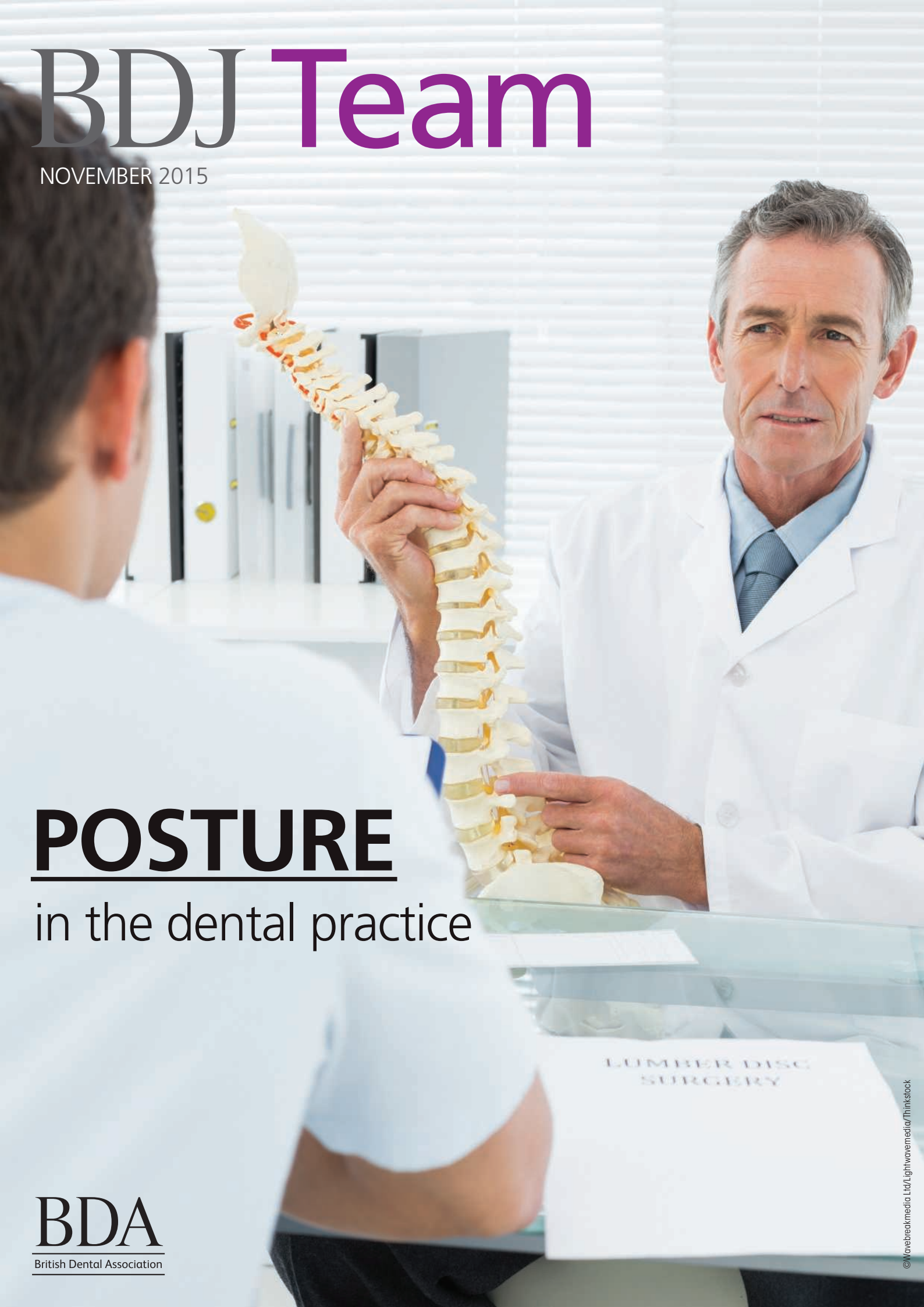
BDJ Team
NOVEMBER 2015



POSTURE
in the dental practice

BDA
British Dental Association

November 2015

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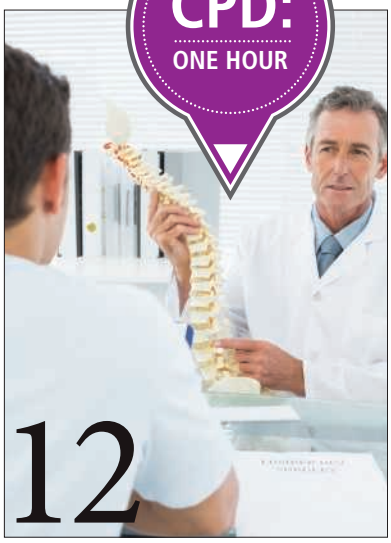
Highlights



Regulars

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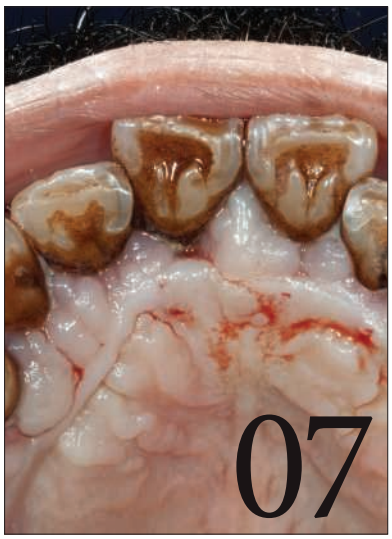
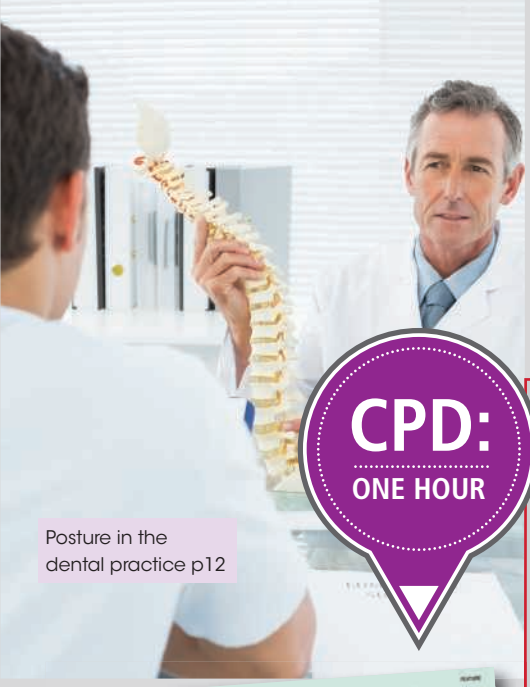


Ed's letter



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So here we are. Again.

OK, so they're lyrics from my favourite Bloc Party song, but it really does feel like this year has gone in the blink of an eye. I'm not usually one for clichés, but 2015 has been a rollercoaster.

We started it under a cloud of ARF doom (well, for dentists), and we end it with hope. The new Chief Dental Officer for England Sara Hurley has promised change where evidence backs it up, and that can only be a positive thing for our profession moving into 2016.

As the year draws to a close, Christmas party doors open for business. Sitting on photocopiers may be an office party cliché, but Fiona McLellan is all too aware of the post-party implications of bending and breaking the rules. Without being a party pooper, read her advice on staying out of trouble this year.

This year's BDA Winter Lecture revolves around 'Diabetes and periodontal disease – an inflammatory combination'. With more and more potential links between perio and general health conditions, we take a look at the evidence behind each link.

The British Society of Paediatric Dentistry is delighted to announce that Robin Mills has taken office as their new President. Robin gives us his thoughts on the future, his goals for office what you can expect from the BSPD in 2016.

Finally we wrap up the last issue of 2015 with 10 top tips on patient compliance. These are tips with a difference, as Michelle Coles is the winner of the BSDHT's 'Oral Hygiene by Design Award'. Her winning submission is a tool to help improve patient compliance, so there's no-one better to offer advice.

All it leaves is for me to wish you all a very Merry Christmas and a Happy, prosperous New Year.

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David Westgarth
Editor
David.Westgarth@nature.com

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THE TEAM

Cover
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Editor-in-Chief
Stephen Hancocks OBE

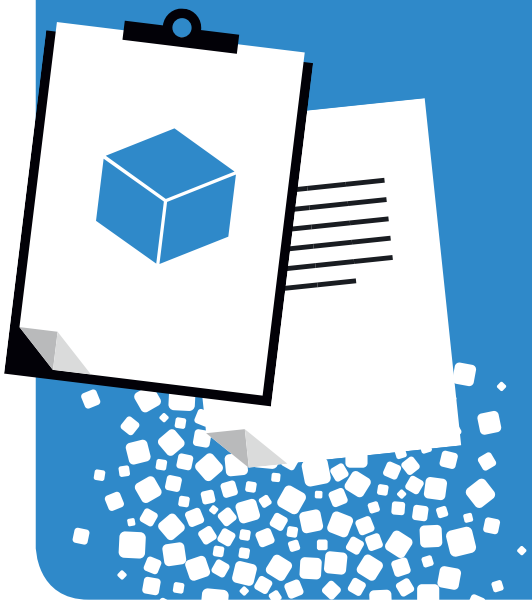
Editor
David Westgarth

Production
Art Editor: Melissa Cassem
Production Editor: Sandra Murrell
Digital Editions Production Controller: Natalie Smith

Advertising
Advertising Account Manager: Andy May, +44 (0)20 7843 4785, a.may@nature.com

Publishing
British Dental Journal
The Macmillan Building
4-6 Crinan Street
London N1 9XW

IGNORING PUBLIC HEALTH ENGLAND REPORT ON **SUGAR REDUCTION** WOULD BE RECKLESS



The British Society of Dental Hygiene and Therapy (BSDHT) fully support the new recommendations on sugar published by Public Health England (PHE) and believe ignoring them will lead to thousands more children needlessly suffering from poor oral health.

