BDJ Team
JULY 2016
RESUSCITATION
in the dental practice
BDA
British Dental Association
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July 2016

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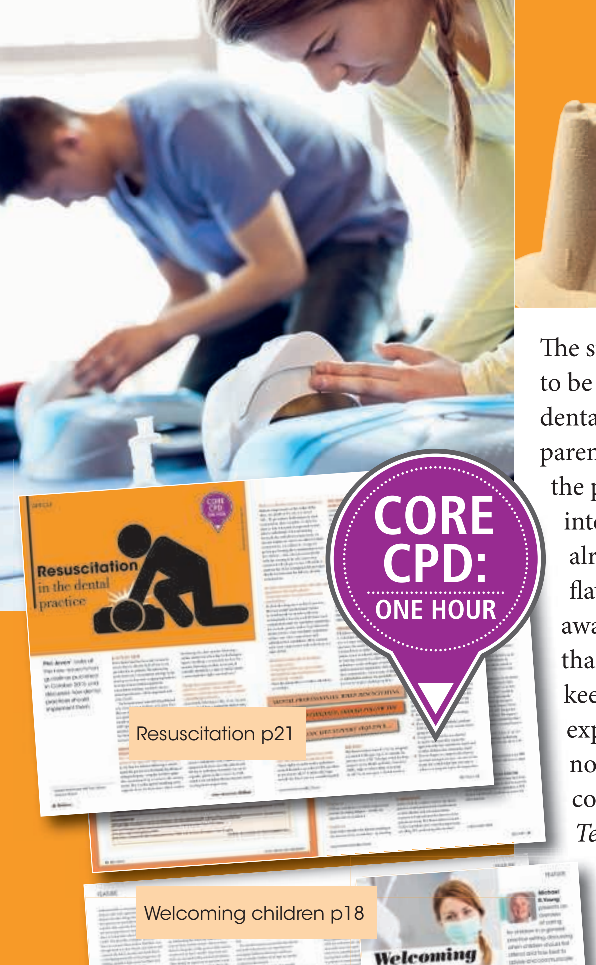

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Ed's letter

The state of children's teeth in this country continues to be in the headlines, despite all of your best efforts as dental professionals and - I'm sure for many of you - as parents. As both an editor in dental publishing and the parent of a toddler, the headlines are of particular interest to me. My son is only 14 months and is already showing a definite leaning towards sweeter flavours (I'm sure this is not rare), and moving away from the bottle with a child who loves his milk more than anything else is a feat we have yet to achieve. So I was keen to sign him up for regular dental appointments. Little did I expect that the first two surgeries local to me that I telephoned would not take children under two! Having mentioned this on social media, our regular contributor Michael Young offered the article you will find in this issue of *BDJ Team*, *Welcoming children into your practice*.

Mike is a former GDP with a special interest in children's dentistry and in this article he answers some of the questions parents and guardians might ask you about their child's dental care.

In complement to this piece, we also include 'top ten tips for toddler teeth', a handy guide that you can use as a reference or even distribute to patients with young children, written by Claire Stevens, a Consultant in Paediatric Dentistry, mum of two and representative of the British Society of Paediatric Dentistry.

It's not all about kids in this issue. Our CPD article is on the very important topic of resuscitation in medical emergencies; we have an interview with a dental hygienist-turned-inventor; and feature an original *BDJ* article evaluating a patient anxiety service led by dental nurses.

This issue also features that rare addition to our regular content, a letters page. Correspondent Claire has reopened a familiar topic, that of dental nurse salaries. If you would like to respond to Claire or open any other topics, please drop me a line or message me on Facebook.

The next *BDJ Team* will be in September - enjoy the summer!

Kate

Kate Quinlan
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bdjteam2016108

THE TEAM

Cover
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Publishing
Publisher: James Sleigh
British Dental Journal
The Macmillan Building
4-6 Crinan Street
London N1 9XW

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DCP OF THE MONTH: JULY 2016

We are delighted to have chosen dental nurse Naeema Nalban as *BDJ Team*'s first DCP of the month.

Naeema's entry to our competition, which was announced in the May issue of *BDJ Team*, was very impressive, so we would like to include it here:

I am a 25-year-old Oral Health Promoter with a sincere passion for oral health. I have been working within the Bradford District Care Trust for the best part of three years and provide a range of programmes which vary from speaking to other health professionals, delivering workshops and attending schools. Our aim is to reduce oral health inequalities in the Bradford District based around the evidence interventions; I plan, design and coordinate health promotion interventions. I do this by creating relevant resources that are underpinned by the Public Health England document: Delivering better oral health: an evidence-based toolkit for prevention.

Alongside my oral health role, I work as a dental nurse in Bradford which is part of the Unplanned Dental Care (UDC) service for patients who require emergency dental treatment during out of hours. We mainly provide temporary treatments which in most cases are extractions, temporary fillings and extirpation which need to be delivered in a fast paced work ethic as there is a high demand of patients waiting to be treated in a short time scale.

Alongside working within the dental environment, I have been driven in enhancing my knowledge within the field and have undertaken courses which include:

- *Preparing to Teach in the Lifelong Learning Sector (PTLLS)*
- *Health Promotion/Public Health MSc Level 7 Certificate – Leeds Beckett University*
- *Dietitians Food Nutrition programme for 0-5 years – St Luke's Hospital, Bradford*
- *Recently completed a Level 2 NCFE certification for Awareness of Mental Health Problems.*

I have also offered my free time to nurse for the DentAid charity who offer their services to treat patients who are not registered (recently featured on Channel 4 news). This has been such a valuable experience seeing patients appreciate what is presented within the clinic and providing robust treatment to relieve them of their dental pain. It has also been an honour to reach out to children within my hometown of Dewsbury by attending a nursery to help them understand the concept of oral health and the importance of looking after their teeth.

I am very enthusiastic and passionate about sharing my knowledge and experience with a wide audience. I believe it is important to embed the concept of oral health from a young age, discussing key messages with the community, as it is such a colossal benefit in driving them to better health and well-being.

We would like to thank Naeema for entering our competition and wish her all the best with her endeavours, and with improving Bradford's oral health! Naeema wins a Little Bear demonstration puppet, sponsored by the Oral Health Foundation.

DCP OF THE MONTH: SEPTEMBER: ENTRIES PLEASE!

The next issue of *BDJ Team* is published on 2 September 2016. If you would like to be considered as DCP of the month for September, email the Editor, Kate Quinlan, k.quinlan@nature.com by 2 August 2016. All entries must include a photo.

The Little Bear and a range of other demonstration products, models and downloads can be purchased from the Oral Health Foundation shop at https://www.educatingsmiles.org/.

BADT TO FOCUS ON AGE-APPROPRIATE HEALTHCARE

According to the British Association of Dental Therapists (BADT), age-appropriate dentistry is essential to ensure successful dental health outcomes in an increasingly more expansive age range of dentate patients. The BADT will be focusing its annual conference on the Office for National Statistics figures that predict that more than one in 12 people in the UK will be aged over 80 by 2039.[1]

The BADT's 'Cradle to Grey' conference theme aims to increase awareness of the impact of age-related oral health care. Speakers will discuss periodontal disease and diabetes; medical challenges in dental patients; and prescribing rights. There will also be a discussion on career pathways to delivering age-related oral care in the twenty-first century and a presentation on the management of root caries. The presidential dinner will follow Friday's plenary sessions, with theory and hands-on practical skills sessions on Saturday.

The BADT Conference takes place at the DoubleTree by Hilton Piccadilly, Manchester on 23-24 September 2016 and offers 10.75 hours of verifiable CPD.

Early bird rates are available until 28 August and are:

- Members £190 (presidential dinner £50)
- Newly qualified/student members £150 (presidential dinner £50)
- Non-members £220 (presidential dinner £60).

To make a secure payment, visit www.badt.org.uk or call 0161 665 5878.

ORAL HEALTH FOR LIFE

The developing dentition

Age: 6 months old
Teething begins.

Age: 2½ years old
All primary (upper and lower) teeth have erupted.

Age: 6 years old
Permanent teeth begin to appear.

Cleaning or wiping can start with the eruption of a child's first teeth. Pacifier bottles with sugary drinks or fruit juices can cause early childhood tooth decay.

Children can start supervised tooth brushing twice a day with a pea-sized amount of fluoride toothpaste. Regular dental check-ups can

Establish good dietary habits, limiting amount and frequency of

Develop a life-time habit of twice-daily brushing with fluoride toothpaste.

CLIMB THE YORKSHIRE **THREE PEAKS** WITH YOUR TEAM FOR CHARITY

The West Yorkshire Section of the British Dental Association (BDA) have organised a Yorkshire Three Peaks walk to support the dental charity Bridge2Aid.

The Yorkshire Three Peaks Challenge starts in Horton-in-Ribblesdale and takes on the peaks of Pen-y-ghent, Whernside and Ingleborough in under 12 hours.

The route is 24 miles long and includes 1,585 metres of ascent. The event is to be held on Saturday 23 July 2016 and promises to be a challenging yet enjoyable day and a good opportunity for the whole dental team to get together to support a worthy charity.

The walk will be led by a fully qualified mountain leader and equipment, water and roadside support will be available throughout the event. If any walkers decide they only want to do part of the route then transport will be available to return to the starting point.

The cost of entering is £40 per person and the event is open to the whole dental team and family members. Full information will be provided on entering the event.

To reserve a space email jasminv845@gmail.com or call 07941402418.

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Age: 12 years old
Most permanent teeth have erupted.

Age: 21 years old
Third molars (wisdom teeth) are the last to erupt.

Start to wear mouthguards for contact sports.

Avoid sweets, tobacco and alcohol.

Good oral hygiene and healthy habits, together with regular dental check-ups, help to avoid tooth decay and periodontal disease. Pregnant women should take extra care of their oral health.

Dry mouth as a result of reduced saliva production may increase risk of diseases. Regular check-ups may help keep a healthy mouth and good quality of life.

ORAL HEALTH **FOR LIFE**

This graphic has been reproduced from *The challenge of oral disease – a call for global action*, the latest edition of *The Oral Health Atlas* published by the FDI World Dental Federation.

The new, second edition of the *Atlas* focuses on the policy actions related to improving prioritisation of oral health. It is available to download at http://www.fdiworldental.org/oral-health-atlas.

TOBACCO LAWS NOW IN EFFECT

On 20 May 2016 the new law stating that tobacco companies must sell cigarettes with the branding on the packaging restricted to a standard size, font and colour came into effect.

All packs must contain at least 20 cigarettes to ensure they are big enough for health warnings to cover 65% of the front and back. In the UK, all packs must be uniformly olive green coloured with large images highlighting the damaging effects of smoking.

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Menthol cigarettes will now be phased out ahead of a total ban in 2020.

It is hoped the new law will reduce the number of smokers across the EU by 2.4 million and will save the NHS an estimated £2.7 billion and the wider British economy a further £2.5 billion in sick leave and lost productivity, according to the British Medical Association (BMA).

MEN *VS.* WOMEN

According to a survey of 1,000 patients by Carisbrook Dental, a private dental practice in Manchester, women change their toothbrush or electric brush head every 92 days, while men keep them for an average of 185 days, or six months.

Other findings from the survey include:

- 72% of men have used their female partner's toothbrush
- Only 26% of women have used their male partner's brush
- 57% of women and 32% of men use electric toothbrushes
- Women spend on average £42 on dental products a year, including brushes, toothpastes and other products such as mouthwash, whereas men spend about £24
- Women are almost five times more likely to have cosmetic dental procedures such as teeth whitening.

Letters

Email bdjteam@nature.com

Or comment on Facebook www.facebook.com/bdjteam

DENTAL NURSES ARE PAID NO MORE THAN SHOP ASSISTANTS

Dear Editor,

I am writing in response to a recent dental survey which I came across (Fig. 1). As a dental nurse in the North West I was disheartened to see the average wage of a registered dental nurse's salary is £15,000 per year.

Since registration began in 2009 it still seems that the dental nurse has not got the 'professional' recognition they deserve. With increasing workload and the prospect of getting sued it makes the dental nurse role seem undesirable. Why would someone want to work for this amount when they have less stress and no professional outgoings as someone who works in retail on the same pay?

