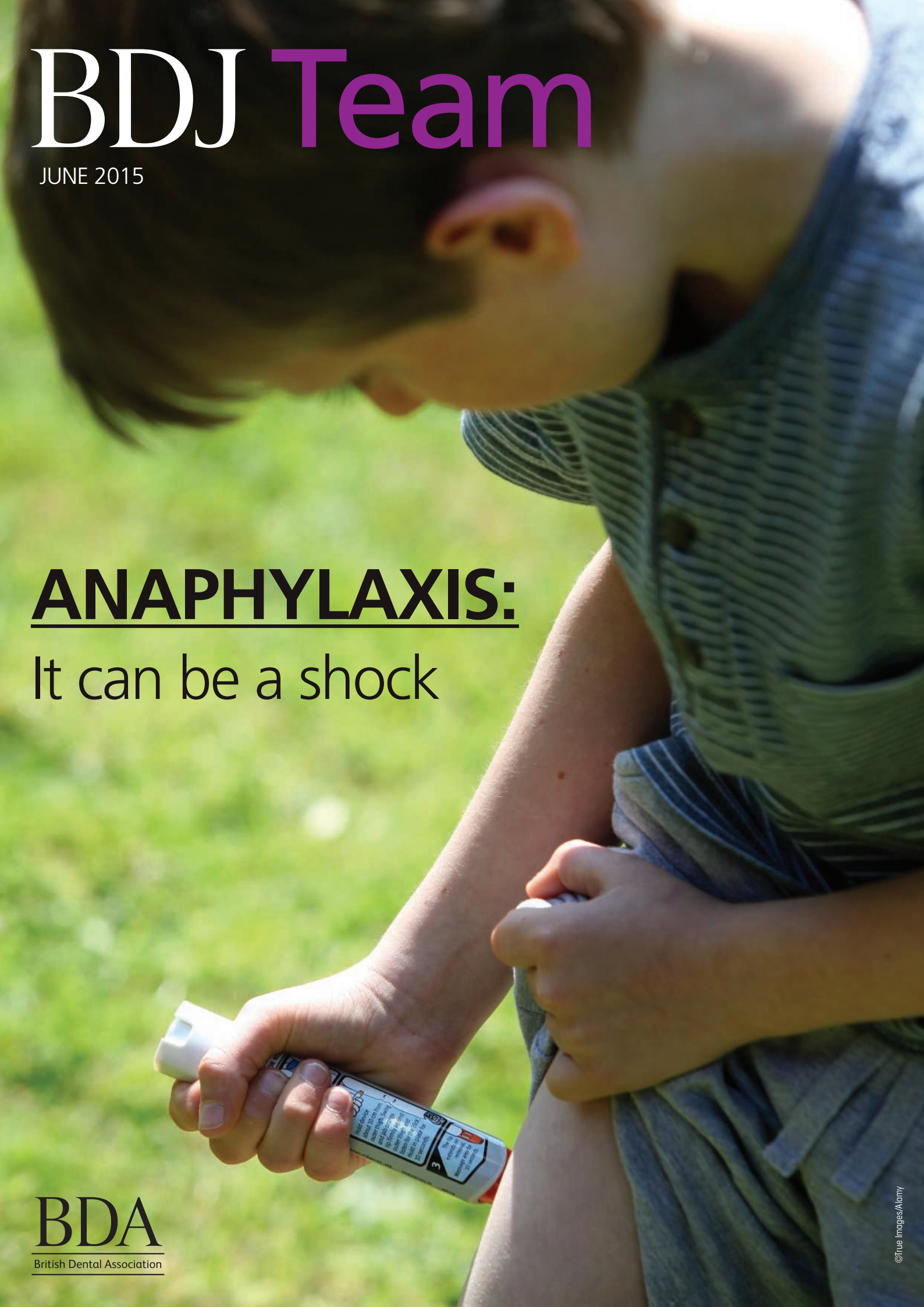
BDJ Team
JUNE 2015



ANAPHYLAXIS:

It can be a shock

BDA
British Dental Association

June 2015

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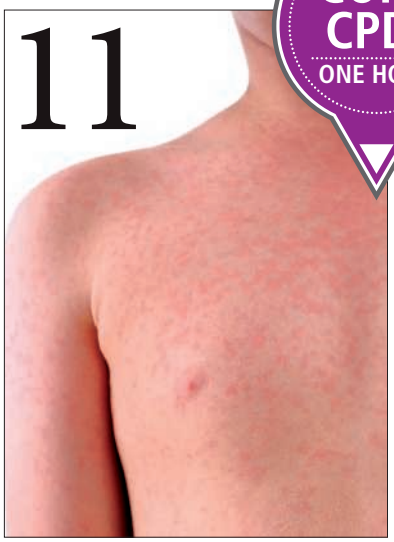

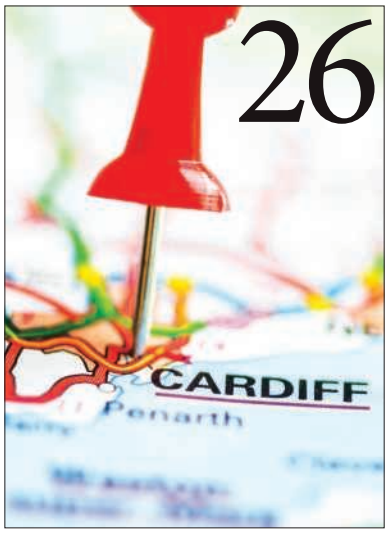

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Welcome all, to the June edition of *BDJ Team*.

Recently the national press reported on a story that got me hot and bothered under the skin, where an investigation by the *BMJ* discovered that 38 MPs had accepted tobacco industry hospitality worth around £60,000.

For the record, all of the hospitality received was properly declared and above board. It is not illegal for members of parliament or peers to accept gifts as long as they are declared. That is not this editor's bone of contention. I find it incredible and morally irresponsible for MPs to be accepting hospitality from an industry that kills people. There are in the region of 100,000 deaths in the UK caused by smoking. For all these 38 MPs knew, some of those deaths could have been in their very own constituencies.

It therefore came as no surprise to learn that 20 of the 38 MPs voted against plain packaging when the vote took place in March. Although the *BMJ* report states 'there is no evidence that the hospitality influenced voting behaviour', it does not take a genius to work out that having the ear of an MP is highly useful when it comes to discussing law. It would be good to know your thoughts on the matter, so email me at bdjteam@nature.com.

This month's edition features a Q&A session with Editor-in-Chief Dr Stephen Hancocks OBE looking at the most recent addition to the *BDJ* portfolio, *BDJ Open*. If you are a budding author, an accomplished writer or weighing up your submission options, Stephen will address some of the key questions you may have.

As the summer draws in and the weather begins to improve, Chief Executive of the British Dental Health Foundation Dr Nigel Carter OBE discusses one of the more prominent topics – diet. The team's intervention from top to bottom is crucial in providing patients good advice, and Dr Carter talks us through some of the main issues.

You will also find Toothbeary owner and founder Nicole Sturzenbaum giving us her ten top tips for a child-friendly environment. Some excellent ideas and well worth a read!

Don't forget to complete your free 1-hour CPD too!

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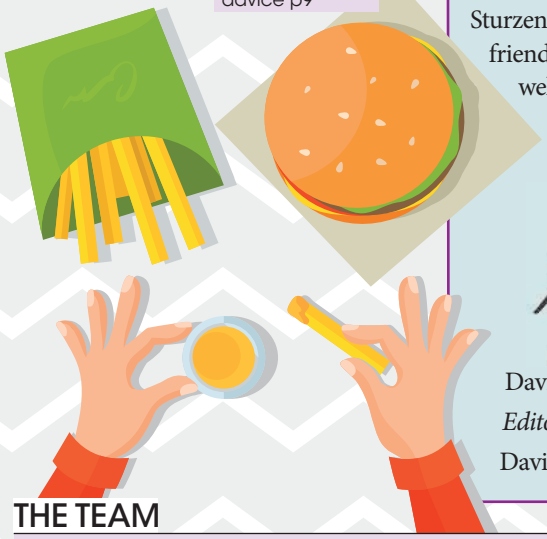

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BDA AND BDIA ANNOUNCE NEW 'STRATEGIC PARTNERSHIP'

The British Dental Association (BDA) and the British Dental Industry Association (BDIA) are delighted to announce that they have agreed a new 'Strategic Partnership' allowing both organisations to work more closely over the coming months and years.

BDA Chief Executive, Peter Ward, commented, 'This exciting new Strategic Partnership will benefit the whole Dental Community and will provide a higher level of engagement, from manufacturers and trade companies, right through to the Dentists and their teams'. The aim of this Partnership will be to;

- Bring both Associations closer together in the eyes of the whole dental sector
- Deliver better value to the sector through a change of culture and a closer working relationship between the BDA and BDIA
- Provide value for members and the wider industry wherever it is possible to do so.

The Partnership recognises the strong identities and individual nature of each Association, whilst effectively looking to deliver a comprehensive business solution for the profession and the industry through activities such as both the BDA's British Dental Conference and Exhibition in the spring and BDIA Dental Showcase in the autumn of each year.

Tony Reed, BDIA Executive Director, added, 'By working in partnership we believe than we can create better value for the members of both Associations. Our two major dental events can together provide all that practices need to maintain an up to date understanding of developments in materials, equipment and techniques and a solution to their educational requirements in terms of clinical and business needs'.

By working in partnership both Associations believe that better value for their members can be achieved.

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CHEMICAL USED IN BEAUTY SALON TEETH WHITENING BANNED BY EU

A chemical often used by illegal tooth whitening clinics and beauticians has been banned by the EU.

Borates, such as sodium perborate and perboric acid have been named on cosmetic products by EU legislation and 'no exception to the ban has been granted', according to the Council of European Dentists (CED). These substances have been classified as carcinogenic, mutagenic or toxic for reproduction (CMR) and so any substance classified as such, independent of its concentration, is prohibited for use in cosmetic products.

The CED has also issued a statement warning of the dangers of a chemical commonly used in unlicensed tooth whitening products in beauty salons. Products of the borate family do have teeth cleaning properties, but are considered to be very unsafe, and are potentially carcinogenic. To safeguard public health, the CED are reminding national authorities in EU states of the banning of the use of borates in cosmetic products and calling on them to take initiatives to ensure that no such products are utilised for tooth whitening or are available on the market.

BDA TO HUNT: TIME FOR ACTION ON 'UNFINISHED BUSINESS' ON PROFESSIONAL REGULATION

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The British Dental Association (BDA) has called on returning Health Secretary Jeremy Hunt to tackle 'unfinished business' on professional regulation.

This letter follows a 12 month period in which the troubled regulator the General Dental Council (GDC) has come under sustained criticism from the dental profession, the courts, parliament and the Professional Standards Authority.

The BDA has now written to the Secretary of State asking him to launch a fundamental review of dental regulation.

The Chair of the BDA's Principal Executive Committee, Mick Armstrong, said:

'Professional regulation cannot get bumped to the bottom of the in-tray for the Health team. The unambiguous and sustained failures at the GDC are unfinished business, and require a clear response.

'Over the last 12 months the GDC has come under unprecedented scrutiny, by the courts, by the PSA and by parliament. And in each case it has been found wanting. Last week's election must not offer an opportunity for a failing regulator to wipe the slate clean.

'In spite of near universal criticism, the current office-holders have failed to show insight or contrition. Nor has anyone admitted culpability or responsibility. It is our belief that until these basic credibility matters have been addressed, the GDC will be unable to fulfil its duty to protect patients.

'It is time for a fundamental review of dental regulation. It must start by looking at accountability, but the profession is clear that there needs to be a much broader overhaul of the way that dentistry is regulated across the United Kingdom. Patients and practitioners deserve a process of regulation that is fair, proportionate and transparent that the GDC in its current form is simply not delivering.'

