BDJ Team
OCTOBER 2018

SACN FEEDING UPDATE

BDA
British Dental Association

October 2018

CPD: ONE HOUR

Highlights

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Ed's letter

Dear Team,

The majority of the UK's 90,000 dental care professionals are women and many of them work part-time. This makes the recent high profile employment tribunal involving two dental nurses (covered in our news on page 5) highly relevant to *BDJ Team* readers. We now know that employers need to take extra care that any change in employment status does not become discriminatory. In his excellent article on page 19 James Goldman explains how employment law looks after the interests of part-time employees.

In a similar vein, in this issue (page 25) we provide information to team members in orthodontic practices who might be affected by the fall-out from current tendering processes. Employment matters are also covered by Cary Cray-Webb's article on staff retention on page 9.

When Chief Dental Officer Sara Hurley took office, she made children's oral health a priority. It took a while for all her work to come together but, as reported in the last issue, resources have recently been made available to dental practices throughout England via Local Dental Networks to support Smile4life.

In this issue we provide some inspiring articles relating to children's oral health. One is the Mini Mouthcare Matters initiative at Great Ormond Street Hospital written by dental nurse Claire Fletcher, another the work carried out in Kenya by a team pulled together by hygienist Rachael England.

Meanwhile, in the UK, Claire Berry is raising awareness of the role of hygienists by championing the cosmetic procedures she can offer.

If you have a story to tell, don't hesitate to get in touch.

Caroline Holland
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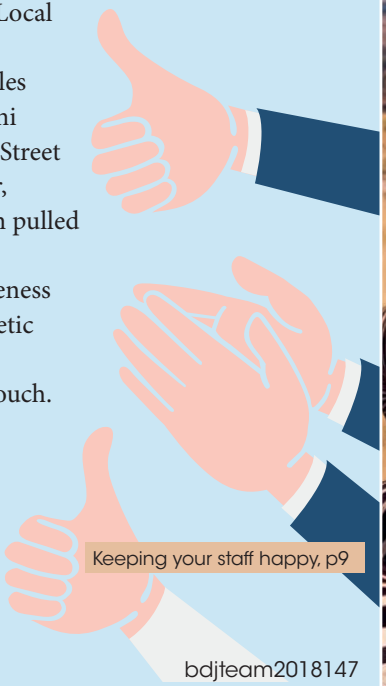

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THE TEAM

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Dates for your *diary*

Oral Health conference

November 23
Birmingham

The Pathway Faculty Homeless and Inclusion Oral Health conference on November 23 2018 will be focusing on caring for people experiencing homelessness and social exclusion. The venue is the BVSC Centre for Voluntary Action in Birmingham. Keynote speakers will include Professor Andrew Hayward (UCL), Martin Burrows (Groundswell), Professor Ruth Freeman (University of Dundee) and Ben Atkins, pictured, (Revive Dental Care) as well as experts with lived experience of homelessness and workshop speakers who will be sharing their "how to guide" to inclusive oral health and dentistry. Tickets to the event can be found on the Pathway website:
https://www.pathway.org.uk/training-and-events/

The National Dental Nurses conference

November 16/17,
Blackpool

All members of the dental team are welcome to attend. Discounted rates for BADN and ONG members; for student dental nurses; and additional discounts for early bird reservations. Prices start at £35 (BADN/ONG Student Member, Friday only, early bird) to £120 (non-member, Friday and Saturday, late booking) and includes lunch, refreshments, Conference Handbook and CPD certificate. Special B&B rates are also available to attendees at the Grand Hotel Blackpool (formerly the Blackpool Hilton).
The Conference offers up to 8 hours verifiable CPD which meets various GDC development outcomes.
To book:
www.badn.org.uk/conference

The British Association of Dental Therapists (BADT) Oral Health Conference and Exhibition

November 23-24,Telford

With the theme "The future is yours", this year's conference is at Telford International Centre. Among the speakers is Janet Taras who will be advising delegates how to manage difficult conversations in the workplace.
To book:
www.bsdht.org.uk/OHC2018

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

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NEW GUIDANCE ON INFANT FEEDING

Updated guidance[1] on feeding in the first year of life published in July by the Scientific Advisory Committee on Nutrition (SACN) has been welcomed by the British Society of Paediatric Dentistry.

Professor Emeritus Andrew Rugg-Gunn (pictured), BSPD's expert and a former member of the SACN panel, commented: 'I welcome this report and the inclusion of the chapter on oral health, rightly emphasising its importance in the general development of infants.'

'Both BSPD and I were delighted to have been given the opportunity to provide input, ensuring that this document is representative and that all concerned with children's oral health can speak with one voice.

The report *'Feeding in the First Year of Life'* states that breastfeeding up to 12 months has oral health benefits and is associated with a decreased risk of dental caries. It goes on to mention that some limited observational evidence suggests that once the primary teeth erupt, factors such as breastfeeding on demand, nocturnal feeding and sleeping with the breast in the mouth may be associated with increased risk of dental caries.

BSPD President Claire Stevens says: 'It's valuable for all organisations working in the interests of children's health to be aware that long-term and on demand breast feeding may be a risk factor for Early Childhood Caries, as highlighted in our own position statement[2]. More research is needed and we look forward to further guidance from SACN on feeding children after the age of one.'

'In the meantime, we are delighted that BSPD's Dental Check by One campaign gets a mention. PHE and Jenny Godson in particular have been very supportive of Dental Check by One, a valuable strategy for exposing families to early preventive advice and getting children onto the best start to their oral health journey.'

Turn to page 13 for an article providing an overview of the new guidance by hygienist Juliette Reeves.

1. https://www.gov.uk/government/publications/feeding-in-the-first-year-of-life-sacn-report
2. https://www.bspd.co.uk/Resources/Position-Statement

BADN AND ONG COLLABORATE FOR CONFERENCE

The Orthodontic National Group (ONG), the organisation of orthodontic nurses and therapists, and the British Association of Dental Nurses are pleased to announce that ONG members can now benefit from special discounted rates at the National Dental Nursing Conference to be held at the Grand Hotel Blackpool on 16 and 17 November 2018.

The discount for ONG members was agreed following a meeting between the ONG President Debra Worthington (pictured) and BADN CEO Pam Swain. The conference includes presentations on counterfeit equipment and materials and how to spot them, head and neck cancer, alcohol awareness training for dental teams, sepsis, oral health care for the homeless and those in recovery, LGBTQ issues, communities in practice and a GDC Update. More information can be found in Diary Dates on page 4.

PAY-OUTS FOR SACKED DENTAL NURSES

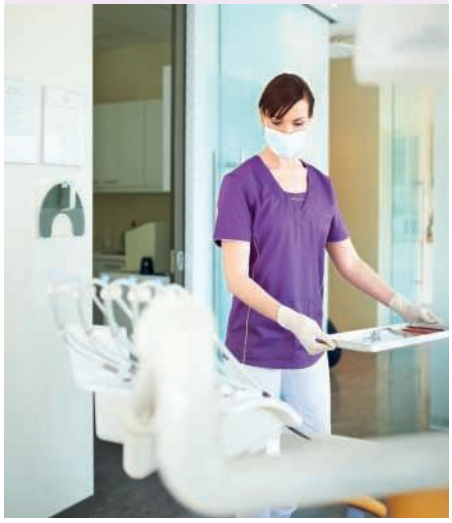
Two dental nurses from Essex were awarded pay-outs of more than £7000 each by an employment tribunal in August. Both dental nurses, who had been working for the same Clacton dental practice for four years, have children and were working part-time when they were made redundant.

Unite the Union took their case to the tribunal which awarded Jessica Rowley £8159 and Billy-Jo Janes £7500. The judge presiding at the hearing said they had been subjected to 'unlawful indirect sex discrimination' because of their part-time status. Their pay-outs included £6000 with £498 interest for 'injury to feelings for unlawful indirect sex discrimination.' The remaining sum was for loss of earnings and statutory rights.

