BDJ Team

NOVEMBER 2017

SENSITIVE PRACTICE

BDA
British Dental Association

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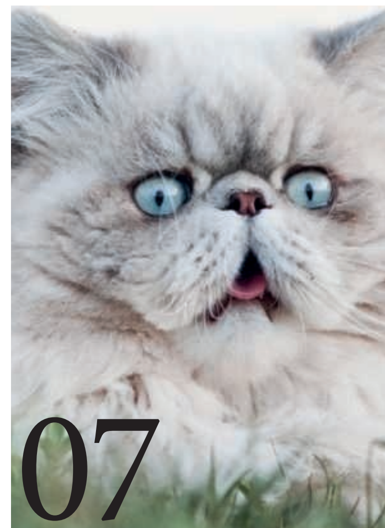

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Ed's letter

Twenty free hours of CPD! That's right, now that the November issue of *BDJ Team* is published, there are 20 hours of free verifiable *BDJ Team* CPD available on the BDA CPD Hub: ten hours from articles published in 2016 and ten hours from articles published in 2017. If you've just registered on the CPD Hub (all GDC-registered DCPs are welcome) you will be in good company as there are currently 2,408 active users of *BDJ Team* CPD. To access the CPD Hub, go to https://cpd.bda.org/index.php. There is also a recap of all 20 CPD articles available, later on in this issue.

The 20th hour of CPD itself can be obtained from reading dental hygienist Linda Douglas' cover story *Trauma-informed, sensitive practice*. Linda explains how patients may fall into the 'more challenging' category as a result of mental health issues, like dental phobia, and this phobia might be a consequence of negative experiences in the past. Linda goes on to outline how dental professionals can help and facilitate feelings of safety in the dental setting for patients.

Also this month award-winning dental hygienist Anna Middleton discusses patient options for tooth whitening and stain removal, and how best to manage high expectations.

Lisa Bainham, President of ADAM, provides a spotlight on dental practice managers - their current concerns and the evolution of their role; we delve into the archive for a look at the dental nurse role back in the mid-1990s; and publish research on social media and professionalism.

So that's 20 hours of CPD and ten issues of *BDJ Team* done and dusted for this year! What are your plans for 2018?

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Kate

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THE TEAM

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CAM2300 10-17

Sixth formers Neha Kanda and Saairah Anwar teach local primary school children about looking after their teeth

SIXTH FORMER TAKES ORAL HEALTH TO PRIMARY SCHOOL CHILDREN

By Neha Kanda

My name is Neha Kanda and I am a sixth form student at Wolverhampton Girls' High School applying for dentistry this October.

While on work experience at various dental practices, the vast disparities in the level of oral health and dental hygiene in children, based upon the socio-economic status of the area, struck me greatly. I spent two weeks at two mixed practices and two weeks at two NHS practices.

With Wolverhampton being within the top 20 most deprived areas in the UK, I initiated a project, following my work experience, to perform a workshop at a local primary school in an area with a particularly low socio-economic status, educating the children about preventative dentistry and maintaining a good standard of dental health in an interactive, informative and memorable way.

The workshop was carried out at Merridale Primary School Wolverhampton with year 2 children, aged 6-7. I was accompanied by my fellow pupil, Saairah Anwar, who hopes to study medicine.

Incorporating the tips and advice given to me by Dr Jonathan Lewney, Associate Editor (Science) *BDJ* Portfolio, I put together and gave the presentation on 25 September, and was commended for carrying out an 'engaging, thoughtful and informative' session.

Ranging from the importance of teeth and a healthy diet, to brushing techniques, fluoride toothpaste and even dental caries, the children interacted well and were eager to learn new information throughout. It was very fulfilling finishing the session knowing that the children had taken something away from the afternoon and were genuinely enthusiastic to put into practice what they had been taught. Beginning the session with the children not even knowing the basics of good oral hygiene, to finishing with a quiz where all 25 children were buzzing with excitement to tell me the correct answer, was one of the most satisfying aspects of the day.

When two dental events become one

The British Dental Association (BDA) and CloserStill Media have announced a major new collaboration that will see the first 'British Dental Conference and Dentistry Show' launched in May 2018.

The new collaboration of the BDA's British Dental Conference and Exhibition, and CloserStill Media's The Dentistry Show, will take place on 18-19 May 2018 at the Birmingham NEC.

The BDA Conference and Exhibition has been running for over 100 years and is the BDA's annual flagship event for its members and the wider dental team. The Dentistry Show will have been running for 11 years in 2018. The new event will now become the key date in all dental professionals' diaries and will be free of charge and open to all.

BDA Chief Executive Peter Ward said: 'We're committed to offering our members and this profession the biggest and best event in the dental calendar. This collaboration with our friends at CloserStill Media will take our landmark event to the next level.

Alex Harden, Event Director of The Dentistry Show said: 'This is an exciting investment for us all. Between us, the team now running The Dentistry Show and The BDA Conference have been responsible for running some of the UK's fastest growing events over the last two decades. Our combined experience, sector knowledge and significant commercial and marketing resources will be focussed on delivering for both exhibitors and the audiences for these powerful brands'.

BSDHT OPENS NEW OFFICES

The British Society of Dental Hygiene and Therapy (BSDHT) was delighted to officially open its brand new offices in Rugby this September.

To mark the occasion, key supporters from throughout the profession visited the new premises to celebrate the organisation's latest achievement.

Helen Minnery, President of the BSHDT, commented: 'The launch of our new office is a momentous occasion for the BSHDT. I'd like to say a big thank you to all attendees who represent the trade, both for your support and for your recognition of our profession'.

Sarah Murray OBE, elected Council Member of the BSDHT, was invited to officially open the new office. Before cutting the ribbon, she shared a few words about what the BSDHT means to her: 'I really value the BSDHT – it is like an extended family for me as I have been a staunch supporter since I was a student. I think the organisation does a fantastic job of moving our profession onwards. The new office is a real landmark for the BSDHT!'

For more information about the BSDHT, visit www.bsdht.org.uk.

COMMUNITY DENTAL TEAM SCREEN FACTORY WORKERS FOR MOUTH CANCER

By Tami Lampert

Mouth Cancer Action Month takes place in November. As part of this national initiative, in 2016 Community Dental Services (CDS) spearheaded an education and screening day at the Vauxhall Motors plant in Luton.

The company was chosen for its profile of workers. Head and neck cancer is the fourth most common cancer in males and 93% are linked to lifestyle factors such as smoking and alcohol.[1] However, it is increasing in females and younger people and the incidence rates as a whole are projected to rise by 2035.[1]

The CDS team included a foundation dentist, a dental nurse and two colleagues from the oral health promotion team. Two smoking advisors from Live Well Luton also supported our event.

We were overwhelmed with workers wanting to see the dentist for a screening and speak to the team. Thirty-two factory workers were screened and no referrals were made, but two smoking referrals were generated. One man was keen to share his experience and survival of mouth cancer, which he only discovered through a car accident.

There was incredible enthusiasm from the factory workers to learn more about oral cancer, many of them unaware that they have a screening every time they go to the dentist. With the emphasis on prevention and early diagnosis all workers were advised to visit their dentist regularly.

CDS plan to return to the Vauxhall plant this year. We would encourage other dental professionals to learn more about Mouth Cancer Action Month and get involved this year: www.mouthcancer.org. We also found the British Dental Association's (BDA's) (in partnership with Cancer Research UK) Oral Cancer Recognition Toolkit to be an invaluable resource for dental professionals and patients: https://www.doctors.net.uk/eClientopen/CRUK/oral_cancer_toolkit_2015_open/.

1. Cancer Research UK. Oral cancer statistics. 2017. Available at: http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer#heading-Three (accessed 4 September 2017).

NEW CHAIRPERSON FOR ORTHODONTIC NATIONAL GROUP

The Orthodontic National Group (ONG), the membership organisation for orthodontic dental nurses and orthodontic therapists, has announced that their new Chairperson is Sally Dye (pictured, left).

This represents a momentous achievement in the history of ONG as Sally is an orthodontic therapist while the new President, Debra Worthington (pictured, right), is an orthodontic dental nurse. It's the first time that both groups of orthodontic professionals are represented at the highest level of their representative body.

Sally has the Certificate in Education (Cert Ed) and has many years' experience of teaching. Debra, the immediate past Chairperson of ONG, has just been honoured with an Outstanding Contribution to Orthodontics Award by the British Dental Association (BDA). Both Sally and Debra will serve for two years in their new roles.

ONG is affiliated to the British Orthodontic Society (BOS) and its membership is open to orthodontic therapists, dental nurses, treatment coordinators and practice managers who work in the field of orthodontics.

ONG is active on behalf of members, representing their interests at meetings with the General Dental Council, the BDA, NHS England, The Royal College of Surgeons (Edin) and of course the BOS.

For more information about the ONG, visit their new website at: www.orthodontic-ong.org.

SPREADING THE WORD ABOUT A DEVASTATING DISEASE

November is Mouth Cancer Action Month and the Oral Health Foundation is asking you to show your support and help save lives by raising vital awareness of mouth cancer.

Mouth Cancer Action Month aims to reduce the amount of lives claimed by the disease and make a difference by promoting the importance of early detection and prevention. The campaign hopes to get more mouth cancers diagnosed at an early stage by educating people on the risk factors, signs and symptoms; while also encouraging the public to discuss them with their dental professional.

Like many cancers early detection makes such a vital difference to a person's chance of survival; in terms of mouth cancer early detection can dramatically increase the chances of survival to 90% from 50%.

In 2016, more than 2,000 dental organisations supported Mouth Cancer Action Month through education of patients and local people about this devastating disease, alongside the huge benefits of good oral health for our overall health.

Dr Nigel Carter OBE, CEO of the Oral Health Foundation, said: 'The good news is that we, and you, on the frontline of the profession are in the perfect position to do something about it; by pledging your support you can help raise awareness amongst your patients and in your local community.

'We remain enormously thankful and humbled by the continued support shown by the dental community for an increasingly important cause.'

To find out how you can get involved in Mouth Cancer Action Month 2017 visit www.mouthcancer.org for inspiration on what you can do to spread awareness.

What is your dental team doing to raise awareness of mouth cancer among patients? Email bdjteam@nature.com or comment at www.facebook.com/bdjteam.

20 hours of CPD! Why didn't you tell me?

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20 free hours

As of this month, November 2017, there are now 20 hours of free *BDJ Team* verifiable CPD available on the CPD Hub. That's ten hours from 2016 and ten hours from 2017.

Any GDC-registered dental care professional (DCP) can take part in *BDJ Team* CPD. Each digital issue of *BDJ Team* contains one CPD article: just read the article then log into the CPD Hub and answer four multiple choice questions based on that article. You can then download your certificate to show you have completed an hour of CPD.

To access the CPD Hub, go to https://cpd.bda.org/index.php

What CPD is available?

2016 HOURS

January

CPD article: The knowledge of dental nurses at one institution of the scope of practice of the dental team members

https://www.nature.com/articles/bdjteam201610

February

CPD article: Infection prevention and control in your practice

https://www.nature.com/articles/bdjteam201632

March

CPD article: How to turn complaints into compliments

https://www.nature.com/articles/bdjteam201651

April

CPD article: Periodontitis: a potential factor for Alzheimer's disease

https://www.nature.com/articles/bdjteam201662

May

CPD article: What's in a bin?

https://www.nature.com/articles/bdjteam201680

June

CPD article: How accurately do members of the dental team detect malignant lesions?

https://www.nature.com/articles/bdjteam2016103

July

CPD article: Resuscitation in the dental practice

https://www.nature.com/articles/bdjteam2016120

September

CPD article: Cannabis: a joint problem for patients and the dental team

https://www.nature.com/articles/bdjteam2016146

October

CPD article: Keeping infection under control

https://www.nature.com/articles/bdjteam2016153

November

CPD article: Evaluating denture cleanliness of patients in a regional dental hospital

https://www.nature.com/articles/bdjteam2016171

2017 HOURS

January

CPD article: 'Your teeth you are in control'

https://www.nature.com/articles/bdjteam201710

February

CPD article: Radiography for the dental team

https://www.nature.com/articles/bdjteam201729

March

CPD article: Medical emergencies: refresh your knowledge

https://www.nature.com/articles/bdjteam201743

April

CPD article: An introduction to crowns

https://www.nature.com/articles/bdjteam201761

May

CPD article: What is safeguarding?

https://www.nature.com/articles/bdjteam201778

June

CPD article: The erosive potential of sour novelty sweets

https://www.nature.com/articles/bdjteam201796

July

CPD article: Treatment of dental caries under general anaesthetic in children

https://www.nature.com/articles/bdjteam2017116

September

CPD article: Stress and well-being in dental hygiene and dental therapy students

https://www.nature.com/articles/bdjteam2017136

October

CPD article: The unbearable sweetness of sugar (and sugar alternatives)

https://www.nature.com/articles/bdjteam2017156

November

CPD article: Trauma informed, sensitive practice

https://www.nature.com/articles/bdjteam2017176

To access the CPD Hub, go to https://cpd.bda.org/index.php

CPD case study

Sarah Smith is a dental nurse in Leigh on Sea in Essex, working in a private dental practice specialising in cosmetic dentistry.

