCATING PATIENTS, I AM A BIT OF A GABBY ANNIE. I GET GREAT JOB SATISFACTION OUT OF SEEING PATIENTS CHANGE THEIR HABITS AND START TO LOOK AFTER THEIR TEETH.'

Debbie has been in dentistry for over 25 years having started out as dental nurse at Liverpool University Dental Hospital (LUDH). She went on to do a Bachelor of Science degree – Oral Health Science – in 2004 at Manchester University. She was one of the few final year students to undertake the combined Dental Therapy and Orthodontist Therapist degree. During her 13 years on the council of BADT she has held several roles including the Chair and now President. Everything goes in fours for Debbie, who with her husband has 4 practices (1 private and 3 NHS), 4 children and 4 is the number of the house where she lives!

bdjteam201941

How to get **ethical approval** for NHS-based research

Helen Rogers and **Greig Taylor** walk would-be researchers through the process of gaining ethical approval.

Introduction

BDJ Team is publishing a series of articles in 2019 to inspire readers to get involved in research in dentistry. There are several roles within research studies that dental care professionals can undertake, whether helping to plan the project, collecting the data or assisting in writing up the study.

Our first article is by the two members of CONNECT (Child Oral health NortherN rEsearch CollaboraTive), a group of paediatric dental trainees committed to high quality, multi-centre research in the field of child oral health.

Research is a core function of health and social care. It should be innovative, improve the evidence base, reduce uncertainties and lead to improvements in care. Research projects should be scientifically sound and guided by ethical principles in all their aspects.[1] Arguably everyone working in healthcare, especially those involved in research, should understand the underpinning principles as well as the processes involved in gaining ethical approval for research.

Ethical guidelines are accepted as imperative in the light of exploitative programmes which have taken place in the past. A notorious example was the Tuskegee Syphilis Study involving 600 African-American men in Alabama which lasted 40 years (1932-1972) and was designed to observe the natural history of untreated syphilis. Shockingly, after penicillin was developed and found to cure syphilis, none of the men in the study were told or treated. Revulsion at the lengths the researchers went to in order to improve their understanding of disease in this and other unacceptable studies led to a rethinking of the law as well as the development of ethical codes.

Emanuel *et al*[2] describes seven guiding ethical principles **(see Table 1)**.

- Social and clinical value
- Scientific validity
- Fair subject selection
- Favourable risk-benefit ratio
- Independent review
- Informed consent
- Respect for potential and enrolled participants.

Table 1: A description of the seven guiding ethical principles

Ethical Principle	Description
Social and clinical value	The answer to the specific research question should be important enough to justify asking people to accept some risk or inconvenience for others.
Scientific validity	The study design should be scientifically robust, valid and feasible to answer the research question. It should follow accepted research principles; have clear methods, and reliable practices.
Fair subject selection	Participants should be recruited for the scientific goals of the study and not based on vulnerability, privilege, or other unrelated factors. Participants who accept the risks of research should be in a position to enjoy its benefits.
Favourable risk-benefit ratio	Everything should be done to minimise the risks and inconvenience to research participants to maximise the potential benefits, and to determine that the potential benefits are proportionate to, or outweigh, the risks.
Independent review	An independent review panel should review the proposal, prior to commencing, to make sure the study is ethically acceptable. An independent panel should be use to minimise potential conflicts of interest.
Informed consent	Potential participants should make their own decision about whether they want to participate or continue participating in research. This is done through a process of informed consent.
Respect for potential and enrolled participants	Individuals should be treated with respect from the time they are approached for possible participation — even if they refuse enrolment in a study — throughout their participation and after their participation ends.

Ensuring these principles are considered is the responsibility of all involved in the study[1]: the chief investigator, funder, research sponsor, research site, employers and health and social care regulators involved in each research study. The law may be authoritative regarding boundaries of acceptable practice but it is not exhaustive. Boundaries cannot always be regulated in advance and therefore ethical guidance and approval is needed.

Health Research Authority (HRA) and Health and Care Research Wales (HCRW)

Applications for ethical approval are now made through a single UK-wide Integrated Research Application System (IRAS) provided by the HRA/HCRW. This decision was made in an attempt to streamline the ethical, legal and governance approvals for all project-based research in the NHS. This approval combines an assessment of governance and legal compliance, undertaken by dedicated HRA and HCRW staff, with an independent ethical opinion provided through the UK Research Ethics Service (RES). This process replaces the need for local participating organisations to each carry out their checks. Adopting this approach allows each of these organisations to better utilise resources on assessing, arranging and confirming their capacity and capability to deliver the study.