DENTAL THERAPISTS MAKE PAIN A THING OF THE PAST FOR AFRICAN KIDS

Two dental therapists joined a group in North Africa to treat more than 350 children suffering chronic oral health problems – in just a day and a half!

The seven-strong team, all from Liverpool Dental Spa, spent three days in a remote Moroccan village, taking with them the necessary equipment to tend to the teeth of the many kids in pain – as well as toys and pens as rewards.

Their destination was Asni, a small town in the Atlas Mountains, one hour from Marrakech.

And British Association of Dental Therapists (BADT) chair, Debbie McGovern, and national conference co-ordinator, Kamran Rasul, were among the team – with both admitting that the three-day trip was an eye opener.

Debbie explained: 'The children are in constant pain. They live on a diet that is, essentially, a block of sugar boiled in rice and baked in bread and honey.

'We took over a classroom at one of the schools built by the Eva Branson Foundation [a charity set up my Richard Branson's mother to improve the lives of women and young girls in the Atlas Mountains] and turned it into a clinic.'

Colleague Kamran Rasul added: 'I didn't expect to react the way I did. Initially, I assumed it was nothing more than kids who couldn't afford dentistry but, in reality, it is about children who have little or no access to dentistry. It makes you realise the things you take for granted.'

The team sectioned the classroom into five areas – triage, treatment, toothbrushing classes, fluoride application and recovery.

Debbie explained: 'Many children travelled by foot for up to three hours from surrounding houses and outlying areas. I lost count of the children we treated either for extraction because their teeth were so rotten, or with fluoride varnish to protect remaining teeth.

'I cannot put into words the joy at seeing how grateful they were. There's a lot of ill health – thrush and head lice, for example – and it's great to make a real difference to their lives by relieving them of pain.

'Some had never seen a dentist – or the only dentist they had seen was a man in a marketplace – so it was important we took the time to build trust with these children in order to practise pain-free dentistry.'

The team carried out extractions, oral health education and fluoride application; to date, the Dental Mavericks charity has taken 3,000-plus Moroccan kids out of daily dental pain.

Debbie added: 'We have so much work to do and will be moving the clinics to even more remote parts. It is so important that we carry on raising money for the trips. It's so hard knowing they won't get any more help until we go again in September.'

Have your say on CPD

Are you interested in having your say on CPD? Then you will be glad to know UCL Eastman are carrying out a nationwide survey to find out your views on the current state of CPD. To fill in the online survey, click here.

NEW INITIATIVES MAKE DENTISTRY SAFER FOR ANXIOUS AND VULNERABLE CHILDREN AND YOUNG PEOPLE

Two important changes which will help promote the welfare of young dental patients have been welcomed by the British Society of Paediatric Dentistry (BSPD).

The use of conscious sedation for the treatment of anxious patients is vital for paediatric dentists and BSPD has been concerned for some time at the regional inequalities in accessing conscious sedation services.

The new national standards have been produced by the Intercollegiate Advisory Committee for Sedation in Dentistry (IACSD) and define the education and training required by those who work in sedation teams, whether they are dentists, doctors, nurses or dental care professionals as well as the settings where conscious sedation should take place.

Of significance to paediatric dentistry is that children under 12 years whose oral health needs cannot be met with care under local analgesia and inhalation sedation should now be referred to a specialist sedation team for assessment[1].

Dr Janice Fearne, President of the BSPD, welcomed the improvement in patient safety that the new standards would help bring about.

Dr Fearne said: 'BSPD welcomes the strong focus on patient safety and recognises that our challenge now is to work with other special interest groups and those commissioning paediatric dental sedation services to support the implementation of these important recommendations.'

She said BSPD looked forward to working with the Dental Sedation Teachers Group and Consultant anaesthetist colleagues to ensure that the requirements of the new standards which relate to children are swiftly met.

The second important change is from the General Dental Council (GDC) which has announced that 'safeguarding children and young people' is to be included as a recommended continuing professional development (CPD) topic for dental professionals.

1 A specialist sedation team should comprise clinicians with – to quote from the document - skills equivalent to and expected of specialists or consultants in paediatric dentistry, working alongside those having skills equivalent to and expected of a consultant in anaesthesia competent in sedation for dentistry using advanced sedation techniques or elective general anaesthesia (GA), in a facility with services equivalent to an NHS Acute Trust.

YOUR VIEWS ON THE NEXT NHS...

The second NHS Confidence Monitor - a survey designed to capture how confident the profession are in the future of NHS dentistry - is now open for dentists to take part and share their views.

The first survey was conducted at the end of 2014 and is being repeated to monitor how confidence levels ebb and flow as new information about the contract reforms emerges and the selected prototype practices reveal their thoughts and findings on the potential new systems. The results will then help to provide a snapshot of how the profession perceives the future of NHS dentistry.

The survey explores the profession's thoughts on the future of:

- Career prospects
- Remuneration levels
- Getting the balance of treatment versus prevention within the NHS right
- The ability of the team to work effectively within the NHS.

Among other findings, the first survey revealed that 39% of the respondents asked were less confident about their career prospects within NHS dentistry over the next 12 months than they were a year ago.

Commenting on the opportunities the survey presents, Eddie Crouch, Vice Chair of the British Dental Association Principal Executive Committee, said: 'It will be very interesting to see how confidence levels in NHS dentistry have changed, particularly in light of the General Election, and I look forward to the results. I hope to see even more NHS dentists taking part in this survey so the profession has a greater insight into the possible future effect of NHS dentistry.'

As an NHS dentist, how do you feel about the future of dentistry? To have your say and help to inform your colleagues, please visit https://www.surveymonkey.com/s/NHSConfidenceMonitor

How Old Is Your Mouth?

A new survey from UltraDEX reveals that in the UK our smile is officially our beauty blind spot. While 89% of people think that bad teeth can make a person look older, 40% of people admitted that they have never considered whether their smile could be ageing them.

We're all aware of the importance of healthy eating and exercise to stay young and we spend millions on anti-ageing skincare products, but UltraDEX have worked with leading dentists who say we overlook how our ageing teeth impact on how well we look, and they have come up with an ageing assessment.

What happens to teeth as we age?

Everyday wear and tear and the natural ageing process takes a toll on our teeth and gums, given all the chewing, crunching, biting and gnashing they do.

Contrary to what many people assume, teeth do not necessarily become more brittle with age, but tiny flaws, chips and cracks develop on our teeth over time. Stains appear where there is organic build-up of plaque, enamel erodes, gums recede and teeth can shift as we lose bone. The risk of gum problems increase with age as pockets form at the gum line where bacteria can grow. Sugary and starchy foods and carbonated sugary drinks are some of the biggest threats to teeth, as carbohydrates ferment, causing the bacteria in the mouth to produce enamel eating acids.

The best way to control ageing teeth and subsequent problems is prevention. Healthy teeth can immediately make you look younger and more attractive. How old is your mouth? To find out take the online test at www.ultraDEX.co.uk/HOIYM.

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Oh, what a night

Shaun Howe, RDH on what dentistry can expect post-election

Since the surprise victory of the Conservative Party on 7 May 2015, discussions about the future of dentistry are slowly gaining momentum. Yet what can the average dental professional glean from any announcements – or indeed a lack of them?

In January 2015 the Department of Health (DH) announced those dental practices selected to be 'prototypes' to trial a reformed NHS General Dental Services contract following a series of trials using various permutations of contracts to deliver care to patients in a more preventative based care system focusing on prevention rather than cure. The introduction of such care systems have caused some concern in the wider dental profession as the concept of Key Performance Indicators (KPI's) is inherent with such a system and presents, arguably, another layer of bureaucracy to provide care to patients. The drive for change is perhaps led by the last Adult Dental Health Survey (2009) which shows a direct correlation between improving oral health and the ever increasing life expectancy; people are living longer, retaining more teeth and cleaning their teeth better than ever before. The evidence base in Delivering Better Oral Health 3 (2013) really shows that prevention really is better than cure and cannot be ignored.

A week before the General Election, NHS England announced the appointment of the new Chief Dental Officer; Sara Hurley BDS(UBrist) MFGDP(UK) MSc(UCL) MA(KCL) has come from the military to this new appointment. Many a cynic may suggest the timing was quite apt but Sara's predecessor, Barry Cockcroft, helped form the way forward for dentistry. In an interview with BADT President Fiona Sandom, Mr Cockcroft is quoted as saying *'The majority of the population are going to have much simpler needs and I think this is bound to lead to dental care professionals (DCPs) having a greater role in the delivery of care – in both the NHS and the private sectors'*. You may make your own assumptions from this but in light of the 'prototype' practices busy trialling new systems it would be foolish to assume that there will not be a paradigm shift over time of how NHS dental care is delivered.

'PREVENTION REALLY IS BETTER THAN CURE AND CANNOT BE IGNORED'

We remain in a period of austerity; it is not for this article to discuss the whys and wherefores of such policies but as Local Area Teams (England) are constrained by budget reforms then those responsible for commissioning such services as dentistry may well be minded to seek out the very best value. There is ongoing concern in the profession that such strategies may just mean that commissioners simply give contracts for services to the lowest bidder although there is nothing to substantiate such fears at this time. The rise of corporate dentistry means there may well be a 'stack it high, sell it cheap' mentality in future bidding processes but again, this is currently unsubstantiated.

It is interesting to note an announcement made in March 2015 by the Welsh Assembly of a ring fencing of dental budgets in Wales for three years which, on the face of it may seem a good thing but may well lead to an actual decrease in funding in real terms as inflation and other factors are taken in to account. The current period of deflation will not persist and as Mark Carney, the Governor of the Bank of England is recently quoted as saying, '*We expect inflation to be very low over the next few months. But over the course of the year as we get towards the end inflation should start to pick up towards our 2% target. The British people should enjoy this period of very low energy prices low, very low food prices, enjoy it while it lasts'*.

The cuts are deep and wide ranging and given there was no mention of dentistry in the last two Queen's speeches then the profession can only assume that it is carry on until time that such announcements are made that will affect the way we all, NHS or privately, deliver care to our patients; representative bodies are pushing for reform at the GDC yet no one really can predict the future of healthcare regulation given the ongoing ramifications of the 5th Shipman Enquiry and the profession can only sit and wait until change is announced; it seems such a shame that we have to react rather than predict.

bdjteam201581

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Nayeem Ali, Consultant Oral and Maxillofacial Surgeon, Barts Health NHS Trust

Why don't people always do what we ask them to do? Helping patients change their oral health behaviours
Koula Asimakopoulou, Senior Lecturer in Health Psychology, King's College London

The GDC Fitness to Practice process
Aubrey Craig, Head of Dental Division and Dental Adviser, MDDUS

Oral medicine
Alexander Crighton, Honorary Clinical Senior Lecturer, Glasgow Dental School

The composite Dahl approach and beyond
Jeremy Rees, Consultant Restorative Dentist, Cardiff Dental School

Food, drink and erosion: a field guide for clinicians and parents
Jeremy Rees, Consultant Restorative Dentist, Cardiff Dental School

Managing and resolving conflict in the team
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Improving nutrition for better oral health:

the importance of educating patients

By Dr Nigel Carter OBE, Chief Executive of the British Dental Health Foundation

The role and influence of a dental care professional (DCP) is now far more wide-ranging than simply the basic care and maintenance of how patients care for their teeth. It's as much about patients developing a healthier way of life as it is purely about the health of their mouth. The relationship between a patient's oral health and overall body health is well-documented and there's a critical role for the whole of the profession to play in making way for a healthier Britain.

One of the most concerning areas that we need to address as a population is that of our diet, which is quickly becoming all too dependent on added sugars. A patient's diet is a decisive factor not only for their general health, partly responsible for the current obesity epidemic, but also one that has a detrimental effect on their oral health too. The crossover nature that diet plays in both of these disciplines, along with the severity of potential patient outcomes, warrants an extensive and cohesive approach by all DCPs to improve the nation's nutritional habits.