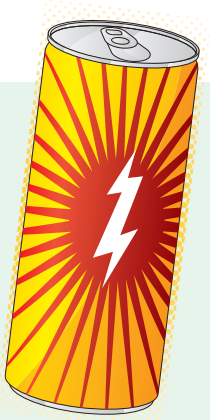
Hazel Coey, President of the British Association of Dental Nurses, said: 'We are shocked that dental practices are still, in 2018, discriminating against female employees in this way – especially given that more than 98% of registered dental nurses are female. We will be inviting both the BDA and CODE to work with us to ensure that dental employers are made aware both of the rights of part time employees, and that gender discrimination is not acceptable in today's working environment.'

While this case was taken to a tribunal by Unite, BADN has a legal helpline so that members who find themselves in a similar situation can call and get advice on their rights as part time workers.

Turn to page 19 for a longer article on part-time working.



GOVERNMENT TO BAN ENERGY DRINK SALES TO CHILDREN IN ENGLAND



A ban on sales of energy drinks to children in England is to be introduced amid growing concern about the impact that the high-caffeine, high-sugar drinks are having on young people's health. A consultation on how to implement the proposed ban has been unveiled, with Downing Street indicating that the principal question to be determined is whether the purchasing restrictions will apply at the age of 16 or 18. A Downing Street source added that introducing a ban was all but certain, saying: 'It's a question not of whether we do it, but how.'

The principal justification for the ban is the high level of caffeine in the energy drinks which has been linked to health problems for children, including head and stomach aches, as well as hyperactivity and sleep problems. A 250ml can of Red Bull contains about 80mg of caffeine, roughly the same as a similarly sized cup of coffee, but three times the level of Coca-Cola. Monster Energy, which is often sold in larger cans of 500ml, contains 160mg of caffeine. Energy drinks often also have higher levels of sugar than soft drinks. According to government figures, sugared energy drinks have 60% more calories and 65% more sugar than normal soft drinks and sugar is one of the largest causes of obesity.

Promote honey rather than antibiotics for coughs

Doctors are to be told to promote honey and over-the-counter remedies as the go-to treatment for coughs rather than antibiotics. They will be told not to offer the drugs in most cases and to instead encourage patients to use self-care products, under new draft guidance from Public Health England (PHE) and the National Institute of Health and Care Excellence (Nice). Patients are instead advised to try honey or cough medicines containing pelargonium, guaifenesin or dextromethorphan, which have been shown to have some benefit for cough symptoms, before contacting their doctor. Antibiotics may be necessary to treat coughs in patients with pre-existing conditions such as lung disease, immunosuppression or cystic fibrosis, or those at risk of further complications, the guidance states.

SCHOOL CHILDREN TO BE TAUGHT ABOUT HEALTHY EATING

School children are to be taught how to cut down on biscuits and sugary drinks in a new drive to tackle spiralling childhood obesity, the Sun reports. Education Secretary Damian Hinds has unveiled a new compulsory health education programme that will warn against food and drink with high calorie and sugar content. For the first time schools will be required to dedicate part of their school day to teach about the "benefits of healthy eating and keeping fit". The proposals will become mandatory for schools to teach from September 2020.

NHS to be franchised around the globe

It's been reported by the Daily Telegraph that the NHS is to be exported across the world as part of efforts to boost investment in Britain post-Brexit. Hospitals and health watchdogs are to be encouraged to set up franchises in dozens of countries, with profits ploughed into supporting the health service. Officials hope to turn the UK's national health service into a global brand, in the same way that the BBC gains significant income from its commercial BBC Worldwide arm.

News briefs

Kellogg's revamps its Coco Pops recipe

The amount of sugar in Coco Pops breakfast cereal has been further reduced by 40%. The revamped recipe, which also has 10% less salt, now has 17g of sugar per 100g rather than 30g. Levels were already cut by 14% this year. It puts the brand ahead of Government's goal of 20% less sugar in cereal and snacks by 2020. Kellogg's said it took three-and-a-half years to reformulate the recipe. Professor Graham MacGregor, chair of Action on Sugar, said: 'We hope Kellogg's will reformulate all of their cereals and set an example for all other food manufacturers. We need mandatory sugar-reduction targets with strict penalties for those who don't comply.'

Poor mental health at work 'widespread'

Poor mental health affects half of all employees, according to a survey of 44,000 people carried out by the mental health charity Mind. Only half of those who had experienced problems with stress, anxiety or low mood had talked to their employer about it. Fear, shame and job insecurity are some of the reasons people may choose to hide their worries. Mind says around 300,000 people lose their job each year due to a mental health problem. The charity - along with The Royal Foundation, Heads Together and 11 other organisations - has created an online resource for employers and employees with information, advice, resources and training that workplaces can use to improve wellbeing. The resource can be found here.

Onwards for Coca-Cola, downwards for dental health?

Drinks giant Coca-Cola has agreed its biggest UK sponsorship deal by becoming Premier League football's seventh and final commercial partner. It will become the official soft drink partner of the league, joining other sponsors Barclays, Carling, Cadbury, Nike, Tag Heuer and EA Sports. The three-and-a-half-year agreement starts in January 2019. The financial details have not been revealed. Coca-Cola also sponsors the football World Cup and the Olympic Games. The company, which employs 3,500 people in the UK, also owns Schweppes, Fanta, Sprite, and Oasis among others.

Striding Edge challenge surmounted

A charity team from the dental world climbed the daunting Striding Edge mountain in the Lake District to raise money and help continue the fight against mouth cancer in the UK.

Volunteers from Dental Health Spa, the Oral Health Foundation, Swiss Dental Academy, TePe and others, were supporting the Moveit4smiles charity. Funds raised by the team will be donated to Mouth Cancer Action and HPV Action.

Moveit4smiles spokesperson, hygienist Christina Chatfield, said of the challenge: 'At seven miles long, Striding Edge may not be the longest walk but it has incredibly high levels of exposure on narrow rocky ridges.'

All the walkers completed the walk in wet and windy conditions, reaching a height of 3000 feet. A portion of the money raised through the Striding Edge challenge will go towards educating teachers, parents and boys about the HPV vaccination.

To donate, visit www.dentalhealth.org/stridingedge or to get involved, find out more about walks in 2019, www.dentalhealth.org/moveit4smiles and sign up with your details.

PETITION TO IMPROVE DENTAL NURSES PAY

A petition has been created to support an increase in the basic salary of NHS dental nurses whose hourly average is £8.29. So far, the petition started by Haleema Abbas has got more than 400 signatures. However, it needs 100,000 in order for the issue to be debated in the House of Commons. You can lend your support by signing the petition online here: https://petition.parliament.uk/petitions/227092

BREXIT-PROOF YOUR BUSINESS SAYS LAWYER

A Manchester solicitor is urging city dental practices to 'Brexit-proof' their businesses in the event the UK crashes out of the EU next March, or else consider selling up and maximising their business value.

'If higher prices are anticipated it would be wise to accumulate equipment and stock at current prices,' says Helen Wong MBE, from Clarke Willmott LLP who specialises in advising the dental sector.

'At the moment equipment follows EU standards, but if the UK adopts its own guidelines there is a potential risk that many of the current or future apparatus or methodologies will not adhere to UK standards.

'For dental practices this could mean added costs to re-standardise, or in a worst-case scenario, they could find themselves in breach of the law solely because of a 'Hard Brexit' and the different standards being imposed.

'Practices should also be reviewing their private dental work fees and factor in the potential extra costs now, rather than to wait and see whether the UK crashes out of the European Union next March or not.'

Helen says she has seen a dramatic increase in Brexit-specific enquiries from dentists over the past two months and that the Clarke Willmott is supporting a number of practices to sell their businesses.

Clarke Willmott LLP is a national law firm with seven offices across the country, in Birmingham, Bristol, Cardiff, London, Manchester, Southampton and Taunton. For more information visit www.clarkewillmott.com

UNIVERSAL WELCOME FOR HPV JAB FOR BOYS

News that boys are to be offered a vaccination to protect against the Human Papilloma Virus (HPV) has been welcomed across the dental world. HPV causes about 5% of all cancers, specifically cervical, vulval and vaginal in women, penile in men, and anal and head and neck cancers in both sexes. HPV also causes genital warts and recurrent respiratory papillomatosis (RRP) in both men and women. The vaccination programme which was previously only available to girls, is due to start in September 2019.