For new studies led from Scotland or Northern Ireland but with English and/or Welsh NHS sites, the national R&D coordinating function of the lead nation will share information with the HRA and HCRW Assessment teams, who can issue HRA and HCRW Approval for English and Welsh sites. As mentioned, HRA and HCRW Approval apply only to the NHS in England and Wales. Studies led from England or Wales but with Northern Irish or Scottish sites, will be supported through existing UK-wide compatibility systems, by which each country accepts the centralised assurances, as far as they apply, from national coordinating functions without unnecessary duplication.

The approval process

To start the approval process, the researcher must make an account and log on to https://www.myresearchproject.org.uk. A new project should be created. A series of project filter questions will be asked. Two key filter questions need to be selected to ensure the project can be put forward to receive ethical opinion:

- Question 4: 'IRAS Form' option should be selected (including all other applications that are needed for your research project)
- Question 5: Confirm NHS involvement in your project by selecting 'yes'.

After completing the filter questions, the researcher should go to the Navigation Page, where their application will appear in the Project Forms list labelled as 'IRAS Form'. Selecting the label 'IRAS Form' will allow the researcher to access this form, and start inputting study-related information. Using the Navigate tab, the researcher can select the section of the IRAS form they wish to complete. Once the relevant information for that section has been inputted, they must click on the 'Mark as complete' button to complete that section. It is essential that all sections relevant to the research study should be marked as complete prior to electronic submission as if not, they will not form part of the final IRAS form. Any supporting documentation should be uploaded using the Checklist tab for the IRAS Form.

Electronic authorisations must be requested and received, from both the chief investigator and sponsor of the study, before electronic submission. Once these authorisations have been validated, the application can be submitted using the e-submission tab where a designated IRAS study number will be provided. However, this is slightly misleading as this is actually a pre-submission phase. For the application form to be submitted it must be assigned to a Research Ethics Committee (REC) using the central telephone booking system. Once booked in, the researcher will be able to submit the application electronically using the e-submission tab on the IRAS form.

For further information and support, the following link will provide a step-by-step guide on how to complete an IRAS form (https://www.myresearchproject.org.uk/help/contents/StepByStep_v2-0_20180628.pdf).

The Research Ethics Committee meeting

Research Ethics Committees (REC) are responsible for reviewing the application submitted via the IRAS system and ensuring that any ethical concerns raised by your project have been addressed. There are numerous regional committees across the UK and you can choose your preferred REC when you make the aforementioned telephone call to submit your application.. Researchers will usually book their application in to be reviewed by their local REC, so that less travelling is required to attend the meeting. Nonetheless, it is possible to book your application in with another REC that may be able to review it sooner. Each REC is comprised of experts from a wide range of healthcare specialties, alongside lay committee members, each of whom will serve for a set term. Between seven and fifteen members of the REC will meet at least 10 times per year, usually in the same location.

Once the application is booked in with the REC, they will invite a member of the study team to attend the meeting to discuss the application. Whilst attendance is not essential, it is highly recommended. Being present at the meeting enables you to explain your study further, and clarify any issues that the REC may have identified. If you have not attended a REC meeting before, it may be beneficial to ask a more senior researcher from your study team to attend with you to provide further support.

'IF YOU HAVE NOT ATTENDED A REC MEETING BEFORE, IT MAY BE BENEFICIAL TO ASK A MORE SENIOR RESEARCHER FROM YOUR STUDY TEAM TO ATTEND WITH YOU TO PROVIDE FURTHER SUPPORT.'

Studies that raise no material ethical issues may only require a 'proportionate review', in which case attendance at the meeting is not normally necessary. Further guidance on whether your study will require 'full' or 'proportionate' review can be found on the HRA website.

The REC meetings are formal, and the panel will discuss a number of applications during each meeting. You will be invited to enter the room once the panel has discussed your application and highlighted any concerns that require further clarification. Following introductions, the Chairperson

Further resources

As a minimum, anyone involved in collecting data must have completed the NIHR Good Clinical Practice Course (https://learn.nihr.ac.uk/course/index.php?categoryid=38) which is available as a face-to-face course, or an e-learning programme. Usually, the ethics application form and REC meeting would be completed by those leading the project, though it is good experience for other members of the research team to get involved with these stages as they can gain a better appreciation of the process involved.