The eagerly anticipated evidence-based, report from PHE[1] recognised the need for high level intervention on sugar and identified a number of key areas for action including banning price promotions and the introduction of a 10-20% tax on sugary soft drinks.

Michaela ONeill, President of the BSDHT, responded to the report: 'This report confirms what we have known for a long time; we need to act now on our nation's addiction to sugar and stop children suffering from potentially painful and distressing oral health problems.

'Shockingly, a recent study found half of eight year olds have visible signs of decay on their teeth and a third of children are starting school with visible signs of tooth decay.

'Children's tooth extractions cost the NHS around £30 million per year with the key cause being tooth decay.

'The BSDHT and our members have long campaigned for action on sugar and these recommendations need to be seriously reviewed and acted upon; the evidence is all there and ignoring them would simply be reckless.

'The BSDHT continue to strive to improve children's oral health though education within dental practices and schools with our First Smiles initiative. But the government needs to act on this report and support the dental industry if we are to really help future generations of children benefit from healthier diets and also allow parents to understand how destructive too much sugar can be to their oral health.'

1. Public Health England. Sugar reduction: from evidence to into action (2015). Available online at www.gov.uk/government/publications/sugar-reduction-from-evidence-into-action

EASING THE DENTAL FEARS OF ADULTS AND CHILDREN WITH COMPLEX NEEDS

A dentist from the Central and North West London Trust has put together an illustrated story booklet that describes a patient journey for children and adults with complex needs and about to undergo major surgery.

Senior Dental Officer, Kirsten Criggie, 30, developed it to help ease the fears of a child with complex needs who is set to have an operation, as well as the parents, by explaining the process in easy to understand terms.

Kirsten, who is part of the Buckinghamshire Priority Dental Service, said: 'We identified the need for this resource when the patient's mother was concerned about her daughter going through the process. They used story boards at school so we thought we could develop one so the process wouldn't be such a big surprise.'

Thought to be the first of its type in dentistry, though not in hospitals, the story board has interested some of her colleagues so she has now adapted it to make it more general to help paediatric patients going for a dental general anaesthetic. It is also currently under development for the special care adult dentistry general anaesthetic pathway. Colleagues in other specialities have also expressed interest.

'We've had a fantastic response. We've shown it to a few children with autistic spectrum conditions and asked them if they would find it helpful and help them to prepare for a procedure and they said yes.

'It's also helpful for parents because a lot of them are anxious. So if they know what's going to happen that should make them less anxious and mean the child is less anxious as well,' she said.

Buckinghamshire Priority Dental Service offers special care dentistry for people in Milton Keynes who are unable to access a general dental practitioner and need dental treatment.

The service is for adults and children living in the Hertfordshire and South Midlands and Thames Valley catchment areas who have learning disabilities, complex medical needs, or severe mental health problems. It is also for children with severe behavioural management problems and adults with very severe anxiety and dental phobias.

And the winner is...

Congratulations to Dr Sualeh Khan, the winner of the *BDJ Team* CPD prize draw. An Apple Watch is on its way to you!

BADN WELCOMES NEW PRESIDENT

Bedfordshire dental nurse Jane Dalgarno became the 55th President of the British Association of Dental Nurses at a Presidential Inauguration ceremony held at the NEC, Birmingham.

Jane, who works as Clinical Workforce Development Manager for the Community Dental Services (CIC) in Bedford, holds a BSc (Hons) in Primary Dental Care and is currently working towards an MSc in Applied Dental Professional Practice.

Jane started her career in Dental Nursing in 1986 on a youth training programme in general dental practice in Luton, passing the National Certificate in November 1993. Since qualifying, she has completed qualifications in Oral Health Education, Sedation and Dental Radiography, gained her Certificate in Post Compulsory Education and also holds the City & Guilds A1/A2 assessors award. She currently teaches on the Oral Health Education Certificate and Certificate in Dental Sedation Nursing courses, is an examiner for the National Examining Board for Dental Nurses for the National Diploma and for the Certificates in Oral Health Education and Dental Sedation Nursing Awards. Jane is also Programme Director for the Foundation Degree in Advanced Dental Nursing for Health Education Kent, Sussex and Surrey.

Jane joined the Bedfordshire Community Dental Services in 1995. The service subsequently became the Personal Dental Services in 2001 and Community Dental Services, a social enterprise, in 2011.

In her inaugural speech, Jane said: I am a practising dental nurse committed to raising the professional voice of the dental nurse in the national arena and seeking appropriate support for dental nurses in the workplace.'

Jane is also a member of the Faculty of General Dental Practice (UK) and of the Society for Education and Training, and sits on the Local Dental Education Committee in Bedfordshire, as well as the NEBDN Sedation Committee. She was previously the Seconded Member for Education to BADN Council, and BADN Regional Coordinator for London and the South East.

African surgeons learn from UK head and neck specialists

A delegation of African surgeons spent four days at Birmingham's Queen Elizabeth Hospital learning from leading UK and world experts in head and neck surgery.

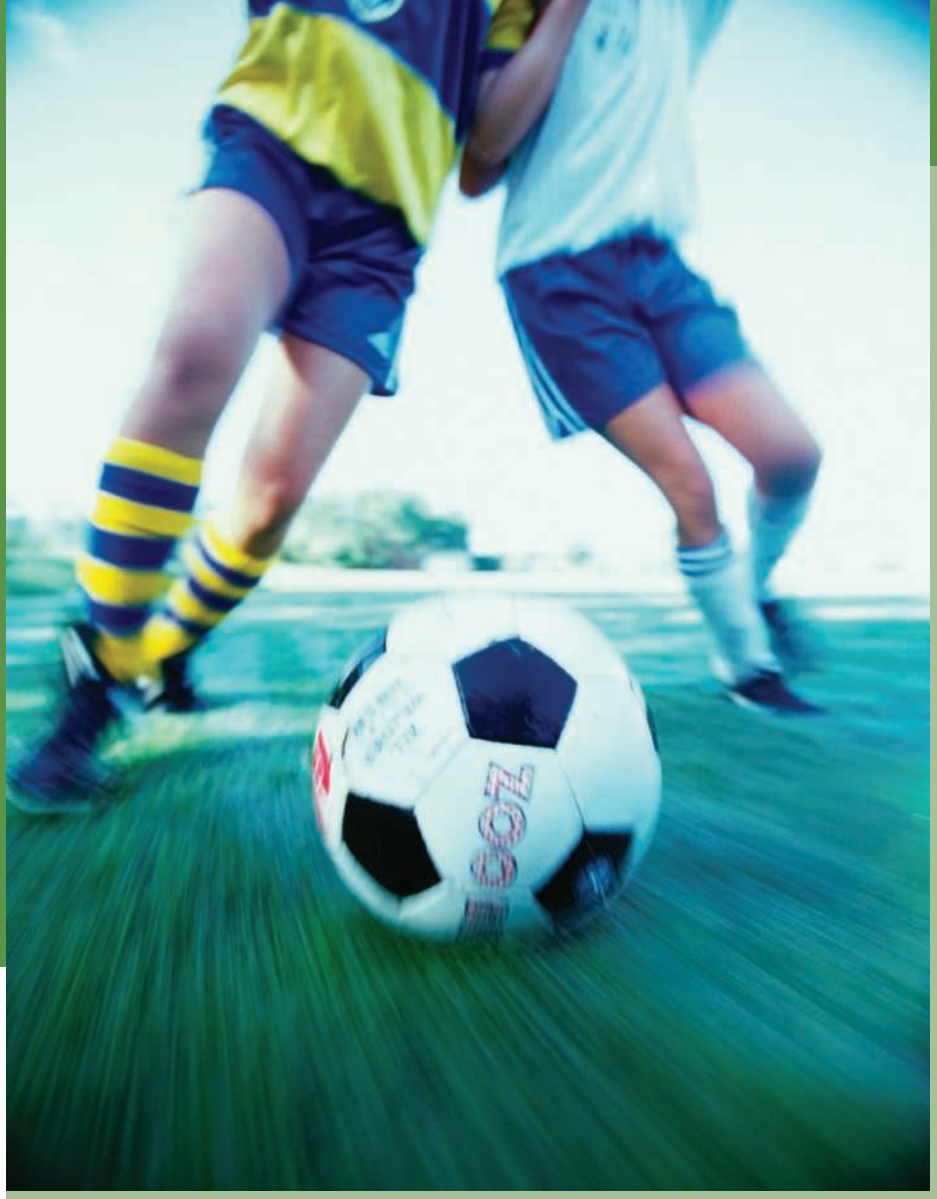
The two specialists visited the UK to attend the European Head and Neck Course led by British Association of Oral and Maxillofacial Surgeons (BAOMS) Maxillofacial and Head and Neck Consultant, Sat Parmar and ENT Consultant Surgeon, Paul Pracy.

The delegation included Rwandan-based doctor, Dr Magabo. The aim of Dr Magabo's visit, which was funded by BAOMS, was to gain a stronger understanding of the UK's approach to head and neck surgery in order to apply the skills and knowledge that he acquired back in his home town.

The three day course covered the current management of head and neck cancer within a multidisciplinary framework. The course aimed to present a combined approach towards the management of patients with head and neck cancer through the use of surgery, radiotherapy and chemotherapy. There was also a one day course on Chemoradiotherapy in Head and Neck cancer aimed at surgeons.

Dr Magabo, 40, who gained his qualifications in Head and Neck Surgery at the University of Cape Town, having previously studied in Nairobi, Kenya and who now works in a hospital in Rwanda, said: 'Oral and Maxillofacial surgery is an extremely dynamic field and this course provides me with the opportunity to catch up on what is happening across it. I am really looking forward to being able to transfer the mass of knowledge I gain from the course back to my hospital in Rwanda.'