How does Sarah do CPD?

'I usually complete my CPD through various courses, some of which are costly. I started reading *BDJ Team* last year and I have since completed over 12 hours of CPD, which I have found very useful. I have found the BDA's CPD Hub very easy to move around and find my CPD records, so useful in fact that I have recommended the Hub to my friends and colleagues.'

What does Sarah think about being a dental nurse?

'My job as a dental nurse gives me much enjoyment and I am very enthusiastic about my position as team leader. I enjoy leading the clinical side of the practice and being the first point of contact with regards to cross infection and CQC.'

CPD case study

Susie McConnachie is a dental nurse in Perth, Scotland, working as an associate dental practice doing a mixture of private and NHS work.

When did Susie start dental nursing?

'In 2004. I qualified in 2006 and worked until 2012 in the Western Isles, and until 2013 in Kyle of Lochalsh as a locum before taking a career break to work in GP practices as a dispenser then an office manager.'

When did Susie start doing BDJ Team *CPD?*

'At the beginning of this year. I came across it while I was searching for good CPD to do. Once I found the CPD Hub, it has become a favourite first stop for CPD articles. The CPD Hub is very easy to use even from my smartphone, enabling me to read and then complete CPD when it appears rather than save it for later, when I might forget!

'During the earlier years of my career, most especially after Agenda for Change and the compulsory registration of dental nurses and need for CPD, it was never made clear how best to get these hours and complete our CPD record. This has prompted me to share your site and all available CPD with my dental nurse colleagues at the practice in Perth, as well as dental nurses in my previous practices - making that search for CPD a little easier!'

What does Susie like the most about being a dental nurse?

'I love that it is almost a partnership between the dentist and nurse, that you can go away from your working day feeling as though you have made a difference to that patient in pain, or that child who is scared by all the sights and smells. Working with my dentist to provide a very efficient, fluid service is a very satisfying career!'

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ARTICLE

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Social media and *professionalism*

Patricia Neville[1] describes the first study to investigate the incidence of social media Fitness to Practise (FtP) cases investigated by the GDC since it established social media guidelines in 2013.

Abstract

Introduction Since 2013, all General Dental Council (GDC) registrants' online activities have been regulated by the GDC's social media guidelines. Failure to comply with these guidelines results in a Fitness to Practise (FtP) complaint being investigated. **Aims** This study explores the prevalence of social media related FtP cases investigated by the GDC from 1 September 2013 to 21 June 2016. **Method** Documentary analysis of social media related FtP cases published on the GDC's website was undertaken. All cases that met the study's inclusion criteria were analysed using a quantitative content analysis framework. **Findings** It was found that 2.4% of FtP cases published on the GDC website during that period were related to breaches of the social media guidelines. All of the cases investigated were proven and upheld. Most of those named in the complaints were dental nurses and the most common type of complaint was inappropriate Facebook comments. **Conclusions** The low incidence rate should be interpreted with caution, being illustrative of the types of issues that might arise rather than the volume. The GDC will need to remain vigilant in this area and ensure that social media awareness training is an active part of CPD for all the dental team.

Introduction

Digital technologies are having an undeniable impact on health. Countless websites, blogs, vlogs, and apps have transformed the health behaviours of the public by providing them with more health information than was previously available to them.[1–3] For healthcare professionals, the advance of social media has also transformed their role and professional responsibilities in society. Social media is defined as 'internet-based channels that allow users to opportunistically interact and selectively self-present, either in real-time or asynchronously, with both broad and narrow audiences who derive value from user-generated content and the perception of interaction with others'.[4] This commonly includes such social networking sites as Facebook, Instagram, and Twitter. A high proportion of healthcare professionals use social media for personal use.[5–7] Others consider social media, especially Facebook and Twitter, as a tool for professional development, as a means of accessing information, marketing practices and services, job opportunities, as well as sharing or adding your opinion on issues of interest to you and to other like-minded individuals online.[8,9] However, other social media research has been conducted that has implications for the profession and the patient-practitioner relationship. Much of this research has highlighted instances where healthcare professionals' social media activities and their content may be damaging the social contract that exists between society and health professionals,[10–15] such as having an online relationship with patients,[16] breaching

[1]University of Bristol, School of Oral and Dental Sciences, Bristol

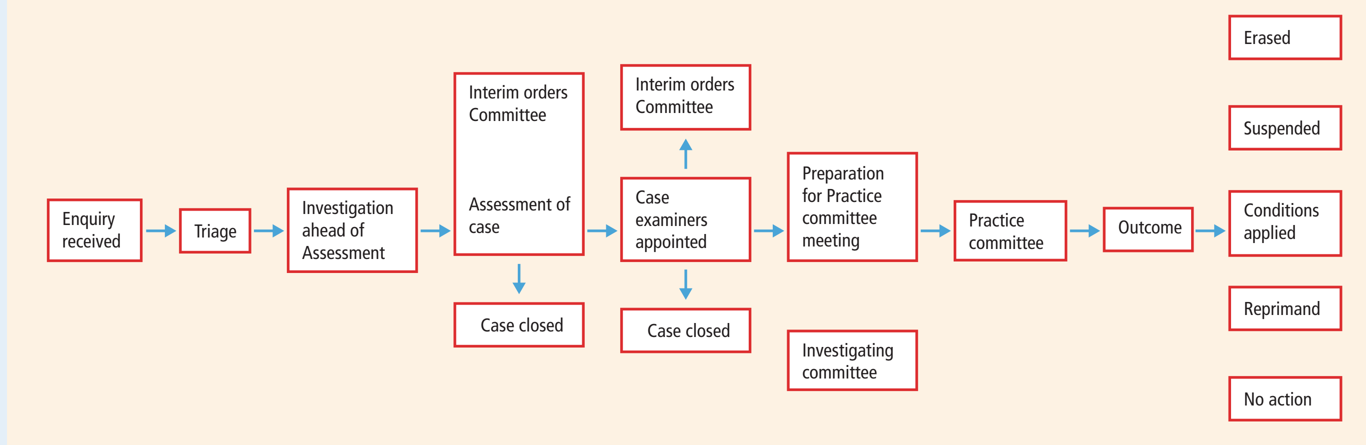

Fig. 1 GDC Fitness-to-Practise (FtP) Process: summary (Adapted from General Dental Council's *How we investigate.* 2017)

patient confidentiality in various postings[17] and writing disrespectful comments about colleagues and employers.[18,19] For instance, in a sample of 880 medical students in Australia,[20] 34% reported to having unprofessional content in their social media accounts, for example, evidence of being intoxicated (34.2%), illegal drug use (1.6%), posting patient information (1.6%), and depictions of an illegal act (1.1.%). Unsurprisingly, many professional bodies have developed social media guidelines for its registrants in order to clearly delineate the professional responsibilities and expectations regarding social media behaviour by healthcare professionals.[21–25]

In September 2013, the GDC published social media guidelines for all its registrants. As a result, inappropriate social media activities by a GDC registrant was deemed one of the grounds on which the public can make a complaint to the GDC about their Fitness to Practise (FtP). These guidelines were revised in June 2016 with respect to registrants' activity on 'a number of internet-based tools including, but not limited to, blogs, internet forums, content communities and social networking sites such as Twitter, YouTube, Facebook, LinkedIn, GDPUK, Instagram and Pinterest'.[21] In light of the recent revisions to the GDC's social media guidelines it was considered timely to investigate the incidence of social media-related FtP cases that have been investigated by the GDC. How many FtP cases have been brought before the GDC due to infringements of the social media guidelines? Was the revision of the 2013 guidelines prompted by a large volume of FtP cases since the establishment of the guidelines and a resultant need to revise and strengthen the existing guidelines? Or, does it merely reflect efforts by a regulatory body to be proactive regarding this rapidly changing dimension to contemporary professional practice?

Aims and objectives

This study was interested in examining the impact that social media is having on dental professionalism. It adjudicated this by examining the number and content of FtP cases relating to social media and the sanctions imposed by the GDC from 1 September 2013 to 21 June 2016. These dates were chosen because they captured two key milestones in the GDC's regulation of the social media behaviour of its registrants: when the guidelines were first established and when they were revised.

This study had two objectives:

- To identify the number of FtP cases concerning social media infringements investigated by the GDC from 1 September 2013 to 21 June 2016
- To quantitatively examine the nature of each of the cases and identify pertinent themes and underlying patterns of these online professional lapses.

This study provides numerical data on the incidence of social media-related FtP cases being considered by the various FtP committees of the GDC. This quantitative data can act as a baseline for official social media complaints received by the GDC. This in turn will enable us to plot and chart changes in this practice in the years to come. Moreover, by quantitatively analysing the details of each of the cases involved, we will gain insight into the types of online professional lapses GDC registrants have made. This detailed information can give us important indicators as to the possible further/future training and professional support registrants need in order to maintain acceptable online professional practice. Overall, it is hoped that this information will stimulate wider debates about social media practices among GDC registrants; not only among dentists but also the wider dental team. This debate may lead to a greater appreciation of and knowledge of the guidelines and facilitate more vigilance in their personal practice.

Method

Under the Dentist Act (1984) dentists in the UK and their fitness to practise are regulated by the GDC.[26] Since 2007, the GDC have taken on the responsibility for regulating clinical dental technicians, dental hygienists, dental technicians, dental therapists and orthodontic therapists.[27]

GDC registrants can expect to have to defend themselves against a Fitness to Practise complaint if they have committed a criminal offence, if a public complaint has been received that their professional conduct has contravened one or more of the nine Standards for Practice (2005) (this includes social media guidelines), or the disclosure that the health of a GDP or some aspect of their professional performance puts patients at risk.[28] Once a complaint has been received, it is triaged within ten days to determine if it meets the investigation test. If there are sufficient grounds for a full enquiry, the case is assessed where it can be considered by an interim orders committee as case examiners are appointed to prepare the case for the Practice Committee. There the decision is made as to whether the GDC registrant's fitness to practise has been impaired and the class of sentence to be passed down. A flow chart for how the FtP mechanism operates in the GDC is outlined in Figure 1.

Records of FtP complaints investigated by the GDC are recorded on the GDC website. These publically available case reports were the source material used in this study. Using

Table 1 Number of Fitness to Practise (FtP) cases published including social media (FtP cases September 2013 to June 2016)

Year	Social media FtP cases	Other FtP cases	Total
2013	0	6	6
2014	0	31	31
2015	2	90	92
2016	4	120	124
Total	**6**	**247**	**253**

Table 2 Summary findings of complaint by gender and occupation

Occupational category	Male	Female
Dentist	1	0
Dental hygienist	1	0
Dental nurse	0	4
Dental therapist	0	0
Total	**2**	**4**

the GDC website of published FtP cases is a reliable data set as it is the responsibility of the GDC to publish all FtP cases and committee decisions in a timely manner in accordance with rule 29 (3) of the General Dental Council (Fitness to Practise) Rules Order of Council 2006.[27] This type of documentary analysis of the GDC or any other regulatory body's archive record of complaints is common practice among researchers interested in professional regulation.[27,29–31] No ethical application was made for this study as the reports are publically available on the GDC website.