A useful starting point could be the Clinical Research Network of the National Institute of Health Research https://www.nihr.ac.uk, the research delivery arm of the NHS.

Additionally, the Health Research Authority has quite a range of material on the web some useful links being

- https://www.hra.nhs.uk
- https://www.myresearchproject.org.uk/help/hlpethicalreview.aspx
- https://www.myresearchproject.org.uk/ELearning/index.html
- http://www.hra-decisiontools.org.uk/research/

may ask you to summarise your research project to ensure the panel fully understand the study in question. Next, the Chairperson will discuss the concerns raised by the panel, giving you the opportunity to justify your study plan. The rest of the panel will then be invited to ask you any further questions, and may make comments or suggestions on how potential ethical issues could be avoided.

If the panel are not satisfied by an answer that you give them, they will explain their concerns and suggest an alternative. They will also ask you whether your project would be negatively affected if you adopted the alternative which they have suggested. Whilst you should give your honest opinion in these matters, ultimately the final decision lies with the REC. The discussion surrounding your project is unlikely to last more than 15 minutes.

The panel will not provide you with an opinion at the time of the meeting, this will be provided via email shortly afterwards. If the REC continues to have concerns about the project, the email will contain a 'no opinion' letter, detailing any changes or clarification that would be required before the project can commence. Once these changes have been made, a favourable opinion letter may be issued at the discretion of the Chairperson, often without necessitating another REC meeting.

Top tips for a positive REC meeting:

1. Be organised

Read through your application in advance of the meeting and take note of any potential ethical issues that you may have not addressed. Consider the ways in which you could minimise any negative impacts on your study participants and be prepared to explain these to the REC. Remember that the application form is a large document – the panel won't expect you to have memorised every minute detail about the project, especially if it is a large study. It is useful to bring a copy of your application with you to the meeting, so that you can refer to it if necessary.

2. Stay calm

Despite the formality, the REC meeting is not meant to be a nerve-wracking experience. The panel aim to be supportive and encouraging of the research, and allows researchers the opportunity to ask their own questions or for further clarification.

3. Don't take criticism to heart

Researchers often put a lot of time and effort into planning a research project which can make it hard for them to hear their hard work being criticised. It is important to remember that the REC has a responsibility to ensure that your project meets the ethical standards, and that ultimately, their comments and feedback will make your study stronger. Try not to be disheartened; it is better to address any issues early, rather than risk complications arising later.

Conclusion

The ethical basis of a study is a primary concern for researchers and participants alike. Seeking appropriate ethical approval is a key part of any study, and so it is beneficial for those involved in research at any level to familiarise themselves with the requirements. Whilst applying for ethical approval for NHS-based research may at first seem to be a daunting process, it is important to remember that there is a wealth of information and support available through the HRA. We encourage you to come on board.

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Helen Rogers

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Greig D Taylor

Greig is an National Institute for Health Research Academic Clinical Fellow/StR in Paediatric Dentistry and is based at the School of Dental Sciences, Newcastle University. Greig is currently a clinical academic trainee developing his research interests whilst undertaking higher specialist training in paediatric dentistry. His research interests include: compromised first permanent molars; dental trauma; health economics in relation to dentistry; child oral health care pathways, including the liaison between primary and secondary care providers. Greig is currently the Secretary of the CONNECT trainee-led research group.

bdjteam201942

Safeguarding training is an **absolute requirement** to work in a dental practice

Mark Foster outlines what it takes to be properly trained and qualified in safeguarding.

Safeguarding training is essential for all individuals who work with children and vulnerable adults, or who come into contact with children and vulnerable adults as part of their role. Every member of the dental team needs to have dental safeguarding training for this reason.

Dental safeguarding training covers elements of child protection, including how to identify abuse and neglect, how to respond correctly to concerns about a child's welfare, and which guidance, laws, and legislation you should be familiar with if you work with or around children. It should also include safeguarding for vulnerable adults and the differences in practice for these individuals.

There are different types of safeguarding training. No matter what your role in the practice, it is a requirement of the Care Quality Commission (CQC) that every member of the dental team has an up to date safeguarding training certificate.

Will I and my dental practice be inspected?

Every dental practice is subject to regular inspection by the Care Quality Commission (CQC) and there are standards of safeguarding that must be upheld in order to pass these inspections.