Sat Parmar, Maxillofacial Head and Neck Consultant said: 'This is a great initiative by BAOMS and ENT UK to sponsor doctors from developing countries aimed at improving treatment in their own countries.'



TACKLE DENTAL HEALTH OF **PROFESSIONAL FOOTBALLERS** TO IMPROVE EVERYONE'S PERFORMANCE

Professional footballers have worryingly poor teeth that could be affecting their performance on the pitch, a study claims.

Nearly four out of 10 UK top-flight footballers have active tooth decay, while one in 20 has irreversible gum disease.

That's according to a study, published online in the *British Journal of Sports Medicine*.[1]

And it's affecting performance and wellbeing, say the experts, led by Professor Ian Needleman, from the International Centre for Evidence-Based Oral Health at University College London.

The authors are now calling for regular dental screening to be a part of routine medical care in professional football, together with an increased emphasis on simple effective preventive approaches to help athletes look after their teeth and gums.

But Melonie Prebble, secretary of the British Association of Dental Therapists, believes much more needs to be done to raise awareness among young men generally about the impact of poor dental health on not just sports performance, but overall health, too.

She said: 'The dental profession is acutely aware that dental health affects quality of life and this study simply confirms and reinforces the message. The football industry must obviously now ensure players receive consistent dental screening, preventive advice and treatment to ensure their wellbeing. But there also needs to be a clampdown on sports drinks and an emphasis on rehydration and remineralisation via other, more health-friendly drinks.

'Perhaps, if oral health education and prevention were introduced and promoted in high level sports, it might have a knock-on positive effect on a wider scale, aiding the education of the general public. Dental teams need to identify those patients who are at an increased risk of developing dental caries and provide tailored advice on how to better manage the risk.'

In a relevant study, published online at the *BDJ* in July 2015 – *Bodybuilding supplementation and tooth decay* – its authors noted that 'bodybuilding supplements are advertised to provide nutrients needed to help optimise muscle building, but they can contain high amounts of sugar. Supplement users are consuming these products, while not being aware of their high sugar content, putting them at a higher risk of developing dental caries'.

In Professor Needleman's survey, nearly four out of 10 (37%) of the players had active dental caries, and dental erosion was evident in over half (53%).

Nearly two thirds (64%) said they drank sports drinks at least three times a week, although the researchers point out that the association between sports drinks and dental erosion 'remains unclear'.

Eight out of 10 players also had gingivitis; in one in 20 (5%) this was moderate to severe – and irreversible. Half the mouth was affected by gum disease in three out of four players.

Around one in six (16%) reported current pain in their mouth or teeth, while around one in four (27%) experienced dental sensitivity to hot or cold food/drink.

Poor tooth and gum health 'bothered' almost half (45%) of them, and one in five (20%) said it undermined their quality of life. Around 7% said that it adversely affected their performance or training.

1. Needleman I, Ashley P, Meehan L, Petrie A, Weiler R, McNally S, Ayer C, Hanna R, Hunt I, Kell S, Ridgewell P and Taylor R. Poor oral health including active caries in 187 UK professional male football players: clinical dental examination performed by dentists. *Br J Sports Med* (2015); Published Online First: 2 November 2015.

Periodontitis and systemic disease

Lewis Winning[1], **Gerard J. Linden**[2]

In recent years there has been considerable interest in possible links between periodontal disease and systemic diseases. The general public are increasingly aware that such links may exist and in some cases are concerned about the implications for them as individuals. Nearly half of all adults in the United Kingdom have some form of periodontal disease,[1] and as such present to dental practices every day. It is essential that all members of the dental team are aware of the periodontitis-systemic disease link, and can provide clear evidence-based advice and information to patients. The aim of this article is to summarise the current state of knowledge so that members of the dental team can convey appropriate advice and guidance to patients.

Basis for a possible relationship – Historical and Current

The notion that a relationship between oral disease and systemic disease might exist goes back over a century. Around 1900 William Hunter, a British Doctor, identified links between oral sepsis and disease of other organs in the body and this was termed the theory of 'focal infection'.[2] The proponents relied heavily on clinical experience highlighting cases where the removal of infected teeth produced improvements in general health. These observations lacked the rigor of modern scientific studies and the theory of focal infection was later discarded.

Skipping forward to more recent times, evidence from well-designed studies began to emerge in the late 1980's of possible linkages between chronic periodontal disease and other systemic diseases.[3,4] Since then there has been an exponential rise in the number of studies that have investigated links between periodontal disease and various diseases with the main areas of interest being: atherosclerotic cardiovascular disease,[5] diabetes,[6] and adverse pregnancy outcome.[7] Associations between periodontitis and many other diseases and conditions have also been reported including respiratory disease; chronic kidney disease; rheumatoid arthritis; cognitive impairment; obesity; metabolic syndrome; and cancer.[8] (*Fig. 1*)

Possible mechanisms

Two main pathogenic mechanisms have been described to explain how periodontal disease could contribute to systemic disease.

1. **Direct mechanism**: As chronic periodontitis progresses, the epithelium lining periodontal pockets becomes ulcerated providing a direct entry point for periodontal bacteria into the systemic circulation. The circulating bacteria could then have direct effects on certain organs, for example periodontal bacteria have been detected in thrombi from patients with acute myocardial infarction suggesting a possible role in the pathological changes

[1] *Research Fellow, Centre for Public Health, School of Medicine Dentistry and Biomedical Sciences, Queen's University Belfast*

[2] *Professor of Periodontology, Centre for Public Health, School of Medicine Dentistry and Biomedical Sciences, Queen's University Belfast*

that occur in atheromatous plaques.[9]

2. **Indirect mechanism**: Alternatively, the inflammatory response to periodontal bacteria or their by-products may have indirect systemic effects. It is now well recognised that inflammation itself is involved in the pathogenesis of many chronic illnesses such as cardiovascular disease, type 2 diabetes, and rheumatoid arthritis. Chronic periodontitis therefore represents a source of chronic inflammation that may be a significant contributing factor in the pathogenesis of other inflammatory based diseases, (*Fig. 2*). The level of C-reactive protein (CRP) in the blood is an accepted method of measuring systemic inflammation in individuals. There is strong evidence that CRP levels are elevated in periodontitis subjects.[10,11]

Difficulties - Confounding and Causality

One of the main difficulties in studying links between periodontitis and systemic disease is that risk factors for many systemic diseases overlap with those associated with periodontitis such as age, gender, smoking, obesity, socio-economic status, etc. This is called **confounding** and when we describe links between periodontitis and systemic disease to patients we should bear possible confounding factors in mind so we do not imply that periodontal disease is the only reason they might have a particular condition. A further difficulty is that most research cannot identify cause and effect relationships. Although plausible, based on the mechanisms outlined, the critical appraisal of studies completed to date cannot distinguish whether periodontitis and systemic disease develop due to similar shared disease pathways rather than because one actually causes the other. Evidence for causality may come in the future when we have more studies that definitively show a temporal sequence where the presence of periodontitis results in a subsequent increase in the frequency of a systemic disease. Alternatively demonstrating that successfully treating periodontal disease has a positive effect in reducing the signs and symptoms of a particular systemic disease would also support a causative link. Until then when we discuss links between periodontitis and systemic disease with patients it is better to describe 'association' rather than 'causation'.

Periodontitis and Atherosclerotic Cardiovascular Disease (ACVD)

Atherosclerosis is a condition in which the artery wall thickens as a result of the accumulation of calcium and fatty materials

Fig. 1 Systemic diseases chronic periodontitis has been linked to.

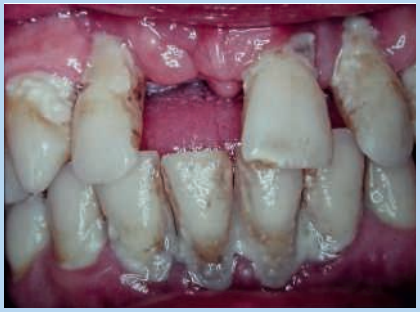


Fig. 2 A patient with generalised severe chronic periodontitis. Ulcerated epithelium may allow an entry point for pathogenic bacteria and/or the by products of inflammation to enter the circulatory system.

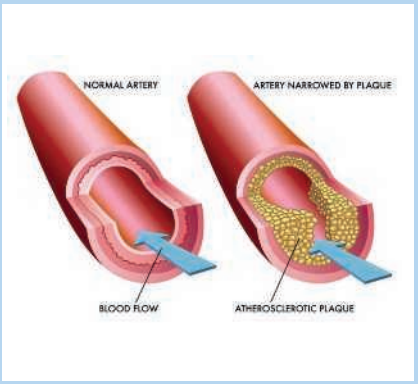


Fig. 3 Atherosclerotic cardiovascular disease (ACVD)

that form plaques and cause the arteries to harden and stiffen, (*Fig. 3*). Depending on location, complications of atherosclerosis include angina, myocardial infarction, stroke, or aneurysm. Together, cardiovascular diseases are the number one cause of death globally.[12] An estimated 17.5 million people died from CVDs in 2013, representing 31% of all global deaths.[13] Bacteria, central to the initiation and progression of periodontitis, may provide a direct or indirect mechanistic link to the development of atherosclerotic disease, (*Fig. 4*). The association between periodontal disease and atherosclerotic cardiovascular disease is independent of other known confounding risk factors.[5] The recent joint workshop of the American Academy of Periodontology (AAP) and the European Federation of Periodontology (EFP) which examined systemic disease links,[5] made the following key recommendations:

- Practitioners should be aware of the emerging and strengthening evidence that periodontitis is a **risk factor** for developing ACVD, advising patients of the risk.
- Periodontitis patients with other risk factors for ACVD, such as hypertension, overweight/obesity, smoking, etc. who have not seen a doctor within the last year, should be referred to their medical practitioner.
- Modifiable lifestyle associated risk factors for periodontitis (and ACVD) should be addressed in the dental practice setting, and in the context of comprehensive periodontal therapy, i.e. smoking cessation programs and advice on lifestyle modifications (diet and exercise). This may be better achieved in collaboration with appropriate specialists and may bring health gains beyond the oral cavity.