The British Association of Dental Nurses said the decision taken by the Joint Committee on Vaccination and Immunisation (JCVI) to advise the Department of Health and Social Care that boys should be included in the national HPV vaccination programme was long overdue.

Approximately 400,000 boys each year have been left unprotected against HPV and the diseases it can cause since the vaccination programme for girls began in 2008. The government's vaccination advisory committee (JCVI) began its assessment of whether boys should also be vaccinated in 2013; decisions were promised but postponed until now.

HPV vaccination for boys is not only supported by the 51 organisations (of which BADN is one) of HPV Action but also by the BDA, BMA, Cancer Research UK and many individual clinicians; the clinical, ethical and equity arguments for gender-neutral vaccination are overwhelming. Approximately 20 other countries are already, or are planning to, vaccinate both boys and girls.

BADN President Hazel Coey said: 'I listened recently to a speaker at The Dentistry Show's Dental Nurse Forum, who explained how the HP Virus caused him to have cancer of the head and neck, changing his life forever; the horrors of the surgery as a result of the disease, the unspeakable life changes and the financial burden that he endured, leading him to thoughts of suicide - not to mention the costs to the NHS! As President of BADN, as well as a mother and grandmother of boys, I greatly welcome this decision to vaccinate our boys and eradicate this heartache.'

HPV Action Campaign Director Peter Baker said: 'The decision to vaccinate boys against HPV is great news for boys and their parents. It will also benefit those girls who for whatever reason have not been vaccinated against HPV. We have waited a long time for this change in policy and it is now imperative that there are no more delays and no more boys left at risk. HPV Action believes it is entirely realistic for boys throughout the UK to be vaccinated from September 2019.'

Doing it *differently*

The decision to sponsor a junior rugby team came from both heart and mind, says dental therapist **Mel Prebble**. Here she explains the benefits.

Sometimes an opportunity comes along and you know you have to go with it. That was how I felt when our local Rugby Football Club, Tabard, announced they were looking for funding. I have an affinity with the club. My husband played there and in recent years my daughter Gracie, joined the Under 11 Mini section, known as the Tabard Mini Warriors.

'THE SPONSORSHIP HAS LED ME TO A FEW NEW CLIENTS WANTING DIRECT ACCESS TO A HYGIENIST AND ALSO SEEMS TO HAVE CREATED MANY OPPORTUNITIES TO TALK ABOUT DENTAL HEALTH'

I decided to sponsor the Warriors for a number of reasons. Some from the head and some from the heart. The funding required was in line with my budget and I saw it as a way to strengthen my brand in the community and also support the team I love. Initially I just thought: 'What a great idea - I'll get a little PR when the warriors are out and about!' And then, when I saw my name sitting there on all the kit, it hit me how powerful the message actually is.

The sponsorship has led me to a few new clients wanting direct access to a hygienist and also seems to have created many opportunities to talk to parents and children about dental health. I am certain it will bring me more business in the future as the response is already very positive.

It's a win win so to speak and on another level, I'm also raising awareness of dental prevention, as well as kids hygiene and therapy.

From the age of 9 mouth guards are worn for rugby so this has been a hot topic of discussion over the years. Parents are keen to discuss the risks and benefits of custom made devices and I am happy to share what I know.

Looking back, I fully understand why I grasped the opportunity. I could have sponsored just anyone or anything, it had to be a head and heart decision. And it's really paid off.

Mel Prebble is a dental therapist at Neel Dentistry and Abbey Road Dental and a key opinion leader for Dentsply Sirona and Phillips Oral Health Care

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How to *value* dental nurses!

Many experienced dental nurses feel undervalued and demoralised. Dental nurse **Cary Cray-Webb** suggests that dental practice owners could improve their staff recruitment – and retention – by providing more training opportunities.

Staff recruitment and retention is a serious issue for many dental businesses. There is a very high turnover of nursing staff, particularly among those qualified for less than five years. One reason for this is the lack of opportunity for career progression. This article sets out the very simple ways that employers can show they value their dental nurses.

Keeping nurses within the profession is not just about paying a competitive wage. The average hourly rate of a dental nurse (who has taken about 18-months to train, requires registration with the GDC and has to pay indemnity insurance, professional fees, etc.) is about £8.29 per hour. Lidl pays checkout staff £9.50 per hour. John Lewis pays the waiters in their coffee bars £10.50 per hour. If it were simply about the money no-one would ever become a dental nurse in the first place!

One of the main reasons people change job is to find better training opportunities. Yet very few practices have formal on-going staff training focused on nurses. With a shortfall of qualified staff developing, this is an obvious area that every practice should consider.

Training options

The main qualification for a dental nurse is a Level 3 diploma or equivalent. These can be gained through a number of routes. In my case, I self-funded a night-school course and took a National Examining Board of Dental Nurses (NEBDN) diploma.

There is also a range of 'apprenticeship' schemes that share the training costs between the government, employer and student and result in an NVQ Level-3.

Training days can be delivered through on-site classes at college, or through distance learning. For the student to be successful, each of these requires differing levels of commitment from the student, tutor, assessor and employer.

In my experience, the NEBDN diploma places more emphasis on the medical and anatomical aspects. NVQ courses compensate with topics related to running the practice, such as how UDAs work. This is something both students and employers should think about.

Which way works best?

I don't enjoy distance learning courses. I find it's harder to build a strong relationship because of a lack of regular contact with the assessor. Assessments therefore become more stressful and it feels harder to get additional support, so you're more reliant on the goodwill of experienced colleagues.

Courses with regular attendance at college offer better access to tutors, assessors, as well as the experiences and opinions of other students.

However, some people find the NVQ works well and its approach based around independent learning feeds their curiosity. It's really horses for courses.

One thing that most nurses agree on is that 'Levison's Textbook for Dental Nurses' is the Bible. If you're a student nurse, READ LEVISON'S. The answer is always in there somewhere.

On the job training

Nurses often tell me they expected their 'in employment' training to be more formal and 'professional', given it is such a complex role.

It is very rare for employers to have designated trainers and training facilities, and surprisingly common for 2nd-year trainees to be left to train new recruits. Also, it's common for trainees to be left to 'get on with it' after an alarmingly short period of training and supervised work – two days in my case.

This contributes to a relatively high number of disillusioned apprentices and trainees failing to complete their courses and qualify, and I think this is something that employers need to pay more attention to.

When you take on a trainee you surely have a moral obligation to ensure they achieve their qualification in a timely manner? With an apprentice, this is a contractual obligation.

Development helps retention

Supporting staff with their professional training and personal development not only increases the skills and ideas we bring to a business but also demonstrates respect for us as professionals. That respect will translate to engagement with the business and develop into loyalty.

Assisting nurses with follow-on qualifications, such as sedation or oral health education, should not be based on just current business needs. Quite apart from the personal and professional development of the nurse, gaining that qualification will probably spark ideas to develop and expand the practice.

For example, I know several nurses who have expressed a wish to gain an oral health education qualification and to provide oral health care to homeless people, or to provide education on the subject to school children. This could easily be linked to a marketing campaign to register school children (and their families) as patients. Likewise, a practice could gain valuable local press exposure from either activity.

As a further example, training nurses in sedation could increase the range of treatments offered by the practice, reducing revenues lost through referrals.

Yet I am aware of practices that refuse to support nurses on these courses, even though the nurses have offered to pay the course fees themselves!

The usual justification for this is that if you train a nurse in a skill you don't currently use they will go elsewhere. But if you don't support training there's a good chance we will move anyway.

Opportunities to build a career

Training is not the only issue making dental nurses feel undervalued. Career progression is also a problem. At most practices, there simply is no career progression – once you're a nurse, that's what everyone expects you to be forever.

So, if qualified nurses are leaving the profession because they have no prospect of promotion, how should the profession respond?

New skills

There are plenty of ways for nurses to progress. The most obvious is to take additional specialised courses, as discussed above.

But once we have new skills, we would like to take on the extra responsibilities to use them. That might mean changing the way procedures are carried out within surgeries. This would, of course, demand a little flexibility from individual dentists, but this is surely a small price to pay for keeping nurses engaged.

I strongly believe this resistance to change needs to be reduced for the long-term future of dental nursing and dentistry as a whole.