I know that a few people will see this letter as negative but at the end of the day the professional status affects the way we behave 24 hours a day and let's face it we all have bills to pay. Don't get me wrong I love my job and in the role that I am in I now feel very, very lucky that I am paid a decent hourly rate, I just feel really disheartened for the dental nurses that are paid near the national minimum wage. It seems unfair that the dental nurse passes a recognised qualification to be on nearly the same wage as someone who possesses no qualifications.

With a lot of dental nurses who are low paid it must be a real financial struggle, with the extra bills like CPD, indemnity and registration - it all seems unfair. I would like to see a wage pay scale that reflects a dental nurse's skills and knowledge.

'IT SEEMS UNFAIR THAT THE DENTAL NURSE PASSES A RECOGNISED QUALIFICATION TO BE ON NEARLY THE SAME WAGE AS SOMEONE WHO POSSESSES NO QUALIFICATIONS.'

Claire Strirrup RDN

		Dental Nurse	Dental Receptionist	Treatment Co-ordinator	Practice Manager	Hygienist & Therapist	Associate Dentist
East Midlands	Quartile Range	£14k-£29k	£15k-£27k	£22k-£29k	£19k-£28k	£30k-£49k	£30k-£74k
	Average	£18.7k	£18k	£24k	£24.5k	£40k	£54k
East of England	Quartile Range	£15k-£29k	£14k-£25k	£19k-£28k	£25k-£26k	£30k-£49k	£50k-£80k
	Average	£19k	£17k	£23.5k	£25.5k	£39k	£60k
London	Quartile Range	£16k-£31k	£18k-£29k	£25k-£31k	£22k-£40k	£53k-£60k	£50k-£90k
	Average	£21k	£20k	£28k	£30k	£51.5k	£80k
North East	Quartile Range	£13k-£24k	£13k-£23k	£16k-£25k	£21k-£26k	£29k-£50k	£30k - £72k
	Average	£15k	£15k	£22k	£21.5k	£42k	£43k
N. Ireland	Quartile Range	£14k-£22k	£14k-£24k	£17k-£26k	£18k-£29k	£35k-£53k	£34k-£76k
	Average	£14.5k	£19k	£23k	£24k	£45k	£45k
North West	Quartile Range	£14k-£22k	£13k-£23k	£16k-£24k	£15k-£25k	£30k-£42k	£30k - £72k
	Average	£15k	£17k	£18.5k	£24k	£40k	£42k
Scotland	Quartile Range	£13-£23k	£13-£24k	£15k-£26k	£23k-£30k	£23k-£46k	£32k - £75k
	Average	£18k	£19.5k	£25k	£25k	£35k	£43k
South East	Quartile Range	£13k-£27k	£13k-£28k	£19k-£28k	£23k-£31k	£32k-£55k	£34k-£72k
	Average	£18k	£18k	£24k	£28k	£42k	£45k
South West	Quartile Range	£13k-£23k	£13k-£26k	£18k-£28k	£17k-£30k	£35k-£50k	£34k-£80k
	Average	£18k	£17.5k	£24k	£26k	£40k	£45k
Wales	Quartile Range	£12k-£20k	£13k-£24k	£15k-£24k	£17k-£30k	£30k-£42k	£30k - £69k
	Average	£16k	£17.5k	£20k	£22k	£39k	£44k
West Midlands	Quartile Range	£13k-£24k	£13k-£26k	£16.5k-£27k	£18k-£28k	£28k-£51k	£35k-£80k
	Average	£16.5k	£17k	£23k	£24.5k	£38k	£45k
Yorkshire and the Humber	Quartile Range	£15k-£23k	£13k-£25.5k	£14k-£28k	£19k-£32k	£25k - £40k	£32k-£78k
	Average	£17k	£18.2k	£21k	£24.5k	£35k	£45k

Fig. 1 DRN Salary Survey 2016. From the Dental Recruit Network: http://www.dentalrecruitnetwork.co.uk/blog/12042016112316-uk-dental-salary-survey-2016

A GREAT DAY SPENT WITH COLLEAGUES

Reader panel member Nicola Sherlock reports back from BDA Conference

So, I'm back from attending this year's British Dental Conference and Exhibition with sore feet and aching shoulders from carrying bags loaded with everything from toothpaste samples to champagne stoppers (not sure I'll use the latter as once my prosecco is open I can't think why I'd seal it again!).

Demonstrating the dental profession's move into the ever-online world, there was a big focus this year on technology and social media presence, particularly smart phone apps (BPE scoring apps, a guide to acid wear app, patient education apps, interactive lectures and even an app to navigate the conference and exhibition) and these may be tools I look at using in the future to help pass guidance and information on to patients and their parents/support teams.

Prevention and sugar were the main themes on the BDA stand and attendees could take the 'Sugar Shock Test' to determine amounts of sugar in popular drinks (something dental nurses preach to patients and parents on a daily basis).

There were stalls where you could try out new flavours of mouthwash, stalls demonstrating new designs of interdental cleaning aids, and even a wheel-of-fortune offering spa breaks as the big win (I won a book and was made-up!). Representatives could be sought out from many of the main dental societies and associations such as the British Association of Dental Nurses, the Oral Health Foundation, and the British Society of Dental Hygiene and Therapy for guidance, advice or simply to put faces to names.

On reflection, this was a great day spent with colleagues, held at the perfect location (I live in Manchester) and there was a great atmosphere. Yes, we got a lot of 'free stuff', but sat on the living room floor sorting through it all, what is evident is that apart from what I gained in just attending the event and the seminars available there, I have enough CPD reading material and links for online verifiable CPD to see me through to the next cycle.

'YES, WE GOT A LOT OF "FREE STUFF", BUT WHAT IS EVIDENT IS THAT I HAVE ENOUGH CPD READING MATERIAL AND LINKS FOR ONLINE VERIFIABLE CPD TO SEE ME THROUGH TO THE NEXT CYCLE.'

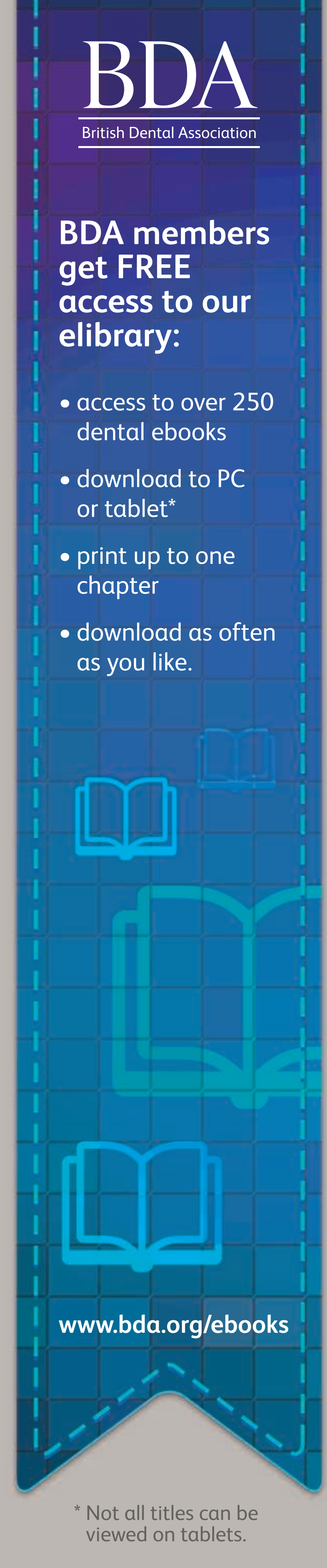
I have flyers and information for further education and extended duties courses, I networked with some great people and got contact numbers for agencies and companies who are currently recruiting for UK/overseas volunteering experiences and gained information-galore on lots of new products, some of which will be of great benefit to the special care patients we see at my clinic.

Dental nurses should not be put off that the Conference seems mainly geared towards dentists and should view the event as a way to increase their knowledge and skills, to network with like-minded professionals and gain large swathes of CPD all in one day.

Nicola Sherlock RDN

Do you have an opinion on something published in *BDJ Team* or on working in the dental industry? Do you need advice from an expert that we might be able to help you with? Just email bdjteam@nature.com.

Letters may be edited for space. Opinions expressed do not necessarily reflect those of the editorial team or the publishers.



* Not all titles can be viewed on tablets.

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Evaluating a dental nurse-led anxiety management service

By J. Porritt,[1] K. Jones[2] and Z. Marshman[3]

INTRODUCTION

The impacts of dental anxiety are well-recognised with dentally anxious adults reporting worse oral health and quality of life than their non-anxious counterparts.[1,2] Highly anxious patients are often referred for pharmacological interventions such as conscious sedation to help them accept dental treatment. However, pharmacological approaches are not as effective as psychological interventions in helping patients manage their dental anxiety.[3,4] Dental services need to use care pathways that combine the use of pharmacological approaches for patients with urgent or high treatment need with psychological interventions to help patients better manage their anxiety longer term.[5–7]

Cognitive behavioural therapy (CBT) is an evidence-based treatment for a number of anxiety-based conditions[8,9] and effective at reducing dental fear in adults.[3,4,10] However, the demand for CBT practitioners and psychological services often outweighs the resources available.[11] One solution has been to use a stepped care model of CBT delivery which utilises 'low intensity' approaches, such as brief or guided CBT delivered by non-experts and 'high intensity' approaches, which deliver an expert-led service over a longer time period.[11,12] Dental nurses are particularly well placed to deliver low level psychological interventions because they are based in dental clinics and have access to dental equipment used in behavioural exposure interventions.

A previous service evaluation, which investigated the experiences of dentally anxious adult patients in Sheffield,[7] reported a lack of psychological services/support for this group of patients. Therefore, an integrated care pathway (ICP) for dentally anxious patients was developed and implemented in 2011. ICPs are standardised multidisciplinary care plans of the services that patients with a specific problem should receive.[13] The ICP aimed to increase psychological support for patients with dental anxiety and reduce demand for pharmacological intervention through the development and implementation of a nurse-led dental anxiety management service (NDAMS) (Fig. 1).

Two dental nurses were trained in the delivery of cognitive and behavioural techniques and were provided with access to regular supervision with a CBT therapist. A telephone triage service, run by the trained dental nurses, assessed patients' suitability for the NDAMS. During the triage appointment the dental nurse would:

i) Explain the service to patients
ii) Collect information related to the patient's previous medical history
iii) Assess the patient's dental concerns and needs.

If patients revealed additional or complex psychological issues this was discussed, then they were signposted or referred to the most appropriate service. No formal clinical assessment tools were used for screening a patient's mental health. Dentally anxious patients were assessed as suitable for the NDAMS if they were:

i) Willing to engage with the service
ii) Had no urgent dental treatment needs
iii) Did not disclose any additional or complex mental health problems which would prevent them from engaging with or benefiting from the NDAMS.

[1]Department of Psychology, Sociology and Politics, Sheffield Hallam University, Sheffield, UK; [2]Yorkshire and the Humber Dental Public Health Team, Public Health England; [3]Unit of Dental Public Health, University of Sheffield

In situations where patients had urgent treatment needs (for example, reported pain/swelling) the patient was referred back to the referring general dental practitioner. In cases where patients had been referred from a general medical practitioner they were referred directly to the community dental service for a dental assessment.

Patients that were assessed as suitable for the NDAMS were offered a course of CBT-based management delivered by the trained dental nurses. Appointments lasted between 30 minutes and one hour and dental nurses and patients had access to dental clinics for behavioural exposure interventions as required. Patients who missed NDAM appointments were contacted by phone/letter and given an opportunity to re-book. On completion of NDAM, patients were offered dental treatment delivered by a salaried dentist in the community dental setting. Dental nurses accompanied patients to these dental appointments and the level of clinical input required at this stage was determined by the clinical needs of the patient.

On completion of NDAM it was the patient's perceived ability to cope with dental treatment (rather than their anxiety level) which determined the subsequent care they were offered. Patients who felt they needed additional support before being able to accept dental treatment were referred to the psychotherapy service or for sedation, which is in line with a stepped care model of anxiety treatment.[12] Once patients completed their course of dental treatment they were referred back to their general dental practitioner (GDP) or able to register with the community dental service (if appropriate). Figure 1 provides an overview of the ICP for patients with dental anxiety.