The landscape of diet on patient's health

Poor diet and nutrition are recognised as major contributory risk factors for ill health and premature death – it's about as serious as it gets. The relationship between poor dietary habits to obesity and tooth decay are major public health problems due to their associations with serious chronic diseases such as type 2 diabetes, heart disease and strokes.

Latest figures in the UK show that we are actually consuming less added sugar than a decade ago, however, we are still eating far too much of them[1]. Added sugars make up 12.5% of our total calorie intake – much higher than the recommended allowance recently set by the World Health Organisation (WHO) at no more than 10% of calorie intake with a recommendation to move towards 5%[1].

We only have to take a look at the latest obesity and tooth decay figures to see that more has to be done to bring about a dietary change amongst many of the population. Obesity currently affects around one in every four adults while a third of children are either overweight or obese. Studies have shown that a reduction of 10% in added sugar in fizzy drinks could result in stopping the increase in childhood obesity in its tracks[1]. And tooth decay presents a similar story, with one in three adults suffering from the disease and one in four five-year-olds.

The main issue is here that both obesity and tooth decay are entirely preventable. Diet is a mind-set, a lifestyle choice, a behavioural outlook and attitude that can either increase our quality of life, or reduce it. Sadly for many patients, the messages just don't seem to be sinking in.

The latest data from an NHS report show that the majority of patients believe their own diet to be 'quite' healthy (71 per cent for men and 72 per cent for women)[1]. Interestingly, the review showed that patients are far less likely to concede their diet as being unhealthy. Around 10 per cent acknowledge themselves to have an unhealthy diet – which is far less than obesity and tooth decay figures suggest that it should be. There is no further analysis here but the assumption is either that patients are ashamed to admit to eating unhealthily or remain completely unaware regarding the impact of diet on their wellbeing.

Either of these alteratives presents a significant opportunity for DCPs to encourage a change in a patient's nutritional habits.

Diet and oral health

From an oral health point of view it is also the frequency of sugar consumption as well as quantity that is the main concern. We have found that it is this frequency message that seems to cause the most confusion amongst patients. The trend suggests we have moved from having three square meals a day to 7-10 snack attacks many of which will contain sugar.

Having this many sugar hits throughout the day simply does not give a patient's teeth a chance to recover. Sugary foods and drinks are allowed but patients need to try to stick to consuming them at mealtimes only. Gum disease, dental erosion, tooth loss, bad breath can all be linked to a patient's poor diet. If you are concerned about a particular patient, ask them to record a food diary in-between visits. Their nutritional intake may not be the cause of the problems, but it will help you give advice on how they may improve their diet.

'A PATIENT'S DIET IS A DECISIVE FACTOR NOT ONLY FOR THEIR GENERAL HEALTH, PARTLY RESPONSIBLE FOR THE CURRENT OBESITY EPIDEMIC, BUT ALSO ONE THAT HAS A DETRIMENTAL EFFECT ON THEIR ORAL HEALTH TOO.'

The role of the dental team

This is certainly a difficult one. Many DCPs find that they are repeating themselves on the same dietary messages time after time to the same patient, many of whom seemingly forget or ignore any advice and guidance the moment they leave the dental practice.

While many of us have recognised that large amounts of hidden sugars such as Sucrose, Maltose, Glucose and Fructose are often added as a cheap bulking agent, relaying that message and similar ones, to the patient is often a cause of difficulty. A good maxim is to get patients to look at the food ingredient list and that anything with an 'ose' at the end is likely to be a sugar and to be a potential problem.

Giving the patient advice and guidance in the form of a physical aid will allow them to recall the information more easily at home. At the British Dental Health Foundation we have worked with dental practices and professionals for more than 40 years to ensure patients are provided with the very best educational resources and materials.

As a charity we recognise the challenge of both the DCP to communicate these messages and that of the patient to recall and understand them to a level where there is a behavioural change. Our resources are specially designed to bridge this gap so I encourage all DCPs to head to www.educatingsmiles.org and take a look for themselves.

A patient's choice

It has to be said that this challenge is ultimately one for the patient. Much like the reduction in smokers over the last ten years, those with poor diets must step up and take responsibility for their own health and make a decision which will positively change their life for the better.

DCPs cannot prevent patients from having poor diets, much like they have no control over whether a patient smokes or not. What we have to do is work harder to motivate that change in mentality. We know people will only change their ways if they want to, but by approaching the topic of lifestyle during each check-up, DCPs can ascertain important information relating to future check-ups in order to make necessary future recommendations.

Teams should be encouraged, not dissuaded to openly discuss lifestyle with a patient. Diet plays such a critical role in both oral and general health that we can no longer afford it to be a side issue in patient education. By engaging patients with food and nutritional information, DCPs can make yet another momentous impact on the landscape of creating a healthier, happier Britain.

1 Health and Social Care Information Centre. *Statistics on Obesity, Physical Activity and Diet - England, 2015 [NS]*. Available at http://www.hscic.gov.uk/catalogue/PUB16988. [Accessed 01.06.2015]

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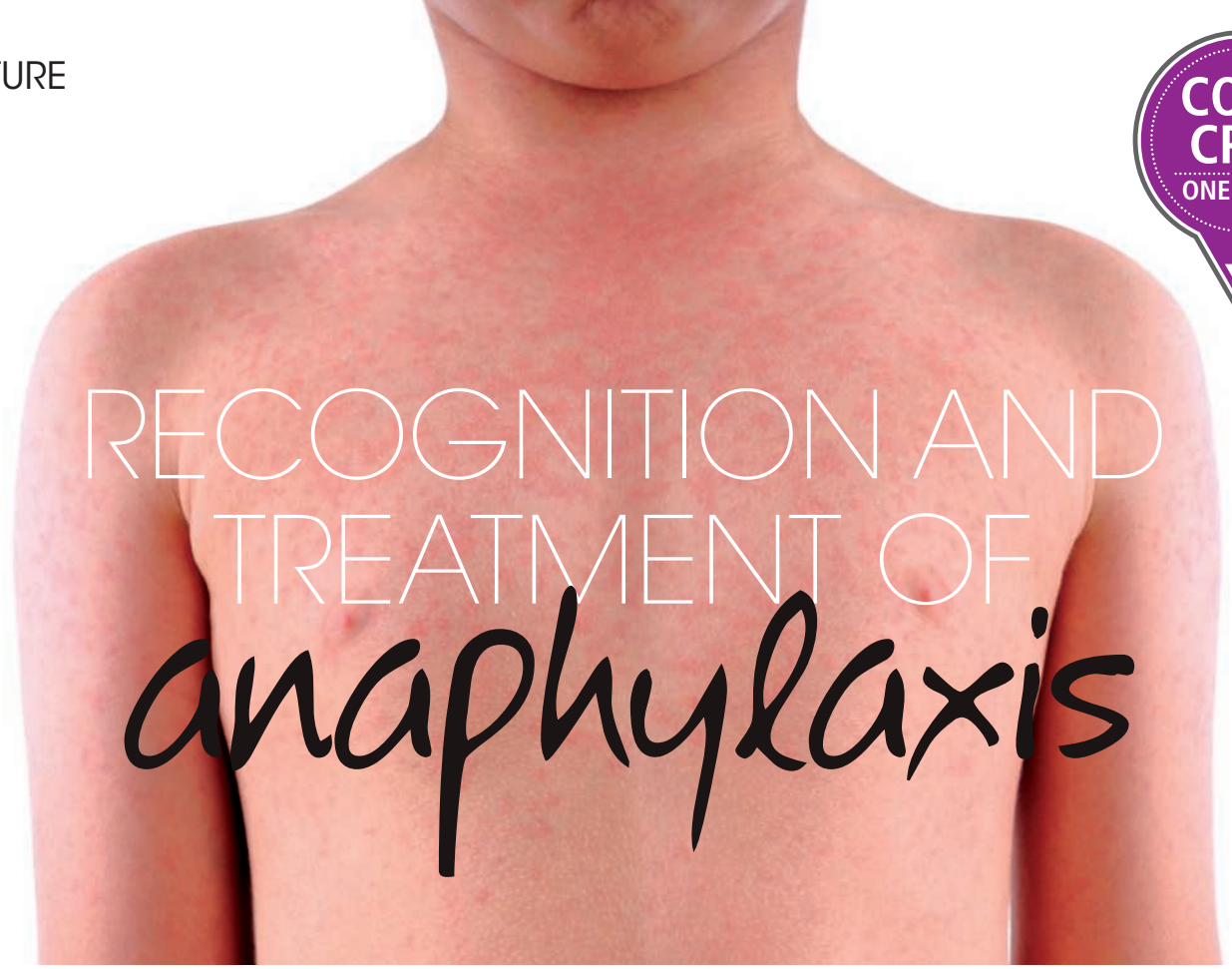
CORE CPD: ONE HOUR



RECOGNITION AND TREATMENT OF anaphylaxis

Do you know what to do if a patient in your practice has an anaphylactic reaction? **Jon Kyle Andersen***, trainer and former paramedic, offers a guide.

*Jon Anderson of ST4 Training was an ambulance service paramedic for 17 years incorporating the roles of aircrew paramedic, paramedic team leader, and operational station officer. The major part of Jon's work is teaching and facilitating courses in First Aid, Basic Life Support (BLS), defibrillation and medical emergencies to healthcare professionals and the general public. Jon is a Health and Safety Executive (HSE) approved First Aid at Work Instructor and Assessor, and holds a City and Guilds 7303 teaching qualification. He is also a CPD Registered Presenter with The CPD Certification Service. Call Jon on 07837 130700 or visit www.st4training.co.uk.

What is anaphylaxis?

'*Anaphylaxis is a severe, life-threatening, generalised or systemic hypersensitivity reaction. It is characterised by rapidly developing life-threatening problems involving: the airway (pharyngeal or laryngeal oedema) and/or breathing (bronchospasm with tachypnoea) and/or circulation (hypotension and/or tachycardia). In most cases there are associated skin and mucosal changes.*'
NICE clinical guideline 134 – issued December 2011.

What is happening?

Anaphylaxis is caused by the sudden release of chemical substances, including histamine, from cells in the blood and tissues where they are stored. This release is triggered by the reaction between the allergic antibody (IgE) and the substance (allergen) causing the anaphylactic reaction. Histamine is a chemical that plays a major role in many allergic reactions, dilating blood vessels and making the vessel walls abnormally permeable.

What are the signs and symptoms?

Airway

- Swelling of the face, throat or tongue
- A feeling that the throat is closing up
- Hoarse voice
- Stridor
- Difficulty swallowing (dysphagia).

Breathing

- Shortness of breath (dyspnoea)
- Increased respiratory rate
- Wheezing
- Respiratory arrest.

Circulation

- Signs of shock
- Increased heart rate (tachycardia)
- Feeling faint
- Collapse
- Myocardial ischaemia/angina (bradycardia is usually a late sign, often preceding cardiac arrest)
- Low blood pressure (the person may be fine when supine, but may go into cardiac arrest if sat up or stood up – blood pools in the legs)
- Cardiac arrest.

Disability (neurological problems – decreased brain perfusion)

- A sense of impending doom
- Tiredness, weakness
- Reduced level of consciousness
- Confusion.

Exposure (skin and/or mucosal changes)

- Skin changes are often the first feature, and are present in over 80% of anaphylactic reactions
- Skin changes can be subtle or dramatic
- There may be erythema (a patchy or generalised red rash)
- Urticaria (hives, nettle rash, weals or welts)
- Angioedema (similar to urticaria but involves swelling of the deeper tissues such as the eyelids, lips, mouth or throat)
- Cyanosis – a late sign!

What is the treatment?

- Intramuscular adrenaline
- Oxygen (highest flow rate with a non-rebreather mask and reservoir)
- Call 999/112 (must go to hospital, even if apparently recovered).