Periodontitis and Diabetes

Diabetes is a condition that results in the abnormal elevation of the blood glucose level (hyperglycaemia). Around 10% of cases are type 1 diabetes,[14] where the immune system attacks and destroys the cells that produce insulin. The remaining 90% of cases are type 2 diabetes where either the body does not produce enough insulin, or the cells have a lowered response to insulin (insulin resistance). The bidirectional relationship between periodontitis and diabetes has been known for some time.[15] Over the last 20 years, consistent evidence has emerged that severe periodontitis adversely affects glycaemic control in both diabetic and non-diabetic subjects. In patients with diabetes there is a direct and dose-dependent relationship between periodontitis severity and diabetes complications.[6] The biological rationale connecting periodontitis and diabetes relates back to the common theme of chronic inflammation. Based on the AAP/ EFP workshop,[6] key recommendations included:

- Patients with diabetes should be told that they are at increased risk for periodontitis. They should also be told that if they suffer from periodontal disease, their glycaemic control may be more difficult, and they are at higher risk for other complications such as cardiovascular and kidney disease.
- Patients presenting with diabetes should receive a thorough oral examination, which includes a comprehensive periodontal evaluation and management as appropriate.
- Patients with diabetes should also be evaluated for other potential oral complications, including dry mouth, burning mouth and candida infections.
- Patients who present without a diabetes diagnosis, but with obvious risk factors for type 2 diabetes and signs of periodontitis should be informed about their risk for having diabetes, assessed using a chair-side HbA1C test (if available), and referred to their doctor for appropriate diagnostic testing and follow-up care.

Periodontitis and Adverse Pregnancy Outcome

The link between periodontitis and pregnancy outcome has emerged mainly due to medical studies showing that inflammation plays an important role in pregnancy especially towards the end of gestation.[16] Maternal periodontitis represents a **potential** source of microorganisms that may enter the circulation, and similarly to mechanisms discussed previously, directly and/or indirectly have potential to influence the health of the foetal–maternal unit. The main adverse pregnancy outcomes that have been associated with periodontal disease include low birth weight, pre-term birth and pre-eclampsia. Although the association of periodontitis with these adverse outcomes are biologically plausible, a recent review described the evidence for an association as 'moderate'.[7] What's more, although periodontal treatment during pregnancy results in improved oral health, the majority of studies have failed to shown a consistent beneficial effect for adverse pregnancy outcome.[17] Key points based on the recent AAP/EFP review,[7] on this subject include:

- In the absence of clear evidence for the association between periodontitis and adverse pregnancy outcome, the emphasis of the message to patients should be better periodontal health means better oral health and wellbeing.
- The well-established risk of pregnancy gingivitis (*Fig. 5*) related to hormonal changes during pregnancy should be addressed by oral hygiene instruction, professional instrumentation and frequent monitoring as necessary.
- Providing non-surgical periodontal treatment to patients during pregnancy is safe and effective.

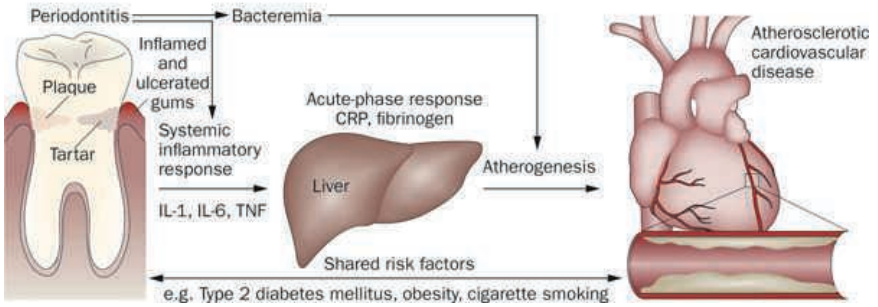


Fig. 4 Overview of postulated mechanisms linking periodontitis and ACVD. Reproduced from: Genco RJ & Van Dyke TE. Prevention: Reducing the risk of CVD in patients with periodontitis, [21].

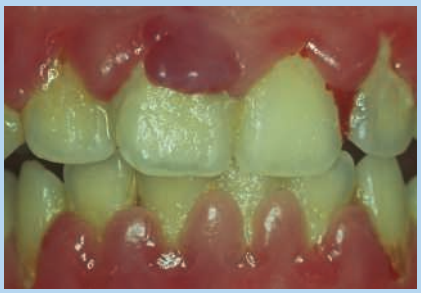


Fig. 5 Plaque induced pregnancy gingivitis. Additionally, the upper right central incisor presents with a pregnancy epulis.

Links between Periodontitis and other systemic diseases

Periodontitis has been an associated with a number of other systemic diseases including respiratory disease, chronic kidney disease, rheumatoid arthritis, cognitive impairment, obesity, metabolic syndrome and cancer. Key summaries for each of these purported links from the recent AAP/EFP review[8] include:

- **Respiratory disease.** Periodontitis has been linked with both Chronic Obstructive Pulmonary Disease (COPD) and Pneumonia. COPD is characterised by progressive airflow obstruction and inflammation in the airways with the main cause attributed to cigarette smoking. Studies investigating a link between COPD and periodontitis remain preliminary and as such there is no clear evidence. Pneumonia, involving infection within the airways, may associate with periodontitis especially as many potential opportunistic pathogenic bacteria are found within the oral cavity. Improved oral hygiene has been shown in randomised controlled trials to have an important role in the prevention of pneumonia in a variety of at risk-populations. However, there are few studies investigating the effects of established chronic periodontitis in relation to acquired lung infections.

- **Chronic Kidney Disease (CKD).** CKD is defined as kidney damage with decreased function (glomerular filtration rate <60 mL/min per 1.73 m^2) for 3 months or more. Although periodontitis has been associated with CKD in several studies, the complex pathogenesis of CKD and its close linkage with diabetes and other co-morbid conditions means a direct link to periodontitis is as yet not completely clear.

- **Rheumatoid arthritis (RA).** RA is characterised by persistent synovial inflammation and associated damage to articular cartilage and underlying bone. Despite early studies reporting an association, there is currently little published evidence the periodontitis represents a risk factor for developing RA

- **Cognitive impairment.** Cognitive impairment includes early changes, which can precede progression to dementia of the Alsheimer's disease type. Evidence from current studies for an association between periodontitis and cognitive impairment is limited and further studies are required.

- **Obesity.** Obesity is defined as abnormal or excessive fat accumulation that presents a risk to health. A modest association between obesity and periodontitis is supported by multiple studies. However, obesity may in fact be a marker of an unhealthy lifestyle resulting in the associated increased risk of periodontitis and the habits of this unhealthy lifestyle may be confounding this link.

- **Metabolic syndrome.** Metabolic syndrome (MetS) is a clustering of multiple atherosclerotic risk factors, including abdominal obesity, dyslipidaemia, hyperglycaemia and hypertension, which identifies a 5-fold increase in risk for developing type 2 diabetes.[18] Currently, evidence of an association of MetS with periodontitis, is limited.[19] The strongly increased risk of type 2 diabetes in those with MetS may confound any association with periodontitis, and as such further studies are needed to clarify this link.

- **Cancer**. The higher incidence of cancer development in those with chronic inflammatory conditions[20] has underpinned research into possible links to periodontitis. Difficulties with studies linking periodontitis to cancer include confounding effects such as smoking and socioeconomic status. Despite this, periodontitis has been identified as a possible risk factor for oro-digestive and pancreatic cancer. Further studies, with long-term follow up are still needed in this area.

Conclusions

The link between periodontitis and systemic disease remains the subject of intense research and debate within dentistry. Patients, whether through topical media or sensationalised news reports, are increasingly aware of possible links between periodontal disease and other diseases. As members of the dental team it is important that we are aware of current research in this important area so that we can dispel myth and provide sound information to patients.