Practice management

For some nurses, the complex responsibilities of being 'the boss' would be a nightmare. For others, practice manager is the way they want to go.

There are courses to help, mostly distance learning or online based, though many of them require nurses to already be in a management position.

But even if the practice manager's job is filled for the foreseeable future, what about developing management skills to be used in other aspects of the business? Why not look at marketing skills? Or for those who are a bit more technically minded, what about training for CQC compliance? Or IT support?

The options are endless, and with the rise of corporate chains, businesses have an opportunity to train their staff for roles that will develop in the future, in the practice or at head office.

Leaving the business but not the profession

Even though I've not been qualified that long myself, I've found myself mentoring younger nurses. I simply enjoy teaching, and that's why I'm currently looking for opportunities as an assessor or trainer.

Most assessor roles will take you 'out and about'. Some people enjoy this aspect, but others need something with a fixed base to fit their personal life. Lecturing, teaching or assessing provides a great opportunity to give something back, and for the profession to keep hold of valuable skills.

It's easy to find courses leading to an assessor's qualification. However, finding a position to teach the NEBDN course or assess NVQ candidates is a little more 'opportunity driven'.

But there are other options that use your professional knowledge, such as becoming a recruitment consultant, or working for a supplies or equipment company.

My advice to employers

So what can you practically do to make it easier to recruit, train and retain dental nurses?

First, get involved with local schools or professional bodies such as the NEBDN and British Association of Dental Nurses to promote dental nursing as a career. The time and effort can be surprisingly small.

Second, think carefully about your recruitment processes and what you are actually trying to achieve. Don't take on an apprentice or trainee just because it's cheaper than a qualified nurse. If you want an apprentice, plan how to support us. If you choose to take a trainee (usually a more mature candidate), make sure we are on the course of study that suits us rather than the one with the cheapest course fees. And if you want a qualified nurse, give us a reason to join you beyond a '25p per hour' pay-rise.

Third, treat nurses well once we're qualified. Make sure we're on a wage competitive with other local businesses (not just other practices), and give us a chance to progress in terms of scope and technical capability. We've gone through a lot to become qualified nurses, which suggests we have a bit of ambition. If you want to keep your nurse, feed that ambition.

After all, training is an investment – recruitment is a cost.

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

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The cosmetic component

Dental hygienists can give patients what they want while telling them what they need, says **Claire Berry**, who expands on the joys of providing cosmetic treatments.

As a dental hygienist my time is mostly spent treating patients to stabilise advancing periodontitis, help them by preventing deterioration in periodontal health and aid in caries prevention. However, I'm going to be honest and tell you that I enjoy the cosmetic side of my job just as much as the bread and butter work. Yes, I just put it out there: the role of the dental hygienist has a cosmetic component and it's on the rise.

Let me explain my enthusiasm. Not all patients thank you for treating their gum disease. Conversely, as a hygienist it's easy to make yourself unpopular. Here's how:

- You're battling a condition that is visible to you but more often than not is invisible to the patient
- Periodontitis doesn't necessarily hurt the patient but once you go 'probing' it's you who is causing discomfort
- The patient didn't notice that mobile tooth until you pointed it out (so you must have caused it)
- That 1mm attachment gain which you want to celebrate has been achieved under duress and your 'high five' will not be welcome.

Add to this that:

- during their treatment they feel like we are trying to drown them
- we 'lecture' them at the end of the appointment
- …and then charge them for the pleasure every 3 months.

This may not apply in every case, most patients do appreciate us, but many patients are likely to question what we do at some point.

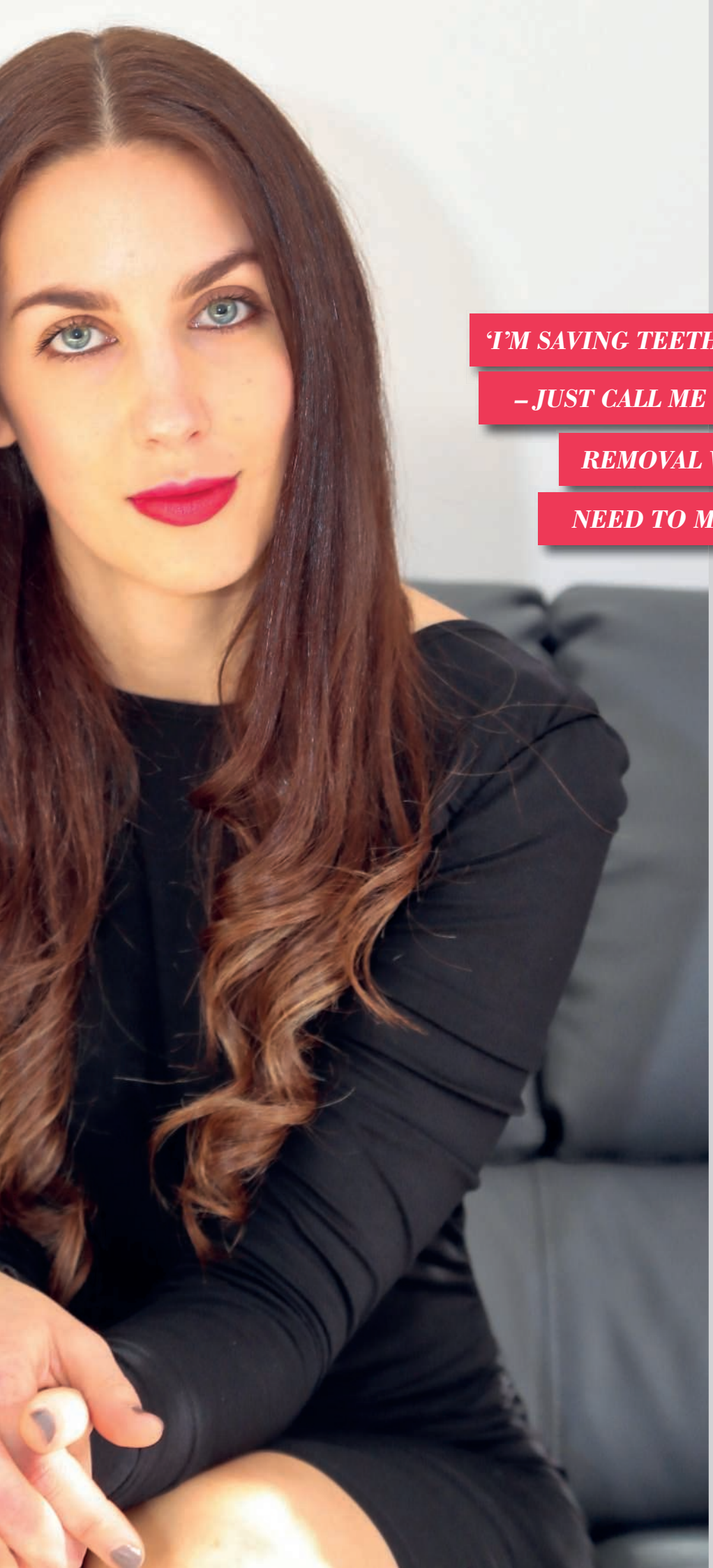
That being said and despite knowing most patients aren't the biggest hygienist fans, I love this side of my job for my own personal professional satisfaction. I know I'm doing a good job: I'm saving teeth left, right and centre - just call me Super Hyg - but a stain removal will always satisfy my need to make my patients happy any day.

There is another more important reason I fully support the rise in the cosmetic dental hygienist however. Direct access allows us to treat patients who we might not otherwise have seen in our chairs. We live in a social media age where everyone is wanting to have shinier hair, bigger lips and whiter teeth. People are becoming more open to enhancement and there is a big rush at the moment (and for the foreseeable future) on their teeth and smile. The whiter and straighter the better in the eyes of the younger generation. This is where a cosmetic dental hygienist swoops in. Being able to offer direct access treatments such as stain removal means we can give the patients what they want while telling them what they need.

I have a saying when it comes to treatments such as these:

'Give the patients what they want, while telling them what they need, until what they need becomes what they want!'