> 'After emergency treatment for suspected anaphylaxis, offer people an adrenaline injector as an interim measure.'

Intramuscular adrenaline (IM doses of 1:1000 adrenaline)	
Adult:	500 micrograms IM (0.5 mL)
Child more than 12 years:	500 micrograms IM (0.5 mL)
Child 6-12 years:	300 micrograms IM (0.3 mL)
Child less than 6 years:	150 micrograms IM (0.15 mL)

'Repeat the dose if there is no improvement in the patient's condition. Further doses can be given at about five minute intervals according to the patient's response' (www.resus.org.uk).

'*Patients with airway and breathing problems may prefer to sit up as this will make breathing easier. Lying flat with or without leg elevation is helpful for patients with a low blood pressure. If the patient feels faint, do not sit or stand them up – this can cause cardiac arrest. Patients who are breathing and are unconscious should be placed on their side (recovery position). Pregnant patients should be placed on their left side to prevent caval compression*' (www.resus.org.uk).

Auto-injectors

- EpiPen www.epipen.co.uk
- Anapen www.anapen.co.uk
- Jext www.jext.co.uk
- Anapen, EpiPen and Jext have an expiry alert service by email or text messaging
- For self-use by patients or carers
- Anyone who has an adrenaline injector should also have a training device to practise with
- Train the patient and carers in using the device (their use is not intuitive)
- Only 30% of patients know how and when to use their injector; have one that is in date, and carry it all the time.

Differential diagnosis

- Severe asthma – can present with similar signs and symptoms to anaphylaxis, particularly in children. Asthma and anaphylaxis compound each other
- Septic shock – hypotension with a petechial or purperic rash (tiny red or purple spots caused by an extravasation of blood into the skin)
- Petechial rash (sometimes referred to as a purperic rash)
- Fainting – a vaso-vagal episode
- Panic attack – victims of previous anaphylaxis may be particularly prone to panic attacks if they think they have been re-exposed to the allergen
- Breath holding in children
- Idiopathic (ie without a known cause) (non-allergic) urticaria or angioedema.

If in doubt - treat as anaphylaxis!

Frequency and reporting of anaphylaxis

The following is an extract from the NICE guideline published 14 December 2011 as reported by the Anaphylaxis Campaign www.anaphylaxis.org.uk:

'*Because of inconsistencies in reporting anaphylaxis, and because it is often misdiagnosed, there is no overall figure for the frequency of anaphylaxis from all causes in the UK ... there are now around 20 deaths each year in the UK from anaphylaxis (although this may be a substantial underestimate) ... in addition, there is considerable geographic variation in both practice and service provision...*'

Recommendations from the new guideline include:

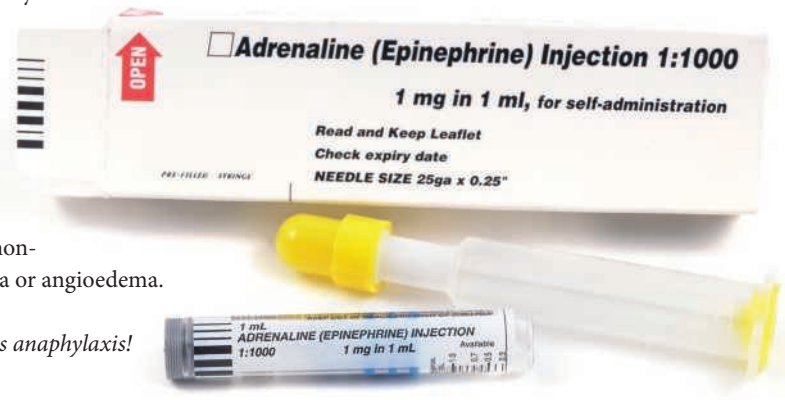
- Record the circumstances immediately before the onset of the reaction to help to identify the possible trigger
- After emergency treatment for suspected anaphylaxis, offer people (or, as appropriate, their parent and/or carer) an appropriate adrenaline injector as an interim measure before the specialist allergy service appointment.

Lynne Regent, CEO of the Anaphylaxis Campaign says: '*The Anaphylaxis Campaign welcomes the NICE guidelines as we believe it is important for all patients who have had emergency treatment for suspected anaphylaxis to be offered a referral to a specialist who can accurately diagnose and manage their condition. We also welcome the recommendation that patients should be given an adrenaline auto-injector before discharge, to ensure that they are equipped in the event of subsequent reactions.*'

Useful websites

Resuscitation Council (UK)
www.resus.org.uk
Anaphylaxis Campaign
www.anaphylaxis.org.uk

bdjteam201583



New workplace pension rules

by **James Dawson**, Head of Advice Publications in the Practice Support team at the BDA

Big pension changes are coming for dental practice staff (indeed for staff across all businesses) over the next few years. Employees will be automatically enrolled in a workplace pension by their boss and contributions deducted from their wages to add to their pension savings.

Auto enrolment

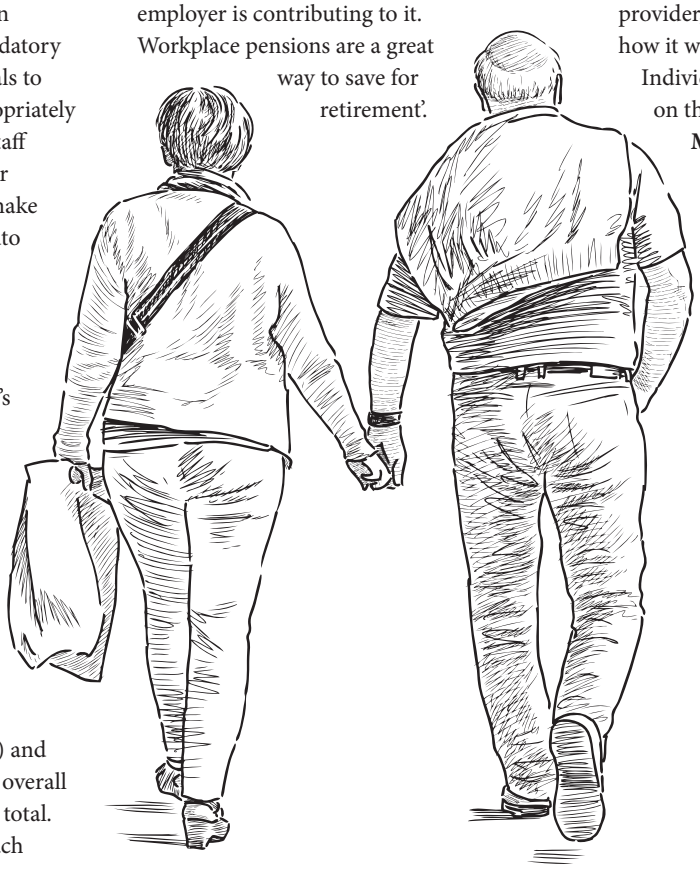
Known as *auto enrolment* the new pensions system covers employees between aged 22-years and state pension age (this in itself is increasing gradually from 65 to 68-years). They must also work in the UK and earn over £10,000 a year. Other staff can also ask to be auto enrolled as long as they are between 16 and 74 years and earn over £5,772 a year.

Eligible staff will automatically become members of their employer's pension scheme. The rules apply in this mandatory way in order to encourage individuals to take responsibility and to save appropriately for their retirement. Nevertheless, staff can choose not to participate in their pension scheme but they can only make this decision after they have been auto enrolled.

Contributions

Both employer and employee must make contributions to the employee's pension fund. The employer will have to handle these through their pay-roll system. Minimum rates have been set, these are being introduced gradually on a sliding scale. By the time work place pension auto enrolment has been fully implemented in 2018 the rates will be 4% for employees (which with tax breaks should work out at 5% in real terms) and 3% from your employer; making an overall contribution of 8% of your salary in total.

This money will be invested on each employee's behalf in a qualifying pension scheme from an independent provider that meets strict legal requirements. Your savings with the pension scheme provider will go into what is known as a *defined-contribution* pension scheme; what is invested in your name from your contributions and the money put in by your employer and the government (in the form of tax relief) will build up a pension pot for you to use at retirement. It is possible to opt-out after you have been auto enrolled and if you do so within a month your contributions will be refunded (if you opt out later contributions already paid will be frozen in your pension pot). You would need to get an opt-out notice, directly from the pension scheme provider. Nevertheless, the independent **Money Advice Service** says that 'for most people, staying in a workplace pension is a good idea, particularly if the employer is contributing to it. Workplace pensions are a great way to save for retirement'.



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When

Staff in large businesses, that is those with over 50 staff have already been automatically enrolled in workplace pensions. Auto enrolment is being rolled out to businesses with between 30 and 49 employees from June 2015. Then staff in businesses with less than 30 staff will be enrolled from 1 January 2016 up to 1 April 2017. Newly established businesses, of whatever size, will have slightly longer, until 1 February 2018. The official watchdog overseeing work-based pension schemes, The Pensions Regulator, will contact your employer about their *staging date* – the date they have to start enrolling you – 12-months before they must start enrolling staff. It is important that employers and employees discuss how this policy will affect them before enrolment starts. You needs to know the details of the scheme and its provider, how much will be contributed and how it will be saved on your behalf.

Individuals can get further information on this change from the independent **Money Advice Service** at www.moneyadviceservice.org.uk or 0300 500 5000. The BDA has produced guidance for your practice owner, it is in the *Staff pensions – automatic enrolment* section of BDA Advice **Employing staff**, which can be found on the website at www.bda.org/advice

James Dawson is responsible for the BDA's guidance documents for members in general practice on legal matters including associate contracts and staff employment

bdjteam201584

10 top tips for a child-friendly environment

The Children's Dental Health Survey 2013 revealed that in England, Wales and Northern Ireland only one in four 12 year-olds have no fear of the dentist. This statistic tells its own tale, but above all highlights the need to improve the child's experience when visiting a dental practice.

Toothbeary, tucked away in Richmond, London, has been designed with children in mind. Every little detail comes together to ensure that Toothbeary is a place where children feel at home. **Founder and principal dentist Nicole Sturzenbaum** (above) offers ten top tips on how to make your practice a child-friendly environment.

1. Think about the concepts

As always, the first impression leads the way to how the child will feel and behave. For instance the reception desk: can you imagine how a child will fell walking into your practice and the only thing they see is a big wall and it will be impossible from them to see who is behind the desk. If you can't lower your desk then ask your receptionist to stand up and lean over the desk to greet the child personally to make them feel welcome. Obviously the choice of colours on your walls/ chairs or uniform can make a difference as well. Paediatric psychologists have defined schemes which make children feel comfortable. The stainless steel and white décor of a standard practice may look pristine to adults, but it is not an environment a child will feel comfortable in. In contrast soft colours such as blue, pink, green or yellow will have a calming effect on the child. Of course the waiting room is equally important as it supports the feeling that your practice is a place where they belong. I suggest you dedicate a corner in your waiting room with age appropriate furniture, games and toys.

2. The work starts before the child even arrives

The initial contact with the parents on the phone is very important. The receptionist should take the time to collect as much information about the child as possible (previous experiences, pain, anxiety etc.), so that everybody knows beforehand how to approach the child and what to expect when (s)he comes for the initial appointment. In addition, we send out a list of do's and don'ts to the parents to help them prepare the child for their visit. Often parents reassure their child by saying 'there is nothing to worry about' or 'it won't hurt', which in fact implies that there might be something to be worried about! Children have no prior association of what a visit to the dentist is like, so why give them a negative one? We encourage parents to use positive words such as 'fun', 'exciting', 'playing' and counting teeth.