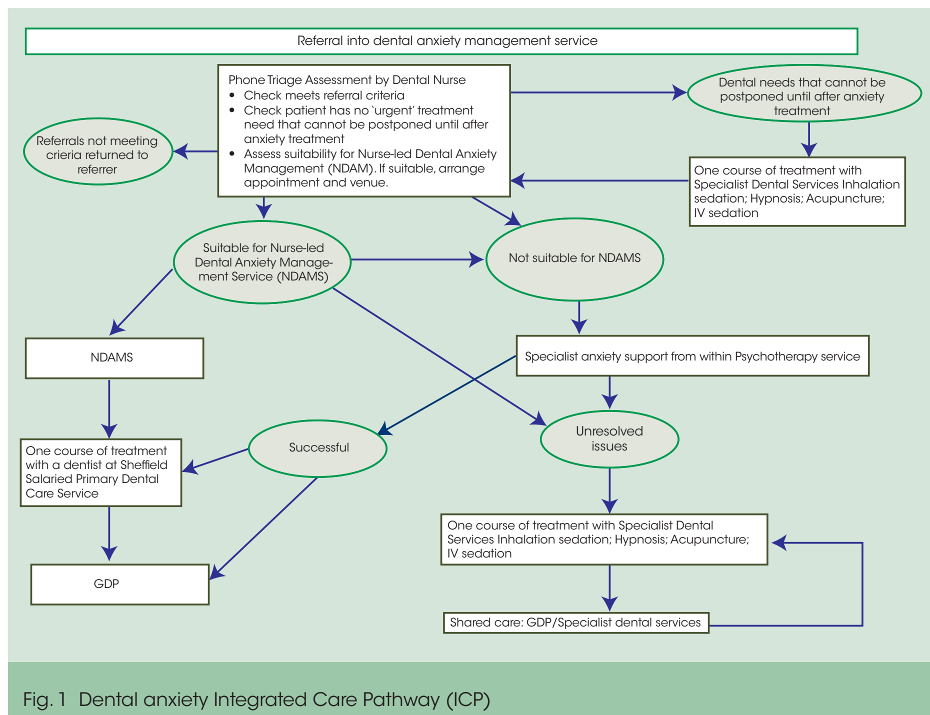

Fig. 1 Dental anxiety Integrated Care Pathway (ICP)

AIM AND OBJECTIVES

The aim of this service evaluation was to explore patients' and staff perspectives of the NDAMS. The objectives of the service evaluation were to:

- Describe the flow of patients through the NDAMS
- Investigate the influence of NDAM on the dental anxiety and oral health-related quality of life (OHRQoL)
- Explore patients' perspectives of the NDAMS
- Explore healthcare professionals' perspectives of the NDAMS.

METHOD

Design and sample

Permission from the Clinical Director of the Salaried Dental Services of Sheffield Teaching Hospitals Foundation Trust was obtained before the commencement of the service evaluation. The service evaluation was conducted by those not involved in the provision of the NDAMS. Referral and appointment information was collected by the NDAMS. Data related to the patients' dental anxiety and OHRQoL were collected at the initial assessment appointment and following completion of the nurse-led support.

Semi-structured interviews were conducted over the telephone with a purposive sample of patients. All patients contacted had provided permission to be approached during initial triage. Patients were purposively sampled using a maximum variation approach (based on age, gender and differing levels of engagement with the NDAMS). Topic guides were designed to explore patients' experiences of the NDAMS and examine the perceived benefits and limitations of the service, the facilitators and barriers related to engagement and their recommendations for service improvement (for example, 'Please could you tell me a bit about your experience of the dental anxiety management service?'; 'Can you tell me why you think it has/hasn't changed your dental anxiety?'; and 'What do you think could have been done differently to have improved the care you received?').

A mixture of one-to-one interviews and small focus groups were undertaken with dental professionals involved in the NDAMS. GDPs, who could refer patients into the NDAMS, and dental professionals who had experience treating patients as part of the ICP were invited to participate in the study. Topic guides were used to obtain information on professionals' perspectives of the dental anxiety care pathway, their experiences of referring into or working within the NDAMS and their recommendations for service improvement.

No formal sample size calculation was undertaken due to the qualitative methods employed, however, data collection continued until data saturation was achieved.

Main outcome measures

Dental anxiety was measured using the previously validated five-item Modified Dental Anxiety Scale which incorporates a five-item Likert response scale (1 = not anxious to 5 = extremely anxious).[14] Referrals of patients with MDAS scores of 19 or above (high dental anxiety) were accepted into the service. Referrals of patients who had borderline levels of severe of dental anxiety (1718 MDAS score) and/or needle phobia (patient reported being 'extremely anxious' in response to the item: 'If you were about to have a local anaesthetic injection in your gum, above an upper back tooth, how would you feel?') were also accepted if referral letters had indicated patients were unable to accept treatment from the referring practitioner due to their anxiety/phobia.

OHRQoL was measured using the Oral Health Impact Profile[14,15] which comprises 14 items to capture impacts related to functional limitations, physical pain, psychological discomfort, physical, psychological and social disability, and handicap. Responses are coded on a five-item Likert scale (0 = never to 4 =

very often) and the measure has good internal consistency (Cronbach's alpha = 0.88). The additive method was used to calculate total OHIP14 scores (range 056). A high OHIP score indicates worse OHRQoL.

Analysis

Descriptive data were presented to provide an overview of the number of patients referred into the ICP and who engaged with NDAMS. Related ttests and repeated measures ANOVAs were conducted to investigate changes in dental anxiety and OHRQoL of patients. For the inferential analysis missing baseline MDAS scores (MDAS at the assessment appointment) were replaced with MDAS scores on referral to the NDAMS and where patients had not completed MDAS/OHIP questionnaires immediately following completion of the NDAMS, their MDAS/OHIP scores on discharge from the care pathway were used.

All interview data were anonymised and thematic analysis[16] was conducted on the interview data to establish themes and sub themes. Inductive coding was undertaken on the data and initial themes were identified by two researchers independently (using a coding notebook). These themes were then compared during analysis meetings and refined in agreement with both researchers.

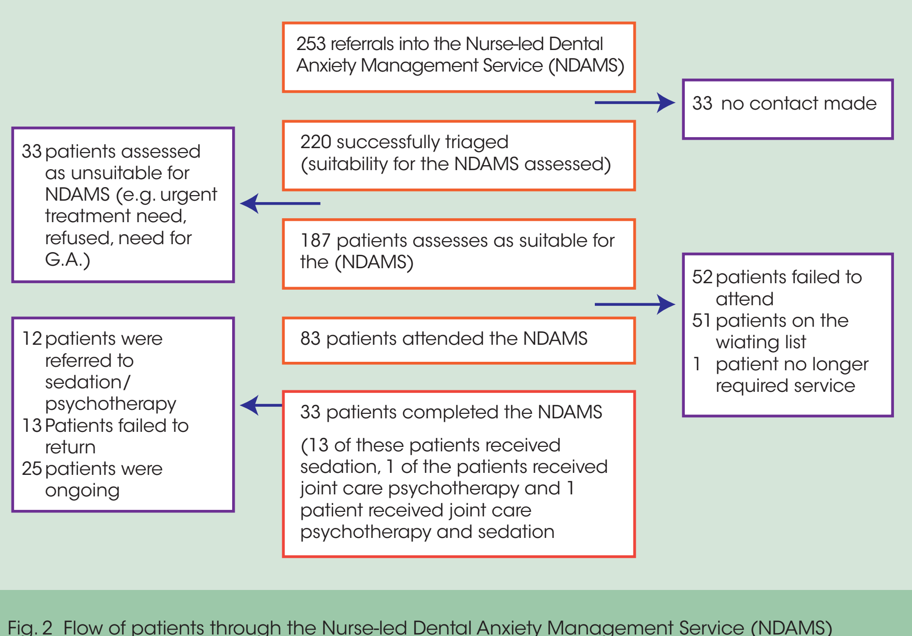

Fig. 2 Flow of patients through the Nurse-led Dental Anxiety Management Service (NDAMS)

RESULTS

Flow of patients through the NDAMS

Between July 2011 and December 2013, 253 patients were referred into the NDAMS (Fig. 2). Contact had not been able to be made with 33 of these patients and therefore 220 people were successfully triaged. Thirty-three patients were deemed unsuitable for the NDAMS for a variety of reasons (for example, urgent dental treatment, complex mental health problems, refusal, need for general anaesthesia) and 187 patients were assessed as suitable for nurse-led support (77% female, mean age = 33.7, SD = 12.4).

Eighty-three patients attended the NDAMS, 52 patients failed to attend the service, 51 patients were still on the waiting list at the time the service evaluation was conducted and one patient indicated they no longer required the service. At the time of the service evaluation 33 patients had completed NDAM (63.6% female, mean age = 39.5, SD = 14.6). The mean number of appointments people attended was 5.7 (SD = 3.8, range = 118). The waiting list for the nurse-led support was approximately 12 months.

The influence of the NDAMS on dental anxiety and oral health-related quality of life

Dental anxiety

The mean MDAS score for the group of patients referred into the NDAM was 22.6 (SD = 2.4, range = 925) and the mean MDAS score for patients who attended the NDAM service was 22.3 (SD = 2.7, range = 1525).

Of the 33 patients who completed NDAM, 32 patients had completed both triage/assessment and follow-up MDAS questionnaires. A repeated measures ANOVA revealed a significant decrease in MDAS scores between assessment (mean = 21.9, SD = 2.9, range = 1625) and completion of NDAM (mean = 13.5, SD = 4.4, range = 622) ($F[1,29] = 8.21$, $P < 0.01$, partial eta squared = 0.22, 95% CI = 7.09.8). There were no significant interaction effects between gender and time ($F[1,29] = 1.9$, $P = 0.18$) or age and time ($F[1,29] = 3.3$, $P = 0.08$).

Oral health-related quality of life

Of the 33 patients who completed NDAM, 23 patients had completed both triage/assessment and follow-up OHIP questionnaires. A related ttest revealed that there was a significant reduction in OHIP scores between assessment (mean = 21.6, SD = 13.1) and completion of NDAM (mean = 14.6, SD = 10.6) ($t = 3.5$, $df = 22$, $P < 0.01$, 95% CI = 2.811.3).

Patients' experiences and perspectives

Seven patients participated in the service evaluation (four females and three males). Individuals were aged between 21 and 57-years-old (mean age = 36.4yrs) and had attended a mean of five appointments (range = 1 to 10). The five themes which emerged from the data were: 'desire to change'; 'developing relationships'; 'differences in anxiety'; and 'service delivery and flexibility'.

Desire to change

Patients talked about the negative experiences they had endured as a result of their dental anxiety (for example, oral health problems, feeling embarrassed) which contributed to their motivation to seek support for their anxiety problem:

'Total joy because you just think you're locked into this miserable experience really so you think when somebody can offer you something, maybe a way out yeah it is very good.'

Developing relationships

The development of the relationship between patients and dental professionals seemed to be crucial to the success of the intervention. Within the 'developing relationships' theme the sub-themes 'trust and patience', 'communication, information and normalisation of anxiety', and 'fear of leaving' were identified.

Trust and patience

Patients discussed the importance of developing trust over time with the dental care professionals/team delivering their treatment:

'It was them having the patience and understanding and giving me the tools that I needed […] they had all the time in the world.'

Communication, information and normalisation of anxiety

Table 1 Themes which reflect the experiences and perspectives of healthcare professionals

Integration of services within care pathway	CBT based intervention
Flexibility	Perceived effectiveness and acceptability
Communication	Suitability
Skill mix	Expectations
Resources	Impact on staff
Support and training	

Having access to equipment which is used within dental treatments was felt to be hugely beneficial and patients talked of how familiarisation with the procedures and environments to which they would be exposed during dental treatments played a key role in helping overcome their fears. The importance of effective communication was stressed by patients:

'She's broken everything down into minutest detail for me and that has been really, really helpful, the equipment that they use, what happens when I get there, what everything is on the dentist's chair, who will be there.'

Fear of leaving

Anxieties about leaving the NDAMS and receiving care from a different dentist were reported. However, a number of patients had made this transition or were optimistic about being able to make this change in the future. Some patients felt that if GDPs were made aware of a patient's dental anxiety and history, this might help them respond to the patient's needs more sensitively:

'I think at the end of it going to the same dentist in the same room with the same chair with the same music and the same squeeze ball was great […] and then all of the sudden they're like "Alright you can't become dependent on the same dentist, you've got to learn to go to a different dentist" that was quite scary and daunting but it had to be done'; and 'Because my treatments are now going to be in the same building they will still be aware that I have been to the surgery for all this anxiety.'