'MOST OF THOSE NAMED IN THE COMPLAINTS WERE DENTAL NURSES AND THE MOST COMMON TYPE OF COMPLAINT WAS INAPPROPRIATE FACEBOOK COMMENTS.'

The research consisted of two stages: first, a search was conducted of all the GDC's online FtP records from 1 September 2013 to 21 June 2016. All cases pertaining to social media FtP cases were identified, logged, and printed off. Second, these social media FtP cases were read closely and subjected to content analysis framework. Content analysis is 'an approach to the analysis of documents and texts that seeks to quantify content in terms of pre-determined categories and in a systematic and replicable manner'.[32] A key tool to content analysis is the design of the coding schedule. This schedule contains 'all the data relating to the item being coded'.[32] The use of coding schemes ensures that the study is replicable and the sampling methods are transparent.[32] In this study, each case was coded according to the following criteria: GDC reference number; brief description of the case; category of FtP case; admission at hearing; evidence of remediation; outcome of the decision; source of complaint; gender of person named in the complaint; professional occupation of person named in the complaint; and hearing outcome. Though the subjects of the complaints are named in the case reports, this research will de-identify the registrants for the purpose of this publication, with alternative handles being used instead, for example, GDC Registrant A, GDC Registrant B etc.

Findings

From 1 September 2013 to 21 June 2016 – 253 FtP cases were published on the GDC website. From this initial data set, six cases were found to involve social media FtP infringements. Table 1 documents the FtP cases recorded from 1 September 2013 to 21 June 2016. In the three years since the social media guidelines were instituted only six cases (or 2.4% of the sample) were investigated in relation to unprofessional social media activities. Instances of FtP cases related to social media first emerge in 2015. Table 2 reveals the summary details of the GDC registrants named in these social media related FtP cases. Even with this small sample, the influence of gender and professional category exists. More social media related FtP cases were brought against women than men and dental nurses were the most prevalent occupation category in this sample. The most common type of social media infringement were unprofessional and offensive postings on Facebook including one instance of a dentist asking to look up a patient on Facebook during a patient consultation (Table 3, Table 4). The sample also revealed one case of using social media to advertise professional services that they were not eligible to perform and one case of breaching patient confidentiality online (Table 4). The leading outcomes for the FtP hearings was that of suspension or reprimand (Table 5).

Table 3 Type of social media implicated in FtP cases (categorised according to GDC definition of social media)

Social media	Number
Blogs	0
Internet forum	0
Social networking sites (Facebook)	6
Total	**6**

Discussion

Since 2013, the GDC has instituted social media guidelines for all registrants to adhere to. Living in a jurisdiction where there are clearly delineated guidelines about social media is beneficial. By bringing social media into the professional standards and guidelines, the GDC are firmly locating social media as another aspect of one's life and lifestyle to which they must be self-circumspect and discerning. This study has found that only 2.4% of FtP cases published on the GDC website were social media-related. For those found to have broken these guidelines these cases serve to reaffirm the professional values of the profession and 'the professional ideal of individual accountability or self-governance'[33]

Table 4 Description of complaints involving Facebook, including hearing outcome

Year	Study identifier	Name	Brief description of case	Hearing outcome
2015	A	Hay, R	Published patient details, including name of patient and details of treatment, on social networking sites and website, published derogatory comments about 2 dental colleagues on a website (July 2014), published derogatory information about dental team colleague (Nov 2014).	Suspension for 12 months with review and immediate suspension.
	B	Erbeling, P	Asked Patient B if he could look her up on Facebook.	Conditions revoked and suspension for 12 months with a review hearing. Immediate order of suspension.
2016	C	Armstrong, N	Post on Facebook considered 'unprofessional', 'offensive' and 'inflammatory'.	Fitness to practise impaired, reprimand issued for 12 months, put on record.
	D	Camacho, H	Comment on Facebook in response to Daily Mail newspaper article with the title 'Muslim staff escape NHS hygiene rule'. Deemed to be 'offensive' and 'unprofessional', content 'deemed inappropriate for publication on website'.	Fitness to practise impaired, reprimand issued for 12 months, put on record.
	E	Moorcraft, L	Comment on Facebook in response to Daily Mail newspaper article with the title 'Muslim staff escape NHS hygiene rule'. Deemed to be 'offensive' and 'unprofessional', content 'deemed inappropriate for publication on website'	Fitness to practise impaired, reprimand issued for 12 months,
	F	Attfield, V	Advertised laser treatment on Facebook page	Suspension for 12 months with review and immediate suspension.

Table 5 Classification of hearing outcomes

Hearing outcome	Number
Immediate suspension-revoked registration	0
Suspension with 12-month review	3
FtP impaired, reprimand for 12 months	3
Total	**6**

in relation to social media. Since all the complaints were proven and sanctions given we can say that the GDC does take the social media behaviour of its members seriously and acts accordingly. However, this low figure needs to be interpreted with caution as it could indicate a problem with underreporting from the public and among fellow professionals. The cases should be regarded as the tip of the iceberg of what occurs in practice, illustrative of the types of issues that might arise but not the volume.

While the sample size is small, certain trends can be commented upon. The study indicated that the most common route through which registrants broke the GDC social media guidelines was via inappropriate Facebook postings. Though there has been recent discussion about the appropriateness of the GDC adjudicating on the private Facebook comments of GDC registrants,[34,35] the Practice Committee in each case deemed the content of their postings to be unprofessional and offensive in nature. Individual cases were also found to show how social media was used to break patient confidentiality and compromise the professional distance and relationship that should exist between a dental professional and their patient. In all of these cases social media acted as a potent vehicle through which unprofessional attitudes and values become apparent. In this way, the GDC's social media guidelines are serving a public value in maintaining the social contract and upholding the reputation of the dental profession. Most of the complaints were brought against and proven against dental nurses. Undoubtedly, the actions of a small minority do not in itself suggest a fundamental problem with the professionalism of dental nurses. However, it does raise the question about whether social media awareness training is part of dental nurse's professional education. The findings of this study would suggest that social media training is important for all members of the dental team, both as part of their initial training but also their continuing professional development (CPD).

It is important to state that this study does not claim to constitute a complete analysis of or representation of the scale of social media breaches among GDC members. Rather its purpose is to start the process of documenting those that have been reported to FtP since the guidelines first appeared in 2013. There is also value in re-stating that the number of FtP cases published on the GDC website is not a contemporaneous record. It is merely a snapshot in time of the cases that the Professional Conduct Committee can practically schedule and progress depending on members availably and within due process. While the current number of social media-related FtP cases is very low, the coming years may in fact show an increase in the number of social media related FtP cases. Many studies have documented how current healthcare students display a degree of ambiguity when it comes to interpreting the professionalism of their online actions.[36] For instance, healthcare professional students are aware of the importance of being professional online but don't think it applies to them until they graduate.[37] Other students consider their social media as a private activity and do not think it appropriate for their social media habits to be discussed or taught as part of their professional education.[38] Another study found that there was a noted 'disconnect between voiced concerns and a lack of any directed action to secure privacy' on Facebook. This was due to their opinion that it was 'tedious' to change/monitor privacy settings, because they self-reported that they didn't have anything unprofessional on their Facebook page, or that they didn't know how to change the privacy settings.[39] These findings suggest that the next wave of graduates may struggle with complying with all the social media guidelines set out by the GDC. The baseline data provided by this study will help us to track any future trends in social media complaints.

Conclusions

This analysis of FtP cases relating to the GDC's social media guidelines supports the assumption that social media can be a vehicle for unprofessionalism. Though the number of actual cases was very low for the study (six cases), it is reassuring that the GDC investigates complaints that are made about the social media behaviour of its members. The study also shows that the revisions of the 2013 guidelines in June 2016 was not precipitated by an increase in social media complaints *per se*, but rather an indication of the efforts of the GDC to remain vigilant and pro-active in regulating the actions of their registrants.

Social media will continue to shape

the institution of healthcare and social and professional interactions between practitioners and the public in the years to come. It is important that dental educators look on social media activity as another aspect of professionalism and incorporate social media awareness training as part of its overall programme of teaching professionalism. It is also incumbent on the GDC to encourage social media training as part of lifelong learning and continued professional development of its registrants.

'IT IS IMPORTANT THAT DENTAL EDUCATORS LOOK ON SOCIAL MEDIA ACTIVITY AS ANOTHER ASPECT OF PROFESSIONALISM AND INCORPORATE SOCIAL MEDIA AWARENESS TRAINING AS PART OF ITS OVERALL PROGRAMME OF TEACHING PROFESSIONALISM.'

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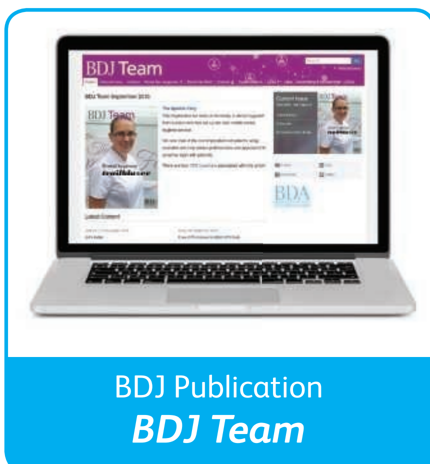

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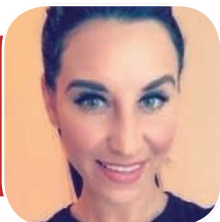
Tooth whitening *versus* stain removal



What are the options and how can DCPs manage patient expectations? asks dental hygienist **Anna Middleton.**[1]

[1] *After qualifying as a dental nurse in 2011, Anna decided to pursue dental hygiene and moved to London to study at the Eastman Dental Hospital. She graduated in 2015 from the Faculty of Dental Surgery at the Royal College of Surgeons. Anna is the founder of London Hygienist, a Philips Key Opinion Leader and an Oral Health Panel expert at CompareTheTreatment.com. You can follow her work on Instagram, Twitter and Facebook @ LondonHygienist.*
www.londonhygienist.com

Discoloured teeth

This year's National Smile Month survey revealed that 48% of the population is unhappy with their teeth. Of this, 64% stated discolouration as the main reason. The quest for whiter teeth is an ever-growing beauty trend and patients ask me daily how they can brighten their smile.

There are now many different 'whitening products' and 'whitening providers' on the market, making it harder for patients to know which ones are safe, effective and won't leave them out of pocket. With more and more press coverage of rogue traders and teeth whitening horror stories, how can we better inform patients of their options and manage their expectations?

It is important to firstly identify what is causing the discolouration, keeping in mind that teeth naturally vary in shade due to the thickness of enamel covering the dentine. There are numerous types of stains – some are genetic, environmental or pharmacological in nature – however, the most common are surface stains on the enamel caused by things like red wine, tea, coffee, various foods and smoking.

So how do we tackle this? We can offer the options of stain removal or whitening, but patients often don't know which one will have the most effective results.

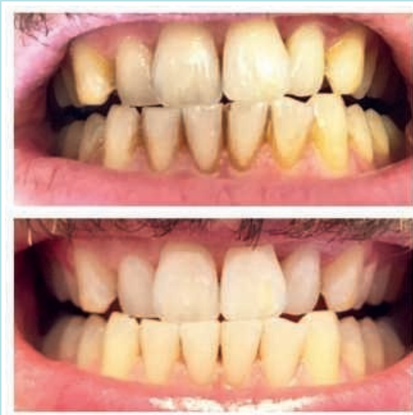
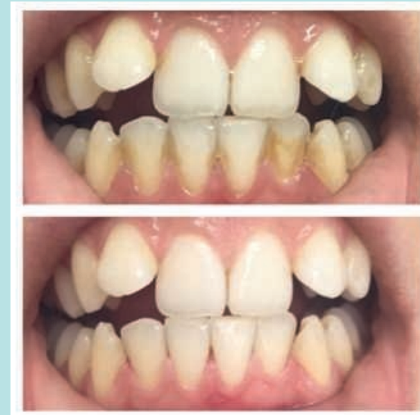
Stain removal

Let's look at stain removal as the first option,

which is ideal for those with extrinsic staining (stained enamel) and generally what the majority of patients have. Stain removal can be achieved during a routine hygiene appointment where the teeth are cleaned with an ultrasonic scaler and hand instruments to remove plaque deposits. The teeth are then polished with either conventional prophy polish or 'Air-flow'.