Whilst there is now good evidence for periodontitis **associating** with various systemic diseases (particularly atherosclerotic cardiovascular disease and diabetes), evidence for a **causative** role is still lacking. Many of the reviews in this area report that 'further studies are needed', but that should not prevent us taking a pragmatic approach in promoting a patient's good oral health benefiting their general health. Treating periodontal disease, where we also address shared modifiable risk factors such as smoking, diabetes control, and diet can only have a positive effect on related systemic disease and as dental professionals we are ideally situated as front line health staff to do this. It is acknowledged that the gaps in our knowledge remain large.[8]

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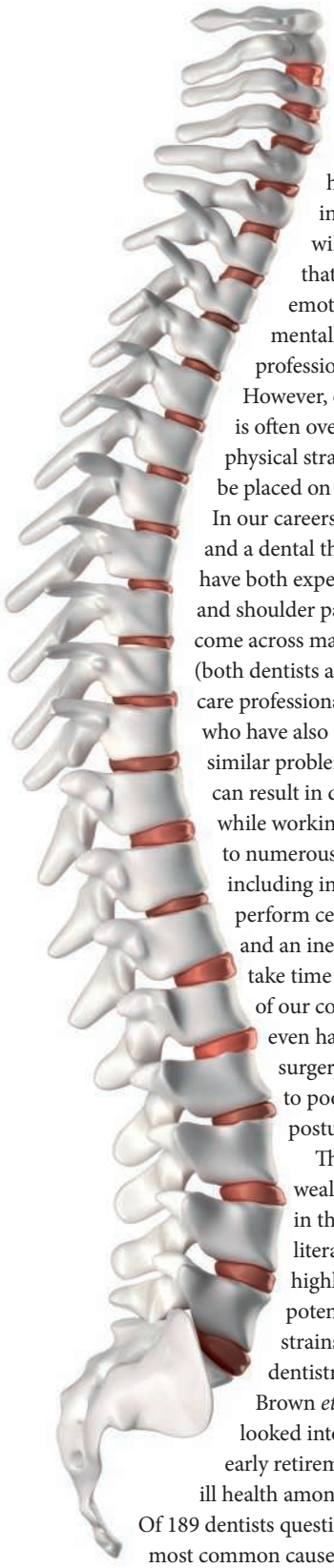
CPD: ONE HOUR

No turning back: posture in dental practice

By **Martin Breslin**[1] and **Shelley Cook**[2]



PHYSICAL STRAIN

Anyone who has worked in dentistry will be aware that it can be an emotionally and mentally challenging profession at times. However, one area that is often overlooked is the physical strain that can be placed on our bodies. In our careers as a dentist and a dental therapist we have both experienced back and shoulder pains and have come across many colleagues (both dentists and dental care professionals [DCPs]) who have also suffered with similar problems. This can result in discomfort while working leading to numerous problems including inability to perform certain tasks and an inevitable need to take time off work. Two of our colleagues have even had to undergo surgery relating to poor working posture.

There is a wealth of evidence in the dental literature which highlights the potential physical strains of practising dentistry. Research by Brown *et al.* in 2010[1] looked into reasons for early retirement due to ill health among dentists. Of 189 dentists questioned, the most common cause of ill health retirement was musculoskeletal disorders. A similar situation is seen with dental nurses[2] and hygienists and therapists alike.[3]

This article will give a brief overview of methods for preventing/controlling back problems and improving posture with particular relevance to the dental professional.

HOW CAN WE MANAGE MUSCULOSKELETAL DISORDERS?

Posture

Prior to the 1950s it was common for the dental chair to be in an upright position with the clinician standing up throughout treatment.[4] However, with the ever-increasing precision and complexity involved in dentistry along with an increase in patient expectation, procedures are taking longer and the operator commonly treats patients in a seated position for the majority of operative procedures. In order to obtain adequate vision and access for periodontal and restorative treatments, operators and dental nurses may be inclined to twist their necks and backs (Fig. 1).

Incorrect working posture is the major cause of musculoskeletal problems in dentistry.[6] Ellis Paul has written extensively on the subject of posture in dentistry.[5,6] The following information on correct working posture is based on work carried out by Ellis Paul who pioneered much of the research in this area and 'close support dentistry'. Readers should consult the references for further information.

Correct patient position

The patient chair should be completely flat to keep the patient completely horizontal[5,6] (Fig. 2). This is an absolutely essential part of working in the correct posture which is often overlooked. In the authors' experience some patients may express a dislike of the sensation of the dental chair moving back into this horizontal position. One way of combatting this may be to have the chair in the horizontal position before the patient sits in the chair, much like how a patient may mount the bed in hospital or when visiting a general practitioner.[5]

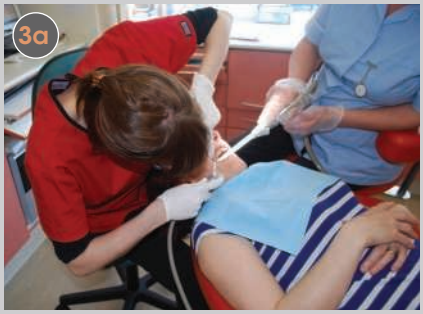
Fig. 1 Here both the operator and dental nurse are adopting a bad posture. They are both bending and twisting their backs to gain a better view of the mouth. The dental nurse's right arm is also raised causing additional stress

Fig. 2 Here the patient is sat completely horizontal and the operator and dental nurse are adopting a good posture. Note also how the dental nurse's eye level is above that of the operator's

It is important to note that some medical conditions may preclude a patient from being completely horizontal such as pregnant patients, those with hypertension or spinal problems.

The vertical height should be adjusted so that the operator has good vision of the patient's mouth without having to bend too far forward. This is usually at the operator's mid sternal (or heart) level (Table 1).

[1] *Martin Breslin is an associate dentist in general practice;* [2] *Shelley Cook is a dental therapist in a mixed private and NHS practice.*



Figs 3a-b Comparison of bad posture *vs.* good posture when treating the upper right buccal surface. The operator is bending her back (and also raising her left arm) to get good vision in the 'bad posture'. In order to improve posture, the patient has turned her head to the left and the operator has moved slightly round the dental chair to the 11 o'clock position. The operator now has good vision of the upper right quadrant without having to bend her back

Figs 4a-b Comparison of dental nurse posture: bad posture *vs.* good posture. In the bad posture example the dental nurse's knees are pointing straight towards the patient. This can lead to 'leaning over' slightly to get good vision of the mouth. In the good posture example, the dental nurse is sat at a slight angle to the patient which naturally brings her closer to the patient and allows good posture to be maintained

Table 1 Correct posture for the operator[5,6]

✔ The operator should sit as close as possible to the patient to avoid having to bend the back too much
✔ Both feet should be on the ground
✔ The upper border of the thighs should be slightly bent
✔ The long axis of the torso should be vertical (ie the back should be straight!)
✔ Both shoulders should be horizontal (not raised)
✔ Both arms should be in light contact with the rib cage

All efforts should be made to maintain this posture throughout treatment. In order to achieve this, the operator will have to make some adjustments. A good habit to get into is to ask the patient to move their head so you don't have to. For example, when working on the buccal surface of the UR6, ask the patient to tilt their head to the left, rather than moving your head uncomfortably to your right. You may also have to move slightly around the dental chair (Fig. 3).

Correct posture for the dental nurse

Feedback from nursing staff suggests that often operators easily forget about the dental nurse's posture. It is essential that the dental nurse avoids repeatedly changing posture by twisting and leaning over as this repeated strain will lead to musculoskeletal problems.[5] Table 2 identifies the key areas and Figure 4 shows a comparison of bad *versus* good posture for the dental nurse.

Dental nurse should sit higher than the operator

This allows the dental nurse to gain good vision of the oral cavity by seeing over the operator's hands (Fig. 2). In our experience many dental nurses sit at the same height as the operator. This can cause back strain, as in order to reach the patient's mouth the dental nurse has to lean across the patient's body and inevitably bend their back.

By sitting higher up, the dental nurse has good vision of the patient's mouth without having to lean forward, allowing them to keep their back straight. As a general rule, the dental nurse's eye level should be approximately 10 cm higher than the operator's.[5,6]

Table 2 Correct posture for the dental nurse[5,6]

✔ The dental nurse should sit higher than the operator
✔ Sit 'at an angle' to the patient
✔ Move your arms not your back

Sit 'at an angle' to the patient

By sitting at 45 degrees to the long axis of the patient, the dental nurse can gain access to the oral cavity without having to lean forward (Fig. 4).

Move your arms not your back

There should be no need to lean forward and bend the back to reach the oral cavity. By following the main concepts mentioned above, the dental nurse should be able to maintain a straight back. Hand and arm movement should be all that is needed. Figure 5 shows the dental nurse sitting too far away from the patient.

Four handed/close support dentistry

Four handed or close support dentistry involves the operator and dental nurse working as efficiently as possible whilst both maintaining correct posture. Essentially the dental nurse carries out as many non-operative tasks as possible while the patient is undergoing treatment.[6] In its purest form, all the instruments are kept on the dental nurse's

> 'The dental nurse's eye level should be approximately 10 cm higher than the operator's.'

Fig. 5 Here the dental nurse is sat too far away from the patient causing her to bend her back to reach the patient

Fig. 6 Please don't work like this!

side who then passes them to the operator when they are needed. In theory the operator should not need to move their eyes from the patient's mouth, avoiding having to bend and twist to reach instruments. With practice the dental nurse should be able to anticipate which instruments are needed in the correct order so that treatment can proceed without any interruptions. This should enable treatment to proceed as efficiently as possible.

As well as being actively involved in instrument exchange the dental nurse also plays a big role in ensuring the operator has good vision by retracting tissues and aspirating. Not only does this improve the efficiency of treatment but it also promotes good posture in both the operator and the dental nurse.

A good dental nurse will be highly motivated and organised to ensure this works efficiently. All instruments for a procedure should be laid out on the dental nurse's side to avoid having to break away to look through drawers or go to the central storage area mid-treatment for a forgotten instrument. Apart from avoiding the interruption of treatment this will ensure the dental nurse maintains good posture by avoiding twisting and turning to reach the instrument. In our experience most dental nurses prefer this way of working as they are more involved in the patient's care. However, this can only work well with lots of practice so that the operator and nurse build up a good understanding.

There are numerous hands-on courses available that teach four handed dentistry and we would highly recommend attending one to gain a better understanding of this subject. These are particularly useful when dental nurses and operators attend them together.

Operating stool

In recent years numerous manufacturers have developed operating stools which are designed to improve working posture. The manufacturers of the Bambach Saddle Seat claim that it can alleviate many of the problems associated with muscle fatigue by ensuring that the natural 'S' shape curve of the spine is maintained.