Differences in anxiety

While the intervention may have made patients more aware, generally they reported a reduction in their dental anxiety since using the service:

'I didn't believe it would work but it did […] I can go to the dentists and have whatever done and it doesn't bother me, completely cured.'

Patients also talked about how their experience with the NDAMS had increased their confidence in looking after their teeth and their children's teeth:

'I'm a lot more proactive […] I'm using interdental brushes, I'm brushing my teeth properly, I'm using the right toothpaste, I can brush my teeth properly […] I've got a lot more confidence.'

Service delivery and flexibility

Patients reported there was a time commitment required to attend appointments, however, patients felt that the service had been delivered in a flexible way to facilitate their engagement with the service and meet their needs:

'They did try and fit me in around the school holidays or the last appointments and things like that. I think it was more of a commitment from them than from me […] because they were giving generous amounts of time, I didn't mind giving my time.'

Experiences and perspectives of healthcare professionals

Five GDPs participated in a focus group, two GDPs participated in a mini focus group and one GDP was interviewed alone. One-to-one interviews were undertaken with the two CBT dental nurses, the clinical director, the lead CBT therapist, two consultants and two dental officers working in the salaried service. Therefore, in total, 16 professionals were interviewed. The representation of themes and subthemes which emerged from interviews with the healthcare professionals can be seen in Table 1.

Integration of services within the ICP

The importance of integrated working was highlighted. It was proposed that the pathway would only continue to be successful if all practitioners involved (for example, nurses, sedationists and psychotherapists) continued to work closely together. Within this theme there were five subthemes which included flexibility, communication, skill-mix, resources and support and training.

Flexibility

The need for staff to be able to adapt to the needs of patients and make judgements about how and when the NDAMS and pharmacological interventions should be delivered was highlighted. While the pathway determines the order in which a patient should be involved with the different services, there was the view that sometimes patients may need to move in and out of different services to prevent them from getting 'stuck' in the pathway:

'The boundaries are incredibly grey and I think the other thing about the pathway is it doesn't take those grey areas into account enough […] I think that setting something up you need to be rigid, you need to have clear ideas about what you want and communicate those ideas clearly I then think that when it's been running for a while and people have got those clear ideas you can then introduce a little bit of flexibility.'

Communication

It was felt that it was important to have an effective feedback mechanism so that referring dentists could be informed of the outcome of their referral and also made aware of their patient's experience following referral (for example, whether they completed NDAMS, whether they needed sedation etc).

Skill-mix

Having the relevant skill-mix and confidence within the pathway team was highlighted as being extremely important. Dental nurses were seen to be ideally placed for delivering the psychological intervention due to the time they had available to spend with patients and their skill base. However, it was recognised that the dentists delivering the dental treatment also needed to have confidence, experience and knowledge of anxiety management approaches:

'Definitely need dentists at the end who can work to the same methodologies.'

Resources

One success of the NDAMS was the decrease in the IV sedation waiting list (which had previously been closed following a waiting time that had exceeded two years). However, there was the opinion that more resources were needed to reduce the waiting list for the NDAMS and there was concern that some patients' dental needs or pain levels could worsen while waiting long periods of time for an appointment:

'Here we are the best we have ever been in my experience of dealing with anxious patients in Sheffield – this is a good as it's ever been except for the waiting list.'

Support and training

The importance of regular and consistent access to psychological supervision and support for the dental nurse was highlighted. It was suggested that there were training needs for referring practitioners so they could be more aware and knowledgeable about which patients they should be referring into the NDAMS.

CBT-based intervention

Within this second theme there were four additional subthemes which included perceived effectiveness and acceptability, suitability, expectations and impacts on staff.

Perceived effectiveness and acceptability

The general view held by the professionals working within the ICP was that the NDAMS was effective in reducing the anxiety of service users. Additional perceived benefits included increasing patients' long-term confidence levels and reducing their reliance on pharmacological interventions. Staff felt it was important to provide psychological support to those patients who were motivated to overcome their dental anxiety. The lack of information on the cost-effectiveness of the service was highlighted.

Suitability

Some referring practitioners felt the usefulness of the NDAMS may be limited due to the patient's reliance on sedation or unwillingness to try a psychological approach. Assessment of a patient's suitability for NDAMS was seen as very important; however, there was a general opinion that it was difficult to make this assessment:

'If there are ways of identifying patients who aren't ready I think we've not got to be frightened of saying to those people you're not ready.'

Expectations

Staff acknowledged that in the early stages of working within the NDAMS they had experienced quite unrealistic expectations. It was felt that it was important that both staff and patients be realistic about the changes they could bring about and acknowledge that for some patients NDAM would not be appropriate:

'At first I tried to fix everyone but I'm getting better at recognising I can't.'

Impacts on staff

It was suggested that managing dentally anxious patients can be stressful for the dentists and dental nurses. The need to have at least two nurses providing the NDAMS to enable peer support was raised. However, the nurses felt the work was rewarding especially when the interventions were successful in reducing a patient's dental anxiety:

'Very, very positive when you get through the treatment plan and send them out fully dentally fit.'

DISCUSSION

The results of this service evaluation suggest that patients who engaged with the NDAMS reported improvements in their OHRQoL and dental anxiety. Patients felt that trusting relationships and effective communication with the dental team had been fundamental to the success of the intervention. There is certainly evidence that would support the importance of patient trust and confidence in dental practitioners on patient-reported outcomes.[17] However, some patients did report reluctance or anxiety over leaving the NDAMS and returning to their GDP who may not understand their anxiety and their specific needs. Communication tools which encourage anxious patients to discuss their concerns and coping preferences with their GDP could help build up trust and understanding between the practitioner and the patient. Patient request forms, which document the individual's requests for emotional support, information and treatment, have been used successfully with dentally anxious paediatric patients,[18] however, there is not yet an equivalent communication tool for adults with dental anxiety. Therefore, patients could be supported to write a 'relapse prevention' report card (on their final appointment with the NDAM service) that they could take to their next appointment with their referring/new GDP, which summarises their coping/treatment preferences.

Flexible integrated working, between all of the teams involved in the care pathway, was seen as essential to meet individual needs and ensure the continued success of the service. The view that the care pathway should be more flexible in order for it to function effectively and efficiently was expressed and it was suggested that a proportion of patients without an 'urgent' treatment need may still benefit from receiving some of their dental work before, or alongside, their engagement with NDAM to enhance their wellbeing or prevent significant deterioration of their oral health. The findings from this evaluation support the argument that dental professionals who deliver psychological interventions to dentally anxious adults should have regular access to supervision and support from specialist psychological services.[5]

Referring practitioners and staff working within the NDAMS expressed concern over waiting times for patients and there was recognition that more in-depth assessment at triage and throughout treatment could help identify those patients who may not be suitable for the NDAMS earlier, reducing waiting lists and drop-out rates. Previous research suggests that non-attendance, poor engagement and drop-out rates for CBT-based treatment can range between 20% and 50%, which highlights the importance of the early identification of patients most likely to benefit from CBT-based approaches.[19,20] However, CBT services for dental anxiety have reported much higher retention rates (85% completion rate).[21] Blenkiron[22] proposed a number of factors that should be considered when assessing a patient's suitability for a CBT-based intervention, which include their motivation for change, willingness/ability to attend regular sessions and ability to identify their own feelings. Some GDPs were sceptical of the value of CBT-based interventions which may have influenced how they introduced the service to patients and thus patients' treatment expectations and subsequent engagement with the NDAMS. Further education for GDPs in the evidence-base of psychological management of dental anxiety could help overcome this potential barrier.

There are a number of limitations associated with this service evaluation which should be recognised. Firstly, the aim of purposive sampling was to examine possible barriers to service engagement. However, we were unable to recruit patients who had not attended the NDAM service to the study (one patient interviewed had dropped out of the service after just one appointment). Therefore, while

'THE DENTAL NURSES FELT THE WORK WAS REWARDING ESPECIALLY WHEN THE INTERVENTIONS WERE SUCCESSFUL IN REDUCING A PATIENT'S DENTAL ANXIETY'

data saturation was reached it is possible that additional themes would have emerged had interviews been conducted with individuals who had not engaged with the service. Additionally, it should be acknowledged that there were some missing patient data which resulted from patients not returning or completing their questionnaires (particularly the OHIP measure) which could have influenced the findings of the evaluation.

One of the strengths of this service evaluation was that it explored a variety of stakeholder perspectives and experiences, and employed a mixed methods approach resulting in a rich source of information which can be used to further develop the ICP. The main recommendations which arose from this service evaluation included: i) that psychological support continue to be made available for dentally anxious patients; ii) that more efficient ways of assessing suitability for NDAM be examined and developed; iii) that there be increased flexibility in the referral process and care pathway in order to allow the services to fully meet the needs of a variety of patients who are referred into the system; and/or iv) that effective communication between the patients, referring practitioners and professionals working within the integrated care pathway be maximised.

The findings provide preliminary support for the role dental nurses can play in the psychological management of dental anxiety. While previous research has found that brief psychological interventions for anxiety can be effectively delivered by trained nurses,[23,24] dental anxiety is different to many other anxiety conditions in that patients may need to accept complex surgical interventions on completion of the psychological intervention. Therefore, it could be argued there is a need for the person administering the dental treatment to be the person who has delivered the CBT-based therapy, and thus gained the trust of the patient. Previous research has revealed, however, that dental anxiety can be effectively delivered by CBT professionals who work closely with the dental team.[25] Future research needs to examine the clinical and cost effectiveness of this particular method of management of dental anxiety.

CONCLUSION

The findings from this service evaluation highlight some of the potential successes, challenges and considerations associated with the development and implementation of a NDAMS within a dental anxiety ICP, which may be of use to commissioners and service providers hoping to develop similar services within their local area.

We would like to thank the patients and professionals who shared their perspectives and experiences of the care pathway, which enabled us to undertake this evaluation. We would also like to thank Rebecca Knapp for her help entering the data and Claire Egan, Lynn Roberts, John Davies and Peter Bateman for their work on the service evaluation steering group.

This article was originally published in the BDJ *on 27 May 2016 as* Service evaluation of a nurse-led dental anxiety management service for adult patients *(**220:** 515-520).*

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bdjteam2016117

Ten tips for terrific toddler teeth

What advice should you give patients with young children to ensure that they establish and maintain good oral health? *BDJ Team* is pleased to publish an article from **Claire Stevens'**[1] ToothFairyBlog.

Well I am now officially the mother of a toddler. Long gone are the days of the quiet and passive baby (actually, I'm not sure I ever had one of those) and instead I am faced with managing a very independent, strong-willed little girl who has very firm views on what she does and does not want to do! It's such a fine balance between encouraging her development without her believing she rules the roost. It's also a time of change – walking, talking and lots of new teeth! So how do you look after toddler teeth and what advice should you give parents of infants and toddlers? Here are my ten tips for terrific toddler teeth to share with your patients.

1) Supervise brushing

Don't forget to supervise your child's brushing up until the age of eight; until this time they don't have sufficient manual dexterity to do the job by themselves. If you have an independent toddler, you might wish to let them have a go whilst you brush your own teeth (toddlers love to mirror their parents or sibling) and then swap so you have charge of the toothbrush for a good clean. We actually have two brushes for Ava because she likes to try and clean my teeth as I brush hers. More recently, she has taken to brushing my bump in the hope of cleaning her baby brother's teeth. Either way, we just about keep her distracted long enough to get the job done.

2) Spit, not rinse

Did you know that dentists recommend spitting, not rinsing after brushing? Now with toddler teeth, that's sometimes a little academic but by rinsing out after brushing you are actually washing away the fluoride, the magic ingredient in toothpaste, which helps to reduce dental decay and yes, the same goes for grown-ups too!

3) Use an adult toothpaste

Start brushing your toddler's teeth as soon as they come through. Brush twice a day using a flat smear of 900–1,100 ppm fluoride toothpaste until they are three-years-old. After that you need a small pea sized amount. It is recommended to brush last thing at night and at one other time during the day. Pick a brush which is the right age for your child – I find a normal manual toothbrush easiest for wriggly toddlers.

4) Reward good brushing

Please remember to reward good brushing once you have your little one on board. It might sound obvious but positive reinforcement that is both specific and timely works wonders.