If a patient wants to see a dental hygienist for stain removal then this is a service that the patient should be able to access directly. The hygienist should still do all the thorough checks as per the direct access protocol. And,



the patient should still be referred to a GDP or specialist, if necessary, and informed if they have a periodontal, gingival or hard/soft tissue issue that requires further treatment or referral. Seeing a patient for a cosmetic issue is a good way to get the patient in the chair in the first instance to make them aware they even have an issue that needs addressing.

'I'M SAVING TEETH LEFT, RIGHT AND CENTRE – JUST CALL ME SUPER HYG – BUT A STAIN REMOVAL WILL ALWAYS SATISFY MY NEED TO MAKE MY PATIENTS HAPPY.'

So how do you convert your direct access 'I just want stain removal and whiter teeth' patients into 'let's address and improve my oral health' patients?

This is where our training in behaviour change comes in handy. While doing all the necessary checks during the direct access protocols, if the patient is deemed high risk for periodontitis, caries or oral cancer (or if they indeed have periodontitis or caries), this is our chance to give smoking cessation advice, explain the aetiology of periodontitis and give necessary OHI and/or diet advice. They then receive more than they thought they came in for, they feel we actually care about more than just the stain and they are open to our advice because they chose to be there. They like the results so much that they choose to be there every 3-6 months. So every 3-6 months I now have access to changing their behaviour and reinforcing good oral hygiene advice.

Marketing ourselves in the right way can eventually lead to us targeting a cohort of people who may never had been interested or even attended an appointment in the first place. This in turn allows us to prevent a host of issues arising in the future. It's just another way to spread the word. Long live the cosmetic dental hygienist!

Claire Berry trained to be a dental hygienist while serving in the army. She qualified in 2009 in Aldershot and now works as a hygienist in the North of England, at practices in Doncaster and York
https://promedicalaesthetics.co.uk

bdjteam2018165

Feeding in the First Year of Life

An update on recommendations from the Scientific Advisory Committee on Nutrition (SACN).

By **Juliette Reeves**

In July this year the Scientific Advisory Committee on Nutrition (SACN) published updated guidelines and recommendations for infant feeding in the first year of life.[1] The last review of infant feeding was undertaken by the Committee on Medical Aspects of Food Policy (COMA) in 1994.[2] Since this time a number of nutrition updates have been published by SACN that have implications for current infant feeding policies in the UK. These include the adoption of the World Health Organisation (WHO) Growth Standards,[3] SACN revisions to Energy Requirements[4] and updated knowledge and information on Vitamin D,[5] Vitamin A[6] and Iron.[7]

This report set out to consider current recommendations on complementary feeding (the introduction of solid foods) in infants up to the age of 12 months, the effects on immune tolerance from early introduction of allergenic foods and oral health risks in formula and breastfed infants.

Breastfeeding

The SACN report upholds current advice that babies should be exclusively breastfed up to six months of age and at least the first year of life alongside giving solid food. The benefits to both infant and mother are highlighted and include the important role breastfeeding has in the development of the infant immune system and gut ecology,[8] a lower risk of maternal breast cancer and endometriosis,[9,10] greater weight loss after giving birth and a lower BMI for the mother in the long term.[11]

Whilst the report also highlighted that breastfeeding was not associated with an increased risk of low bone mineral density (BMD) or risk of osteoporosis in later life,[12] maternal BMD can decline by 5-10% in the first six months of breastfeeding,[12] taking up to 6-12 months to return to baseline.[13] Clearly it is an important time to ensure that adequate maternal calcium and bone mineral nutrient intake is achieved to adequately recover baseline BMD in the 6-12 months following the cessation of breastfeeding.

Goat's or cow's milk formula are considered the only suitable alternative to breast milk for babies under 12 months old. The use of soya-based formula should only be on medical advice due to the possible health effects of phyto-oestrogens in soya-based formula.[14]

CPD: ONE HOUR

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Introduction of Solids

The advice on complementary feeding (the introduction of solid foods) remains unchanged and should not be introduced before six months of age. Breast milk, infant formula and water should be the only drinks offered after 6 months of age. Unmodified cows' milk should not be given as a main drink to infants under 12 months of age as this is associated with lower iron status as the iron content and bioavailability in cow's milk is low.[15]

A wide range of textures and flavours should be offered alongside breastfeeding as this enhances the acceptance of new foods and the consumption of a varied diet. Repeated exposure to rejected foods improves acceptance.[16] It has also been proposed that vegetables should be introduced as the first solid foods to facilitate acceptance and improve intakes of vegetables in both the short and long term[17].

Allergens

The joint SACN/COT review recommended that foods containing peanut and hen's egg can be introduced from around 6 months of age and need not be differentiated from other solid foods. This represents a change to previous policy. The guidance from Public Health England (PHE) recommends that allergenic foods, such as peanuts, nuts, seeds, egg, cows' milk, soya, wheat (and other cereals that contain gluten, for example, rye and barley), fish and shellfish 'should be introduced into the infant's diet in very small amounts and one at a time, watching carefully for any symptom of an allergic reaction.'[18] Families of infants with a history of early-onset eczema or suspected food allergy should seek medical advice before introducing these foods.[19]

Infant Micronutrient Requirements

The SACN report acknowledges that adequate intakes of micronutrients are vital in supporting the growth and development of infants and have an impact on health outcomes throughout life. It is estimated that at least 50% of children worldwide aged 6 months to 5 years suffer from one or more micronutrient deficiency.[20] The SACN report focuses on iron, vitamin D and vitamin A.

'THE SACN REPORT ACKNOWLEDGES THAT ADEQUATE INTAKES OF MICRONUTRIENTS ARE VITAL IN SUPPORTING THE GROWTH AND DEVELOPMENT OF INFANTS'

Iron

Iron deficiency anaemia (IDA) affects approximately 20% of pregnant women and 25% of preschool-age children worldwide.[21] Low iron stores in the infant at birth are associated with maternal iron anaemia,[22] obesity and smoking.[23]

From 6 months of age, it is recommended that infants receive iron from a variety of dietary sources. Iron is found in animal and plant tissues such as cereals, vegetables, nuts, eggs, fish and meat.[7] The consumption of unmodified cows' milk as a main drink is associated with lower iron status in infants younger than 12 months of age.[15]

Vitamin D

Vitamin D plays an important role in the regulation of calcium and phosphorus metabolism and is important for bone health. Dietary sources are essential when sunlight containing UVB radiation is limited (for example, during the winter months) or exposure to it is restricted.[5]

In a departure from previous advice, this latest report on infant feeding recommends that all infants from birth to 1 year of age who are being exclusively or partially breastfed should be given a daily supplement containing 8.5 to 10µg of vitamin D (340-400 IU/d) . Infants who are fed infant formula should not be given a vitamin D supplement unless they are consuming less than 500ml of infant formula a day, as infant formula is fortified with vitamin D.

Vitamin A

Vitamin A is a fat-soluble vitamin and is required for vision, embryogenesis, growth, immune function, and for normal development and differentiation of tissues.

The latest data from the Diet and Nutrition Survey of Infants and Young Children[24] shows that infants under 1 year are consuming above the level of the RNI set at 350µg retinol equivalents (RE)/ per day, suggesting that vitamin A insufficiency is not likely to be a health concern for this age group. Infant formula was the largest contributor to vitamin A intake, followed by 'commercial infant foods'.

As a precautionary measure the government recommends that children from the age of 6 months to 5 years are given a daily supplement of vitamin A (233µg), unless they are consuming over 500ml of infant formula a day.

Oral Health

The SACN report concurs with the 'Delivering better oral health – an evidence based toolkit for prevention'[25] guidance relating to dental caries prevention in infants and young children (under 3 year olds) and reiterates infant feeding advice and oral health messages. (**Table 1**).

Table 1 : Delivering Oral Health – Evidence Based Toolkit

- From around 6 months of age infants should be introduced to drinking from a free-flow cup, and from age 1 year feeding from a bottle should be discouraged
- sugars should not be added to foods or drinks
- the frequency and amount of sugary foods and drinks should be reduced
- parents/carers should brush or supervise toothbrushing
- start brushing as soon as the first tooth appears (usually at about 6 months of age), at least twice a day with fluoride toothpaste last thing at night and on at least one other occasion
- see a dentist as soon as the first tooth appears and no later than the first birthday (British Society of Paediatric Dentistry, 2018)
- use fluoridated toothpaste containing no less than 1,000 pm fluoride
- use only a smear of toothpaste.