Safeguarding training is therefore an absolute requirement; you must hold a verifiable dental safeguarding certificate for every member of staff in your dental practice. Expired certificates will not be accepted. Failure to provide evidence of each staff member's safeguarding certificates will result in the loss of valuable marks during inspection.

The CQC guidance states that safeguarding training should be refreshed every three years. Online safeguarding courses are acceptable for training at Levels 1 and 2.

According to the General Dental Council Principles ('*Standards for the Dental Team*', https://standards.gdc-uk.org/Assets/pdf/Standards%20for%20the%20Dental%20Team.pdf):

- **8.5.1** You must raise any concerns you may have about the possible abuse or neglect of children or vulnerable adults. You must know who to contact for further advice and how to refer concerns to an appropriate authority such as your local social services department.
- **8.5.2** You must find out about local procedures for the protection of children and vulnerable adults. You must follow these procedures if you suspect that a child or vulnerable adult might be at risk because of abuse or neglect. See our website for further information.

Furthermore, the Intercollegiate document, which is a statutory framework that sets out safeguarding training responsibilities for all healthcare staff working with children and young people in the UK, states that:

- To protect children and young people from harm, all healthcare staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. It is the duty of employers to ensure that those working for them clearly understand their contractual obligations within the employing organisation, and it is the responsibility of employers to facilitate access to training and education which enable the organisation to fulfil its aims, objectives and statutory duties effectively and safely.[1]

Do dental safeguarding training certificates expire?

Yes. All verifiable safeguarding certificates will have an expiry date, as the laws and guidance surrounding safeguarding change frequently and you need to be aware of these changes as a professional.

Typically, safeguarding certificates have a lifetime of 1 to 3 years. Each of the Child Protection Company's verifiable online dental safeguarding training certificates expires after 2 years.

Do I need to take a specific safeguarding course for my role in the dental practice?

You will need to take safeguarding training that is suitable for the responsibilities and expectations of your role. For example, a dental receptionist will not require the same level of safeguarding training as a specialist paediatric dentist. However, everyone working in the dental practice, including admin staff, volunteers, and trainees, will need to take an introductory level safeguarding course.

You can take a safeguarding course with any verifiable training provider, but it is always best to choose a provider who specialises in dental safeguarding training.

What safeguarding training do I need as a dental receptionist?

As a non-clinical member of the dental team, you are still required to take Level 1 safeguarding training, but you do not need to have further training unless deemed necessary by your practice manager.

An introductory safeguarding course like the Child Protection Company's **Introduction to Adult/Child Protection** online training course may be the most appropriate training for you. This covers both child protection and vulnerable adult safeguarding and meets the needs of Level 1 safeguarding training as outlined in the Intercollegiate Document.

What safeguarding training do I need as a dental care professional?

The Intercollegiate Document states that all dental staff working in a clinical capacity must take safeguarding training at Level 2. Therefore, as a dental care professional, you will need to take an introductory level and a further level safeguarding course.

To get Level 1 training, you must first take an introductory level safeguarding course such as the Child Protection Company's **Introduction to Adult/Child Protection**. To achieve Level 2 safeguarding training, your knowledge should then be built upon in their **Further Adult/Child Protection** online safeguarding course. Taking both of these courses together will give you the appropriate level of safeguarding training required for your role.

What safeguarding training do I need as a trainee dental professional?

Even while training or on work experience, you are still a part of the dental team and therefore will need to meet the CQC safeguarding training requirements. At the very least, you should have a Level 1 safeguarding certificate, but if you are training in a clinical capacity then you will also require a Level 2 safeguarding certificate.

What safeguarding training do I need as a specialist dental professional?

The safeguarding training needs of specialist dental professionals will vary. As a minimum, however, you are required to have safeguarding training at Level 2.

Training at higher levels cannot be taken online, so you must get in touch with your practice manager or NHS Trust to find out where you can take a safeguarding training course beyond Level 2 in your locality.

'FAILURE TO PROVIDE EVIDENCE OF EACH STAFF MEMBER'S SAFEGUARDING CERTIFICATES WILL RESULT IN THE LOSS OF VALUABLE MARKS DURING INSPECTION.'

References

1. Royal College of Paediatrics and Child Health 2014. Safeguarding Children and Young people: roles and competences for health care staff. 2014. Available at https://www.rcpch.ac.uk/sites/default/files/Safeguarding_Children_-_Roles_and_Competences_for_Healthcare_Staff._Third_Edition_March_2014.pdf (accessed January 2019).