---

[1] *Claire Stevens is a Consultant in Paediatric Dentistry and works for the NHS providing dental care for children and young people from birth to 16 years. Claire now has two children, Ava (3) and Archie (1) and is Vice President Designate and Media Spokesperson for the British Society of Paediatric Dentistry.*

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Positive reinforcement is very different to bribery. Bribery is a reward that is promised in advance of the event, for example, 'If you brush your teeth, I will read you an extra story tonight' whereas with positive reinforcement, the reward is only mentioned after the good behaviour – 'You were so good with your brushing tonight. Would you like a sticker for your chart?'. The 'specific' means that 'Wow, you are opening your mouth so wide and staying so still' is more effective than 'Good girl' and 'timely' in that the reward needs to be given straight after the positive behaviour so that the child links the two. Science aside, a pack of stickers is my go-to parenting trick of the moment. The £2.50 I spent on these cat and star stickers has been money well spent and a major part of our success in getting Ava to wear clothes (yes, really) and allow herself to be strapped into the car seat without a major tantrum…

5) Stop the bottle

From the age of six months you can begin to introduce a free-flow cup, with the aim of eliminating the bottle by the time your child is one. The best drinks for young children aged one to two are full fat milk and water and from two-years-old, semi-skimmed milk and water as long as they are a good eater. Please, please, please don't ever put any sugary drinks such as juice (including no added sugar squash which still contains sugars) or sweetened tea in a bottle – they are a recipe for disaster as far as toddler teeth are concerned as they bathe the teeth in sugar over the course of the day (and night).

6) Get your position right

What you are looking for here is a position which allows you to keep your wriggly toddler more or less in check, but also in direct eye contact. I sit Ava on my left knee and with my left arm support her head in the crook of my arm and hold her left hand whilst her right hand is tucked behind my back. This means that she is resting back just a little, allowing me to see into her mouth and so that she can see me smiling when she is helping (and giving the 'Mummy look' when she is not). In terms of technique, try using small circles to brush the top and bottom teeth in turn, making sure to include the gums and the biting surfaces of molars which often trap food during chewing.

> **'ALTHOUGH MILK IS A LOW SUGAR FOOD, IT CAN STILL CAUSE DAMAGE IF LEFT TO POOL IN THE MOUTH OVERNIGHT'**

7) Look at your own diet

Becoming a Mum has really made me look at my own diet, after all I can't have an unhealthy snack and not expect Ava to want the same. Work on keeping snacks to a minimum. The reason for this is that when whenever we have anything containing sugar to eat, it takes our mouths time to recover and to move from the process of demineralisation (making holes in teeth) to remineralisation (rebuilding them again). I actually give Ava four meals a day – breakfast, lunch before her nap, a snack on wakening such as a sandwich and fruit and then tea which we finish by 6, before bed at 7. I find that this makes her less likely to ask for snacks at other times, thus minimising the number of intakes of food she has in a day. Also take care with giving dried fruits as a snack. This is because the process of drying makes the sugar more concentrated and produces a sticky food which can stay on toddler teeth for hours. Fresh fruit is much less damaging to teeth.

8) Lose that dummy

I'm not against dummies or pacifiers per se, in fact there is some evidence now that suggests they might actually reduce the risk of SIDS. That said, please don't ever dip the dummy in something sweet to get your child to take it... Also take care with prolonged dummy use (by that I mean after the age of one) because this does have the potential to cause something called anterior open bite where the teeth do not grow together and a gap is left at the front of the mouth. You should also find it less traumatic to lose the dummy if you try before a real emotional attachment has formed around 18 months of age.

9) Work on eliminating the bedtime feed

I used to love the fact that Ava nodded off after a bedtime feed. It was such a peaceful way for her to go to sleep and of course entirely appropriate when she was a baby. That said, from the age of one, try bringing the bedtime feed earlier so that ideally any bedtime milk is eventually merged with tea, and finished an hour before bed. I've talked about the golden hour before where the ideal is to try and have nothing aside from water in the hour before bed. When we sleep, our mouths dry out and we lose the protective effect of saliva. This is why eating in the hour before bed is a recipe for disaster. Although milk is a low sugar food, it can still cause damage if left to pool in the mouth overnight, especially if your toddler has got used to suckling on demand through the night.

10) Don't beat yourself up

Finally, parenting can be a tough job, and after a rough night with a nocturnal toddler it is downright exhausting. Implementing change, especially with a strong-willed child involved, can try even the most patient of souls. Be gentle on yourself if things take a little longer than you had hoped, but make sure you are still heading in the right direction slowly, but surely. Call in support in the form of other family if you can but above all try to be consistent. Take it from me, a smart toddler will remember the time you alter the routine in their favour and they won't be in a hurry to let you forget it!

To read more articles on Claire's blog, visit www.toothfairyblog.org.

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Welcoming children into your practice

Michael R. Young[1] presents an overview of caring for children in a general practice setting, discussing when children should first attend and how best to advise and communicate with parents.

Children's dentistry is a specialty in its own right. However, every GDP and every DCP should know how to treat children in a knowledgeable and compassionate manner so that their very young patients end up with a disease-free mouth and a very positive attitude towards dental health and dentists in general.

This article will help you answer some of the questions parents (and guardians) might ask you about their child's dental care. It will also hopefully help you see that treating children is different to treating adults.

The first visit

Let's begin at the beginning and ask, 'When should a child first see the dentist?' Opinions vary between from birth to when they have teeth to not until they are two-years-old. There is no hard-and-fast rule or even guidance it seems. However, experience has shown that children who regularly visit a dental practice from an early age develop a very positive attitude towards their own dental care and to dentistry in general. Early-age dental visits for a child helps them become accustomed to the sights, sounds and smells of a dental practice, and helps eradicate any fear they may possibly have.

Parents may be sceptical about their newborn needing to see the dentist before they have any teeth. This is perhaps

[1] *Michael R. Young is a former GDP with a special interest in Children's Dentistry. He was also a clinical teacher at two dental hospitals, and an expert witness. He is the author of the prize-winning book* Managing a Dental Practice the Genghis Khan way.

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understandable as most people associate dentists with *teeth*, ignorant of the fact that dentists do other things besides look at teeth! New parents are probably too busy to make a dental visit a priority for the baby, so why not encourage them to make a note in their diary to bring baby when they get their first tooth? This provides a tangible reminder. You can reassure Mum and/or Dad that even though there is a lack of teeth, the dentist will examine the baby's mouth and check that it is developing normally. In the long term, all children should, I hope, have had their first dental visit by their first birthday.

Baby teeth are important

To start off with, some parents don't see their child's baby (deciduous) teeth as being important. Getting the message across that baby teeth *are* important is a good place to start. What do you say to the parent who places so little value on dental care that they ask you, 'Why should I take my child to the dentist; aren't their baby teeth going to fall out anyway?' Baby teeth are important because they help the child to:

- Chew their food easily
- Learn to speak clearly
- Have a pleasant smile.

'GETTING THE MESSAGE ACROSS THAT BABY TEETH ARE IMPORTANT IS A GOOD PLACE TO START.'

You could point out that the early loss of baby teeth because of decay can lead to crowding problems, which may later require lengthy and expensive treatment. There is also the risk that the child's general health can suffer if diseased or broken teeth are not treated early.

Sowing positive seeds

Some parents might ask for advice about what they should say to their child about seeing the dentist for the first time. Here you can help sow some very positive seeds. A child's knowledge is based on what they have experienced for themselves and what they have been told by others. Tell them to always talk to the child about their visit in a positive way, using words that they are able to understand. Ask them not to allude to unpleasant memories of their own (possibly childhood) dental experiences, and to try very hard not to put the child off by displaying their own dental fears. One of the major problems with treating children is that they often come to the dentist having already been told or having heard negative things about the dentist that fill them with dread. It is part of your role to counter this negative message.

Gently remind the parent that if they don't know what the dentist plans to do at their child's appointment, then do not make things up. Misleading the child will undermine their trust in them and the dentist. Stress to them that it is the policy of the practice that emotive words such as 'hurt', 'needle', 'injection', and 'drill' are not used within earshot of children. They should be urged not to use these words within the practice, or when they talk to the child about the dentist. Older siblings can be a problem or a blessing. Ask parents to look out for and discourage older siblings from trying to scare a younger brother or sister with made-up stories about the dentist. However, if the young child has an older sibling who is a model patient then use the latter to encourage positive behaviour in the younger child.

Mutual trust and understanding

Perhaps the biggest problem GDPs have treating children is managing their behaviour. Difficult adult patients are difficult enough, but at least this is a one-to-one encounter. Difficult children come with a parent in tow and this three-way relationship needs to be worked on if the goals of the child's dental care are to be achieved. Co-operation between the parent, the GDP and DCP, and the child is very important because there must be a relationship of mutual trust and understanding between all parties. An initially difficult child will gain confidence and develop the trust needed to become calm, unafraid and co-operative when the parent and dentist work together. By working together, the GDP, DCP and parent can help develop a positive attitude in a child, which leads to a lifetime of good dental experiences. This communication triangle (child, parent and dentist) is a very important part of a child's long-term dental care. Never underestimate parental influences, good and bad.

You should reassure parents that the dentist and staff at the practice are experienced at managing children's behaviour and know how to handle children of all ages in a gentle, compassionate manner.

If you can train the parents, you are half way there to being able to manage the kids. Setting out a very clear list of dos and don'ts, which the parents will hopefully take heed of, helps enormously (see below).

What to expect

You could be asked, 'What will happen during my child's first visit?' Obviously this depends on the age of the child – not all children are first seen as early as you would like! However, and assuming the child doesn't require emergency treatment, then you should tell the parent the following:

- Their teeth will be counted to see that their development is normal for their age
- Each tooth will be examined for signs of decay
- Their cheeks, tongue and gums will be examined for evidence of disease
- The way in which the teeth meet when your child bites together will be checked
- X-rays of the teeth may be taken to look for hidden decay

- X-rays may be taken to check for the presence and position of unerupted teeth.

As well as the above, you could add that both the parent and child will be given advice on how to maintain the child's teeth and help their mouth stay healthy.

If treatment is required

So far I have covered what could be termed the preparatory phase of managing a young child, but unfortunately not all children get away with never having to have treatment, even if it is something as straightforward as having their teeth polished. What do you say to parents to reassure them if and when their child does need treatment?

The practice should have guidelines whereby all children are introduced to dentistry gently, usually by having a simple procedure carried out at the first visit. Polishing a child's fingernail with a rubber polishing cup (no polish to begin with, and maybe not using a hand piece) then progressing through to them eventually allowing the dentist or hygienist to polish their teeth, is a simple, step-by-step method of gaining a child's *and* their parent's confidence. Children's dental treatment requires the same, high level of treatment planning that adults generally receive as a matter of routine. You should therefore tell the parent that once the child has been examined and any proposed treatment discussed with them *and* your child, then a treatment plan will be drawn up. It is important that if parents are to have confidence and trust in the practice, the practice must demonstrate that it takes the care of its child patients seriously; treatment plans and discussion help do this.

Pain control, and more specifically injections, are a major concern for parents, so you must reassure them that it will be used whenever it is clinically necessary. In the background, the GDP must know how to give pain free injections, and DCPs must know how to prepare injections and pass them to the dentist (if this is how you work) without the child being aware of what is going on. The routine use of a topical analgesic gel is to be recommended.

Parents in the surgery

A major, contentious, and often divisive, issue in children's dentistry is whether parents should be in or out of the surgery. What do you think? Your practice might not have hard-and-fast rules about whether parents are allowed into, or are excluded from, the surgery. As a rough guide the following factors should be considered:

- The child's age
- The child's previous dental experiences
- The child's behaviour
- The parent's attitudes and behaviour.

Some children react well when a parent is present in the treatment room and others behave better when their parent remains in reception.

Parents often believe that if they are excluded from the surgery they are abandoning their child. It is important that you reassure them by saying that sometimes their presence can undermine communication and rapport between the GDP and the child, and the only way to regain the child's attention is by the parent being elsewhere. The GDP should decide, based on their experience and knowledge, whether it is in the child's best interest to have their parent in the treatment room. In my experience, an uncooperative child will almost always calm down and co-operate if the parent is out of sight.

This article is no more than a very brief overview of caring for children in a general dental practice setting. If you would like to learn more about managing child patients you can read *Guideline on Behavior Guidance for the Pediatric Dental Patient* from the American Academy of Pediatric Dentistry, which can be found online at http://www.aapd.org/media/policies_guidelines/g_behavguide.pdf.