PHE (2014) Delivering better oral health: an evidence-based toolkit for prevention (Third Edition).

The available evidence indicates that breastfeeding up to 12 months of age is associated with a decreased risk of dental caries and may offer some protection when compared with infant formula.[26]

With diversification of the infant diet to include foods and drinks other than breast milk or infant formula, the risk changes depending on the free sugars* content of the foods (and drinks) and how frequently such foods (and drinks) are consumed.

The effect of infant feeding on malocclusion was also considered. A systematic review and meta- analysis concluded that breastfeeding infants were less likely to develop malocclusions than those 'never breastfed' up to 12 years of age. Children who were breast fed for longer were less likely to have malocclusions than those breastfed for shorter periods. The authors concluded that breastfeeding decreased the risk of malocclusions.[27]

Conclusion

Good nutrition and a healthy start help to lay the groundwork for good oral health throughout childhood and into adulthood. Oral health and nutrition habits are learned during childhood and lay the basis for later life. As healthcare professionals we can have an impact on an individual level by helping people to change their behaviour, encouraging early intervention and giving appropriate and timely advice on health and wellbeing.

**SACN have adopted the term free sugars to replace the term NMEs*

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Key Points – Oral Health

- Discourage bottle feeding from 12 months
- Provide milk and water as drinks between meals
- Discourage baby juice or sugary drinks at bed time
- Breastfeeding up to 12 months is associated with decreased risk of dental caries
- Risk of dental caries increases with frequency of foods, particularly those containing free sugars*
- Breastfed infants are less likely to develop malocclusions than "never breastfed"

**SACN have adopted the term free sugars to replace term NMEs (non milk extrinsic sugars)*

SACN Report on Infant Feeding in the First Year of Life. July 2018

Mills DA (2011) Human milk glycobiome and its impact on the infant gastrointestinal microbiota. *Proc Natl Acad Sci U S A*. 108 Suppl **1:** 4653-4658.

'AS HEALTHCARE PROFESSIONALS WE CAN HAVE AN IMPACT ON AN INDIVIDUAL LEVEL BY HELPING PEOPLE TO CHANGE THEIR BEHAVIOUR'

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7 SACN (2010) Iron and health. Available from: www.gov.uk/government/publications/sacn-iron-and-health-report (accessed 16/8/18).

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11 Bobrow KL, Quigley MA, Green J, Reeves GK & Beral V (2013) Persistent effects of women's parity and breastfeeding patterns on their body mass index: results from the Million Women Study. *Int J Obes*. **37(5):** 712-717

Key Points – Infant Feeding

- Exclusive breast feeding is encouraged for the first 6 months and thereafter with solid foods until the age of 12 months
- Cow and goat's milk formula are the only suitable alternatives to breast milk. Soya milk formulas are not advised
- A variety of solid foods are introduced at 6 months, varying in flavour and texture
- Breast milk, infant formula and water are the only recommended drinks after 6 months. Cow's milk should not be given as a drink under 12 months
- Foods rich in iron and low in salt and free sugars* are advised
- Peanuts, hens' eggs and other food allergens need not be withheld when solid foods are introduced at 6 months
- Infants from allergenic families should have these foods carefully introduced one at a time
- Infants up to 12 months old partially or exclusively breastfed or receiving less than 500mls formula milk should receive Vitamin D supplementation of 8.5ug to 10ug daily
- Infants up to 12 months receiving less than 500 ml formula milk should be given Vitamin A supplementation of 233µg as a precaution

SACN Report on Infant Feeding in the First Year of Life. July 2018

Infant and Toddler Feeding Resources:

- www.nhs.uk/start4life/baby/first-foods/
- www.nhs.uk/conditions/pregnancy-and-baby/solid-foods-weaning/#what-foods-to-give-your-baby
- https://www.nutrition.org.uk/healthyliving/nutrition4baby.html
- https://www.gov.uk/government/publications/child-oral-health-applying-all-our-health/child-oral-health-applying-all-our-health
- https://www.healthystart.nhs.uk/

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Juliette Reeves is a dental hygienist and trained nutritionist with over thirty years experience. She has written and lectured internationally over the last eighteen years on the systemic associations between nutrition and oral health with a particular focus on chronic inflammation.

She is Clinical Director of Perio-Nutrition and an elected executive committee member to the British Society of Dental Hygiene and Therapy. Juliette regularly provides post-graduate training courses internationally and in the UK and was recently the recipient of the Dr Gerald Leatherman Award.

CPD questions

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bdjteam2018166

Mini MCM a mega experience for dental nurse Claire

A job at Great Ormond Street Hospital has given new impetus to **Claire Fletcher's** career as a dental nurse and the opportunity to be involved in the pioneering Mini Mouthcare Matters. She told **Caroline Holland** her story.

Q: *How is it that you now work at GOSH?*

A: I trained about 10 years ago in a hospital setting. The system was frustrating and I didn't feel I could do my best because of lack of time, resources and support. After about six years I became disillusioned and left to go travelling in Asia for 6 months. The experience was well worth it, but it opened up my eyes. While travelling in South Korea, I suffered a minor injury in Seoul and had to go to hospital. It was then I realised how convoluted and tricky their health care system was. When I came back from my travels, I found myself being drawn back to the NHS. I applied for a job in a community dental setting. I was involved with paediatric and domiciliary patients and even helped run a clinic for the homeless. Lack of funds and an uncertainty around the future of the community service due to competitive tendering did little to assuage my frustration at the system.

It was around this time an opening for dental nurse was advertised at Great Ormond Street Hospital (GOSH). I had the necessary qualifications and motivation to involve myself in change, so I applied. In all honesty, I wasn't expecting to be offered such a life changing position, but I am here now and am excited about future opportunities. GOSH has created a platform for me to get my ideas across, teach other health care professionals about what we do and explore openings for other projects, audits and presentations. If you put yourself out there, there are opportunities to be found.

Q: *Tell me about a typical working day?*

A: Every day has its challenges. It's unlike any other dental nurse post I have ever had over the years. The cohort of patients we see can have very rare conditions, are seriously ill or have multiple complex conditions. In addition to the typical nursing duties that we have organising and supporting clinics, we run a nurse led oral hygiene clinic, visit wards to give advice and take part in projects that promote oral health within the hospital. General anaesthetic lists for our dental patients are challenging due to complex medical needs as well as the extra challenge of young patients who have higher anxiety levels than usual.

The work is similar to most dental hospital settings, but the opportunity to learn far more about obscure medical conditions is much higher.

Q: *What are your favourite parts of the job?*

A: As with any job of this nature, my favourite part of the job is working with patients and their families. It's an absolute honour to be so involved with their treatment and patient experience. Some of the youngest patients we see are so inspiring and it's always a pleasure to be involved in their care in some way. I have a lot of respect for them and their families, compassion, care and patience, as well as the motivation and experience to deliver professional, up to date care for them. Sometimes their situations are very poignant, given the nature of the hospital, but I am honoured to witness some of the best aspects of human nature. This is a a major motivator for my work.

Q: *You are now working on Mini Mouth Care Matters - how did this come about?*

A: I was approached by consultant paediatric dentist Urshla Devalia about this project. Because of my previous interest in oral health education for general nurses, and recent work with an oral health presentation to GOSH's new intake of nurses, my drive to expand the platform was probably what drew us together for Mini Mouth Care Matters (Mini MCM).

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'EVERYTHING ABOUT MINI MCM HAS BEEN A GREAT EXPERIENCE, THE MESSAGE IT GIVES, THE TRAINING AND ADVICE AND THE TEAMWORK INVOLVED IN UNDERTAKING SUCH A PROJECT.'

Q: *Please tell me about the programme and your part in it*

A: My part in Mini MCM is to provide the dental nursing perspective to the training, information, and policy write up.

I also support project lead Urshla Devalia and have been involved with audits, correspondence with interested parties, outreach with nurses on the wards, and training and advice materials.

MiniMCM aims to create a healthcare team that is more responsive and personalised to patients.