'Air-flow' is a powerful combination of water, air and fine powder – usually sodium bicarbonate or erythritol-based powder. It will remove biofilm, surface stains and early calculus quickly and gently. The results are usually instant, leaving teeth smooth, bright and clean. It takes less than a few minutes at the end of a routine hygiene appointment and is used instead of conventional polish, which can be abrasive and scratch enamel.

'Air-flow' is a good first step before whitening as the teeth will be completely free of surface stains and deposits, leaving teeth looking whiter. The cost is minimal, usually between £50 and £100 for a 30- to 60-minute appointment.

Examples of stain removal

'WITH MORE AND MORE PRESS COVERAGE OF ROGUE TRADERS AND TEETH WHITENING HORROR STORIES, HOW CAN WE BETTER INFORM PATIENTS OF THEIR OPTIONS AND MANAGE THEIR EXPECTATIONS?'

Whitening

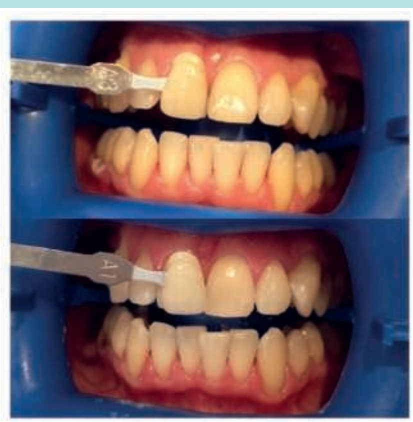
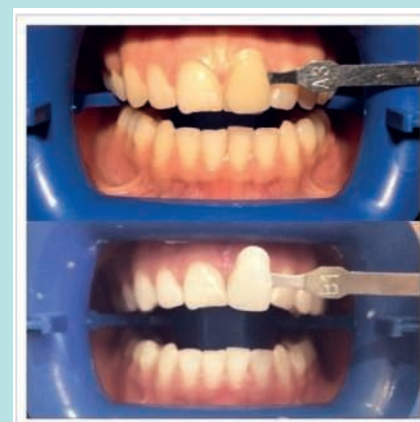
On the other side of the fence is whitening, and in fact, professional whitening is the only way to actually *change* the colour of teeth. Whitening is an extremely popular treatment as patients report feeling younger, more attractive and confident. However, there's a negative side to the growing popularity of whitening: rogue traders are capitalising on the eagerness and naivety of patients by offering illegal and unsafe treatment while claiming to provide the white teeth patients strive for. Yet despite all this, consumers are still dangerously misinformed.

Regulation and treatment

Teeth whitening used to be unregulated until 2012 when the European Union passed legislation stating that only dental professionals could perform teeth whitening procedures, providing they had the correct training. Even as a dental hygienist, I still need a prescription from a dentist to ensure a patient is dentally fit before I carry out the procedure. I constantly remind my patients that if they see whitening offered in a shopping mall or their local beauty salon, it is illegal.

EU regulation has also capped the level of the active ingredient used in whitening. Once upon a time the active ingredient, either hydrogen peroxide or carbamide peroxide, was as high as 38%. Today the maximum amount of active ingredient allowed is 6% hydrogen peroxide or 16% carbamide peroxide. These are the only two chemicals that will change the colour of the teeth. The way it works is through the chemical reaction that breaks apart the carbon bonds that create yellow stains. Once the bonds are broken, they no longer reflect a yellow shade.

The products we can offer our patients are safe and effective. Developments in whitening technology mean the process has become easy to do with minimal fuss or mess. Whitening is more expensive than stain removal, with prices ranging between £200 and £700. It does take time too with in-surgery whitening taking approximately 60 minutes, but for best

Examples of tooth whitening

results, patients should follow their treatment with at-home whitening for up to two weeks.

For patients who are budget conscious or short on time, Philips Zoom! QuickPro is a fantastic choice as it's a simple four-day take-home varnish system containing 6% hydrogen peroxide. The patient applies the varnish and sealant to the teeth using a brush, eliminating the need for trays, and leaves it on for 30 minutes. This is done twice a day for four days and will give a noticeably whiter smile, up to four shades whiter.

Outside of professional treatment, there's not much that can be done to improve the colour of teeth, despite what some products may say. However, that hasn't stopped oral hygiene brands from capitalising on the market by offering whitening and charcoal toothpastes, although patients should be cautious about using these.

While whitening toothpaste may remove surface stains, it can be abrasive and damage the enamel, making it even more prone to staining. It also doesn't contain any active whitening ingredients or may be missing key ingredients for healthy teeth, like fluoride.

Charcoal toothpaste is not as abrasive, however there is no evidence to prove its effectiveness on stain removal. In fact, it may even contribute to negative aesthetic effects as the particles can become embedded in cracks in the teeth or restoration margins.

'CHARCOAL TOOTHPASTE MAY EVEN CONTRIBUTE TO NEGATIVE AESTHETIC EFFECTS AS THE PARTICLES CAN BECOME EMBEDDED IN CRACKS IN THE TEETH OR RESTORATION MARGINS.'

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Setting realistic expectations

It is important to set realistic expectations for patients as results can vary. A full oral exam looking at tooth anatomy, any calcifications, the patient's age, the condition of their dentition, their oral hygiene and lifestyle factors will help to best advise patients on which treatments would be suitable for them. Teeth with yellow and brown stains will achieve greater success when it comes to whitening, while those with grey shading from tetracycline or other medications may experience little to no results.

A few lifestyle changes can also make an enormous difference. Encouraging patients to give up smoking, cut down on alcohol and use a straw when consuming acidic drinks are all effective in reducing staining. I also like to warn patients against using chlorhexidine-based mouthwash without instruction from a dental professional as this could be the cause of their discolouration.

My top five tips

So, what is the secret to maintaining a healthy, bright, white smile? Here are the top five tips I provide my patients:

1. Invest in an electric toothbrush and brush twice a day with a fluoridated toothpaste, and be sure to include some form of cleaning in between the teeth, either with floss or inter-dental brushes.
2. Have regular dental and hygiene appointments. Visit the dentist at least once a year and the hygienist a minimum of twice a year to keep teeth healthy and gleaming.
3. Use a straw for drinks and try and rinse your mouth with water after consuming dark-coloured foods and drinks. Keep acids and sugars to meal times only, and aim for no more than three to four sugary/acidic snacks per day.
4. Chewing gum is not just for freshening breath. Sugar-free gum increases salivary flow, which can neutralise plaque acids, help remove food debris, strengthen teeth and reduce dry mouth. I suggest opting for chewing gums with Xylitol as an ingredient, as it can help fight tooth decay too.
5. Make lifestyle changes – quit smoking or cut back on the red wine and coffee. Your body will thank you and so will your teeth!

Did you see *A clearer future for tooth whitening* by Karen Coates? Karen discussed the latest developments surrounding the ever-evolving battle against illegal tooth whiteners: https://www.nature.com/articles/bdjteam2015109

bdjteam2017175

CPD: ONE HOUR

Trauma-informed, *sensitive practice*

Linda M. Douglas[1] explains how to provide 'The Umbrella of Safety' for patients with dental phobia.

I was inspired to write this article after hearing comments from exasperated colleagues about our more challenging patients. For example: angry, or seemingly apathetic individuals; those who refuse to be reclined in the chair when there is no obvious physical impediment; irregular attenders; and those with poor self-care. These behaviours might be a result of mental health issues, like dental phobia. Since reading *The handbook on sensitive practice for healthcare practitioners: Lessons from adult survivors of sexual abuse*,[1] and literature on trauma-informed practice,[2] I gained some insight into what might be happening with these individuals, and now feel more empathy.

Dental phobia is classified as a specific phobia within the *Diagnostic and statistical manual of mental disorders*.[3] Dental phobias might be a consequence of negative experiences with childhood dental care: for example, some individuals might have suffered from childhood neglect, resulting in frequent dental pain. In the past, many indigenous children in Canadian residential or Indian day schools endured non-consensual dental treatment, and extractions without local anaesthesia.[4]

Others with dental phobia might have a history of being childhood victims of violence, or sexual abuse. Survivors of abuse have experienced violation of their personal boundaries. They have been traumatised, betrayed, and are often stigmatised, and made to feel powerless. Childhood sexual

CPD questions

This article has four CPD questions attached to it which will earn you one hour of verifiable CPD. To access the ***free*** *BDA CPD hub, go to* ***http://bit.ly/2e3G0sv***

[1] *Linda Douglas, RDH, BSc, is a British dental hygienist based in Ontario, Canada. Linda has previously written for* BDJ Team *on caring for dental patients with eating disorders (http://go.nature.com/2fKzNaF) and making oral cancer screening a routine part of your patient care (http://go.nature.com/2xvO8e0 and (http://go.nature.com/2xuCrJk).*

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abuse, particularly of young children may also be oral in nature, causing many survivors to experience difficulties tolerating various aspects of oral healthcare.

Factors causing irregular attendance

A history of trauma or abuse could lead to depression or low self-esteem, and feeling unworthy of proper health care. Patients might also have an aversion to being touched, and having their personal space invaded. Certain aspects of a dental visit might trigger flashbacks, making such patients feel abused all over again. This can manifest as distrust, anxiety, hypersensitivity, irritability and a tendency to startle easily; some individuals also display anger, or aggression. Triggers vary considerably: from sights, sounds and smells, to something about a clinician's appearance which reminds a survivor of their abuser. For example, the view of the ceiling while lying in the dental chair could be a trigger, which reminds the survivor of the position they were forced into while being abused.

Some victims of abuse cope with the violation of their body or personal space by entering a dissociative state, in order to detach themselves from the abuse they are powerless to fight off. In this state, they experience altered perception, sensation and sense of time. These individuals have also learned to ignore or dissociate from pain, which could lead survivors to ignore symptoms of disease and delay seeking help, thus delaying an accurate diagnosis.

'A HISTORY OF TRAUMA OR ABUSE COULD LEAD TO DEPRESSION OR LOW SELF-ESTEEM, AND FEELING UNWORTHY OF PROPER HEALTH CARE. PATIENTS MIGHT ALSO HAVE AN AVERSION TO BEING TOUCHED, AND HAVING THEIR PERSONAL SPACE INVADED.'

Prevalence of childhood abuse

The incidence of child abuse, especially sexual abuse, is under-reported because the victims are usually coerced into secrecy with threats of harm; many survivors maintain this secrecy into adulthood, partly out of shame. A 2003 study found that 32.3% of women and 14. 2% of men reported sexual abuse in childhood, and 21% of adults who reported histories of childhood sexual abuse also experienced other physical maltreatment.[5] Research has shown that child abuse occurs in all countries studied,[6] and is not limited by ethnicity or socio-economic status. Children with disabilities are more likely to be abused than children without disabilities.[7] Studies suggest that sexual abuse of male children by adult females occurs more frequently than was previously thought. Sadly, this is often taken lightly, as an experience any boy should be glad to have, when they experience as much violation and trauma as female survivors.

Factors which compromise self-care

Survivors of sexual abuse are often stigmatised, feeling hate, shame and guilt about their bodies that can lead to a distorted sense of self, and low self-esteem. This could contribute to a failure to care for oneself: manifesting as risky behaviours, self-harm, poor health practices, and poor hygiene.

Survivors who became dissociative during episodes of abuse might continue to dissociate whenever they are under stress. If they are stressed during their visits for dental care, they might appear to be apathetic.

How can we help?

Understanding how these factors affect our patients is termed trauma-informed practice.