3. Never treat the child on the first visit

It is important you get the first appointment right, which is why you need to take the time to really get to know your new little patient. At Toothbeary the nurse will start seeing the

child on her own and have a chat for at least 10 minutes about oral hygiene/ diet and hobbies etc. This will make the child feel comfortable and relaxed. By the time I come in (and I am dressed in the same colours as the nurse), the child will already feel less intimidated by the whole situation. It is all about building rapport and trust. For this reason I only do an exam and do try not to treat children on their first visit, but instead let them go home with the positive feeling of having had their teeth counted and having been a good helper.

what they can exchange their token for and a host of other things. We always wrap positive messages into the questions we ask. For example I would never say 'please get on the chair/bench now', but rather 'I think it would be a great idea if you would lie on the chair so you can see the movie better, would you like to try'?

6. Positive reinforcement

Positive reinforcement is a key component of success, not just with us, but for their overall development. Everything you say/do can be wrapped into a positive reinforcement. If a child is nervous or appears anxious, it is better to start with an easy appointment (like a visit to the Toothbrushing School or having fissure sealants applied). In this way the child will feel that they have achieved their goal and will reinforce the child's positive behaviour for the next visit.

'ALWAYS TRY TO KEEP THE CHILD AT THE CENTRE OF ATTENTION. AT THE END OF THE DAY, THIS IS THEIR VISIT AND NOT THE PARENT'S ONE.'

4. It's about the child, not the parent

Always try to keep the child at the centre of attention. At the end of the day, this is their visit and not the parent's one. Use open questions in a child appropriate language, which they can answer with 'yes. Basic postulates of psychology state that if the child answers five questions in a row with 'yes', (s)he will not say 'no' when you ask them if they want to lay down to have their teeth counted. At the same time, your active listening will have a reassuring effect and imply that everything is normal. Of course it is important to discuss all treatment details/ possibilities with the parents and get their consent, so when you have finished 'counting teeth' ask your nurse to take the child to the play area while you talk to the parents. In this way you avoid that the child hears words they don't fully comprehend which can potentially scare them.

5. Give them choice

As any parent can testify to, giving children directives does not always work, especially when they are in an unfamiliar environment. At Toothbeary we give them choice. Choice over what DVD they wish to watch while they are lying on the treatment bench, choice over

7. Tell the truth!

Telling the truth is a fundamental principle of Toothbeary and the same should apply to parents. Parents should tell their children why they are visiting a dentist, but equally reinforce the positive notions. It is important to uphold the positive but true representation of the dentist. For example if the child asks if he/she will need an injection don't just say yes but instead emphasise that they will get a special children's injection with magic gel.

8. Be prepared

When it comes to the actual treatment the most important thing is to be fully prepared. Children have, at most, a 20 minute attention span. Therefore it is important to keep treatment times to a minimum while doing as much treatment as possible in one visit. That means everything has to be ready and the parents need to be aware and informed, so that they don't ask questions or interrupt the treatment. Prepare your equipment in advance and ensure it is out of sight when the child enters the treatment room. Then you can fully concentrate on the treatment and guide the child through it. Don't be afraid to use behaviour management, voice control or visual imagery.

Ideally try to incorporate your nurse as much as possible to reduce the treatment time and best use a rubber dam, which will make the treatment safer and more comfortable. I always allow the parents to accompany their child to the treatment (but ask them to sit quietly in the corner of the room and let me lead the child through the treatment), this ensures that the child feels safe.

9. You have one opportunity, so make it count

If you do treatment then make sure it will last. If you feel the child won't cope and you don't have the facilities for sedation, then refer the child. Any treatment should be a long term solution, as there is nothing more traumatising than having to return to the dentist several times because of the same problem. A pleasant appointment, resulting in oral comfort is the best reward the child can get.

10. Improve prevention education

Personally, I believe dentists should focus more on prevention education. Parents always act with good intentions but some inadvertently can negatively impact on their child's oral health. For example, many parents believe that smoothies, juices, dried fruit or muesli bars are part of a healthy life-style, but in fact they are bad for your teeth. At Toothbeary we continue to balance education and prevention – in doing so we will continue to improve the oral health of children.

Implementing any one of the above tips in isolation will likely not have much impact, however by integrating as many as possible you will improve the overall experience, patient attendance and ultimately promote good oral health of our next generation!

bdjteam201585

Dentistry *in the national news*

Missed out on the hot topics of the month? Here we recap some of the dental stories making the news this month.

BRITISH PEOPLE 'TOO TOLERANT' OF BAD TEETH

British people tolerate a higher rate of dental decay and staining than their American counterparts TV doctor Dr Chris van Tulleken has claimed in the *Daily Telegraph*. In the article Dr van Tulleken said Britain has become 'internationally renowned' for having 'really lousy' teeth. While having stains and decay is frowned upon in America and other countries, he said 'it doesn't really bother us' in the UK.

STUBBED OUT ON SAND

Smoking could be banned in parks, sports grounds, playing fields, car parks and one beach in Pembrokeshire, *BBC News* reported.

The story reported the local council is looking at trialling a plan to ban smoking on one beach in a bid to discourage young people from taking up the habit. E-cigarettes and vaporisers would also be banned.

CHILDSMILE SAVING £5M A YEAR, SAYS SCOTLAND'S PUBLIC HEALTH MINISTER

Scotland's Childsmile to improve children's dental health is saving almost £5 million a year in treatment costs, the Public Health Minister Maureen Watt has said. Childsmile offers every child attending nursery in Scotland free daily supervised tooth brushing. In the most deprived areas, this extends into primary schools. Children are also offered free toothbrushes, toothpaste and two fluoride varnish applications per year. The number of primary one children with 'no obvious decay experience' has risen from 54 per cent in 2006 to 68 per cent in 2014. Ms Watt said the scheme has led to substantial savings in treatment costs because fewer children require extractions, fillings and general anaesthetics. The story is reported by the *Scotsman*.

STOP 'PUSHING' SUGARY SNACKS, NHS CHIEF WARNS FOOD FIRMS

The *Times* reports on an interview with NHS Chief Executive Simon Stevens in which he suggests that the food industry has a responsibility to reduce sugar in its products. He says that fizzy drinks and sugary snacks should become socially unacceptable and hints that laws could be implemented if firms fail to cut sugar voluntarily.

In response to an interview Mr Stevens' gave on the *Andrew Marr Show,* the *Times* carried a brief item highlighting a response by the Food and Drink Federation. They said it was wrong to target one ingredient in tackling obesity and that sugar was not a poison.

CALL FOR LEVY ON TOBACCO INDUSTRY TO FUND ANTI-SMOKING MEASURES

The government should impose a new levy on tobacco companies to help pay for the harm they cause, according to a story in the *Guardian*. By 2035, the proportion of the population who smoke should be brought down from 18.5 per cent to just five per cent, says the group, which is led by Action on Smoking and Health (ASH), Cancer Research UK and the British Heart Foundation.

BAD TEETH STOP ONE IN FOUR SMILING IN PHOTOS

A quarter of people refuse to smile in 'selfies' and pictures - because they are worried about their teeth looking bad on social media, according to a survey by Bupa. The survey reported in the *Daily Mail* shows a quarter (28 per cent) refuse to smile in pictures to hide their teeth while 81 per cent of people worry about how their teeth look in photographs. Of those surveyed, 42 per cent confessed their teeth were the number one thing they would change about themselves and more than a third admitted being embarrassed about the appearance of their teeth. Sixty-three per cent said they wished their teeth were whiter and cleaner and 53 per cent of those polled said they feel pressured to have impeccable teeth because of those displayed by modern celebrities and public figures. On the subject of oral health 47 per cent of respondents admitted they don't know how to brush their teeth properly, 29 per cent don't use toothpaste, 50 per cent don't use mouthwash, 68 per cent don't use floss; and nine per cent admitted to regularly sharing a toothbrush with someone else. The results also revealed 13 per cent don't polish behind their teeth, 41 per cent don't brush their tongue and 16 per cent don't clean their gums. One in five said they regularly use chewing gum as a substitute for brushing their teeth.

COSMETIC PATIENTS SHOULD GET 'COOLING-OFF' PERIOD

BBC News has reported on a story that says doctors who carry out cosmetic procedures should give patients time to think before agreeing to go ahead, according to new guidance from the GMC. Some of the main points in the new guidance say that doctors should:

- Be open and honest with patients and not trivialise the risks involved
- Give patients enough time and information before they decide whether to have a cosmetic procedure, allowing them time to "cool off"
- Ask patients to tell them how they have been affected by a cosmetic procedure, both physically and psychologically
- Not target people under 18 through their marketing and seek additional advice from professionals who treat young people
- Not make unjustifiable claims about the results they can achieve and not give away procedures as prizes.

BDJ Open

Launched in 2015, *BDJ Open*, the newest addition to the *BDJ* Portfolio, does exactly what it says on the tin. Created to give open access to oral health research from a multitude of backgrounds and disciplines, *BDJ Open* offers authors – both aspiring and established – a further opportunity to have their work published. In the words of Head of Academic Journals David Bull, 'there has been a significant rise in demand for open research from both researchers and practicing dentists. To fit this need, we are delighted to see the launch of a new journal, *BDJ Open* – the latest venture in our 18 year partnership with the British Dental Association.'

We spoke to Editor-in-Chief Stephen Hancocks OBE about why *BDJ Open* will bring a new flavour to an established household name in the dental world.

Hello Stephen. What is BDJ Open*'s unique selling point?*

Each and every year we get in the region of 800 papers submitted to us for inclusion in the *BDJ*. For space reasons, we can only publish somewhere around 150 of those, which leaves a significant amount of high-quality research unpublished in the *BDJ*. I can say first-hand how exciting and promising some of those research papers are, and *BDJ Open* offers authors the opportunity to have their work published in the *BDJ* portfolio with the added benefit of open access.

Why should authors take note of the open access to the journal?

There is a growing trend towards open access documentation, and *BDJ Open* provides us with the conduit to offer peer-reviewed, translational research in all aspects of oral health development for the benefit of the wider dental community in particular and, of course, the world in general. The *BDJ* has a wide international appeal, and this is a perfect opportunity for our international colleagues to present some of their fine research to a worldwide audience.

What will authors gain from submitting a paper?

I must admit the recent Euro Perio conference highlighted how well-known and well-received the *BDJ* is globally, and authors accepted for *BDJ Open* will be able to take advantage of the gravitas the title comes with. As we are in our infancy there is no impact factor yet, but we are confident that when we get one it will be at the very least on par with the *BDJ*.

What do authors need to know about BDJ Open*?*

My question would be what do they want to obtain by submitting research? There is a fee involved which is £1,300 and competitively priced at that. The lure of open access coupled with the *BDJ*'s global reputation has truly excited contributors to date.

What three pieces of advice would you give to anyone considering submitting a paper?

Good question. My first would be to have good, scientific method to the research. So often interesting topics lack the direction to really explore the subject in compelling detail, and those assets are what *BDJ Open* will come to represent.

I would also say make the research relevant to oral health. This may sound obvious, but it is certainly worth reiterating. The stronger the link to oral health the better. Presenting research on a material that can be used in oral health equipment may not entice readers as much as research on perio, orthodontics or paediatrics.

Finally I would say if you have new, innovative research that goes against rhetoric seen before, *BDJ Open* is an excellent avenue for this. If you have any questions, please do contact me and I can provide clarity.

If you wish to contact *BDJ Open* please email bdjopen@nature.com. Guidelines on how to get published can be found here.

bdjteam201587

THE FOUNDING OF BADN

The Association was founded in 1940 in Leyland (Lancashire) by the dentist PE Grundy and his dental surgery assistants, Amelia White and Madeleine 'Bunty' Winter, who became the first General Secretary, and was originally called the 'British Dental Nurses' and Assistants' Society'.

Madeleine Winter

In 1946 a full time General Secretary, Rita Methven, was appointed, replaced two years later by Jean Smith who remained in post until 1985. The Association remained in the North West, moving first to premises in Poulton-le-Fylde, then to various premises in Fleetwood and is now based in Thornton-Cleveleys. Jean Smith retired from the Association in 1985 (although she continued working for the Exam Board until 1991) and was replaced by Sue Adams (nee Ward) in 1985 and then current Chief Executive Pam Swain in 1992.