Further information

If you would like to speak to a member of the Child Protection Company's friendly customer support team about your dental safeguarding training needs, please email help@childprotectioncompany.com, or call them on **01327 552030** today. The Child Protection Company's (www.childprotectioncompany.com) online dental safeguarding courses are recommended by the British Dental Association, and each course is worth 3 hours of verifiable CPD under the General Dental Council Lifelong Learning Scheme.

Mark Foster
As Commercial Director of The Child Protection Company Mark worked with the British Dental Association (BDA) in 2011 to create dental specific versions of the company's safeguarding courses. After schools, dental practices are the company's largest client group.

Away from work Mark is a keen motorcyclist and he jogs or cycles every day before work – mainly to find some peace and quiet away from his three noisy children!

bdjteam201943

BADN members beyond reproach rewarded with a *loyalty brooch!*

More than 2000 years of commitment to dental nursing is being celebrated by the British Association of Dental Nursing (BADN) with loyalty brooches awarded to some 90 members.

Long service awards for more than 25 years of BADN membership were presented by President Hazel Coey to Janet Goodwin, Joan Hatchard and Maureen Stone at the National Dental Nursing Conference. The rest were posted out to dental nurses who have been BADN members for 25 or more years, but who were unable to attend Conference.

Hazel also presented 10 year badges to Sara Helliwell, Sapna Mandalia and Jennifer Wood, 15 year badges to Anne Hewitt and Honorary Associate Member Sophie Schneider and 5 year badges to Rebecca Silver and Sohni Malhotra. Also, the BADN Award for Exceptional Commitment as a student was given to Rebecca Silver.

Read on for more about Rebecca Silver and Maureen Stone.

Exceptional and *ecstatic* too

Rebecca Silver outlines her career to date

My name is Rebecca and I have been a dental nurse for 9 years and qualified and registered with the GDC since 2012. I fell into dental nursing as a job, but little did I know that it would turn into a passion and career.

Where do I work?

I am currently employed as a specialist Dental Nurse at Waterside Dental Health in Canary Wharf in London. This is a fully private practice (with a very small NHS endodontic and periodontic contract). I have been here for 5 years and work with the specialists in; endodontics, periodontics, orthododontics, prosthodontics and occasionally oral surgery. I am also the trained sedation Dental Nurse so I will also assist with sedation procedures when I am needed.

Whilst here I have obtained post certificate qualification in Conscious Sedation and also a Foundation Degree with Distinction in Advanced Dental Nursing from the University of Kent.

Why have I been recognised?

I would like to think that I have been recognised due to the fact that I have a passion for learning and for excelling in anything I do.

I have gained

1. Oral Health Education Certificate
2. Conscious Sedation Certificate
3. Foundation Degree in Advanced Dental Nursing with Distinction
4. Dental Nurse of the Year South 2018 - Dental Awards
5. BADN Exceptional Commitment as a Dental Nurse Student 2018
6. Best Dental Nurse London 2018 - Dentistry awards

I always try and attend the yearly BADN conference and have made some great life long friends.

I won Dental Nurse of the Year South in May 2018, and as mentioned previously, gained a degree in Advanced Dental Nursing. This is still a new qualification. I enjoy my job immensely and I think this shows through with my passion for anything to do with dentistry!

'I WOULD LIKE TO THINK THAT I HAVE BEEN RECOGNISED DUE TO THE FACT THAT I HAVE A PASSION FOR LEARNING AND FOR EXCELLING IN EVERYTHING I DO'

How do I feel?

Ecstatic!

That's the only way to describe it. Having my commitment to the profession recognised by the BADN is a great feeling. They are an association that really cares about it members, and I feel proud that they have recognised me. Here's to another 5!

Main picture: The award winners

Left: President Hazel Coey presenting Joan Hatchard with her award

Top: Award winner Janet Goodwin wearing her brooch

Above: The 25 Year BADN long service award

HIV, OHE, **Destiny** and me

Maureen Stone looks back on a quarter century during which she, supported by the BADN, has contributed to making dental nursing ever more professional and rewarding

My career in dentistry came about by accident, or perhaps it was destiny! I had worked for 10 years in a hospital infection control/isolation unit nursing some of the first patients with AIDS. Within the hospital there was a dental clinic for the treatment of blood borne diseases/special needs. Their existing dental nurse left very abruptly and as I had limited dental experience, I was invited to apply to join the team.