These nine Principles of Sensitive Practice form the framework of The Umbrella of Safety, and facilitate feelings of safety for our patients:

1. **Respect:** this means acknowledging the inherent value of each individual, and suspending critical judgement. Respect means a great deal to survivors of abuse; we can show respect by listening to the patient, and heeding their concerns. This helps to foster trust.
2. **Taking time:** making the patient feel genuinely heard and not rushed.
3. **Rapport:** display caring, concern and empathy; use active listening techniques.
4. **Sharing information:** being transparent, by informing patients of their choices so they can give us their informed consent. They also need to know what to expect during their treatment, and the rationale and length of time needed for each procedure. Follow up verbal oral health counselling with written materials.

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5. **Sharing control:** Helping the patient to feel a sense of control during treatment by working *with*, not just *on* the patient addresses abuse-related fears and facilitates compliance. We should ask them what they can tolerate. In addition to obtaining informed consent before a procedure, we should reaffirm consent at different stages of the appointment. The patient should be assured that they can stop for a break at any time, and that they can indicate if they are not comfortable by communicating with previously agreed hand signals.
6. **Respecting boundaries:** the total disregard of personal boundaries during abuse teaches victims that their wants and needs are of no consequence. We should ask for consent before entering the patient's personal space, as well as before beginning a procedure.
7. **Fostering mutual learning**: survivors of trauma have often learned not to question professionals, and may need encouragement to assert their autonomy and participate fully in their own health care. We clinicians can also learn from our patients how best to manage their care.
8. **Understanding non-linear healing:** the ability of the patient to tolerate examination and treatment might vary from one visit to the next, as they experience good days, and bad days.
9. **Demonstrating awareness and knowledge of interpersonal violence:** we can do this by having educational brochures on this topic in the dental practice; this also shows survivors they are not alone, and helps them to feel more comfortable about disclosing their history to us.
10. If a patient chooses to disclose their history to us, we must ensure that he or she is comfortable with how we record their history in our notes, and whether they want other healthcare providers to be informed also.

Oral health counselling for survivors

We mean well, but tend to couch our health education in negative terms, by warning patients of the dire consequences of not following our advice, rather than focusing on the positive results they can achieve by improving their self-care. Knowledge alone is usually not sufficient to motivate change within a patient; empathy, open-ended questions, and active listening on our part are necessary to facilitate change. Motivational interviewing[8] integrates well with the principles of sensitive practice, because it is a collaborative, non-judgmental, and non-confrontational technique that fosters patient autonomy; we are in partnership with our patient.

'HELPING THE PATIENT TO FEEL A SENSE OF CONTROL DURING TREATMENT BY WORKING WITH, NOT JUST ON THE PATIENT ADDRESSES ABUSE-RELATED FEARS AND FACILITATES COMPLIANCE.'

Active listening techniques include open-ended questions, to encourage patients to do most of the talking, affirmations to validate their feelings, reflective listening and summarising to show that we respect what the patient has to say, and show that we have been listening carefully. The desire for improved health, and the motivation to change comes from the patient, and is therefore more lasting and effective.

Conclusion

Child abuse, especially sexual abuse is under-reported; less than half of survivors disclose their experiences to anyone; therefore dental health professionals cannot always be aware of which patients are survivors of abuse. For this reason, implementation of the principles of sensitive practice, and trauma-informed practice should be the standard of care for all of our patients.

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bdjteam2017176

Service quality in dentistry: *the role of the dental nurse*

This *From the archive* article by **M.T. Mindak** was originally published in the *BDJ* on 23 November 1996 (**181:** 363-368). Were dental nurses well motivated and satisfied with their roles 21 years ago? Did dentists' and dental nurses' perceptions of the dental nurse's role differ? Was there good communication within dental teams? Read on and see how 1995/6 compares to your experience in 2017.

Patients judge the dental service they receive by the interaction with the service providers - the dentist and his or her staff - as they are unable to judge the technical quality of the service. To perform well as a service provider, employees such as dental nurses have to be well motivated and satisfied with their position. A study of the role of the dental nurse in contributing to service quality in dentistry was carried out through interviews with dentists and nurses at 20 dental practices in the South Thames region in 1995. The results revealed that while dental staff believed that the role of the dental nurse was important in terms of the patient's view of the practice, perceptions of the nurse's role differed. The majority of dentists felt that the nurse's role should be to anticipate their needs, while the nurses' opinions were evenly divided between putting the needs of the patient first or those of the dentist. Nurses also felt that their role was stressful and reported a lack of praise and recognition of their efforts by dentists. Few practices had written contracts or performance appraisals. The results indicated a lack of effective communication in many dental practices, producing role strain for the nurse and reducing job satisfaction. Increasing job satisfaction reduces staff turnover, resulting in more consistent service quality and reducing associated costs. In order to achieve this, several recommendations are made with the aim of improving communication between staff in dental practices.

The actions of health care representatives play a critical role in the public perception of any health care service. The provision of dental treatment provides a good example of this as a patient cannot judge the technical aspects of dentistry and so will judge the quality of the service provided by the quality of the interaction with the service providers - the dentist and his or her staff.

The dental nurse is an essential member of the dental team. The dentist and dental nurse need to have a clear understanding of their working relationship and the factors that affect it, in order to be effective in the process of service delivery. The importance of an effective interaction between dentist and dental nurse is further highlighted by the fact that there is a possibility, albeit rare, of that interaction working to save the life of a patient who has been taken ill during treatment.

The real benefit, however, in developing an improved working relationship between dentist and nurse, is in creating a more harmonious working environment. This, in turn, produces a more pleasant, friendly atmosphere for the patient, who perceives an improvement in the quality of service. As a result, the patient is more likely to stay with the practice and recommend it to friends and family.

There is a high turnover of dental staff.[1] This causes problems in delivering consistent service quality due to the disruption of routine for the dentist and loss of relationship continuity for patients when a staff member leaves. There is also the expense and time required to recruit and train a new member of staff. It is useful, therefore, to know what factors affect this turnover in order to try to reduce it. The aim of this study was to examine aspects of the role of the nurse in order to provide recommendations for reducing staff turnover and improving service quality in dental practices.

Materials and methods

A study was conducted by means of a series of qualitative interviews with dentists and nurses at 22 practices selected from the South Thames Health Authority region. Qualitative research was deemed to be the most appropriate

method as the study was to be exploratory in nature, to ascertain general themes, which required a more flexible approach than would be possible by a standardised structured questionnaire.

It was decided to select 11 NHS practices and 11 private practices for the purposes of the study. The practices were chosen from three FHSAs from within the South Thames Health Authority region: Lambeth, Southwark and Lewisham FHSA, Bromley FHSA and Bexley and Greenwich FHSA. One hundred dental practices were initially selected, 50 practices from the NHS and 50 private practices.

Each practice was contacted by letter detailing the nature of the research. They were each then telephoned and asked if they wished to participate. Many practices did not wish to participate or else stated that the dates during which the study was being held (June to August 1995) were not convenient. The final sample of 22 practices (11 NHS and 11 private) was therefore, in part, self-selected.

The only selection criteria applied by the author were those of the practice being in one of the three FHSA areas, that the practice agreed to participate and that the interviewees consisted of one dentist and his or her own dental nurse and not a nurse who routinely worked with a colleague.

Pilot interviews were carried out at two additional dental practices in the London area to clarify the nature of the questions to be asked in the main study interviews. The main study interviews were conducted at the dental practices during July and August 1995. The vast majority took place during the practice lunch break and consisted of individual semi-structured interviews of approximately 20 to 30 minutes.

The interviewer first asked general closed questions regarding qualifications, hours worked and so on and then asked open-ended questions regarding the role of the dental nurse. Two sets of questions were used for the interview frameworks - one for the dentists and one for the dental nurses, but both followed the pattern of closed followed by open-ended questions. The interviews were conducted face-to-face with the author who travelled to each practice.

> ***'THE VAST MAJORITY OF THE DENTISTS VIEWED THE ROLE OF THE DENTAL NURSE PRINCIPALLY TO BE ANTICIPATING THE DENTIST'S NEEDS: HAVING INSTRUMENTS READY, THE SURGERY CLEAN AND SO ON.'***

The dentist and his or her nurse were interviewed separately and encouraged to speak freely, being assured that the other members of the practice would not be informed of any comments made. All interviews were tape-recorded with individuals being informed of this prior to the interview and consent obtained. The taped interviews were then transcribed for analysis. Recurring themes and topics were then grouped together to produce the results.

Quantitative results

One dentist and his or her dental nurse were interviewed at each practice, a total of 40 individual interviews out of a possible 44. The results from two practices, ie four interviews, were deemed unsuitable for inclusion in the study. The reasons for this were that for one practice there was a mechanical fault with the tape recorder resulting in only half the interview being recorded, and in the other practice, the dentist concerned declined to continue with the interview and did not wish to answer the questions. This left a final sample of 20 practices - 10 NHS and 10 private.

Characteristics of the sample: dentists

AGE AND GENDER

The age range of dentists was from 27 to 58 years, with the majority between 30 and 40 years old. Four of the 20 dentists were female.

DATE OF DENTAL QUALIFICATION

The date of the dental qualification was naturally correlated with age and ranged from 1963 to 1991. Ten of the UK's 16 dental schools were represented, from all parts of the country. Two respondents had trained abroad - Nigeria and India.

TIME AT CURRENT PRACTICE

Time at current practice ranged from 11 months to 32 years, with 12 respondents being at the practice for more than two years. The majority of respondents were the practice owner and would therefore be expected to remain at the practice.

NUMBER OF STAFF AT THE PRACTICE

The number of staff was calculated to include part time staff as well as full time. The range was from two, where the nurse was also the full time receptionist (three practices), to one practice of 24 staff. The majority had four to six staff.

NUMBER OF PATIENTS SEEN PER DENTIST PER DAY

For NHS practices, this ranged from 18 patients (in two newly established practices) to around 40. The vast majority were in the range 25-30. In private practices the figures were rather lower; the range was 10-25, with most being around 15.

Characteristics of the sample: nurses

AGE

The range was from 16 to 57 years old. Two were over 50, three in their 40s and the remainder 39 or under. Two were teenagers. The average age of nurses in private practice was around nine years older (35 years) than that for NHS practices (26 years).

LENGTH OF TIME WORKED AS A DENTAL NURSE

This varied from eight months to, in one case, 39 years (the nurse having left school at 14).

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The sample was fairly evenly split between those who had worked as a nurse for 10 years or less and those who had worked as a nurse for more than 10 years.

TIME AT CURRENT PRACTICE

For NHS practices, this ranged from two days to six years. Seven out of 10 nurses had been at the practice for two years or less. In private practice, the range was from 10 months to 15 years. Five nurses had been at the practice for two years or less and the other five for two years or more.

DENTAL NURSING CERTIFICATE

Six out of 20 nurses had a qualification, five in private practice and one in the NHS. Two further nurses in the NHS had taken the exam and failed, but did not intend to retake it. Two nurses in private practices were currently on the training course.

Qualitative results

All those involved in the study agreed that the role of the dental nurse was very important in terms of how the patient viewed the practice. The nurse was seen to be the patients' confidante and provided reassurance:

'It's always you they will ask' (nurse aged 25, private practice)

'If they've got a problem, I talk to them because at times they don't want to talk to the dentist, so they talk to me and I can pass the message on to the dentist' (nurse aged 30, NHS practice)

The study also produced other findings that can be grouped into three areas:

1. A difference in perceptions of the role of the dental nurse between nurses and dentists.
2. The lack of appreciation and acknowledgement of nurses' efforts by dentists, as felt by nurses.
3. The lack of formalisation of the nurse's role in terms of written contracts or performance appraisal and the lack of regular staff meetings.