The 1945 AGM

For the first ten years, all Presidents of the Association were male dentists, but in 1950 Beatrice Green was the first President to be female and a dental surgery assistant (as dental nurses were then known). Since then, there have been 1 male and 52 female Presidents – all DSAs/dental nurses. The Presidential term of office was for one year until 1994 when it extended to two years.

The first Journal was published in the mid-forties, and changed its name from 'The British Dental Surgery Assistant' to the British Dental Nurses' Journal in 1994.

In 1943, the Association founded the British Dental Nurses' and Assistants' Examining Board and held the first examination – only dentists were allowed to be examiners until 1978! The Board changed

its name in 1988 to the National Examining Board for DSAs (NEBDSA) and again in 1994 to the National Examining Board for Dental Nurses (NEBDN). It became a completely separate entity in the 1980s and is completely independent of the Association. Until that point, the Association, the Exam Board and the Register had all been run out of the same office using – in those pre-computer days – index cards and three different coloured pens – green for the Register, red for the Exam Board and blue for the Association!

Madeleine Winter was a candidate in the very first Exam (see her qualification certificate above) – she told us that training took place in the practice every morning before seeing patients. As the first patients arrived at 8am, training was very early in the morning!

In October 1964 the Association established the Voluntary National Register to encourage DSAs to train and become qualified – the original registration fee was £1. In the late 1970s, the Register became the responsibility of the Registration Committee of the GDC's Dental Surgery Assistants' Standards and Training Advisory Board (DSASTAB, later DNSTAB), although the day to day administration of the Register was carried out by the Association until it closed in 2005.

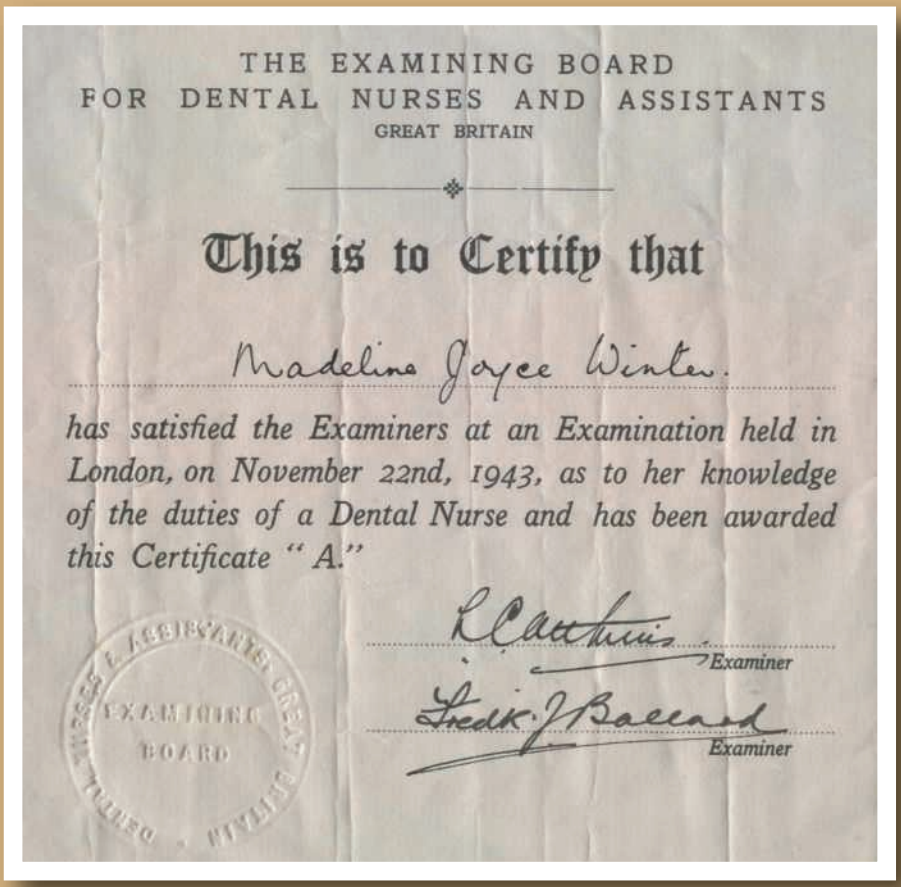
Up till 1994, dental nurses had been known officially as 'Dental Surgery Assistants' or 'DSAs', but at the Association's AGM in 1994, members voted unanimously to change the title to 'dental nurse' (which was what most patients and the general public called them anyway) and the name of the Association from the 'Association of British Dental Surgery Assistants' to the 'British Association of Dental Nurses'. The Exam Board and STAB followed suit and amended their names to reflect the change in title.

In 1995, in preparation for statutory registration and in response to the need to ensure high quality dental nurse training the Training Advisory Service (TAS) was formed by the Association, with financial assistance from DNSTAB. TAS then became an independent body, with administrative support provided by NEBDN, providing voluntary accreditation of dental nurse training courses; and is now NEBDN's Quality Assurance department which monitors and accredits courses leading to NEBDN qualifications.

In 1999 the GDC took the historic decision to agree in principle to the statutory registration of all Professionals Complementary to Dentistry or PCDs (as they were then to be called), including dental nurses. It took until 2006 for registration to actually be implemented; by then what had originally been known as 'auxiliaries' and then PCDs (hygienists, therapists, technicians and dental nurses) had been designated Dental Care Professionals or DCPs. As of 2008, only dental nurses with an approved qualification may register with the GDC, although the 2006-08 window allowed those with specified experience to 'grandparent' onto the Register.

During the last 75 years, BADN has moved forward and adapted to meet the changing needs of dental nurses. It now offers indemnity cover to members who are eligible, as well as Continual Professional Development (CPD) in the Journal, which is now digitally accessed so members can read it anywhere they have a computer, tablet or phone. Initial legal advice is offered via a telephone helpline, as is counselling for members experiencing difficult times in their personal or professional lives. The range of member benefits is constantly revised to ensure that what is available to members is relevant and contemporary, and gives a wide ranging and eclectic selection discounts and special offers to enable members to save money in both their personal and professional lives. The latest development is an e-membership for student dental nurses.

At the 75th anniversary celebration at the In & Out Naval & Military Club, BADN President Fiona Ellwood paid tribute to the founding members and looked to the immediate future and beyond. Fiona said:



THE EXAMINING BOARD
FOR DENTAL NURSES AND ASSISTANTS
GREAT BRITAIN

This is to Certify that

Madeline Joyce Winter.

has satisfied the Examiners at an Examination held in London, on November 22nd, 1943, as to her knowledge of the duties of a Dental Nurse and has been awarded this Certificate "A."

Examiner

Examiner

EXAMINING BOARD

'TRAINING TOOK PLACE IN THE PRACTICE EVERY MORNING BEFORE SEEING PATIENTS. AS THE FIRST PATIENTS ARRIVED AT 8AM, TRAINING WAS VERY EARLY IN THE MORNING!'

BADN President Fiona Ellwood with the commemorative glass presented by the British Dental Industry Association

'BADN IS PROUD TO HAVE OFFERED INFORMATION, ADVICE AND SUPPORT TO DENTAL NURSES FOR THREE-QUARTERS OF A CENTURY – AND LOOKS FORWARD TO CELEBRATING ITS CENTENARY IN 2040!'

'It is right that we look back and recognise those who have paved the way, but it is equally important to look to the future. I thank you on behalf of the British Association of Dental Nurses for joining us in our celebrations, I know many of you have travelled far to be with us. Many of you have been part of this journey and will know how much the role of the dental nurse has changed over the years, when registration finally came to fruition nobody could have imagined the sheer impact that it would have and indeed what it will mean for the future, but it is one with much greater opportunity and who knows where it will end. It is a privilege to be in post at such a momentous time for the Association, nevertheless this year will see the end of my tenure.'

Membership fees

Student dental nurses are currently being offered a special rate of just £10 a year;

Full Membership for Registered Dental Nurses starts at £50 a year without indemnity or £88.41 with basic indemnity cover.

For more information on BADN membership, go to www.badn.org.uk or call 01253 338366.

bdjteam201588

FLASH INTERVIEW

Karen Healy-OConnor

Karen is a 23-year-old dental nurse at Claremont Dental Practice in Manchester. She lives with her little boy Shea.

Name: Karen Healy-OConnor

Age: 23

Job title: Qualified dental nurse.

Town: Manchester.

Most recent workplace: Claremont Dental Practice.

Marital status: Single.

Any children? One little boy called Shea. He's two.

How long have you worked in dentistry? Seven years.

Why did you choose dentistry for your career? I was 16 looking for a job as I was unsure what course to take in college and there happened to be a vacancy for a trainee nurse at a local practice.

What do you like best about dentistry? Working with a variety of people and making a difference to a patient – it is super rewarding.

What is the most challenging part of your job? The most challenging part is always having to be ready for anything. One day is never the same as the next.

What do you like to do outside work? I love to spend time with my little boy and keep fit.

Tell us a secret. I hate sharing food. I'd rather buy you 10 bags of malteasers than share one of mine!!

What do you like about BDJ Team? Keeps you up to date and provides great CPD.

What three things could you not live without (besides people)? Domino's pizza, rum and of course a toothbrush!

bdjteam201589

Awards leave Amy and Carly

all smiles

©asmakar/iStock/Thinkstock

BDA Education have awarded two DCPs the Outstanding Student of 2014 Award.

The accolade was awarded to the two students that achieved the highest standing in their BDA Radiography and Oral Health Education examinations held in 2014.

The awards were presented by Mick Armstrong, Chair of the BDA Principal Executive Committee, and Professor Nairn Wilson, BDA President, at the British Dental Conference and Exhibition 2015 held in Manchester in May. This is the second year that the Award has been given for Radiography, but the first time for Oral Health Education.

'I FELT VERY PROUD TO BE HONOURED WITH MY AWARD, AND IT WAS LOVELY TO MEET A DIVERSITY OF PEOPLE FROM THE DENTAL SECTOR'

Amy and Carly shared with us their feelings on receiving their awards, and their experiences of completing their online qualifications.

Amy Hambly-Symons, BDA Education Outstanding Radiography Student of 2014.

Amy attained the highest examination result for her performance in the March 2014 Radiography exam. She qualified as a Dental Nurse in 2011, winning the "Gold Award" that year for achieving the highest mark in the UK. Amy has been working at River Practice Specialist Centre in Truro, Cornwall since 2013.

How did it feel to win your prize?

The Midland Hotel was the perfect host for a fantastic evening. I felt very proud to be honoured with my award, and it was lovely to meet a diversity of people from the dental sector. I very much enjoyed the jazz band too!

What did you think of the online Radiography course?

I found the course interesting, well-structured and easy to fit around working full time. Logging in was straight forward and it was great to have the option of repeating past content. I really enjoyed it!

How did you feel about taking the final examination online, rather than going to an exam centre?
Taking the exam online was actually less daunting than going to an exam centre. Plus, as all of the modules had been online, the similarity put me at ease.

Since passing the exam, how have you used your Radiography qualification?
I have mainly used my qualification for taking OPGs for orthodontic records. I also take PAs when working with our Implantologist and Endodontist.

Will you undertake any more further education courses?
Yes, I am going to Cardiff University in September 2015 where my qualification will help me achieve my goal of becoming a Dental Therapist.

Carly Wichall, BDA Education Outstanding OHE Student of 2014
Carly won the award for achieving the highest mark in the exam held in September 2014. She is the first student to be presented with the award for OHE. Carly qualified as a Dental Nurse in 2011, and has been working at Euro Dental in Swindon for the past five years.

How did it feel to win your prize?
The Award ceremony provided an opportunity not only to receive recognition for a lot of hard work, but also to meet and speak with many dedicated and inspirational members of the dental industry. It was an honour to be presented with my award.