This clinic became inundated with many more patients suffering with very sore raw mouths, Kaposi's Sarcoma and Pneumocystis Carinii, which we learned later signified the conversion of HIV to AIDS.

Working in this special clinic was to become the most challenging but rewarding role I had in my career. Many of our patients were generally very sick and some we visited and treated them in the specialist ward in Oxford's Churchill Hospital. We had a regular theatre slot for our patients.

Witnessing the great loss of young lives, which included hundreds of haemophiliacs, was a learning curve for me. I saw at first hand the terrible prejudices that many of these patients had to suffer. Thankfully, I like to think we have become a more educated, tolerant society, and, of course, we now have a greater understanding of the conditions and treatments available.

During my time in this clinic, I worked with many interesting groups of patients. One particular group that comes to mind was the Multiple Sclerosis patients trialling cannabis whose mouths we checked. We also treated patients with Oral Cancer, Motor Neurone disease and other long-term health problems, including skeletal and metabolic disorders. I have always had more than one job and most of the time at least 3!

Other roles I trained for and undertook were:

- An OHE qualification
- Dental Nursing tutor
- Training advisor
- NVQ assessor

Alongside these roles, I worked for the National Examination Board for Dental Nurses for many years. I worked with other tutors within the City and Guilds organisation to bring about the National Diploma.

'NOWADAYS I AM VERY PROUD TO SEE MANY OF MY EX-STUDENTS WORKING IN GENERAL PRACTICE, IN COMMUNITY AND IN HOSPITAL, MANY IN SENIOR POSTS.'

During my time with the local FE College, I happened upon my next passion. When interviewing prospective students, I found many of them had failed their Dental Nursing exam, some many times. They were set some basic tests and through these and discussion it became apparent that most of them had special educational needs. My next learning curve was to support students with Dyslexia and Dyspraxia; this group of very capable and intelligent students were being let down by teaching methods that did not match their style of learning. Nowadays I am very proud to see many of my ex-students working in general practice, in community and in hospital, many in senior posts.

My clinical work has always been in hospital oral surgery departments. The last hospital I worked for was Stoke Mandeville Hospital in Buckinghamshire; it was a very enjoyable part of my career, working as a Senior Nurse with a professional, caring and dedicated team.

During the build-up to the General Dental Council's Compulsory Registration of Dental Nurses I worked for the Oxford Deanery. My colleague Hazel Coey and I devised a programme for the Thames Valley area to make this transition as seamless as possible. Our programme of study and a short exam enabled very experienced nurses to be registered and to continue to work in their practices.

My next role with HEE was as a Dental Tutor/Practice facilitator in Buckinghamshire. In addition to supporting dental practices with day-to-day running and regulation, I planned and supported postgraduate training, running suitable courses at Stoke Mandeville Hospital Post Graduate Centre. The other aspect of my role was teaching Dental Nursing at the John Radcliffe Hospital in Oxford.

This new world of Dentistry requires us all to be professional, accountable and open to the future. I am proud to say that over the last quarter of a century, everything I have done in my career, fully supported by the BADN, has kept me looking forward, training to deliver the service that my profession and our patients need.

bdjteam201944

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.

WIDEN THE OPTIONS

Traditionally zirconia has been unavailable for NHS patients due to its cost. However, with Monolith Full Contour Zirconia from CosTech Dental Laboratory this is no longer the case. Thanks to bulk buying, the steadily decreasing cost of zirconia and automating the production process, CosTech can now offer zirconia restorations for under £30 including free postage to and from the laboratory.

Available as both anterior and posterior crowns and up to 3 unit bridges, this aesthetic and strong material is perfect for a wide range of indications, meaning you can provide more patients with a truly trustworthy solution.

For more information about CosTech Dental Laboratory, please visit www.costech.co.uk or call 01474 320076.

GUIDED BIOFILM THERAPY SPECIALIST EMS GETS SET TO OPEN UK OFFICE

EMS has announced the opening of its new UK-based premises, to be headed up by General Manager Derek Hampton. This move will offer EMS customers – both current and prospective – unrivalled levels of support in their efforts to provide patients with the best possible dental prophylaxis and preventive care, including their world-renowned guided biofilm therapy (GBT).