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Do's and don'ts

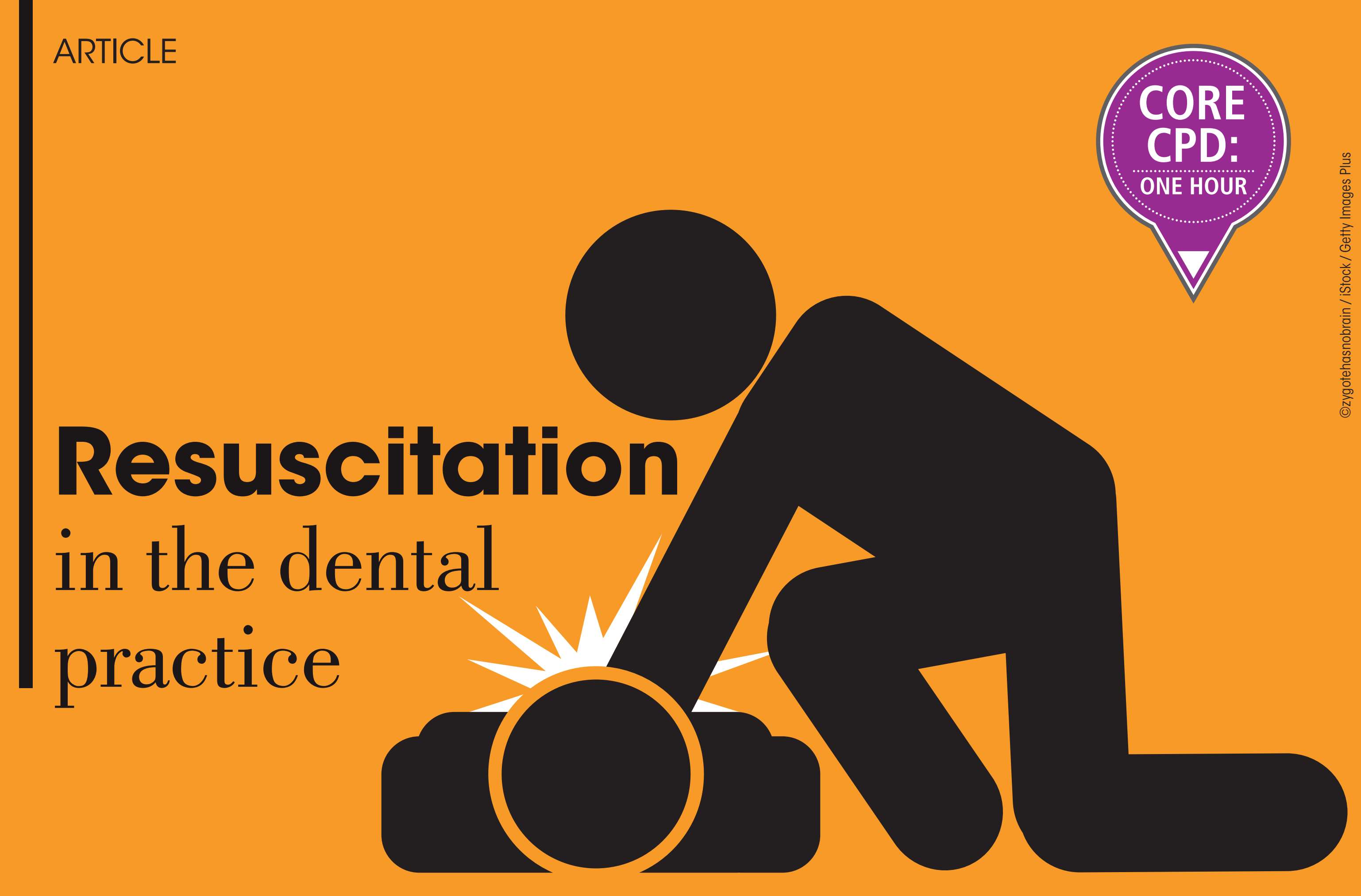
I think it is a good idea to set out some rules for parents: this not only helps the child, but it will also benefit the practice. In a way these rules are a summary of this article. Here are the rules I had for my parents:

- Try to instil a positive attitude towards dentistry in your child
- Allow your child to 'experience' dental care on its own. This helps them to be confident when faced with many new situations. If you are in the surgery with your child, then remember that it is the dentist and dental nurse who will tell your child what is expected of them
- Let your child go into the treatment room alone if this is what the dentist prefers
- Work with the dentist to maintain your child's dental health – it is a team effort!
- Try to be on time for appointments
- Bring your child to the practice immediately if they injure their teeth or mouth, even if there are no obvious signs of damage.

Then there were things we asked them **not** to do:

- Don't bribe your child into going to the dentist
- Don't use a dental visit as a punishment
- Don't use emotive words that may frighten your child
- Don't let your child know of your anxieties about the dentist
- Don't let anyone tell your child scary stories about dental visits
- Don't expect your child not to like their dental visits – many enjoy them!
- Don't feel guilty if your child needs treatment
- Don't forget your child's appointments – their dental care is important.

'CHILDREN'S DENTAL TREATMENT REQUIRES THE SAME, HIGH LEVEL OF TREATMENT PLANNING THAT ADULTS GENERALLY RECEIVE AS A MATTER OF ROUTINE.'



Resuscitation in the dental practice

Phil Jevon[1] looks at the new resuscitation guidelines published in October 2015 and discusses how dental practices should implement them.

[1] *Walsall Healthcare NHS Trust, Manor Hospital Walsall*

A DUTY OF CARE

Every dental practice has a duty of care to ensure that an effective and safe service is provided for its patients. The satisfactory performance in a resuscitation attempt in the dental practice has wide-ranging implications in terms of resuscitation equipment, resuscitation training, standards of care, clinical governance, risk management and clinical audit.

The Resuscitation Council (UK) published new resuscitation guidelines in October 2015. The aim of this article is to understand these new guidelines and how dental practices should implement them. It highlights that the AED sign should be clearly displayed and that practices should display the 'Resuscitation in the Dental Practice' poster (Fig. 1) as an *aide-memoire* for the dental team.

GUIDELINES 2015: IMPORTANT MESSAGES

Promptly assess the unresponsive patient for signs of normal breathing

In the first few minutes following a cardiac arrest, the patient may be hardly breathing, or taking infrequent, irregular and slow gasps, often accompanied by a characteristic snoring sound. This is called agonal breathing and it originates from the brain stem, which remains functioning for a few minutes following a cardiac arrest even when deprived of oxygen. Agonal breathing is common in the first few minutes following a cardiac arrest and, if correctly identified as a sign of cardiac arrest, is associated with higher survival rates.[1]

Always be suspicious of cardiac arrest in a patient who presents with seizures: carefully check if the patient is breathing normally

Immediately following cardiac arrest, because cerebral blood flow is reduced to almost zero, a short seizure-like episode may be witnessed that could be confused with epilepsy. Dental staff should be suspicious of cardiac arrest in any patient presenting with seizures.

Minimise delay to starting chest compressions

On confirming cardiac arrest, stay with the patient and start chest compressions immediately while asking colleagues to call 999 for an ambulance and to fetch automated external defibrillator (AED)/resuscitation equipment. If alone, leave the patient, call 999 for an ambulance (consider the use of a speaker phone facility), fetch the AED, switch it on and follow the instructions before starting chest compressions.

Perform effective chests compressions

Deliver compressions to the centre of the chest, at a depth of 5-6 cm, at a rate of 100–120 per minute. Following each chest compression, allow complete recoil of the chest as this will result in improved venous return to the heart (NB avoid leaning forward after each chest compression). As rescuer fatigue can lead to less effective chest compressions, it is advised to change the person performing chest compressions every two minutes – this coincides conveniently with the working of an AED (every two minutes it will ask you to stop CPR while it analyses the ECG). Changing CPR providers should not interrupt the delivery of chest compressions.

As soon as possible switch the AED on and follow the instructions

Combine chest compressions with ventilations

In clinical settings such as dental practices, there are usually good clinical reasons to avoid mouth-to-mouth ventilation; consequently it is rarely used. Perform chest compressions until the ventilation equipment, for example, pocket mask or bag/valve/mask device, arrives. Once ventilation equipment arrives, stop chest compressions and administer two ventilations. Then continue with chest compressions and ventilations at a ratio of 30:2.

Minimise interruptions to chest compressions

Only stop CPR if you are certain the patient has recovered and is breathing normally

Once the paramedics arrive they will advise accordingly.

'DENTAL PROFESSIONALS, WHEN RESUSCITATING INFANTS AND CHILDREN, SHOULD FOLLOW THE ADULT BASIC LIFE SUPPORT SEQUENCE...'

Register the dental practice's AED with the local ambulance service

This is highly desirable so that ambulance control dispatchers can direct CPR providers to the nearest AED.[2] A visible AED sign outside the dental practice would be helpful.[3]

RESUSCITATION IN THE DENTAL PRACTICE POSTER

A new 'Resuscitation in the Dental Practice' poster (Fig. 1) which has been endorsed by the British Dental Association (BDA) has been developed, which incorporates the new Resuscitation Council (UK) adult basic life support algorithm. This algorithm now includes the use of an AED (there is no longer an automated external defibrillation algorithm). This poster can be printed from the *BDJ Team* website (PDF) or downloaded from https://www.walsallhealthcare.nhs.uk/Data/Sites/1/media/documents/health-and-safety/resus.pdf.

'IT HAS BEEN SHOWN THAT DEFIBRILLATION WITHIN 3-5 MINUTES OF COLLAPSE CAN PRODUCE SURVIVAL RATES AS HIGH AS 50-70%'

IMPORTANCE OF THE AED

It has been shown that defibrillation within 3–5 minutes of collapse can produce survival rates as high as 50–70%.[4] In dental practices, this could be achieved if an AED is immediately available. In the event of a cardiac arrest in a dental practice, as well as ensuring someone has called 999 for an ambulance, send a colleague to fetch the AED (and resuscitation equipment) while starting chest compressions. Each minute of delay to defibrillation reduces the probability of survival to hospital discharge by 10%.[5]

AED SIGN

The Resuscitation Council (UK) has designed a standard AED sign (Fig. 2) to indicate the presence of an AED. This sign, which has been accepted by the Health and Safety Executive (HSE), helps to reduce delay in locating an AED in an emergency. Dental practices should consider displaying the sign, as it will act as a constant reminder where their AED is stored. Some dental practices also display the sign on an external door or window, thus raising local awareness that there is an AED on the premises. To download the AED sign go to https://www.resus.org.uk/defibrillators/standard-sign-for-aeds/.

DEBRIEFING FOLLOWING AN EVENT

Following an event such as a medical emergency, the Resuscitation Council (UK)[6] recommends a period of 'debriefing' which will enable dental staff to reflect on how the event was managed and how the patient was treated. Discussion could take place on how a similar event could and perhaps should be managed if it were to happen again.

PAEDIATRIC RESUSCITATION GUIDELINES

Cardiorespiratory arrest occurs less frequently in children compared with adults, hence both healthcare professionals and lay people are less likely to be involved in paediatric resuscitation. Most cardiorespiratory arrests in children are not caused by a primary cardiac problem but secondary to other causes, mostly respiratory insufficiency. The priority with paediatric resuscitation is, therefore, usually to reoxygenate the child.

The Resuscitation Council (UK)[7] advises that dental professionals, when resuscitating infants and children, should follow the adult basic life support sequence of 30:2 with the following modifications that make it more suitable for use on children:

- Five initial ventilations before starting chest compressions
- If on your own (very unlikely), perform CPR for approximately one minute before going for help
- Compress the chest by one-third of its depth: in infants this equates to approximately four centimetres depth and in older children five centimetres depth
- Use two fingers to compress the chest in an infant younger one year; use one or two hands for a child older than one year to achieve an adequate depth of compression.