The difference in perceptions of the nurse's role

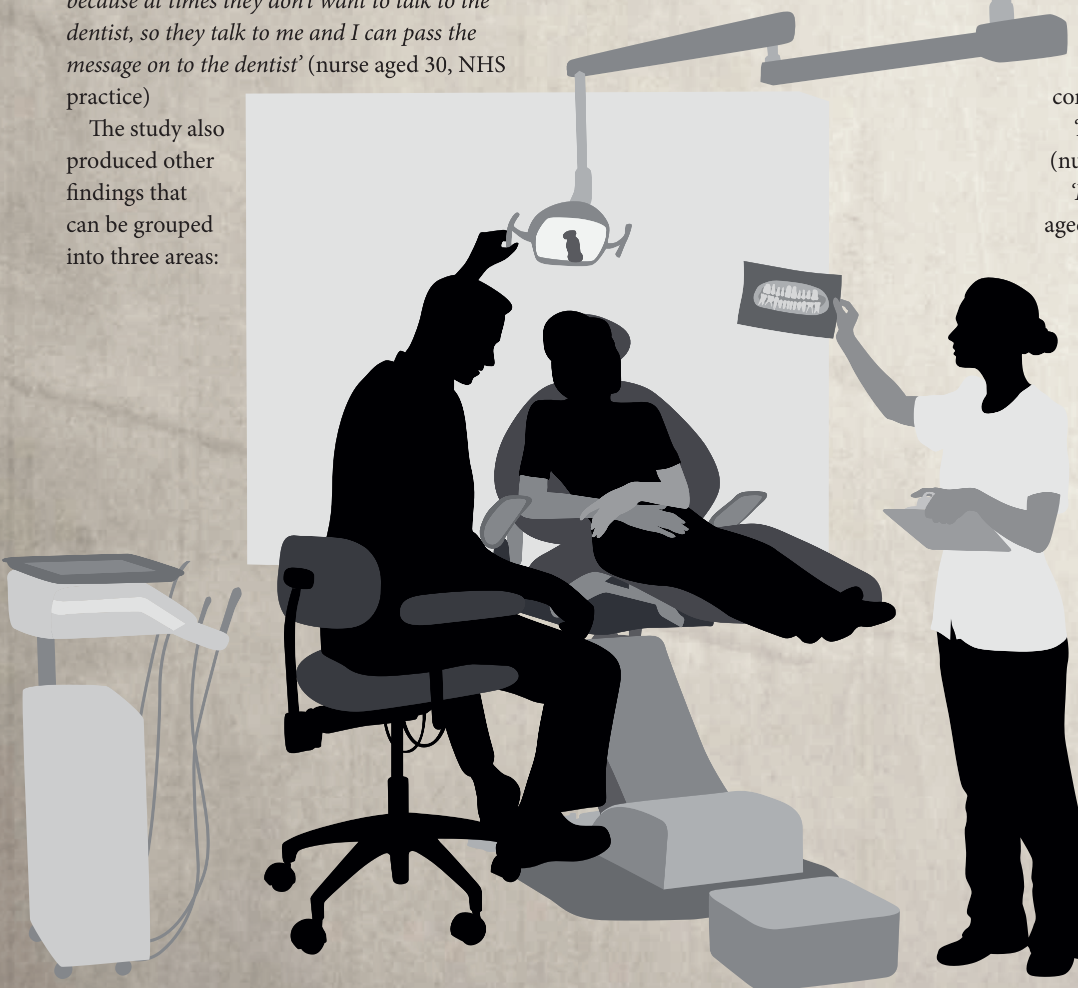
THE DENTISTS' VIEW

The vast majority of the dentists (18 of 20) viewed the role of the dental nurse principally to be anticipating the dentist's needs: having instruments ready, the surgery clean and so on. They wanted the nurse to be able to think ahead for them:

'You get to a stage where she's got it ready before you say anything and then when you get one stage further, you can ask for the wrong things and get the right things' (male dentist aged 47, private practice)

Dentists felt that reliability was very important in fulfilling the nurse's role:

'I've had situations where after being her for three or four months a nurse has taken her pay cheque on the Friday and then not come in on the Monday, without telling me that they're not coming back' (dentist aged 31, NHS practice)



Many of the dentists, 12 of 20, expressed a preference for older nurses rather than teenagers, and for those who had gained previous experience, saying that they found younger staff to be far less reliable in terms of timekeeping and attendance:

'If I had a choice of someone to employ, I would happily go for someone in their late 20s onwards with children. We've found that with younger women, their attendance can be distinctly "iffy" and the merest sniffle, they're off' (dentist aged 39, private practice)

Dentists also felt that an empathetic and cheerful personality was important, not just for patients' sake, but also for their own morale. All dentists said that an efficient and friendly nurse acted to greatly reduce the day to day stress of practice:

'If you've got a very close relationship with that person (the dental nurse) for eight hours a day and if they're not happy it can drain on you and affect the relationship with the patient' (female dentist aged 30, NHS practice)

'My stress level goes up enormously if she isn't working with me ... she makes life a lot easier without a doubt' (male dentist aged 35, private practice)

THE NURSES' VIEW OF THEIR ROLE

In contrast to the dentists, dental nurses were divided as to their principal role: 10 nurses clearly stated that the patient was their first priority, while the other 10 said that the dentist's needs come first.

'My role is actually thinking for the dentist' (nurse aged 30, NHS practice)

'I think for him, I'm one step ahead' (nurse aged 31 private practice)

'To help the patient feel as relaxed as possible' (nurse aged 18, NHS practice)

'Primarily, to make sure the patients feel comfortable and welcome' (nurse aged 43, private practice)

Nurses also said that they saw a major part of their role to be acting as an intermediary between dentists and patients and that this could be very stressful. They said that patients saw them as representing the practice and would want explanations as to why an appointment was late, for example, while the dentists would be telling them to go out and keep the patient calm:

'They (patients) quite often treat the nurse very differently to the dentist ... the patients have a real moan and then go into the surgery and be as nice as pie and you think "oooh"!' (nurse aged 22, private practice)

The lack of appreciation

Many nurses, 11 of 20, reported problems in communicating with dentists. Areas of concern were principally the lack of definition of the nurses' role by dentists and lack of appreciation by dentists for the nurses' efforts. Nurses reported being given little instruction when joining a practice and were often expected to know what to do in the surgery:

'He just expected everything there without telling you or asking you. Me sitting there not doing it because I don't know what he needs and him probably thinking, "Oh she's just sitting there", but it's not, it's because he's not actually explained what he needs and therefore I can't mix it when I don't know' (nurse aged 24, NHS practice, describing life as a trainee at 17)

Most nurses, 14 of 20, reported being spoken to in a derogatory manner, which they felt indicated a lack of respect. This got worse when the dentist was under stress. Many understood that dentistry was stressful and wanted to help the dentist, but still wished to be spoken to courteously.

'MOST NURSES, 14 OF 20, REPORTED BEING SPOKEN TO IN A DEROGATORY MANNER, WHICH THEY FELT INDICATED A LACK OF RESPECT. THIS GOT WORSE WHEN THE DENTIST WAS UNDER STRESS.'

'He was very rude, he used to swear at you and abuse you if you did things wrong' (nurse aged 31, private practice)

'I was a trainee and he was just very impatient and used to be sarcastic in front of patients and I didn't like that because it made me look stupid' (nurse aged 22, private practice)

Some dentists apparently coped with stress in unusual ways:

'There was one guy, if he didn't like things or things didn't go his way or he couldn't get a matrix band on, he'd throw tweezers at your ankles ... It wasn't anything to do with the nurses, it was just his own pure frustration, but he was quite well known for it' (nurse aged 43, private practice)

Dental nurses wanted their efforts recognised and acknowledged by the dentist and felt that this rarely occurred. When this did happen, it was much appreciated and was felt to contribute to a more pleasant atmosphere in the practice, which, nurses said, was noticed by the patients:

'If the dentist appreciates what the nurse is doing, then the nurse gives her best to the dental surgeon. You've got to work as a team ... if you work as a team and you can be friends then the patient gets so much more out of that because the atmosphere is so different. I think a patient can feel an atmosphere when they go into a surgery. If they feel a good atmosphere, then they get good vibrations and they relax more' (nurse aged 44, NHS practice)

A nurse with 24 years' experience said of her employer, a dentist aged 39, in private practice:

'I think really a dentist should include their nurse in the work or they can make them feel just like the washer-upper and I feel very included here ... he's terrific, absolutely terrific. This dentist will at the end of the day say "thank you". That's not usual, normally they're tools down and gone and leave you to clear up'.

Some dentists said they found managing staff difficult, especially in the first years of practice. Three of the four female dentists felt that the task was harder as a woman than for a man. Their nurses felt that female dentists were more sensitive in dealing with staff and would help the nurse more than a male dentist would.

RESPONSIBILITY AND EXPANSION OF THE ROLE OF THE DENTAL NURSE

At present, the role of the dental nurse is limited in terms of direct clinical interaction with the patient, in contrast to other countries such as the USA and New Zealand. Dentists and nurses were asked their views on the possible expansion of the nurse's role, as considered in the Nuffield Report.[2]

Most dentists, 11 of 17 (three did not respond), were not in favour of the dental nurse taking on any clinical duties, apart from taking radiographs. Many did not see any real benefit of the nurse undertaking these tasks and expressed concern about the level of training for nurses that would be necessary to ensure patient safety. The majority of nurses however, expressed a desire to expand their role and mentioned the lack of a career path. Several nurses mentioned that being given responsibility made their job more enjoyable:

'Having the responsibility brings our your best qualities because everybody's got a forte at something' (nurse aged 31, private practice)

Six of the 20 had a dental nursing qualification, and five of these were in private practice. Many expressed a desire to expand their role with the patient and said they felt frustrated at not being able to do more in the surgery. Five of the 20 interviewed had made a definite decision to obtain further qualifications towards that end and had registered to train as a hygienist (1), dental therapist (2) oral health educator (1) and general medical nurse (1).

SALARY

Four of the 20 nurses brought up the subject of their salary. They felt it was far too low for the job and felt unappreciated as a result. One nurse said:

'You are risking yourself as much as dentists, with AIDS and all that, and their pay is good ... that makes me sick ... they sort themselves out and forget the nurses' (nurse aged 24, NHS practice)

Some dentists seemed to be unaware of just how sensitive an issue this was. Nurses in private practice, not surprisingly, reported being paid more than in NHS practices and had left NHS practices as a result. Some private dentists said that they felt higher salaries to be a worthwhile investment to attract good staff.

The lack of a formalised role

WRITTEN CONTRACTS AND STAFF APPRAISAL

Only five practices in the survey had a written contract for staff and only one carried out a formal staff appraisal. Nurses said that they would welcome a regular appraisal of their performance, as some had just occasional comments made to them. Several complained of being readily criticised if they made a mistake, yet never praised when they performed well.

PRACTICE MEETINGS

Similarly, only five practices held practice meetings on a regular basis, while a few more held them on an occasional basis. The practices that did currently hold meetings found them to be valuable aids to communication and staff participation. Some nurses however, felt that little was achieved by meetings: they had attended them in the past

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and said that little attention was paid to their opinions or suggestions. In a lot of practices, both dentists and nurses did not see any need for meetings at all.

Discussion

The results of the study should be interpreted with caution as this was a small and self-selecting sample. Nonetheless, several of the findings are relevant to dental practice management. It was evident from the study that there are problems in communication between the dentist and the dental nurse in many dental practices. These problems were manifested in the different perceptions as to what the role for the nurse actually entailed, in the way the required role was explained, the lack of written job descriptions, coupled with little positive feedback or appraisal, and a derogatory manner used in addressing the nurse. In addition, very few practices provided an opportunity for the nurse to raise problems, make suggestions or participate in decision making, by means of mechanisms such as a regular practice meeting. The lack of management skills training for dentists may well be a contributory factor here. These findings confirm previous research that has been carried out into job related for the dental nurse.

Table 1 Achieving better communication

- The aim should be to give praise and encouragement to staff straight away, even for a small effort, as it will be appreciated.
- The dentist should hold an informal conversation with their dental nurse to discuss her role and any areas of the working relationship that may be causing concern. This is an ideal situation in which to use active listening. The aim should be to stress how important her role is in terms of the patient's perception of the practice.
- To deal with behaviour that needs to be changed, the dentist should discuss with the nurse why it is necessary to change and how it should be changed. This should be done in a positive way by giving encouragement and praise, and setting realistic goals.