This will include:

- An oral health policy and tooth brushing chart, that will be fully adaptable to any hospital Trust
- An oral health screening tool to identify patients who may be at a high risk of developing oral problems
- A training package which will encourage all nursing, medical and health care professionals to 'lift the lip' and identify common oral health/dental conditions
- A range of tools applicable to paediatric in-patients that can be used by all hospitals hoping to join Mini MCM, including posters, booklets and baseline audit tools

Q: *What has the experience of being involved in Mini MCM been like?*

A lot of work. When I first heard of the project I envisioned it would be an audit, a training package for nurses on how to brush their patient's teeth on their wards, and some leaflets to promote oral health. It has since snowballed into something so much bigger, simply because there is so much interest in the project. It is great to see that there is acknowledgement of the urgent need to roll out this training, and to stop overlooking the mouth and teeth of every patient and to 'put the mouth back into the body'.

Everything about Mini MCM has been a great experience, the message it gives, the training and advice and the teamwork involved in undertaking such a project.

As with most things, the obvious single downside is lack of time. There is so much interest in this body of work, but we aim to provide the most informative and comprehensive advice and training for all hospital settings.

Q: *What do you hope will be the outcome of the initiative?*

A: I hope the initiative changes cultural perception of the mouth and mouth care in hospitals as well as in the wider public domain. It's shocking when I hear medical colleagues say 'it's just teeth' and then come running to us when they have a critically ill patient with infection risk from their teeth. It's part of basic care, but it's almost deemed optional. If a patient wasn't bathed or turned in their beds to prevent pressure ulcers, that would be a major incident. But a second thought isn't spared for the patient who hasn't brushed their teeth or maintained their oral hygiene. I hope the initiative gets people thinking and eventually becomes part of legislation. The time, money and resources saved just from oral health maintenance will surprise everyone.

Claire Fletcher is a Specialist Dental Nurse at Great Ormond Street Hospital's Maxillofacial and Dental Department. She specialise in paediatric dental nursing and has a specialist interest in conscious sedation for anxious patients.

bdjteam2018167

DON'T discriminate, communicate

The case of two dental nurses awarded a combined figure of more than £16k by an employment tribunal highlights the importance of treating part-time workers equally. The BDA's **James Goldman** explains the concept of indirect discrimination and how to avoid being accused of it.

Two dental nurses were made redundant in July 2017 because the practice was overstaffed. This was according to the many reports covering the employment tribunal which awarded them more than £16k between them. The problem was that the two staff in question were part-time workers. The tribunal said the dismissals were unfair and amounted to indirect sex discrimination.

So what is indirect sex discrimination, and how does it affect part-time employees in a dental practice?

Indirect discrimination against women involves having a rule or condition that makes it more difficult for women to comply with. For example, if you have a minimum height rule, it will be more difficult for women to comply because women tend to be shorter than men.

There will be some jobs where you need a minimum height rule. Say, for example, police motorcycle riders, who need to be able to put their feet on the ground when they're riding their motorcycle. Otherwise they'll fall off when they stop. So employers can have a minimum height rule if they can justify it.

But even this example of a police motorcycle rider is not clear cut. Employment law will want the police to try and accommodate shorter people. It could be there is a simple adjustment that could be made that would allow a shorter person to ride the bike, or another type of bike, safely.

Another common rule that makes it more difficult for women to comply is requirement to work full-time. More women than men work part-time. So a rule that makes it more difficult for women can be indirect discrimination.

And, in the case of these members of practice staff, selecting the part-timers for redundancy is as good example as any of indirect discrimination. The practice would need a compelling reason to have a rule that only part-timers were selected for redundancy. That compelling reason could not exist if the dental nurses already worked part-time at the practice before. And they did!

Equal treatment for part-time workers

Employees who work on a part-time basis should be treated the same as full time workers. They should get the same pay for the same work. They should get the same amount of paid holiday pro-rata, the same access to opportunities and training.

Treating part-time workers less favourably than full time workers may well be against the laws protecting part-time workers and may also be indirectly discriminatory.

Requests to work part-time

Although part-timer workers are protected by employment legislation, they cannot demand to work whatever hours they want. And part-time workers are not immune from dismissal or redundancy.

Employers are able to ensure that they have the staff necessary for their business to function effectively. Practices cannot, for example, be forced to open later and close earlier to accommodate part-time workers. I would argue that most employment law is aimed helping employer and employee to talk to each other effectively. Requests to work part-time is as good example as any of this.

'FROM OUR EXPERIENCE OF ADVISING DENTAL PRACTICES, MANY PRACTICES APPEAR TO HAVE PART-TIME STAFF TO SOME DEGREE. AND MOST PRACTICES FIND A WAY TO MAKE IT WORK.'

Put simply, the law say that employees can ask to change their hours. The employer has to consider the request. If the employer cannot readily agree it, then the employer and employee need to meet to discuss the request. The law sets out a procedure that needs to be followed. A record of the conversation should be made.

From our experience of advising dental practices, many practices appear to have part-time staff to some degree. And most practices find a way to make it work.

In some cases, a dental practice may well find it difficult to accommodate a request to work part-time. If that's the case, then that may be fair enough. If asked about the refusal, the employee should be saying (truthfully) 'My employer was really good about my request. We sat down and discussed it in detail. We explored different options. I do understand why my employer couldn't agree, and it is fair enough.'

There is no reason why employers cannot try allowing someone to work part-time to see how it works. The parties could always agree to revert to the original hours if the trial didn't work.

In most cases, problems can be resolved with good communication, a little common sense and some careful thought. Managers and practice owners may find that their staff have some constructive suggestions. Engaging with staff should lead to better outcomes and fewer problems.

Unless employers try and discuss things with their employees first, they may find themselves in difficulty. All employers should remember: good communication will protect you from charges of discrimination.

James Goldman is the BDA's Associate Director of Advisory Services and a lawyer with over 15 years experience.

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The birth of the *Maasai Molar* movement

Hakuna Matata is the Swahili for 'No worries'. Dental hygienist **Rachael England** describes how these two words became the mantra for a group of volunteers providing badly needed dental care in rural Kenya.

My phone beeped for the thousandth time that day. A group of us, mostly from dental backgrounds, were trying to meet in Nairobi as the starting point for a week's volunteering in Aiotong, Kenya. This time the text was from our only dentist Dr. Jamshed Tairie and his wife Zohra, who were travelling from Amsterdam. 'Our flight has been cancelled!' they said. We were boarding soon, all I could do was furiously tweet their airline and hope they were on the next flight.

I had visited Aitong, Kenya in 2015. I carried out oral health lessons in three village schools and held a dental hygiene clinic while the dentists were busy providing pain relieving extractions and some basic fillings. Knowing the high treatment need and worrying no-one had returned to the region since, I decided to set up a return expedition myself! It couldn't be that hard.....

Arriving in Nairobi we quickly cleared customs, with only a brief struggle to import 2000 toothbrushes, 2000 toothpastes and an assortment of dental materials and instruments! Seeing our guide Simi waiting was such a relief, he had an update – Jamshed and Zohra would arrive that evening and he had already arranged a taxi to bring them out to us. But, Yasmeen, joining us from Saudi Arabia, had missed her flight and wouldn't arrive until the next day!

The catchy refrain from Disney's Lion King came to mind and we told ourselves: Hakuna Matata, the Swahili for 'no worries'. We decided set up the clinic the next day as planned, and hopefully have a full team by the afternoon. Simi, our host, had worked hard to find us accommodation and got us booked into a brand new hotel, quite an upgrade from the tents we were expecting! The hotel staff at Enaitoti Hotel were absolutely amazing. Despite having opened early especially to accommodate us and having no hot water for the first part of the week, they greeted us with such hospitality, cooked three fantastic meals a day, held two parties and treated us like family. I can't express my gratitude enough for the way they went 'above and beyond' to make sure we were happy.

After a much needed night's sleep the team rose early to set up the clinic in Aitong medical centre. Having visited before I was already aware that we would have water and electricity, but limited lighting. The electric set-up runs from solar panels on the roof but switches to a diesel-run generator from about 3pm, costing approximately $20 per day. Sterilisation and cross-infection can be an issue in low-income countries when carrying out humanitarian work, but careful planning by Hilary Browne meant the team were well prepared with an entire decontamination process and two pressure cookers, ensuring both clinician and patient safety.