What did you think of the online Oral Health Education course?
Working full time whilst studying can be really tough, but via the BDA's online OHE course, I was able to complete modules at a time that suited me. I found the course to be well set out and the accompanying textbook "Basic Guide to Oral Health Education and Promotion" offered excellent support alongside the online lectures.

How did you feel about taking the final examination online?
The course allowed students to download the exam software prior to taking the formal exam. This meant that I was able to familiarise myself with the software in advance, making an online examination feel less daunting.

Since passing the exam, how have you used your OHE qualification?
I am currently working with my practice manager to put in place a referral system and the possibility of arranging regular OHE sessions. I am also planning to create topical displays for my practice to help engage and inform patients on the wide range of topics within oral health care.

'CARLY WON THE AWARD FOR ACHIEVING THE HIGHEST MARK IN THE EXAM HELD IN SEPTEMBER 2014. SHE IS THE FIRST STUDENT TO BE PRESENTED WITH THE AWARD FOR OHE.'

Will you undertake any more further education courses?
I am hoping to continue my education in the dental industry and therefore further my career. I am looking to study to become a dental hygienist.

The British Dental Association has run online courses for DCPs in Radiography and Oral Health Education since 2006, and began launching its own examinations in these subjects in 2013. Over 1,500 DCPs now hold nationally-recognised BDA qualifications.

If you're interested in expanding your education in a convenient and accessible way, earning verifiable CPD and enhancing your career prospects, then don't hesitate to contact BDA Education with any questions you might have. Please visit https://www.bda.org/dcps or call 0207 563 6888 (Radiography) or 0207 563 4551 (OHE).

FLASH INTERVIEW

Afton McKechnie

Afton is a 25-year-old dental nurse at Ivory Dental Care in Blackpool. She lives with her partner Nathaniel and her dog Jessie

Name: Afton McKechnie

Age: 25

Job title: Dental Nurse.

Town: Blackpool.

Workplace: Ivory Dental Care.

Marital status: Co-habiting.

Partner's name and job: Nathaniel – Litigation Manager.

Children and names: N/A

How long have you worked in dentistry? Five years.

Why did you choose dentistry for your career? Dentistry has always interested me since I was a young girl. I always used to ask my dentist questions.

Do you have any special responsibilities within your dental practice/workplace? I am responsible for training new Dental Nurse Cadets and Ivory Dental Care social media.

What do you like best about your job? The team I work with.

What is the most challenging part of your job? Time-keeping.

What do you like to do outside work? Socialise with friends, spend time with family and go on holidays.

Tell us a secret. I used to have a crush on a young Jean Claude Van Damme.

What do you like about BDJ Team? It's very friendly and informative.

What three things could you not live without (besides people)? My dog, my toothbrush and bananas!

So what have BSDHT been doing?

President of the British Society of Dental Hygiene & Therapy **Michaela ONeill** on First Smiles, EuroPerio and a new award

On Friday 19 June, the British Society of Dental Hygiene & Therapy launched First Smiles, a campaign aiming to introduce oral health education to young children in the classroom.

This programme aimed to make children feel more at ease about seeing dental professionals. We wanted to forge important links between schools and their local dental practices, improve the oral health of children across the UK and increase the amount of time oral care is taught in the classroom in order to reduce the amount of primary school children in the UK with tooth decay.

We are so proud of the number of our members who got involved and made the campaign a huge success. Teaching good habits and routines at an early age means they are more likely to be continued on into adulthood. By instilling the importance of a healthy mouth, we are not only creating good health for these children now, but the benefits will most likely continue far into the future. Hopefully we can build on this next year.

We have also just co-hosted EuroPerio 8 which was a huge conference with around 9,000 attendees. It was impossible to see everything but all agreed it was an amazing experience. Now the hard work starts as we endeavour to collect the whole team together for our flagship Oral Health Conference in Belfast on 18 and 19 November 2016. Bitter sweet for me as this will be the conference I step down at, but no better place for a party!

In October we will be holding our AGM at the BDIA showcase in Birmingham. We have a jam packed day for our members. BSDHT is offering 300 lucky members the chance to receive up to four hours FREE CPD delivered by world renowned speakers. We know there will be a high demand so we will be issuing tickets on a first come first served basis. More details on this will be found on our website www.bsdht.org.uk.

As well as the CPD we will be unveiling a number of awards. These are:

- The winner of the Oral Hygiene by Design Award with a mock-up of the winning design
- The winner of the Students Leaflet prize with some of the winning leaflets printed and ready for use
- The Dr Leatherman prize will also be awarded and the research poster awards will be on display and the winners recognised.

All this and the chance to visit the largest dental trade show in the UK for FREE, you can't afford to miss it.

As for the political side; there are many changes I would like to see in our profession. Being able to prescribe is one. We have had quite a few meetings on this topic over the years. In order for BSDHT to move forward with their request to be a non-medical subscriber we need to gather information on how the need to have an individual prescription for each treatment episode affects daily practice. This prescription must be given, not for a course of treatment, but for every time a patient attends and must include the name of the medicine, the route of administration. (e.g. infiltration, intraligamentary) and the dose. For those of us in practice we know how frustrating this is, hence we will be taking a survey to find out its impact. Look out for this in the coming weeks.

Another area where we need to see movement is on the ability to open a course of treatment in the NHS. Each country in the UK has the same restriction but all have differing ideas on how to move forward. At present a dentist has to examine a patient in order to open a course, even if the appointment is for a 3/12 maintenance appointment with the hygienist. Surely this time costs the NHS money?

One of the more fun parts of this role was to represent BSDHT at the launch of National Smile Month. This is an important team event in the dental calendar and obviously well recognised throughout the general public. Even the Cats Protection Charity compiled a Cheshire cat gallery for National Smile Month. Not exactly the target audience but raised a smile all the same!

Best wishes,

Michaela ONeill,
President, British Society of Dental Hygiene & Therapy

bdjteam201592

'FOR THOSE OF US IN PRACTICE WE KNOW HOW FRUSTRATING THIS IS, HENCE WE WILL BE TAKING A SURVEY TO FIND OUT ITS IMPACT'

Management of residual and recurrent caries in adolescents

By dental therapist and hygienist **Carolyn Renton***

Dental caries

Dental caries is a reversible progressive disease of the dental tissues initiated by the action of bacteria on fermentable carbohydrates in the biofilm on tooth surfaces.[1]

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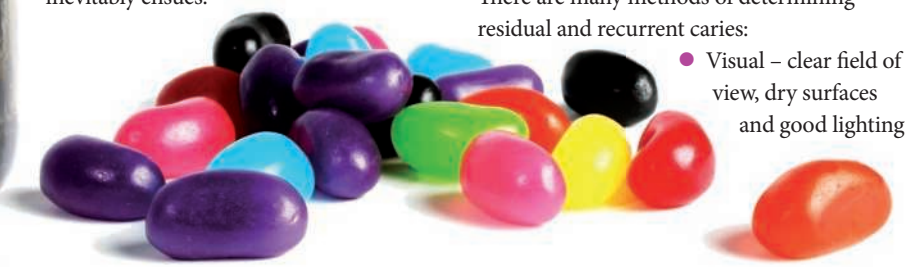
Streptococcus mutans and *lactobacilli* quickly produce acid from fermentable carbohydrates adhering to the tooth surface because of their ability to synthesise sticky extracellular polysaccharides from dietary sugar. Fermentable carbohydrates and cariogenic plaque need to be present on a tooth surface for acid to form. 'Stephan's curve' illustrates pH changes and shows that the gradual return of pH will result in the acid diffusing out of this plaque. This is because the saliva has a 'buffering ability' where calcium and phosphate fluoride enters by facilitated transport over membranes over the salivary gland tissue. Many theories have been considered into the aetiology of caries but to date it is the acidogenic theory described by Miller in the 1800s that has been proved the most likely cause. Epidemiological studies such as Tristan da Cunha in the 1930s, Hopewood House in 1942, and the Vipeholm study in 1945 all demonstrate that when refined carbohydrates are introduced into the diet at an overwhelming rate, dental caries inevitably ensues.



Residual caries

Residual caries is demineralised tissue left behind when a filling is placed[2] and it can be active or arrested. It is difficult to determine what the lesion is as there is a continuum of transient changes that can either: rapidly progress, slowly progress, or not progress at all: at this point the arrested lesion becomes chronically remineralised. If the lesion is not active no treatment is required, however, when it is active treatment is required to further prevent demineralisation.

Recurrent caries

Recurrent caries is a primary caries lesion next to a pre-existing filling. It usually forms cervically and interproximally due to plaque stagnation.[3] Recurrent caries is potentially serious as once dentine is reached it can spread rapidly.[4] When limited to the immediate area of margin the caries can be removed and a 'repair' restoration can be placed.

Residual and recurrent caries determination

There are many methods of determining residual and recurrent caries:

- Visual – clear field of view, dry surfaces and good lighting

- FOTI – Fibre Optic Trans-Illumination
- Radiography (pros: shows interproximal lesions and depth of lesions; cons: does not distinguish between cavitated and non-cavitated lesions)
- Tooth separation (pros: suitable for teenagers – well tolerated and accepted; cons: time consuming – needs a minimum of two visits).

Residual and recurrent caries can easily be confused with marginal leakage. It is recommended that intervention is postponed and polishing and smoothing of the restoration junction takes place, with regular monitoring, prior to intervention.[5] Amalgam fillings may display ditching and discolouration but this is neither synonymous with, nor indicative of, decay especially on the occlusal surface.[3] Composites similarly may have stain and colour change but this does not reliably predict active decay. When making decisions in operative dentistry, it is suggested to consider why new lesions have occurred,[6] as new lesions suggest the patient is not complying with preventative regimes. It is crucial to find the origin of the aetiology of recurrent caries to prevent an ongoing cycle which may be detrimental to the teenage patient. The first step is to explore the patient's current habits.

Factors to investigate

1. Medical history

- Sugared medicines - teenagers are more likely to prefer medicine to tablets
- Saliva inhibiting disease - Sjögren's syndrome, radiotherapy, xerostomia, hyposalivation
- Substance abuse - alcohol, methadone, smoking
- Chronic illness - mental illness leading to poor dexterity
- Bulimia

2. Dental history

- High caries rate
- Heavily restored dentition
- Phobias, anxieties

3. Oral hygiene

- Tooth brushing frequency
- Interdental cleaning habits
- Fluoride toothpaste or mouthwash usage
- Rinse or spit habits
- Orthodontic appliances

4. Social and demographic factors

- Lifestyle changes
- Socio-economic group.

'It is essential to remember that caries of any kind can become arrested at any age or stage.'

When all of these considerations have been explored the clinician is in an optimum position to facilitate a teenager in managing the current situation and preventing further episodes. It is essential to remember that dental caries of any kind: new, residual or recurrent can become arrested at any age or stage of destruction, so passive management is the essential initial step. Prevention is best performed with the patient in a systematic way.

Stages in management

1. Patient motivation

- Communication
- Education

2. Diet

- Dietary analysis – as advised by Moynihan[7] (adapted for *Vital* in summer 2007 http://www.nature.com/vital/journal/v4/n2/full/vital597.html)
- Dietary advice: including modification of sugar frequency, Department of Health[8]
- Sugar-free alternatives advice
- Cheese
- Xylitol sugar-free gum after meals - considered controversial by Maguire and Rugg-Gunn,[9] but recommended by Burt[10]

3. Oral hygiene advice

- Effective removal of plaque; suitable toothbrush
- Bleeding caused by brushing; understanding inflammation resolves with good OHI
- Quality over quantity

4. Interdental cleaning

- Efficient technique – wide range of aids available
- Understanding the cause of bleeding with brushing

5. Fluoride

- Community: H_2O (1 ppm)
- Toothpaste 1-5000 ppm (depending on caries rate)[11]
- Mouthwash 0.05% 0.1% NaF daily or 0.2% weekly[11]
- Topical - gels/varnish 2.25%

6. Regular professional monitoring

- Plaque disclosing
- Plaque removal
- Fluoride varnish 2%

7. Treatment

- Fissure sealants
- Glass ionomer restorations.