GBT has transformed practice and patient experience in many dental surgeries, and Faye Donald, a certified dental hygienist and trainer for EMS, had this to say about it: 'As a clinician passionate about minimally-invasive dentistry working in busy general practice with increasing demands from patients, working with EMS has afforded me the tools to meet the standards I now pride myself on. With a base of operations opening in the UK, I am excited to share that message with even more dental professionals.'

Adding to Faye's words about the UK operation, Derek, who has worked in dentistry for over 30 years and has operated at all levels, acquiring incredible insight into what dental professionals need from their industry partners, said: 'EMS is not just about providing products – we also want to offer a great level of repair, maintenance and customer service, as well as more continuing education opportunities, and having a base in the UK will enable us to add to the great work our distributors over here have already done.'

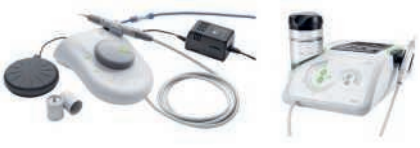
For further details about what EMS has to offer dental professionals in the UK, please visit www.ems-dental.com. Alternatively you can complete the form at https://www.ems-dental.com/en/gbt-demo and a member of the UK team will be in touch to answer any questions you may have.

STOP, LOOK AND LISA

Leading manufacturer, W&H, offers clinicians the all-new Lisa sterilizer, which delivers outstanding performance without compromise. Improving efficiency and saving time, Lisa offers an exceptionally fast B cycle, at half an hour for an average load, or just 13 minutes for unwrapped instruments.

Safety and reliability is assured. Information is easily accessible through a user-friendly touch screen or via the new app, for intelligent and easy handling of traceability. All you need from a sterilizer can be found in Lisa. Start saving precious time on your procedures, safe in the knowledge that this technologically advanced, cost-effective solution will last for years to come.

To find out more visit www.wh.com/en_uk, call 01727 874990 or email office.uk@wh.com.



ALL PATIENTS COVERED

Amongst the quality product portfolio from Wisdom Toothbrushes are the No. 1 selling rubber interdental brushes in the UK,[1] the Wisdom Clean Between Interdental Brushes. These brushes are clinically proven to reduce gingival disease.[2,3]

The Wisdom Clean Between Easy Slide Tensioning Flossers featuring a Waveform Tension Control System are another favourite. The floss harps hold the silk-like tape taunt between two arms for effortless, comfortable cleaning between the teeth.

Other solutions include the Wisdom Pro-flex Interdental Brushes with a unique flexible hinge and curved profile, the Wisdom Easy Flosser with PTFE tape and the Wisdom Interproximal Brush, ensuring all your patients' needs are covered.

To find out more, please visit www.wisdomtoothbrushes.com or call 01440 714800.

1. UK Dental Accessories Value Sales IRI All Outlets 52 w/e 8th September 2018.
2. Yost K G, Mallatt M E, Liebman J. Interproximal gingivitis and plaque reduction by four interdental products. *J Clin Dent* 2006; **17:** 79–83.
3. Ratka-Krüger P *et al*. Clinical trial of a metal-free interdental brush. University Medical Centre Freiburg: Germany, 2010.

VEGAN-FRIENDLY TREATMENT

Veganism is growing in popularity, but patients might not be aware of the possible oral health implications of this plant-based diet. Due to their increased intake of naturally sugary and acidic fruit and vegetables, vegans are more likely to suffer from dental erosion. As they are often guilty of snacking and grazing between meals, vegans are also at an increased risk of dental caries and periodontal disease, resulting from a build-up of plaque.

Remind patients to follow effective at-home oral care routines with high quality, vegan-friendly adjuncts supplied by leading oral healthcare specialist, Curaprox. This includes the CS 5460 ultra soft manual toothbrush, which has been innovatively designed with fine CUREN® filaments to facilitate efficient, but gentle tooth brushing.

When combined with the Black Is White range, Curaprox delivers the complete dental cleaning solution, so that patients can ensure their teeth always look and feel their best.

For more information please call 01480 862084, email info@curaprox.co.uk or visit www.curaprox.co.uk.

OPEN CHILDREN'S MINDS WITH CALCIVIS

Having difficulty getting your young patients to understand the impact of oral hygiene and diet on their oral health? Then try the new, advanced CALCIVIS imaging system that can be used with patients from the age of six.

Designed to help the dental team detect active tooth enamel demineralisation by applying a luminescent (light emitting) photoprotein, CALCIVIS serves as a great visual tool as it displays a glowing map of active demineralisation right at the chairside.