Table 2 The practice meeting

- A practice meeting with all staff should be conducted to discuss improving communication in the practice. Participation with ideas and suggestions should be encouraged.
- Regular practice meetings should be established thereafter, for example, once a fortnight, as an opportunity for staff to discuss problems and contribute ideas for managing the practice.
- To deal with behaviour that needs to be changed, the dentist should discuss with the nurse why it is necessary to change and how it should be changed. This should be done in a positive way by giving encouragement and praise, and setting realistic goals.

'SOME PRIVATE DENTISTS SAID THAT THEY FELT HIGHER SALARIES TO BE A WORTHWHILE INVESTMENT TO ATTRACT GOOD STAFF.'

The consequences of poor communication

A lack of communication between and employer and employee results in several negative outcomes which researchers have found affect job satisfaction.[6,7] Two principal ones are role ambiguity and role conflict. Role ambiguity occurs where a role has not been clearly defined and responsibilities are ambiguous, as was clearly felt by the nurses in the study. Role conflict occurs when the employee is expected to carry out contradictory tasks, such as trying to please both patient and dentist. The stress nurses mentioned at being the 'intermediary' is well recognised in the literature, this position being described as the 'boundary-spanning' role ie the boundary between the organisation and the customer. Such roles have been associated with high degrees of stress for employees.[7]

These factors result in role strain, which has been shown to decrease job satisfaction. Dentists stated that the main problems they had with dental nurses were poor timekeeping and absenteeism. Both these behaviours have been shown to be symptomatic of reduced job satisfaction.

Staff turnover

A reduction in job satisfaction is directly related to the employee's tendency to leave the organisation.[9] It is known that dental nurses have a high employment turnover, with the resultant increased costs and inconsistency of service quality for the dental practice as previously mentioned. Turnover of staff adversely affects the consumer's perception of the service, with the result that they will go elsewhere. So in order to provide and maintain service quality in the eyes of the consumer (the patient) staff turnover is to be avoided.

The results of this study show that a lack of communication between dentist and nurse could well be contributing to the high turnover rate. In order to reduce turnover of dental nurses and increase job satisfaction, positive steps should be taken to improve communication.

Recommendations

The process of good communication involves the processes of active listening - concentrating on exactly what a person is saying, not jumping to conclusions or assumptions; feedback on how the role was performed helps to clarify discussion and self-disclosure - an atmosphere of trust and openness should be established so that staff feel able to make comments and suggestions.[10]

Many of the suggestions made below are not new.[11-16] However, this survey shows that they are still relevant and that improving communication is still necessary for many dental practices. Several of these improvements can be made immediately and the majority can be implemented at little or no financial cost.

Immediate changes in the dental practice

To make changes towards improving communication in the dental practice work, it is best to start with small and simple things that are easy to implement and are likely to succeed. Early success will encourage staff and reinforce the new approach.

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Table 3 Further clarify roles by written descriptions
■ Provide written contracts/job descriptions for all existing and new staff.
■ When interviewing for new staff, ensure that the description of the expected role is accurate and detailed, so that new employees have realistic expectations of the role.

Table 4 Build in praise and recognition by:
■ Conducting regular formal staff performance reviews eg two or three times a year.
■ Implementing an annual salary review - consider an increase/bonus system.

Table 5 Training and delegation
■ Invest in training for all staff. Establish in which areas individuals would like to obtain more skills. Consider courses for the practice as a whole, such as in interpersonal and team-building skills.
■ Consider areas in the practice for which individual staff can be solely responsible, and delegate appropriate tasks and responsibilities (after ensuring that they have the necessary information and training to carry them out).
■ Build a sense of identity with the practice: consider formal job titles, uniforms and business cards.

ACHIEVING BETTER COMMUNICATION

Praise and recognition are powerful 'motivators'. These are therefore ideal areas with which to start (Tables 1-5).

THE PRACTICE MEETING

Efforts to improve communication in the practice should involve all the staff, not just the nurse, and the suggestions below are relevant for all staff. In addition, practice meetings are a valuable tool.

Changes in the medium term

The initial approaches will start to improve communication in the practice and can be reinforced over the following few months by further measures - further clarify roles by written descriptions, build in praise and recognition and build up an atmosphere of trust by training and delegation.

Long term changes - recommendations for the profession

As we can see, these are relatively simply changes that can be carried out in a short period of time. However, for the profession as a whole, there remains the issue of training for both dentists and nurses which needs to take into account communication and interpersonal skills, which, as the study showed, are so necessary. In addition, the recommendations in the Nuffield Report[2] regarding the training of dental nurses, ie the introduction of a national training standard and statutory minimum qualification, should be implemented as soon as possible. A better career structure for dental nurses will act to retain and motivate staff, raise standards of care, improve service quality and thereby the patients' view of the practice.

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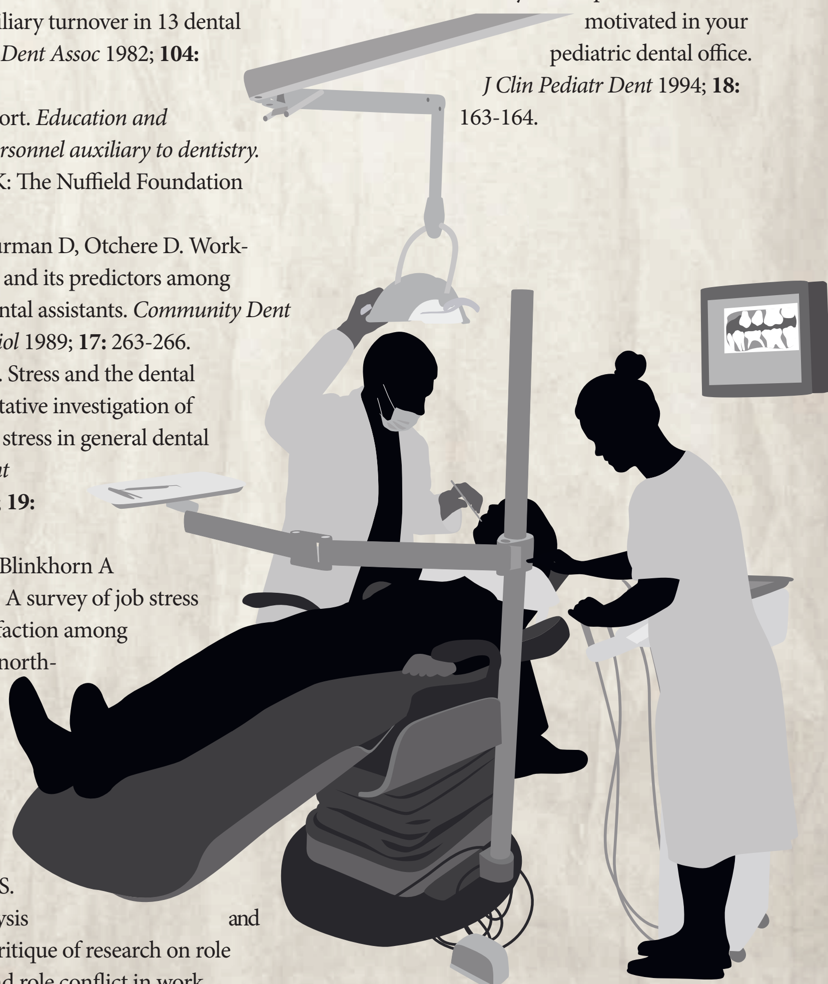

bdjteam2017177

Focus on **dental practice managers**

Lisa Bainham, President of the Association of Dental Administrators and Managers (ADAM), considers the current concerns of dental practice managers, and how the role of the dental practice manager has evolved over the years.

Current concerns

Dental practice managers (DPMs) need broad shoulders. The days of a DPM being a receptionist who did the cashing up and staff rotas are over. Today's successful dental practice needs a dedicated team with an effective DPM at the heart of it.

But what are the major issues that are landing on DPMs' desks across the UK? Having surveyed the Association of Dental Administrators and Managers (ADAM) membership, here are our top five:

1 CQC/Regulation. Far and away the dominant issue affecting DPMs and their practices today. Quotes included:

'Definitely the ever changing and increasing regulations; whilst there are compliance packages available, we shouldn't need to be buying in further help. Some of the compliance companies are also fuelling the system by adding in all sorts of unnecessary policies and protocols. It is becoming very difficult to know what is actually required, and what is totally over the top. One CQC inspector will interpret things one way, and another will have a different opinion. I understand that they are trying to be more standardised in how they inspect, but there are still far too many variants out there for anyone to tick all the boxes.'

'It's hard to keep up with changes and regulation; there are not enough hours in the day. You tend to be buried in paperwork, when you should be available to deal with staff and patients and to let them know you are there for them.'

'The other problem is the new CQC inspections on the KLOEs [Key Lines of Enquiries] – is the practice well led? To an extent yes, it is as all governance, health and safety, information governance to name just a few are complete, but as the principal is the registered manager and doesn't invest in the practice or staff, this affects the outcomes of some of the CQC requirements. Whereas I can identify the learning needs of the staff, the principal will not pay for any training other than CPR/medical emergencies. So I am not in a position to support the staff to meet the requirements of the registration.'

'...keeping up with regulations and CQC requirement is quite stressful.'

2 Staff – recruitment of the right team members

'I think the biggest concern at the moment is the lack of qualified and experienced dentists and dental nurses who want to work in an NHS practice that is open 8-8, which is how our site operates. Even though we offer modern facilities and have a very good, qualified support team, if someone leaves, we have been finding it extremely difficult to recruit these two key roles for about two years now. Even securing a locum dentist who wants to work these hours has proved almost impossible.

'I hear anecdotally from colleagues that many dentists are choosing to work outside the NHS, even after completing their VT, which makes one concerned for the longterm future of NHS dentistry.'

'Recruiting qualified nurses is becoming harder. I have been advertising for months and no interviews.'

'Recruiting experienced dentists is a constant struggle – there are very few applying for jobs. My worry is after Brexit this will become even more difficult as most of our dentists are Europeans.'

> *'WITH THE COST OF GDC, INDEMNITY AND DBS (WHICH STAFF HAVE TO PAY THEMSELVES) STAFF ARE NOW STARTING TO LEAVE AND GO INTO JOBS IN SUPERMARKETS ETC AS THE PAY IS HIGHER...'*

3 Tendering and LATs

'The subject of tendering has now come up as although we are told by our health board it will just be reviewed like the end of previous contract times, we cannot assume. This may change and we may have to tender for our large orthodontic contract.'

'E-referral systems are being set up now throughout England for minor oral surgery and orthodontics with us in September 2017. We are an orthodontic practice but we also have a paper referral waiting list. The Local Area Team (LAT) are asking us to add all of these onto the e-referral system as well as still using our own software - double the work and to what end? The LAT don't really know yet. The LAT get audit figures from the BSA already. All very annoying!'

4 The economy. This was a particular worry of those who had a small or no NHS commitment

'We are an independent non-NHS practice in a market town. If the economy does worsen that will have an effect on our patients' ability to pay for treatment; recruiting new patients is always something which we worry about.'

5 Staff – retaining the right team members

'My current challenges are retaining staff and keeping them motivated. With the cost of GDC, Indemnity and DBS (which staff have to pay themselves) staff are now starting to leave and go into jobs in supermarkets etc as the pay is higher and there are no outgoing costs involved in doing your job and no outside bodies coming in and inspecting the way things are done.'

'In the 30 years we have been in dentistry, getting the right team together is the biggest issue. Finding that special person has always been a challenge! You do get what you PAY FOR!'

The evolution of dental practice managers

Looking back on almost 20 years' experience as a dental practice manager, never before has there been as much responsibility on the shoulders of practice managers, and now more than ever, they are finally getting the acknowledgement they deserve.

When I began as a DPM back in 1998 at the age of 19, the role could be quite basic and there was not the level of compliance or responsibility that comes with it now. In those days I learnt as I went along, and quite frankly from the many mistakes that I made.

There cannot be too many careers in which one is expected to be an HR Manager, Marketing Manager, Compliance Manager, Business Manager, to name just a few, whilst also being an approachable, occasional shoulder to cry on and not forgetting referee! The role needs to be carried out to the highest of standards, often without any formalised, additional training, other than core CPD.