Conclusion

Dental caries occurs when fermentable carbohydrates and cariogenic plaque are left on a tooth surface for a period of time, on a frequent basis. It can be new, recurrent or residual and it can be arrested at any stage. There are many stages and factors to take into consideration before clinical intervention and the dental care professional (DCP) can be invaluable in educating, advising and monitoring the development and halt of dental caries.

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**Carolyn Renton qualified as dental therapist and hygienist in 2006 and has nearly 20 years' experience in the dental industry. She works in two dental practices in Leicester and Nottingham and is currently studying for a BSc in Dental Studies at the University of Central Lancashire.*

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DCP COURSE DIRECTORY 2015 WALES

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1. Cardiff Metropolitan University Cardiff School of Health Sciences
BSc (Hons) Dental Technology
Foundation Degree in Dental Technology (FdSc)
MSc Dental Technology
Location: Llandaff Campus, Cardiff
Length: Three years full time for the degree; three years part time for the Foundation degree; distance learning for the MSc
Details: www.cardiffmet.ac.uk/health/courses/Pages/Foundation-Degree-in-Dental-Technology-FdSc.aspx
Telephone: 029 2041 6899
Email: rjwilliams@cardiffmet.ac.uk

2. Cardiff University Dental Hospital
Level 3 Diploma in Dental Nursing
Telephone: 02920 748303
Email: penny.barker@wales.nhs.uk

3. Cardiff University School of Dentistry
HE Diploma in Dental Hygiene
Length: Two years full time, starting September
Details: http://courses.cardiff.ac.uk/undergraduate/course/detail/B750.html
Places available: Typically 10
Telephone: 029 2074 2468
Email: dentaladmissions@cardiff.ac.uk

4. BSc in Dental Therapy and Dental Hygiene
Length: Three years full time, starting September
Details: http://courses.cardiff.ac.uk/undergraduate/course/detail/B752.html
Places available: Typically 11
Telephone: 029 2074 2468
Email: dentaladmissions@cardiff.ac.uk

5. Tooth Fairies
Location: Cardiff
NEBDN National Diploma in Dental Nursing
City & Guilds Diploma in Dental Nursing
Impression Taking
Fluoride Application
Decontamination Lead
Cross Infection Control
Oral Health Education
CPR & Medical Emergencies
Health & Safety at Work
ILM Level 3 Management
Dental Receptionist
Legal & Ethical Issues
Child Protection & POVA
PDP Development
Manual Handling
Fire Safety
Appraisal Training
Study Day
Technician Study Day
Online Diploma dental nursing course
Online CPD programme for whole dental team
Trainee dental nurse positions
Details: www.toothfairieslimited.co.uk
Telephone: 02920 837433
Email: info@toothfairieslimited.co.uk

6. Wales Deanery (School of Postgraduate Medical and Dental Education)
Locations: Aberystwyth, Bangor, Cardiff, Haverfordwest, Penlan Road, Newport, Newtown, Porth, Denbighshire, Swansea, Wrexham
Undergraduate Certificate of Higher Education in Dental Nursing (two years part time, email dentalcert@cardiff.ac.uk)
Certificate in Practical Oral Health Promotion
Safe start dental nurse induction/return to work programme
Dental Receptionist course
NEBDN Certificates in Dental Radiography/Special Care Dental Nursing/Orthodontic Dental Nursing
ILM Endorsed Practice Managers course
Protection of Vulnerable Adults (POVA)
Extended duties: impression taking, fluoride varnish application, suture removal
CPD courses - core topics, in-practice training, human patient simulator training
Core CPD topics for dental technicians
Introduction to practice for dental therapists
Practice management programme
Aspects of professionalism
Introduction to special care dentistry
Health and safety
Details: http://www.walesdeanery.org/index.php/en/dentistry/1335-human-patient-simulator-for-the-dental-team.html
South Wales enquiries: Call Kath Liddington on 029 20687498, email liddingtonke@cardiff.ac.uk
North Wales enquiries Call Rosemary Roberts on 01745 534587, email rosemary.roberts@wales.nhs.uk
Also see *The Essential Guide to educational activities for dental professionals*, published by Wales Deanery:http://www.walesdeanery.org/images/stories/Files/Documents/dental/CPD/resources/essential-guide-2012-web.pdf.

7. Tempdent, Wales
NEBDN National Diploma for Dental Nurses
Summary: 12 month course. Choice of evening, weekend and daytime classes in training centre. Two intakes per year. Please check start dates available by contacting number below. Can be run in-house. Please contact for further details.
Telephone: 020 8371 6700

BDJ Team also recommends checking your local colleges and online

bdjteam201594

BDJ Team continuing professional development

CORE CPD: ONE HOUR

CPD questions – June 2015

CPD ARTICLE: Recognition and treatment of anaphylaxis

1. What chemical substance can cause anaphylaxis?
A. Histamine
B. Cephalosporin
C. Serotonin
D. Sebum

2. According to NICE in 2011, what is thought to be the number of deaths in the UK each year from anaphylaxis?
A. 15
B. 32
C. 20
D. 5

3. How much adrenaline should you give a 6-12 year-old child?
A. 150 micrograms
B. 200 micrograms
C. 250 micrograms
D. 300 micrograms

4. What percentage of patients know how and when to use their auto-injector and carry one that is in date all the time?
A. 100%
B. 80%
C. 10%
D. 30%

How do I take part in *BDJ Team* CPD?

BDJ Team is offering all readers **TEN hours of free CPD** in 2015 through our website. The ten free hours of free CPD that we offered in 2014 are also still available until the end of 2015.

Just go to www.nature.com/bdjteam/cpd to take part!

If for any reason you are unable to access CPD, please contact bdjteam@nature.com or subscriptions@nature.com

CORE CPD: ONE HOUR

Missed **core** CPD?

You can complete *BDJ Team* CPD through our website, any time in 2015.

Just go to www.nature.com/bdjteam/cpd to find out how!

Topics covered so far

➤ April 2014: **Disposing of clinical and dental waste**

➤ May 2014: **Emergency oxygen therapy in the dental practice**

➤ July 2014: **Needlestick and occupational exposure to infections**

➤ August 2014: **Medical emergencies: the drug box, equipment and basic principles**

➤ October 2014: **Radiation protection in dental X-ray surgeries**

BDJ Team CPD – through the post

Can I take part in *BDJ Team* CPD through the post?

YES! Just print off this page, complete the form and send it with your payment of £6, to cover administrative costs. **Send to: BDJ Team CPD, Nature Publishing Group, 4-6 Crinan Street, London, N1 9XW.** We will check your answers to the CPD questions, process your payment and send you a certificate through the post.

You can now participate in this *BDJ Team* CPD through the post until the end of December **2015**.

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2. Payment details – SUBMISSIONS SENT IN WITHOUT PAYMENT WILL NOT BE PROCESSED

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I would like to pay for more than one person and enclose a cheque for £_____ made payable to Nature Publishing Group (£6 per person for an hour of verifiable CPD).

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Please debit the sum of £6 or £_____ from the following credit/debit card (tick box):

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Card number: _____

Expiry date: _____ Issue no. (Switch/Maestro): _____

Name of cardholder: _____

Address of cardholder (if different to above): _____

3. I am answering the CPD questions in the _____ issue (PLEASE ENTER MONTH):

	A	B	C	D
Q1	☐	☐	☐	☐
Q2	☐	☐	☐	☐
Q3	☐	☐	☐	☐
Q4	☐	☐	☐	☐

4. Please add any comments or feedback that you might have below or email bdjteam@nature.com.

Products & services

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

BREAKTHROUGH IN ANTI-AGEING TECHNOLOGY

To help age protect your smile it is important to follow a comprehensive oral health regime. The UltraDEX Recalcifying & Whitening range is a breakthrough in anti-ageing technology, the first of its kind, a protect-restore-eliminate formula that leaves teeth more resistant, smoother, brighter and younger looking. The British brand is leading the anti-ageing oral care sector and calling for the nation to 'age protect' their mouth.

The powerful combination of stabilised chlorine dioxide, fluoride and hydroxyapatite creates the optimal environment for strong, healthy teeth and remineralisation. Professor Robert Hill from Queen Mary University London explains: 'Smart and safe chemistry is at work in your mouth when you use these products. The mineral fluorapatite crystalises onto the surface of the tooth. Fluorapatite is an important part of tooth enamel. To put it into context, chalk dissolves in acid, fluorapatite does not.'

Step 1: The iQ+ ActiveOxi Technology (Stabilised Chlorine Dioxide and Fluoride) within UltraDEX instantly eliminates odour-causing compounds and unwanted bacteria to help prevent tooth decay, plaque and gum problems. It also and brings back the natural colour of your teeth by gently oxidising organic stains.

Step 2: The SensiShield technology (with hydroxyapatite - the key building block of teeth) provides a strong and protective enamel shield and recalcifies tooth surfaces by filling in the microscopic enamel cracks, blocking exposed dental tubules and restoring the natural whiteness of teeth. This leaves teeth smoother, brighter, less likely to stain and protects them from acidic food and drink.

More than one in three (35%) people said that a nice smile is the first thing they notice about someone, so considering how much time and money we tend to spend on skincare, fragrances, and hair products, perhaps an oral care routine upgrade is all that's needed to protect and perfect your smile, taking years off of your appearance.

Contact Ann Generlich at ag@periproducts.co.uk or 020 8841 5181.

NATURAL TEETH FOR LIFE

EndoCare brings together a talented group of experienced Endodontists who are ready and available to assist you and your patients with all aspects of root canal treatment.

They believe in the benefits of endodontic therapy over extraction and are passionate to ensure your patients have their natural teeth for life.

Patients are treated to a first class service and state-of-the-art facilities, which come with the promise that we will do everything we can to save their teeth. The expert team of Endodontists are all widely published, and are dedicated to root canal treatment and the diagnosis and alleviation of dental pain.

What's more, for complete peace of mind they will always communicate with you at each stage of your patient's journey with us, and will return them to you pain-free, confident and happy with the quality of treatment they have received.

For further information call EndoCare on 020 7224 0999 or visit www.endocare.co.uk

ACADEMY GOING MAD

The British Academy of Cosmetic Dentistry (BACD) is proud to announce its support of the fantastic dental charity, Make A Dentist (MAD).

MAD is a nationwide humanitarian campaign that provides education and clinical goods for dental students in Zimbabwe.

Education is of vital importance to the BACD, whether through its prodigious accreditation system, its innovative annual conferences or regular regional meetings – keeping dental professionals up-to-date with the most cutting-edge and innovative learning opportunities available is one of its key mandates.

Which is why the BACD is making a generous donation, equivalent to a year's full membership, to MAD, in order to support dental professionals in less fortunate countries – and extend more effective learning to those who need it most.

For enquiries about the BACD, call 0207 612 4166, email Suzy Rowlands at suzy@bacd.com or visit www.bacd.com.

Visit www.makeadentist.com to find out more about Make A Dentist.

THE TEETH TEAM – IMPROVING CHILD ORAL HEALTH

543 Dental Centre and Genix Healthcare, both members of the Association of Dental Groups (ADG), are dedicated supporters of the *Teeth Team* charity.

The well-established school-based supervised tooth brushing programme aims to promote the importance of oral health among children, reducing inequalities and instilling effective dental routines in young people.

The charity's recent review of dental health among children involved in the scheme found an overall reduction in the presence of decayed, missing or filled teeth (dmft) in the past year. The number of those needing treatment reduced from 25% to 19% between January 2014 and May 2015.

For more information about the ADG visit www.dentalgroups.co.uk