This enables children to physically see demineralisation that could lead to dental caries and helps them to understand the consequences of a bad diet and poor oral hygiene.

For more information about how CALCIVIS could transform patient education in your practice, contact the team today.

For more information visit www.CALCIVIS.com or call 0131 658 5152.

STOP PATHOGENS IN THEIR TRACKS!

Effective decontamination protocols and cleaning regimes are the key to preventing the spread of illnesses in your practice. But are your cleaning products up to scratch?

Stop pathogens in their tracks by using the Steri-7 Xtra range of disinfectants from Initial Medical. Able to deactivate 99.9999% of all pathogens including viruses, yeasts, spores, bacteria and fungi, these multi-purpose cleaners can be used around the whole of your practice, providing effective defence against the spread of diseases. They also form a barrier that prevents pathogens recolonising for up to 72 hours after application.

For further information please visit www.initial.co.uk/medical or Tel: 0870 850 4045.

BDJ Team CPD

CORE CPD: ONE HOUR

CPD questions: February 2019

How to save a life with CPR and an AED

In each of the four questions below, choose only **one** answer.

1. In order to achieve a good chance of survival, within how many minutes should CPR and defibrillation be carried out?

A) 1-2 minutes

B) 2-4 minutes

C) 3-5 minutes

D) 5-6 minutes

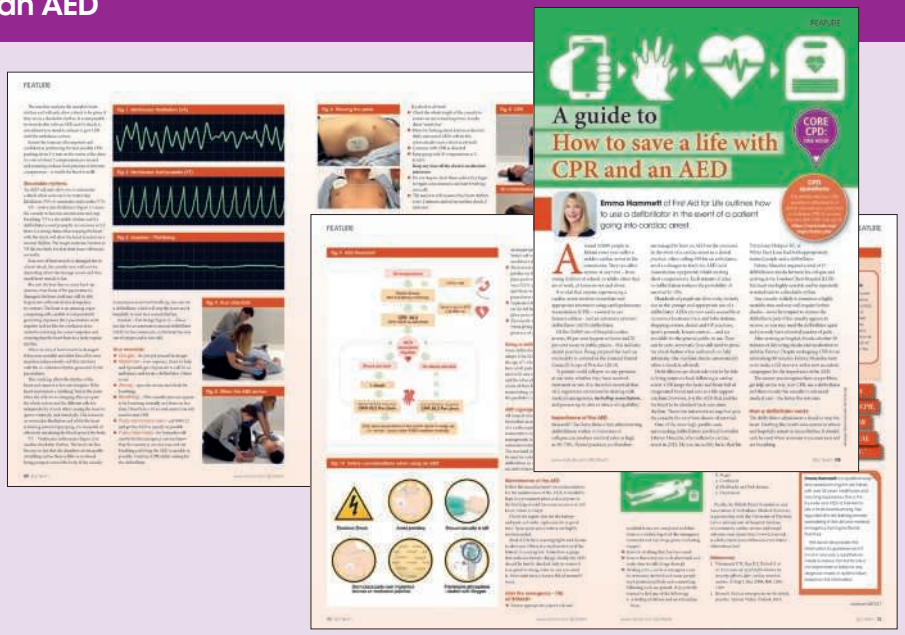
2. If the patient appears to be recovering from a cardiac arrest, should you:

A) Start doing mouth to mouth

B) Take the defibrillator pads off

C) Leave the defibrillator pads on

D) Carry on with compressions



3. You are advised to keep six essential items with your defibrillator – which among the following items should not be on the list:

A) Gloves

B) Paperwork

C) Razor

D) Scissors

4. After the patient has gone to hospital, what steps should you take?

A) Phone next of kin

B) Invest in a new AED

C) Speak to a solicitor

D) Check everyone is OK and take time to talk

BDJ Team is offering all readers **10 hours of free** *CPD a year on the BDA CPD Hub! Simply visit* **https://cpd.bda.org/login/index.php** *to take part!*

How to take part in *BDJ Team* CPD

BDJ Team CPD is available through the BDA CPD Hub. This site is user-friendly and easy to navigate. There are still 10 hours of free *BDJ Team* CPD on the CPD Hub from 2018, in addition to this issue's CPD hours.

Just visit https://cpd.bda.org/login/index.php.

To send feedback, email **bdjteam@nature.com.**