Fig. 1 Resuscitation in the Dental Practice poster

RESUSCITATION IN THE DENTAL PRACTICE

Unresponsive and not breathing normally

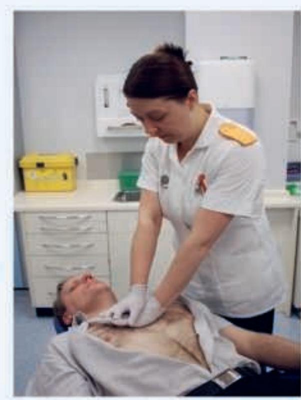
↓

Call 999 and ask for an ambulance

↓

30 Chest compressions

↓



2 Rescue breaths

↓

Continue CPR 30:2

↓

As soon as AED arrives switch it on and follow instructions

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Acknowledgements

Poster designed as an aid memoir by Phil Jevon Medication Education with the help of Mr N Rashid & Miss R Joshi ED Consultants, Mrs S Church, Consultant Orthodontist, Steve Webb Clinical Skills Technician and the dental nurses, Walsall Healthcare NHS Trust, Manor Hospital Walsall. UK

Adult basic life support algorithm reproduced with kind permission of the Resuscitation Council (UK), London

Ambulance image kindly supplied by WMAS

Simrun Rehsi, Undergraduate BSc Computing for Business (ITMB), Aston University, Birmingham for her IT support

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Defibrillation is rarely needed in children, although it is advised to use paediatric electrode pads for defibrillation of children under eight years of age. If they are not available, adult electrodes placed in an antero-posterior orientation will suffice.[6]

TEAM APPROACH TO RESUSCITATION

Resuscitation requires a system to be in place to optimise the chances of the patient surviving. This system requires technical and non-technical skills (teamwork, situational awareness, leadership, decision making).[6] An effective team leader is paramount. Ideally, the dentist should assume the role of team leader, allocating team members specific roles they understand and are able to undertake.

Whether the emergency is in the dental surgery itself, or in another part of the building, it is important to ensure there is 360 degree access to the patient ('Circle of Life').[6]

Position 1

Airway & ventilation – if a bag/valve/mask device is used, then ideally two persons are needed; one to open the airway and ensure a good seal with the mask while a second person squeezes the bag. The person holding the mask on will find sitting on the dentist's stool more comfortable.

Fig. 2 Automated external defibrillator (AED) sign

'PROMPT RECOGNITION OF CARDIAC CHEST PAIN AND RAPID ACTIVATION OF THE EMERGENCY SERVICES WHERE APPROPRIATE REMAINS A PRIORITY FOR DENTAL PROFESSIONALS.'

Position 2

High quality chest compressions – at patient's left side. The dental chair should be horizontal and at a comfortable height for the person performing chest compressions. Be prepared to alternate with the operator at position 3 to avoid fatigue.

Position 3

AED use and alternative chest compressions provider (avoiding fatigue) – ideally the opposite side of position 2.

Position 4

Team leader (usually the dentist) standing at the foot end of the dental chair - by standing back and overseeing the resuscitation attempt, the dentist will be in a better position to help ensure that the resuscitation attempt runs smoothly, effective resuscitation is provided, appropriate decisions are made and the patient and rescuer's safety is maintained.

PREVENTION OF CARDIAC ARREST

In the majority of sudden cardiac deaths outside hospital, there is a history of heart disease and warning symptoms (usually chest pain) in the hour preceding cardiac arrest.[8] The prompt recognition of cardiac chest pain and rapid activation of the emergency services where appropriate remains a priority for dental professionals, as well as ensuring immediate access to an AED.

CONCLUSION

In the event of a cardiac arrest in the dental practice, dental professionals should ensure a swift, effective and safe resuscitation response to help optimise the chances of the patient surviving. The Resuscitation Council (UK)'s Guidelines 2015 stress the importance of calling 999, performing effective chest compressions and switching on the AED and following its instructions as soon as possible.

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This article was originally published in the BDJ *on 11 March 2016 in Volume 220 issue 5, pages 261-263.*

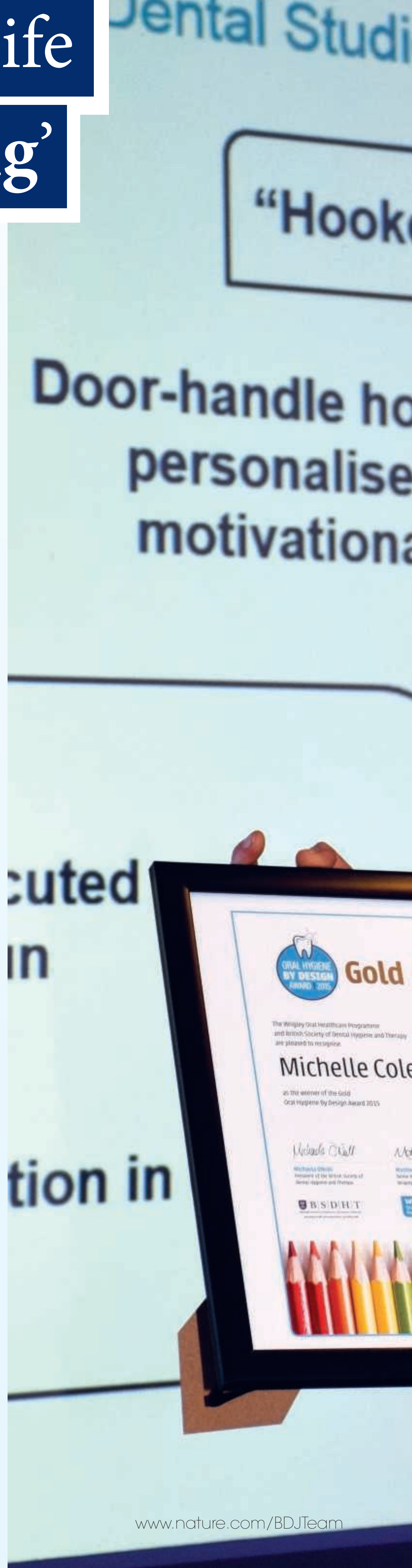
MEDICAL EMERGENCIES POSTERS

Did you see our earlier article from Phil Jevon, *Updated posters to manage medical emergencies in the dental practice?* It was published in *BDJ Team* in March and is available to read at the following link: http://www.nature.com/articles/bdjteam201655

bdjteam2016120

‘To see my idea come to life has been **totally amazing**’

Dental hygienist **Michelle Coles** won an award for designing the patient tool ‘Hooked on Oral Hygiene’ (pictured). *BDJ Team* interviewed Michelle to find out about her background in dentistry and what inspired her invention.



FACT FILE

Name: Michelle Coles

Age: 48

Marital status: Engaged

Job title: Dental hygienist

Workplace: Dental Studios, Borehamwood, Hertfordshire

Hometown: Edgware in North London

Current town: St Albans, Hertfordshire

Qualifications: DSA RDH

Hobbies: Gardening, local history, country walks, spending time with family and friends, shopping and eating out, reading crime thrillers

Did you want to work in dentistry when you left school?

Yes. I remember going to the careers office while at school and thinking that I wanted a career that would involve working with and helping people. I always enjoyed the sciences while at school, especially chemistry and biology.

Were you a dental nurse before becoming a dental hygienist?

Yes, my first job when I left school was as a trainee dental nurse at a local family dental practice. It was such fun and I learnt from a wonderful team of people. It felt like being in a large family and the patients picked up on this atmosphere and often said how nice it was there. I quickly realised that I wanted to become a qualified dental nurse so I applied for and was accepted on the course to train as a Dental Surgery Assistant at the Eastman Dental Institute in London.

Where have you worked in your career so far?

I have worked in family dental practices offering NHS and private treatment in Hitchin, St Albans, Harpenden, Borehamwood, Hemel Hempstead and Berkhamsted. I have also worked in a Sedation clinic in Tottenham, London.

Dental Studios where I currently work in Borehamwood is a general dental practice that also offers specialist services for endodontics, periodontics and implants. I am one of three dental hygienists at the practice.

What attracted you to becoming a dental hygienist and where did you study?

I loved being a dental nurse but I wanted to learn more and get more involved in the treatment of patients. I did the Diploma in Dental Hygiene in 1988, also at the Eastman Dental Institute.

Do family and friends ask you for dental advice?

Of course but thankfully they all know how to look after their teeth so it’s just the odd emergency or query about something unusual.

If you have children, are you very strict with their diet and their oral hygiene routines?

I don’t have children but my cat’s got very good teeth! Well that’s what the vet always says - I don’t actually brush my cat’s teeth, I just buy the cat dry food.

Do you come across people who still hold the misconception that dental hygienists 'just clean teeth'?

No, not too much. I have noticed that I now treat more male patients than when I first qualified. This is perhaps due to better oral health awareness or maybe they want to improve their appearance. Either is good

'I WANTED A WAY THAT I COULD GIVE ANY ADVICE TO ANY PATIENT IN A WAY THAT THEY WILL REMEMBER AND ACT UPON'

and from that starting point you can try and connect with the patient and get them on board to improving their oral health.

What gave you the idea for the Hooked on Oral Hygiene tool?

I wanted a way that I could give *any* advice to *any* patient in a way that they will remember and act upon. We all give tailored advice to our patients in the clinic every day of the week but it can be easy to forget this advice if it is not written down. I needed a simple idea that would help patients remember this advice long after they have left my consultation room. Therefore, it was important to consider the format; a post-it note or a scrap of paper is easily lost at the bottom of a bag, or left in a drawer. So, I thought about how to keep the message on display, and that's how I came up with the idea for the Hooked on Oral Hygiene tool.

It is a hanger style hand-out, similar to a 'Do Not Disturb' sign that you find at hotels. It is printed on steam proof paper so it can survive in any bathroom environment. I think the final design looks great, and it's something that patients should be happy to hang on their bathroom door or cabinet as a visual reminder of the advice they received from their dental professional. On the front of the hand-out there are three boxes where we can write personalised tips and advice for patients, such as brushing twice a day, flossing or chewing sugar-free gum in between meals. There is even space to write the time and date of the patient's next check-up. On the reverse side, there is an illustration of the patient's mouth that can be marked up to show them which areas to focus on more when brushing. I really hope it will encourage patients to

improve their oral hygiene, and maintain those good habits in between dental check-ups.

How did you go about making your idea into an actual product?

It was a very exciting experience to develop the tool; I worked closely with the Wrigley Oral Healthcare Programme (WOHP) team, the British Society of Dental Hygiene and Therapy (BSDHT), the graphic designer and the whole project team, and to see my idea come to life has been totally amazing.

The development of the tool definitely required a lot of thought and creativity. The wider project team and I met on a regular basis to discuss aspects of the design, the type of paper that should be used, the presentation and various other facets of the tool.

The wider project team and I met regularly to discuss aspects of the design; it was important for the designers to really understand the interaction between dental professionals and our patients in order to help me produce the perfect tool. There were many discussions around the look and feel of the tool, the prescription-pad style design, the design of the mouth, and the best paper to use so it wouldn't fall apart in the bathroom. We tested several different types of steam proof paper to make sure we got everything just right.

The tool was officially launched on 20 March 2016, to coincide with World Oral Health Day. As part of the announcement I was honoured to speak at the BSDHT Thames Valley regional group Spring Scientific meeting the day before, allowing me to introduce the tool to other members. A press release was also distributed throughout the UK and the BSDHT shared an email announcement with their network.

How did you hear about the Oral Hygiene By Design Award?

I first became aware of the award when I saw a large colourful advert in a copy of the BSDHT's journal *Dental Health*. It said 'Unleash your creative talents and design your ideal oral hygiene tool' and I thought it would be interesting to see what the eventual winning entry would be because I couldn't think of anything initially.

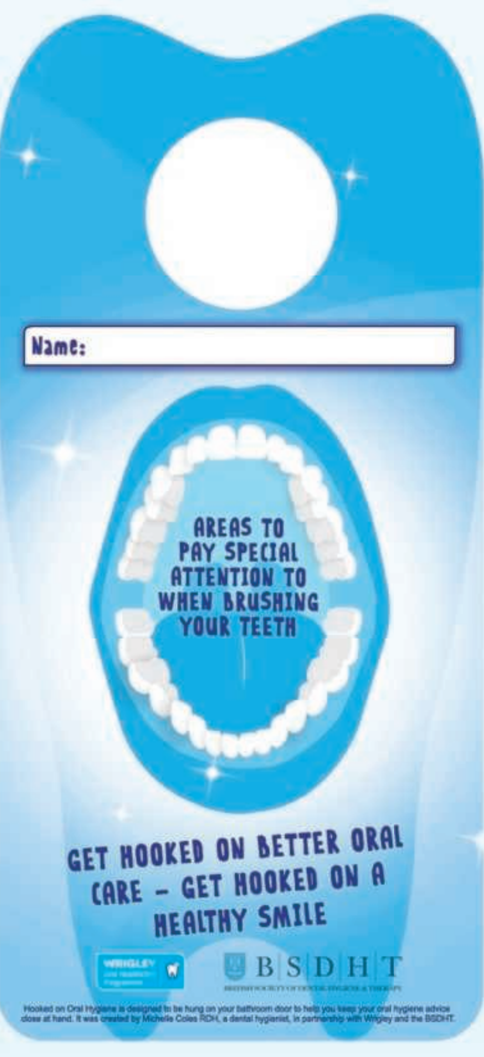
I have been a member of BSDHT since I first qualified as a dental hygienist and really enjoy going to the different scientific meetings held by the various Regional Groups - the ones that I am able to travel to.