However, it would be fair to say that the role has evolved at different rates in different practices. ADAM's 2017 Salary Survey demonstrated that there was a huge range of pay disparity that was often (although not always) dependent or linked to the scale of responsibility the DPM was working at. So, is this the fault of practice owners not understanding, or DPMs not asserting themselves and demanding the credit and pay that is due to them? Part of the problem for DPMs is not being aware of what they don't know, and then finding out where they can gain the training and skills to equip them in their roles. There are often no allowances for error, and certainly not in areas such as HR and Compliance where there are legal implications.

In my experience, the majority of DPMs are happy to take on a huge workload, but too often are also expected to be a receptionist one day and maybe a dental nurse the next in addition to their DPM roles and often without the reflection in remuneration. Many dentists are so busy treating patients (which is as it should be), that they sometimes don't realise the extent of the workload or the systems that are in place and being used by the whole team, to ensure the smooth running and success of their practice.

I would like to say that I don't believe there is a vast swathe of DPMs that are being undervalued, but for those grafting away and feeling overworked, under appreciated and underpaid, the quote, 'You get what you pay for' springs to mind.

Many of you may not know that Chris Barrow was involved with the British Dental Practice Managers' Association (BDPMA - ADAM's former name) in the 1990s. I caught up with him and asked for his take on the massive changes in the role of a dental practice manager over the last 20 years.

Chris Barrow: 'Back in 1997, when the BDPMA was representing the profession, I wonder what the reaction would have been if I had predicted that 20 years later the fully functioning practice manager would have to demonstrate leadership and management skills in:

- Financial monitoring and analysis
- Branding
- Direct marketing
- Digital marketing
- Patient relationship management
- Treatment co-ordination
- Post-treatment follow-up
- The patient experience
- Clinical governance
- Compliance
- The complete HR function.

'I also wonder what the reaction would be if I said the practices in which they work would include:

- Vast nationwide corporates with over 500 locations owned by healthcare insurers and financial institutions
- Rapidly growing sector of privately owned multiple location micro-corporates
- In-store dental chains owned by (or renting from) major high street retailers
- Economy, business and first-class environments
- The world in which they work being dominated by the Internet of Things, bringing a digital perspective to every aspect of their work
- That private dentistry in the UK would have grown from £1 billion to £5 billion a year of sales (and that the £2 billion NHS dental budget in 1997 would be £2 billion in 2017).

'A good practice manager is integral to the running of a successful practice. Indeed, John Milne, CQC's Senior National Dental Adviser, recently said at a CQC Reference Group Meeting that the CQC inspection programme, to date, has found that "a delegated and empowered practice manager is a key component of a well led practice".

'Considering that the majority of failed CQC inspections are in the area of the "well led" outcome, surely there is no better reason to not only look after your practice manager but delegate, empower and reflect this in their salaries based on responsibilities.'

Would anyone like to predict where we will be in 2037?!

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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.

NEW MINERALISING FLUORIDE-FREE TOOTHPASTE LAUNCHED

A new fluoride-free toothpaste, formulated to adhere to the tooth surface and slowly release calcium and phosphate ions, has been launched by BioMin Technologies.

BioMin C, which helps replace lost minerals from tooth surfaces, is designed for those who for a variety of reasons do not wish to use fluoride-containing products but still want to have the benefits of a protective toothpaste. It is also designed for those parts of the world where high levels of fluoride are naturally present in the water supply.

This launch follows the successful introduction of BioMin F – the slow release fluoride version – in April 2016 with BioMin C now being available through dental practices and online. The new toothpaste contains a patented calcium chloro-phosphosilicate that releases chloride ions as opposed to fluoride ions. Chloride ions are already present in all body fluids.

In addition to remineralising tooth surfaces, the new BioMin C toothpaste may help protect teeth, reduce sensitivity and diminish the risk of initial tooth decay.

BioMin C has been developed as a result of extensive research undertaken at Queen Mary University of London in recent years. Over 65% of BioMin F test evaluators suffering from tooth sensitivity reported a significant reduction in sensitivity and 15% claimed to be symptom free after two weeks of use.

BioMin F is now available in more than 13 countries. www.biomin.co.uk

ASSURED QUALITY MANAGEMENT SYSTEM

Being able to offer an assured quality management system is critical when dealing with medical devices, such as handpieces or small equipment products, and related repairs or services. For many years, B.A. International has been certified to ISO 13485:2008, the quality management system for medical devices. B.A. International is unique in offering full accountability for products and services provided, giving total peace of mind to all its customers.

Total Care Solutions means that one simple fixed monthly payment provides handpieces, maintenance and any potential repair. Total Care Solutions means not having to worry about anything relating to your handpieces whilst under contract.

Trusted Value Solutions offers handpieces and small equipment at incredible value and repairs at lowest possible prices. Complying with all regulations applicable to these medical devices is a given. Not only that, but B.A. stands behind any products offered for years to come. Trusted Value is the assurance of remaining risk free.

Twenty-four hours repair turnaround times, direct communication with the B.A. technician and repairs to any budget are all part of the B.A. International offering.

https://www.bainternational.co.uk

REVITALISE YOUR PATIENT DENTAL CHAIRS

Meditelle-Dental provides a professional onsite re-covering service to rejuvenate your dental patient chairs at your surgery.

This onsite service covers the whole of the UK and specialises in the re-upholstering of most makes and models of patient dental chairs. All procedures are carried out at your premises ensuring your equipment is not out of service for any length of time, minimising disruption and downtime. Flexible appointments and early time slots prior to opening are offered to work around your practice's schedule.

Meditelle's re-covering service will keep your patient chairs hygienic and ensure that the safety of your equipment is maintained. Re-upholstering may be all that's required if you have any scuffs, slits or tears in your dental chair vinyl that could present an infection control hazard.

Meditelle uses hydrophobic, anti-microbial medical grade vinyls which are MRSA and E-coli resistant and offered in a wide range of colours.

Offered in conjunction with this specialist service are the additional options of having a made-to-measure foot guard fitted and your operator stools re-covered to match your revitalised dental chair.

Obtaining a no-obligation quotation couldn't be easier, just email a full image of your chair front and back to Meditelle along with your postcode.

Telephone 0121 332 1850, email enquiry@meditelle.co.uk or visit www.meditelle-dental.co.uk.

A PARADIGM SHIFT IN STERILISATION

Metafix (UK) Ltd is introducing new technology to the British market for the sterilisation of dental instruments and handpieces, providing the shortest cycle times, simplicity of use and significant reduction in energy costs: six minutes - unwrapped instruments; eight minutes - unwrapped handpieces; 12 minutes - wrapped instruments and handpieces.

Unlike an autoclave, no steam or vacuum is required, so you can say goodbye to filling and draining the steriliser with costly deionised or RO water and no drying cycle or wet instruments.

The technology employed by the manufacturer CPAC Equipment Inc. uses High Velocity Hot Air (HVHA), a forced air heat exchange process that induces rapid air movement (up to 3000 ft/minute) at 190C to efficiently sterilise instruments. HVHA rapid sterilisation eliminates excessive heating - the prime cause of instrument damage.

HVHA technology enables longer instrument life, maintaining instrument sharpness with no dulling, pitting or corrosion caused by steam in autoclaving.

Load capacity for the Cox RapidHeat HVHA steriliser using double-decker cassettes is more than 200 instruments per hour and the all new HV-Pro11 has four times this capacity.

Contact Greg Jackson at Metafix on 01933 461907 or visit www.metafix.co.uk.

LEAVE BIOFILM DEAD IN THE WATER

For almost ten years, CleanCert has been providing dental practices and laboratories with effective and 'easy to use' infection control solutions.

CleanCert+ biofilm cleaner, for example, is a revolutionary one-stage waterline cleaner that is independently proven to be efficacious, as well as safe and simple to use. Used just once a week for five minutes (using reverse osmosis or distilled water the rest of the time) and priced at only £41 for a six-month supply for one dental chair, it offers incredible value and unrivalled safety (MSDS).

LabCert, meanwhile, is a powerful and highly effective ready-to-use disinfectant, which can be employed on all materials and appliances that are transferred between dental practices and laboratories, ensuring the wellbeing of staff and patients alike in all premises.

For further information on how to simplify your infection control HTM 01-05 'best practice' compliance with the full range of proven, innovative dental infection control and water purification products available from CleanCert, visit cleancert.co.uk, email sales@cleancert.co.uk or call 08443 511115.

WHY SHOULD YOU WEAR A STAFF BADGE?

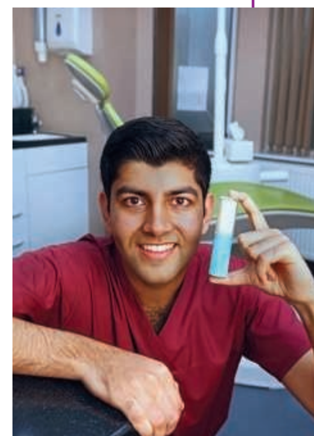
There are five key reasons why your dental team might choose to wear a staff badge:

1. Professional image - A staff badge will give a sense of professionalism and high standards
2. Creates a great first impression - You only get one chance to make a first impression, make it count
3. Approachability - Patients feel more comfortable and will engage more with named members of staff
4. Accountability - Encourages staff to perform well as an ambassador of the company
5. Brand/corporate awareness - The use of logo, type and colour can all be integrated to help promote and instil your company branding.

There are other excellent reasons to wear a staff badge, including security, trust, sense of team spirit and service feedback.

www.staffbadgesdirect.co.uk.

THE WORLD'S FIRST ADULT TEETHER



A dental student has invented the world's first adult teether - to combat the agony of problem wisdom teeth.

Jeevan Boyal came up with the EZ Teether after spotting a baby sucking on a teething aid while he was suffering with his own painful wisdom teeth.

The 21-year-old University of Sheffield dentistry student had been surprised to discover that there was little help available for painful wisdom teeth. The baby in the pram inspired his idea for an adult teether.

He went away and designed his own device based on angles for the jaw and mouth set out in his dentistry textbooks. Now he is selling his device, trademarked as the EZ Teether, on his own website EZteether.com, at £12.99 each, as well as through online retailer Amazon.

While the teether contains no painkillers, the action of biting down on its rubber-like surface provides instant pain relief to irritable wisdom teeth. The device acts in the same fashion as a child's teething aid, and works by massaging the affected gums to ease discomfort.

Jeevan hopes the adult teether will be popular with other young adults and could also make a useful gift choice for parents keen to pack their sons and daughters off to university with everything they could possibly need.

The EZ Teether is 11 cm long with a plastic handle and a Santoprene biting surface. Each device weighs just 35 grams.

For more information about the EZ Teether device visit www.EZteether.com.

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

BDJ Team CPD

CPD questions: November 2017

Trauma-informed, sensitive practice

1. A history of being abused could lead to which of the following:

A) anxiety and depression
B) low self-esteem and feeling unworthy of proper health care
C) an aversion to being touched
D) all of the above

2. Individuals in a dissociative state:

A) experience altered perception, sensation and sense of time to detach themselves from stressful situations
B) experience hypersensitivity and feel pain more acutely than normal
C) have learned to ignore or dissociate from pain or symptoms of disease
D) both A and C

3. Nonlinear healing is:

A) the circle of healing
B) patients might experience good days, feeling improvement or bad days, so their ability to tolerate treatment might vary from one visit to the next
C) when a patient's symptoms rapidly improve
D) the triangle of healing

4. Motivational interviewing is:

A) interviewing patients to correct deficiencies in their knowledge of oral care
B) the clinician motivating the patient by describing the dire consequences of not following our advice
C) a collaborative, nonjudgmental technique that fosters patient autonomy
D) is motivation by embarrassing patients who have poor oral hygiene

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

How to take part in *BDJ Team* CPD

BDJ Team CPD is available through the BDA CPD Hub. This site is user-friendly and easy to use. There are now **20** hours of **free** BDJ Team CPD on the CPD Hub: **10** hours from 2016 and **10** hours from 2017!

To take part, just go to https://cpd.bda.org/login/index.php.

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