A study conducted at the University of Birmingham found that posture was significantly better in dental students using a Bambach Saddle Seat compared with a 'regular' seat.[7] However, some commentators on the subject, notably Ellis Paul, have expressed concerns with these saddle chairs. The saddle chair causes the operator to sit slightly higher up and their thighs to splay outwards. This may prevent the dental nurse from sitting close enough to the patient (as the operator's thighs get in the way) and from sitting high up enough. Both of these factors could force the dental nurse to lean forward and bend their back to gain access to the oral cavity.[8]

Magnifying loupes

These are optical systems worn by the operator which magnify the image of the patient's teeth. As well as the obvious benefits of improved vision of the oral cavity they can also help to promote good posture by being set up so that they only give a clear image when the operator has an upright posture.[9] For instance the operator position adopted in Figure 3's example of bad posture would not be possible as at this proximity to the patient the operator's vision would be 'blurred'.

Regular exercise

The benefits of regular exercise have been well documented for many years. As dentistry is a sedentary profession it is particularly important that dental professionals take regular exercise. Apart from the obvious health benefits, regular exercise helps to maintain mobility and flexibility of the joints of the body.[6] Activities such as swimming and Pilates or yoga have been found to be particularly helpful as they can improve flexibility and strengthen back muscles.[10]

Surgery design

One final important point which should be mentioned is that poorly designed surgeries with inadequate space may hamper efforts to maintain good working posture. However, if the dental team are organised and plan ahead it is possible to overcome most problems.

Conclusion

It is essential that all members of the dental team are aware of the importance of taking steps to avoid musculoskeletal problems. With the average age of retirement continuing to rise, avoiding musculoskeletal problems in dentistry is likely to be more important than ever.

A final note - please don't work in the positions shown in Figure 6!

Thank you to staff at Stepping Stones Family Dental Health Centre, Ludlow for the photographs.

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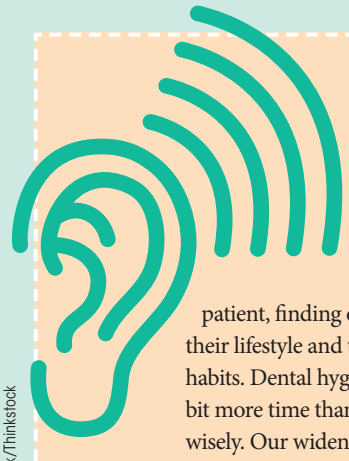
bdjteam2015164

10 top tips for improving patient compliance

There are many challenges the dental team face on a daily basis. Challenging contracts – internally as well as NHS – always seems to top the list, but improving patient compliance and shifting toward a preventive world remains one of, if not the greatest challenge of modern dentistry. Dental Hygienist and winner of the BSDHT's and WOHP 'Oral Hygiene by Design' Award **Michelle Coles**, gives us her 10 top tips for improving patient compliance.



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1 Listen to your patients

Listening is almost a forgotten art. There is a lot to be said for just talking to the patient, finding out a bit more about their lifestyle and their oral hygiene habits. Dental hygienists do have a little bit more time than dentists, so use it wisely. Our widening role enables us to have conversations and gain a better understanding of our patients.

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3 Build a rapport with them

At the end of the day we are healthcare professionals. We should have a rapport with our patients. I always find if you be memorable but not obsessive then they will be more likely to return having listened to the advice you sent them home with. Building that trust and confidence will go a long way, and chances are you will see higher levels of compliance. It is a skill building relationships. You can't teach it, but it is so important.

'IT IS A SKILL BUILDING RELATIONSHIPS. YOU CAN'T TEACH IT, BUT IT IS SO IMPORTANT'

2 Use that to understand them

Once you've got all of that down, use it to understand them. So they might enjoy a few drinks at a weekend, which means you'll need to be a bit more vigilant in some areas. It will also mean that they don't brush their teeth when they get home at night, so by talking to the patient you can build a picture. Everyone is different, so you can't approach things with a rigid approach.

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4 Give them relevant information...

If you have listened and used the information to build up an accurate picture of their habits and lifestyle, you're now in a better position to offer the right advice. Diet, alcohol and smoking are all areas that we should be talking to patients about. You need to find their interest trigger. I often use visual aids and props to support my oral hygiene discussions in clinic, but I wanted to create something simple and appealing that helps patients remember this advice once they get home. I recall chatting to one patient about their alcohol consumption, and they genuinely believed one bottle of wine per night was acceptable. Needless to say I was very surprised!

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5 ...But don't overload them!

Dentistry is an incredibly complex area, so keep it nice and simple. That's where my Hooked on Oral Hygiene idea came from. It is a tool that houses strips of personalised oral hygiene advice, helping patients to 'hang-on' to their oral hygiene advice even after they leave the clinic. Small, digestible chunks of advice are great, and always consider the way you're giving them information. Is it by video or leaflet, by email or by talking to them? Assess what works best for your patient.

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6 Avoid jargon

We are so used to reading about gingivitis, periodontal disease, xerostomia and all that we actually forget patients will not have a clue what we're on about. Nice short, snappy bits of information they can understand like 'spit don't rinse' can be invaluable.

'spit don't rinse'

9 Provide user-friendly home care

I'm a firm believer that you don't need expensive gadgets or complex routines to improve compliance. For some people electric toothbrushes might be better than manual ones, and vice versa. The questions and advice should be are you brushing for two minutes twice daily, are you using a fluoride toothpaste, are you taking your diet into consideration. Dentistry is not as expensive as many people perceive it to be.

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7 Don't be a mum and nag them

There are many approaches that I find can yield better compliance, but one of them is most certainly not nagging patients. Praise and positive reinforcement can go a long way to not only encouraging someone to start flossing (for example), it can be the deciding factor in them keeping it up. Fear and finance are two of the biggest barriers to care I see. Patients don't need any excuse not to visit the dentist, as they believe there are many already. We need to reassure them visiting the dentist is a worthwhile and cost-saving exercise.

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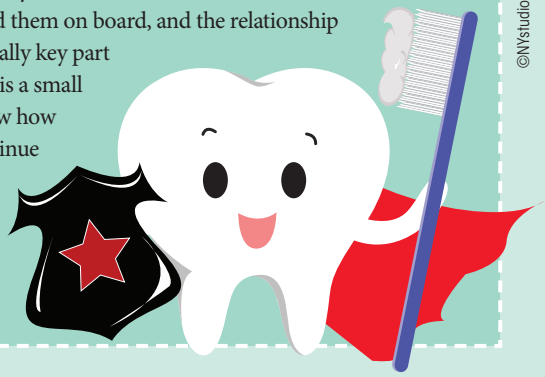
'PATIENTS DON'T NEED ANY EXCUSE NOT TO VISIT THE DENTIST'

8 Motivate, motivate, motivate

People have to want to make improvements to be onside, motivating them to get on board is absolutely critical to the success – or otherwise – of their care plan. You do need them on board, and the relationship and trust-building steps are a really key part of setting that in motion. There is a small percentage of patients who know how their oral health is, but still continue to do the absolute minimum. It's for the children who are visiting for the first time. Get them excited and you will find compliance improves.



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10 Schedule regular recall periods

Lifestyles and circumstances can change at the drop of a hat. One day you might treat a female patient, and the next day she might be pregnant. If you set a nine or 12-month recall period you are missing out on dispensing crucial information that will help her. I firmly believe the maximum recall period of two years is too much. I would definitely suggest more frequent appointments, even if you believe their oral health is of a good standard.

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'Hooked on Oral Hygiene' helps patients 'hang-on' to oral hygiene advice even after they leave the clinic. The bathroom door hanger contains personalised oral hygiene advice and motivational tips. It will be launched to dental clinics nationwide in 2016 by the BSDHT and WOHP.

bdjteam2015165

'Tis the season to be jolly...?

The nights are drawing in, the temperature is dropping and Christmas is just around the corner bringing with it, and often dreaded by employers, the staff Christmas party!

Staff Christmas events should be a fun occasion at which staff are rewarded for their hard work during the year and enjoy themselves thereby boosting staff morale and employee relations. However, you will all have heard horror stories about parties which have been ruined by alcohol fuelled antics such as fighting and lecherous behaviour. These stories mean many employers opt not to organise a Christmas event, which is unfortunate given the positive benefits staff events can have.

This article looks at the issues/risks arising from staff events and offers guidance, which should enable practices to hold a successful event that doesn't leave them with a nasty employment law hangover.

Employers' obligations

There are various obligations that employers have to their staff and associated liabilities, which are relevant to staff events, in summary these are:-

- Statutory/implied duties to take reasonable care of the health and safety of employees, including protecting employees from unacceptable behaviour such as bullying and harassment;
- vicarious liability for the acts of staff in the course of employment whether or not the employer knew about it or approved. Conduct in the course of employment would include acts committed immediately before, at or after staff events, even when the event is held outside working hours and away from the employer's premises. Employers can avoid vicarious liability by showing they have taken *reasonable steps* to prevent discrimination arising, for example by having anti-discrimination policies in place, training staff and taking action when discrimination arises;
- It is an offence for an employer to knowingly permit the use, production or supply or any controlled drug taking on their premises; and
- It is an offence for employers to allow staff under 18 to drink alcohol.

Against this backdrop what steps can an employer take to ensure a successful Christmas **PARTY** ….?

P is for *planning the event*

Forward planning will assist employers in minimising the risk of issues arising at the Christmas party.

When sending out invitations employers should ensure all staff are included. For example, staff on maternity or shared parental leave should not be forgotten and it might be appropriate to invite staff who are on sick leave depending on the nature of their ill-health.

Whilst it is good practice and minimises the risk of complaints about discrimination to invite all staff to the party, employers should not insist that staff attend. Some staff may not wish to or may be unable to attend a Christmas party. For example, non-Christian staff may feel uncomfortable about attending or have other commitments, for example, Jewish Hanukkah takes place from 7 to 14 December 2015. Also, staff with family/caring commitments may be unable to attend an event outside usual business hours.