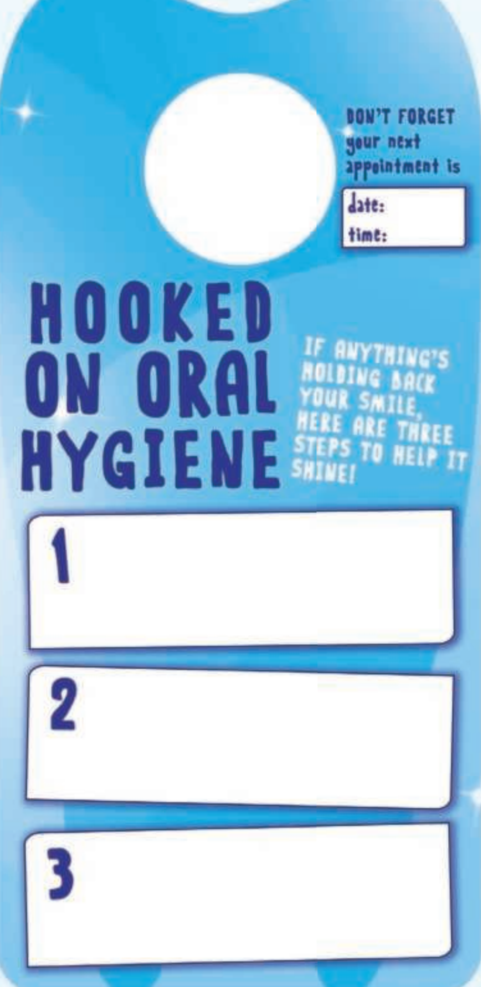
How did it feel to win the award?

I was absolutely delighted and still am!

Do you know roughly how many patients are now using the Hooked tool?

Since the tool launched in March, WOHP has been inundated with requests and I have personally handed out 6,000 tools to dental hygienists and therapists at various BSDHT events. I have also been able to share the tool with work colleagues, patients and friends and family. It's been very rewarding to see patients taking the Hooked on Oral Hygiene tool away with them after their visits to clinic. So far my patients have responded very well to the tool and have been keen to take them back home with them and I would encourage other practitioners to give the tools a try with patients in their clinics as well. If anyone wants to order the tool to use with their patients, they can request them for free via the WOHP website www.wrigleyoralhealthcare.co.uk/.





Do you have any plans to create other tools or products (they may be secret!)?

Maybe. Before I came up with my idea I did toy with a few other concepts, but I rejected these for different reasons - but I could think about it again ... I hadn't really considered it before now.

What are you future career plans?

Winning the award has created a number of opportunities. I am going to my first ever international conference next June in Switzerland, where the tool will be available to delegates, and then I am going to the BSDHT Oral Health Conference in Belfast in November. I'm interested to see what other international events will be held and what I might learn from them.

Are you passionate about teeth and being a dental hygienist?

Yes it's a passion you have to have. It's a caring profession and to be fully committed to caring you have to be passionate about it.

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Product news

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WHY NOT TAKE ON A DENTAL NURSE APPRENTICE?

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Your team is a great resource with a wealth of knowledge and experience to pass on to apprentices, making them perfect teachers and mentors. As they become involved in training they will feel valued and respected, increasing their own personal development and job satisfaction.

The Dental Nursing Apprenticeship programme is an 18-month course combining practical dental nursing skills with theoretical knowledge. Apprentices mostly learn in the workplace, becoming part of the dental team with access to all the resources and support they need to complete their studies and perform their role competently.

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The Dental Nursing Apprenticeship programme is delivered through Barnet and Southgate College with start dates in July and periodically throughout the year.

It's a win-win situation, so find out more about apprenticeships today.

For more information contact Barnet and Southgate College at on 0203 764 4333 or visit www.barnetsouthgate.ac.uk.

FREE ONLINE TOOTH WEAR CPD MODULE

ESCARCEL, a recent pan-European study, amongst 3,187 subjects aged 18-35, concluded that 1 in 3 young adults suffer from tooth wear. In a survey of 200 dental professionals completed in 2013, 84% said they see signs of erosive tooth wear on a weekly basis and 86% felt the condition is on the rise. This emphasises how common erosive tooth wear is throughout the population.

To help raise awareness of the risk factors for tooth wear associated with eating and drinking acidic foods and drinks found in today's diet, Pronamel are offering dental professionals access to a specially developed online module. Topics include identifying signs of tooth wear, condition management advice, the use of the Basic Erosive Wear Examination tool (BEWE) and the role of Pronamel in protection from the effects of acidic diets.

The Pronamel online CPD module is available in an easy to use format which is free of charge. Available 24 hours a day, you can access this module whenever is convenient. Completion of the module can contribute up to 1.5 hours towards your verifiable CPD.

In addition, it provides information on the Pronamel range and how it can help protect patients from the effects of erosive tooth wear.

Visit www.gsk-dentalprofessionals.co.uk/pronamelcpd1 to complete the module now.

SPONGES THAT HOLD 40-50 TIMES THEIR WEIGHT IN BLOOD

Haemostasis is crucial for controlling blood flow during dental interventions. HYGITECH haemostatic sponges are made of high quality gelatine, highly processed and purified, offering good adhesion to the bleeding site, promoting the formation of the fibrin network essential to efficient coagulation. Resorption is complete in 3-4 weeks.

As a macro-porous sponge, HYGITECH haemostatic sponges are insoluble in water with a rapid absorption capacity, equivalent to 40-50 times their weight in blood or other liquids. HYGITECH sponges are easy to use and malleable; they are combined with an antibacterial agent; and they can be cut to fit the bleeding area. They are delivered in single sterile blister packs.

HYGITECH is a German manufacturer and distributor of specialised dentistry products, from dental instruments to surgical preparation to sterilisation.

Visit hygitech.uk or telephone 0203 808 1110.

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

THE FIRST TOOTHBRUSH WITH POSITION DETECTION TECHNOLOGY

The newly-launched Oral-B Genius intelligent toothbrushing system features ground-breaking Position Detection Technology, combining cutting-edge motion sensor technology located in the brush and video recognition using your smartphone's camera to track areas being brushed - so that no zone in the mouth is missed.

When patients brush with the Oral-B Genius, they receive instant feedback on the brushing of each zone of the mouth via the Oral-B App 4.1, including guidance on pressure applied and brushing duration. These features, combined with the Oral-B Oscillating-Rotating-Pulsating Technology and the unique round brush head, helps patients improve their oral health.

The real-time feedback given through the app helps patients to brush for the recommended two minutes and avoid pressing too hard or missing an area of the mouth - for example right-handers not spending enough time in the lower right hand side of the mouth.

Oral-B Genius enables more effective brushing every day. It comes with a smart travel case which charges both the brush and a USB device such as a smartphone; a practical smartphone holder supporting placement of your phone on the mirror in the bathroom; a lithium-ion battery for at least two weeks of brushing between charges; and SmartRing, a personalised multicolour 360° lighting system, featuring 12 different coloured lights for customisation.

The Oral-B Genius and 4.1 App are available from July 2016. http://oralb.com/en-us/product-collections/genius

BRIDGING THE GAP BETWEEN PROFESSIONAL AND HOME CARE

Preventive maintenance is key to increase the success rate of treatments and reduce risks of implant failure due to poor oral hygiene. Extraordinary plaque control, elimination of Volatile Sulphur Compounds (VSCs) and preventive tissue maintenance are of critical importance to the favourable long-term prognosis of implant effectiveness. UltraDEX Implant Care Kits can help to bridge the gap between professional and home care and can be personalised to your practice, to promote treatments, enhance patient compliance and increase revenue and practice profile, all at the same time. These kits have been developed to fit perfectly into the oral hygiene process, before, during and after implant treatment. Backed by scientific research, the clinically proven technology within UltraDEX PROTECTS against plaque, RESTORES natural whiteness and ELIMINATES bad breath instantly for at least 12 hours. To find out more and to receive your FREE personalised kit (one per practice, terms and conditions apply), email dental@periproducts.co.uk.

IMPROVE YOUR DENTURE PATIENTS' CONFIDENCE

Up to 86% of patients are affected by food becoming trapped under their dentures. This can lead to discomfort and can cause bad breath.

Results have shown that Poligrip denture fixatives have the ability to seal out food particles helping to reduce gum irritation and lead to increased levels of confidence, comfort and chewing efficiency.

The Poligrip range of fixatives include:

- Poligrip Flavour Free Fixative Cream
- Poligrip Ultra Denture Cream.

For further information on Poligrip and dentures, why not complete the Poligrip distance learner module and earn up to 1.5 hours of CPD. Simply visit www.gsk-dentalprofessionals.co.uk today.

FREE CPD ON GUM DISEASE

GSK, manufacturers of Corsodyl, have launched a new distance learner for dental professionals on the topic of gum disease.

According to the *Delivering better oral health* toolkit, maintaining periodontal health and preventing periodontitis should be based on detecting periodontitis early using the Basic Periodontal Examination (BPE) and managing the factors that expose patients to a greater risk of the disease, eg smoking, diabetes and medications.

The 2009 Adult Dental Health Survey found that only 17% of dentate adults in England, Wales and Northern Ireland had very healthy periodontal tissue and no periodontal disease. This confirms a need for continued patient education regarding gum health.

The Corsodyl distance learner module provides training on periodontal disease, the BPE, and patient management to treat and prevent the condition. It is suitable for the whole dental team to use and is available 24 hours a day. On top of this, there is no time limit to complete this module and completion of the module can contribute up to 1.5 hours towards your verifiable CPD.

Visit www.gsk-dentalprofessionals.co.uk to complete the module now.

CPD questions
July 2016

Resuscitation in the dental practice

1. Select the **incorrect** statement:
A) dental professionals should be suspicious of cardiac arrest in any patient presenting with seizures
B) agonal breathing is common in the first few minutes following a cardiac arrest
C) if agonal breathing is correctly identified as a sign of cardiac arrest, it is associated with higher survival rates
D) on confirming cardiac arrest, you should start chest compressions immediately whether you're alone or not

2. Which of the following sets of figures corresponds to the ratio of chest compressions to ventilations that should be administered?
A) 15:2
B) 30:2
C) 32:1
D) 60:3

3. a) The person performing chest compression should be changed every two minutes to avoid fatigue; b) compressions should be delivered to the centre of the chest to a depth of about 6 cm
A) only a) is correct
B) a) and b) are correct
C) only b) is correct
D) a) and b) are incorrect

4. In the event you might have to resuscitate a child of 11 months old, which is **false**?
A) you should compress the chest to approximately 4 cm in depth
B) you should use two fingers to compress the chest
C) you should go for help before anything else
D) if defibrillation is required, adult electrodes can be used in an antero-posterior position

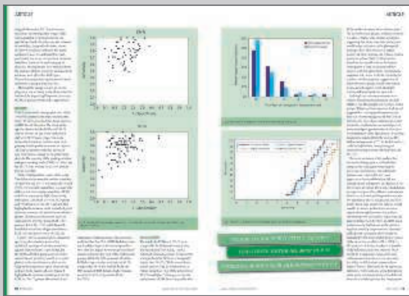
BDJ Team CPD

CPD: ONE HOUR

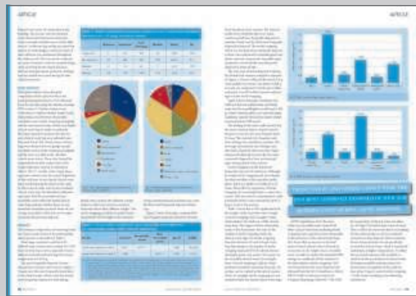
Missed **CPD**?

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

➤ June 2016: **How accurately do members of the dental team detect malignant lesions?**



➤ May 2016: **What's in a bin?**



➤ April 2016: **Periodontitis:** a potential risk factor for Alzheimer's disease

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

➤ March 2016: **How to turn complaints into compliments**

➤ February 2016: **Infection prevention and control in your practice**