When organising the event consideration should be given to the location and ensuring it is accessible to and suitable for all staff, including in particular those with disabilities.

Whilst employers are no longer liable for harassment of their staff by third parties it would nonetheless be prudent to consider the suitability of any entertainer booked for the event, to avoid upset/offence being caused and which could lead to complaints afterwards. A comedian of the Frankie Boyle school will not be everyone's cup of tea!

A is for *alcohol*

Parties without festive fizz may be rather flat affairs, however, drink unfortunately tends to be the cause of the party horror stories we read about and which can lead to a variety of post-party hangovers.

Providing a free bar is a generous gesture but an easy way for things to get out of hand. In this regard a lesson can be learnt from the ET unfair dismissal case brought by 3 employees (ironically) of a brewing company who got drunk at a staff event and had a fight. The 3 employees were successful in their claims for unfair dismissal on account of, amongst other things, the fact that their employer had provided a free bar and

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therefore condoned their drunken behaviour.

As a result it would be wise to take some simple steps to guard against staff over-indulging on the booze and ending up twerking and making a fool of themselves on the dance-floor or worse. For example, limiting the amount of free alcohol available and ensuring that food (which caters for the dietary requirements of your staff) is available will reduce the risk of staff becoming inebriated. Also, some form of entertainment, such as music/a disco might prevent employees from knocking back drinks at the bar all evening.

It would be wise to ensure a senior member of the practice is tasked with ensuring that any employee who has drunk too much is asked to stop drinking and/or assisted home; thereby nipping potential issues in the bud.

Given the risk of an employer being liable for an employee's drunk-driving after a Christmas party, employers should think carefully about how staff will get home after the party and what (if any) arrangements it needs to make, for example providing transport for staff or information about reputable taxi firms and public transport.

If the day after the Christmas party is a working day it will be important to ensure that employees are fit and capable to work. This is particularly important for dentists and dental nurses. The usual rules should apply to protect patients where there are concerns about an individual's ability to work safely.

'PROVIDING A FREE BAR IS A GENEROUS GESTURE BUT AN EASY WAY FOR THINGS TO GET OUT OF HAND.'

R is for *reminding staff about the appropriate standards of behaviour*

Practices would be wise to issue clear guidance to staff before the party about what will constitute unacceptable behaviour at and after the Christmas party (i.e. getting drunk, verbally insulting colleagues, fighting, damaging property and harassing or intimidating colleagues) and the possible consequences of misbehaving/discriminating (i.e. disciplinary action).

Staff should be reminded that whilst the party is intended to be fun and informal it is a work-related event and the normal standards of professional conduct will be expected. This is especially important for functions held off-site and in public.

Whilst this guidance could be viewed as a dampener on spirits, it could be of significant assistance to an employer seeking to utilise

the reasonable steps defence to a post party claim of harassment made by one employee against another for which the practice could be vicariously liable; as it would demonstrate that action had been taken before the party to prevent discriminatory behaviour occurring.

T is for *tweeting (and other social media)*

The rise of social media usage creates potential risks for employers in the context of work events and makes the infamous photocopying antics of old pale into insignificance.

The prolific use of social media means there is potential for pictures of your event and your staff looking the worst for wear or in compromising situations being posted on line and/or misplaced comments about the practice and its staff being posted publicly.

Postings on social media sites could give rise to data protection issues from staff unhappy about their data being posted on line and could also cause reputational damage that could have a significant impact on the Practice.

It is therefore recommended that dental practices which don't have social media policies, ensure that any guidance for staff issued in advance of the party includes a statement about the (appropriate) use of social media during and after the Christmas party, so as to avoid issues for them and the practice arising.

Y is for *you said what …?*

Alcohol lowers inhibitions and may embolden staff to say (and do) things they would not otherwise have said (or done), which can create a variety of issues for employers at and after the party.

Not surprisingly in a recent case involving a senior manager sacked for insulting colleagues at a Christmas party and telling his boss to *"stick his ****** job up his ****"*, the employee's claim for unfair dismissal was unsuccessful. However, inappropriate comments are not always as clear cut as this and senior managers should also be careful to avoid making statements that could be regarded as an agreement or promise to staff.

In a recent case, an employee raised proceedings claiming that his manager had promised an increase in salary during a chat at the Christmas party. When the increased salary did not appear the employee resigned claiming constructive dismissal on the basis that the manager had broken the promise. In that case the ET found that the promise was not certain enough to amount to a binding contract and this was upheld at the EAT which focused on the context, namely a conversation at a party. Depending on what is said though the courts could take a different view to that taken in the recent case on intent and the binding nature of any oral promise creating potentially significant exposure for a practice.

Practice owners/senior managers should avoid entering into conversations about individual employment issues such as performance or conduct matters or individual employee's pay and benefits to avoid problems arising.

A recent ET case serves as a reminder, especially for smaller organisations in which gossip can be rife, that discussions about a colleague's conduct at a staff event could create issues and should therefore be addressed by employers. In that case an employee was successful in sex and pregnancy discrimination claims arising from gossip following a Christmas party about the employee's subsequent pregnancy as she had been seen leaving the party with a colleague who was not the colleague with whom she had been in a relationship at the time.

Conclusion

The guidance above should assist in addressing the key risk areas for employers holding a festive event and ensure the event runs smoothly and successfully.

However, if you are unlucky enough to have an issue at your Christmas party it will be important not to have a knee-jerk reaction but rather to tackle the possible disciplinary or discrimination issues after the event in the cold (and sober) light of day; to avoid exacerbating any issues or negatively affecting the investigation process. It will also be important to ensure that any issues are dealt with swiftly (while memories are clearer), in line with your relevant procedures and that the employee involved (there will usually be two or more) are treated consistently. If in doubt on the best way forward or if the issues are serious and/or delicate take legal advice.

Try not to let the horror stories or possible risks/issues put you off arranging a Christmas event for your hard-working staff, with the right planning and precautions (as set out above) it should be a jolly and morale boosting affair – enjoy!

Fiona McLellan,
Partner, Hempsons solicitors

'THE RISE OF SOCIAL MEDIA USAGE CREATES POTENTIAL RISKS FOR EMPLOYERS IN THE CONTEXT OF WORK EVENTS AND MAKES THE INFAMOUS PHOTOCOPYING ANTICS OF OLD PALE INTO INSIGNIFICANCE.'

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Protecting our future

Newly-elected **Robin Mills** shares his vision for term in office with the British Society of Paediatric Dentistry (BSPD) in this month's President's Column.

2015 has been a particularly busy year for the Society which has been involved with an international event, our annual scientific meeting, contributing to a Commissioning Guide for Specialist Paediatric Dentistry and also to a Commons Health Select Committee Enquiry into children's oral health. We have also had involvement in radio and TV programmes and national newspaper articles highlighting children's oral health.

In July, we hosted the International Association of Paediatric Dentistry Congress in Glasgow with the theme of 'The Voice of the Child'. This was a very successful event and we had inspiring speakers from all parts of the world.

Our annual scientific meeting and AGM is held once a year in September and is organised by the local branch of the incoming President. This is a wonderful tradition and gives a regional and different flavour to the meeting every year. We have had social functions in such diverse venues as Cambridge Colleges and Stormont Castle. Our meeting in September this year was hosted by the South West Branch in Bath. The theme of the main meeting was 'How safe is your child?' The distressing subjects of FGM and modern slavery were highlighted and gave delegates an insight into relatively new safeguarding issues that all members of the dental team should be aware of. It was pleasing to see that the GDC has also just issued guidance on FGM. I have served on 2 local safeguarding children boards simultaneously for several years. This is an excellent way of forging links with other agencies and we would like to see a dental surgeon on local safeguarding children boards made mandatory. Another tradition in our society is that the President during their year of office embarks on a 'lecture tour' to some of the regional branches.

We are working with NHS England at present to help produce a commissioning document for Specialist Paediatric Dentistry. The Chair of our Commissioning Working Group is Dr Stephen Fayle who is a Consultant in Paediatric Dentistry at the Leeds Dental Institute and a member of the Board of the Faculty of Dental Surgery. This working group has already met with NHS England in London, with focus group meetings with parents and children planned for early next year.

In July, as Vice President, I gave a presentation at the Westminster Forum. I highlighted the lack of 'joined up thinking' for children within the NHS and elsewhere, citing the omission of dental surgeons from databases such as the NHS Spine and the SIMS database in schools that contain a child's GP but not the dentist.

> ***'I WOULD LIKE TO SEE SOME CHANGES THAT I BELIEVE WOULD MAKE A SIGNIFICANT DIFFERENCE TO THE HEALTH OF CHILDREN'***

I would like to see some changes that I believe would make a significant difference to the health of children. For example, when applying for a nursery or school place, the child's dental surgeon and optician should be on the application form in addition to the doctor. Small details such as these are, in fact, big details. Our own medical history forms should also include a space for opticians as well as the GP. Does a GP ask whether our children visit a dental surgeon or an optician on their forms? In any new relationship, whether it is between people, schools or clubs, we want to make a good impression and will not want to miss out questions. If we ask on a form for clinicians who all children should see on a regular basis, we have raised an issue that is important and carers with parental responsibility will see this. As professionals, we know that not only is it important, but it is essential for 'preventing impairment of children's health or development' (Working Together to Safeguard Children - March 2015). If we ask on forms only for the GP then the perception is that only having a GP is important for a child to be healthy. By asking the question 'why put other clinicians on a form that requires a GP entry' you will now realise that the answer is 'why not?'

Next year, we will be also holding a 'Stakeholder Day' as part of our drive to raise awareness of contemporary challenges in paediatric dentistry and the work of the membership.

In my completely unbiased opinion, I consider the BSPD to be one of the friendliest and committed societies that a dental professional could be a member of and it is a huge privilege to be their President. We welcome members of the dental team and at £15, £40 or £60 per annum depending on your role (less with tax relief!), this gives you 6 issues of the International Journal of Paediatric Dentistry every year, the opportunity to discuss and ask questions with colleagues and up to date information via email on current issues. As a member of your local branch, you can become a council member and be involved in deciding how the society should evolve in the future – you may even be writing this column! We are always happy to give a warm welcome to new members and details of how to join are on our website -www.bspd.co.uk.

Dr Robin Mills BDS MSc DDS
Specialty Doctor in Paediatric Dentistry - Royal United Hospitals Bath NHS Foundation Trust
Honorary Research Fellow - University of Bristol
President BSPD - 2015-2016

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Product news

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

STATE OF THE ART CUSTOMER EXPERIENCE CENTRE AND HEAD OFFICE OPENS

Situated just outside Coventry and within the spectacular Ricoh Arena – home to the Wasps, Europe's most progressive rugby club – Planmeca welcomed their new distribution partners and esteemed guests to officially open a new customer experience centre and UK headquarters.

The showroom was opened by Tuomas Lokki, Planmeca Group Senior Vice President and Karl O'Higgins Managing Director of Planmeca UK.

Tuomas said: 'This is a new era for Planmeca UK and our new home is one of the most important foundations from which success can be built upon. This new facility offers the perfect environment to discover our range of digital imaging solutions, world class CAD/CAM system and our range of highly innovative digital dental units.'

Karl echoed Tuomas's comments by saying that the stunning facility is testament to Heikki Kyöstil 's vision for Planmeca UK to be an integral part of Planmeca's global success – Mr Kyöstil is founder and president of the Planmeca Group, who unfortunately could not be present for the event, but wished the local team and distribution partners well for the future.

Via their new and expanded distributor network, alongside a world class product portfolio and innovative mobile showroom, Planmeca are now well positioned across the UK and Ireland. Any dentist or DCP wanting to experience Planmeca's innovative digital workflow now has that opportunity through multiple channels and in multiple environments.

The new customer experience centre features a dedicated CAD/CAM training zone alongside a full range of 3D imaging machines showcasing the latest in imaging technology. The showroom also includes Planmeca's range of digital dental units, all combined through the comprehensive and modular Romexis software. The showroom can be easily transformed into a small conference and event facility capable of hosting courses for up to 40 delegates.

The showroom is equipped with the latest technology to ensure seamless presentations with full HD LED projectors and multi speaker surround sound installed, ensuring a seamless experience for both presenters and delegates. There are a number of meeting rooms available, all of which are equally fitted out with the latest conference technology and catering is available from the Ricoh Arena in-house hospitality team. If you have need for a high quality Midlands lecture and events facility, give them a call.

To view the complete range of Planmeca digital solutions at their NEW customer experience centre, call 0500 500 686 or alternatively email marketing@planmeca.com.

EXPLORING THE WORLD OF SCIENCE IN ORAL HEALTH

A unique digital content partnership is set to raise awareness of the role of science in oral care and how technology can promise a bright future for patients

Sensodyne, manufactured by GSK Consumer Healthcare, has announced a partnership with Discovery Network to develop a global digital content series. *Future Now* is a four-part series of short documentaries exploring how technology and science are impacting on healthcare, particularly oral health. The thought provoking content is available to view now at http://www.discoveryuk.com/future-now.

Topics in the series include repairing the human body and the role of Bioglass technologies, how the technology developed for space exploration is giving insight into the oral environment and how modern lifestyles are impacting on our bodies. The series takes us back in time, considers current challenges and looks at how technology could help offer patients a brighter future.

'Sensodyne has been dedicated to helping people care for their sensitive teeth for over 50 years with its range of science based products', says Dr Teresa Layer, VP Oral Health Research & Development GSK.

Videos will be available online for patients and professionals to view until December 2015.

Thought provoking content is available to view now at http://www.discoveryuk.com/future-now

BDIA DENTAL SHOWCASE 2015 DELIVERS BUSINESS AND INNOVATION

BDIA Dental Showcase, the UK's leading B2B dental trade show, opened its doors to three days of brisk business and networking at Birmingham's NEC from Thursday 22 to Saturday 24 October.

The exhibition, organised annually by the British Dental Industry Association (BDIA), brought together over 330 exhibitors and the widest selection of dental equipment, products, services and demonstrations of the latest techniques for the profession to discover what's new, meet with product experts and conduct business deals.

With sponsorships deals in place with the major oral healthcare companies for the next two years, as well as exhibition bookings now being taken up to 2017 in response to exhibitor demand, BDIA Dental Showcase is firmly established as the premier business event for the dental industry.

Visitors to the exhibition had an exceptional opportunity to experience a significant number of innovations first-hand with more dental companies than ever choosing this event to unveil or showcase their latest products to the UK market including Oral-B, Cattani Esam, Ceramic Systems, Cerezen, DMG, KaVo, NSK, Philips, Software of Excellence, TePe, Voco and W&H to name but a few.

Although overall footfall at the exhibition was a little lower than in previous years it was clear that the event continues to be the place to see what's new, do business and network with colleagues, with plenty of key purchasers and influencers in attendance.

Current ADI President, Philip Friel, said: 'Our programme at Dental Showcase has been a fabulous opportunity to share the advances we have made in implantology. And it was pleasing to see the huge level of interest from dental professionals and be able to answer their questions and provide advice.'

BDIA's Executive Director Tony Reed added: 'Showcase plays a vital role in facilitating business for the sector enabling exhibitors and buyers to meet on a one-to-one basis to conduct business.

'Like many others within dentistry I am concerned about the proliferation of events diluting audiences both for exhibitors and the profession. This has refined our audience significantly. A substantial amount of business of mutual benefit has been conducted during Showcase and we are looking forward to another productive event in London next year.'

BDIA Dental Showcase 2016 will be held at ExCeL London from 6-8 October 2016, so make a note in your diary and start planning your visit now!

Delegates can download their CPD certificates from this year's exhibition by visiting www.dentalshowcase.com.

PRACTICE SALES 'STABLE'

The dental practice sales market has been relatively stable over the last quarter. That's according to the latest quarterly goodwill survey from NASDAL (The National Association of Specialist Dental Accountants and Lawyers).

Alan Suggett, specialist dental accountant and partner in UNW LLP, said that the survey showed a steadiness in the overall market although the average goodwill value of 109% of turnover is considerably up on the start of 2014. NHS practices were sold for an average goodwill value of 125% with a range of 51-209%. Private practices fetched an average goodwill figure of 81% with a range of 15-135%. Mixed practices sold for an average of 115% of goodwill with a range of 20-202%.

Alan said: 'My own personal view is that the market has been rising steadily over the past year or so. We have seen the very high prices paid in the London area spreading to other major conurbations such as Nottingham and Manchester.'

The goodwill figures are collated from accountant and lawyer members of NASDAL on a quarterly basis in order to give a useful guide to the practice sales market. These figures relate to the quarter ending 31st July 2015.

Alan went on to add: 'We do of course need to remind all parties that as with all averages, these statistics should be treated as a guideline only.'

BE PREPARED – TAKE THE **ORAL CANCER CPD MODULE**

As part of this year's Mouth Cancer Action Month launch, the Association of Dental Groups (ADG) is pleased to announce the return of the oral cancer CPD module.

Designed by {my}dentist, the module reflects the work of the campaign and focuses on the early detection and treatment of the disease.

As early detection of mouth cancer can result in a survival outcome of 90% the ADG is urging dentists to use this powerful tool to help improve knowledge and raise awareness.

Except for a small cost of £25 plus VAT for those wishing to apply for a CPD certificate – £5 of which will be donated to the British Dental Health Foundation and the Mouth Cancer Action Month campaign – the comprehensive and interactive online module is available for free to all dentists and oral health professionals throughout the UK.

To be part of the movement against oral cancer, contact the ADG today.

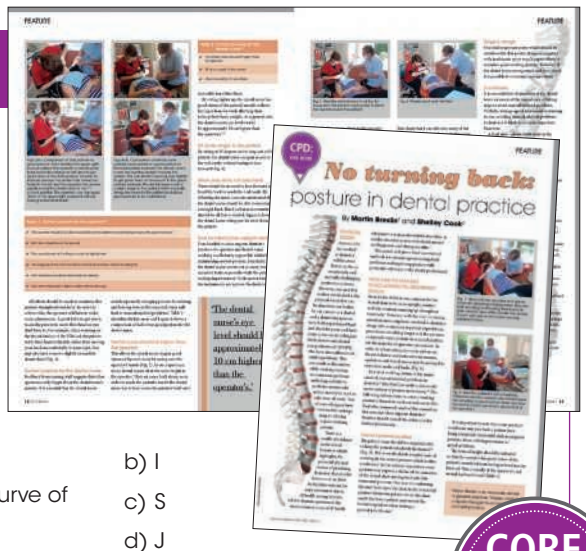
To find out more about the free oral cancer training available visit http://www.dentalgroups.co.uk/mouth_cancer.php.

BDJ Team continuing professional development

CPD: ONE HOUR

CPD questions – November 2015

CPD ARTICLE: No turning back: posture in dental practice



1. What is the most common cause of ill health retirement?

a) Musculoskeletal disorder
b) Stress
c) Old age
d) None of the above

2. What is the correct patient position?

a) At 45 degrees
b) Completely horizontal
c) Sat up
d) A combination

3. As a general rule, what should the dental nurses' eye level be at?

a) 1.0cm higher than the operator
b) 100cm higher than the operator
c) 10cm higher than the operator
d) 50cm higher than the operator

4. Which of these best describes the natural shape curve of the spine?

a) B
b) I
c) S
d) J

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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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.