A dental hygiene clinic was set up with 2 portable ultrasonic scalers and oral hygiene aids. Hasna Hafsi, Yasmeen Arafsha, Hanan Abdalla and Shaima Obaid bin Rabeeha carried out dental screenings, preventative treatment and prophylactic scaling for the local school children. Hanan and Yasmeenalso held fun and interactive oral health lessons for groups of children, where they sang and learned about tooth brushing and healthy snacks. Patients often request cleaning to remove the brown stains seen frequently in the Mara. This discoloration is due to the high levels of fluoride found in the ground water. Despite community efforts, filters to remove such high concentrations are expensive to maintain and local people continue to be afflicted with severe fluorosis. Unfortunately, the global trend for fizzy drink consumption and refined carbohydrates is also an issue in

Above right: Maasai woman visiting the medical clinic

Top: Hasna Hafsi and Shaima Obaid bin Rabeeha carry out dental hygiene treatment and buckets become spittoons!

Left: Lisa Hicks registers patients visiting the dental clinic

Aitong, leading to caries and according to the community doctors, also a rise in diabetes and cardiovascular disorders.

In the main surgery patients were triaged by dental hygienists Karina Carniato and Stephany Gardner. They used their full skill set to assess and anaesthetise patients ready for dental therapist Maddie Tucker and dentist Dr Jamshed Tairie to carry out basic restorative care and extractions. Zohra oversaw the surgery, tracking treatment and helping with patient care.

Outside our general volunteer Lisa Hicks, registered patients and created a basic filing system to ensure future expeditions have patient treatment records. On my previous visit, with only Simi to interpret the local language of Swahili for the whole clinic, I struggled. This time I recruited four local young men to assist in translation and clinic organisation. One of the young men, Delama, had been both deaf and mute due to a childhood illness and abandoned by his mother as a result. The whole community were able to sign language with him and he totally ran the clinic for us! He really inspired the whole team with his positive attitude and told us that despite his challenges, he has gone on to lead a fulfilled life and have three beautiful children of his own.

The first day in clinic went smoothly as word spread throughout the community that a dental team was in town. The majority of people attended with pain or broken teeth due to caries, but some children also requested removal of outstanding upper canines – which normally would undergo orthodontic treatment, an impossibility at the moment, which raised an ethical question 'should healthy teeth be removed for aesthetics?' especially in still growing teens. I advised the team to leave them in situ and we could review next time we visit if they have dropped into place any further.

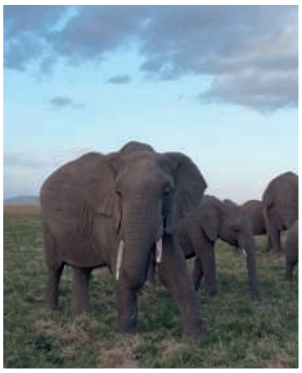
'BY USING THE TRIAGE MODEL AND THE FULL SKILL SET OF THE TEAM WE WERE 100% MORE EFFECTIVE THAN A DENTIST WORKING ALONE.'

It wasn't all work and no play for the team, Sunday, Wednesday and Thursday were spent in the Maasai Mara National Park, where they were lucky enough to see elephants, lions, leopards, zebras, buffalo and cheetahs. They were also welcomed with traditional singing and dancing by the village elders at the local Maasai village of local Manyatta. Maasai are great pastoralists, living semi-nomadic lives which have remained unchanged for hundreds of years. They are easily recognised by their colourful clothes, elaborate beaded jewellery, stretched ear lobes and the absence of the lower central incisors, which are extracted in childhood. Their diet mostly consists of milk, meat, vegetables and maize, leading to low rates of dental caries and virtually no heart disease!

Monday and Tuesday were long days in the clinic, working from 08.30 to the last light of the day. Although it was school holidays the local Head Teacher, Mr Ndarasi Dismas had arranged

for local children to return for the day to have a dental screening and any treatment needed. Happily about 150 children made the trip to see us, who then in a huge surprise performed songs for the team.

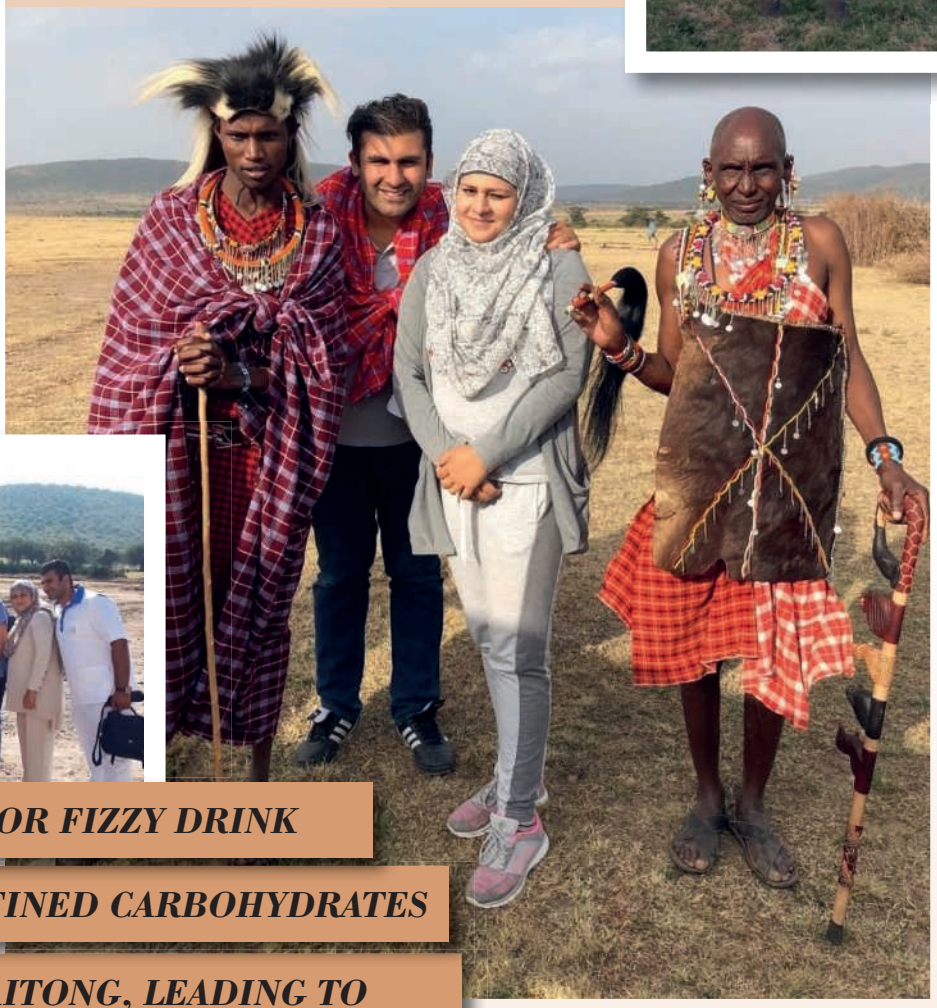
Many children live at the school to avoid the perilous journey walking across the Mara to reach lessons. Facilities are basic but clean and safe, with wonderful, enthusiastic teachers. The team and I will be working with the school in future to ensure more children are able to receive an education which costs $20 per month –beyond the pocket of some families on the Mara. St. John Paul II school receives no government funding and relies solely on community support and external donors. Currently 394 children reside at the school, yet there are approximately 2000 children living in the region. Thanks to the RagstoRiches charity in the UAE we were able to distribute 270 home-made sanitary kits to local girls. Ragstoriches is an amazing group of volunteers who recycle bedsheets into reuseable sanitary pads to help reduce the stigma of menstruation, allowing girls to stay in school throughout the whole year.



Right: Getting up close with elephants on the Maasai Mara

Main photo: Dr Jamshed and Zohra meet the Maasai Chief and his son.

Left: The team with Enaitoti staff



'THE GLOBAL TREND FOR FIZZY DRINK CONSUMPTION AND REFINED CARBOHYDRATES IS ALSO AN ISSUE IN AITONG, LEADING TO CARIES AND ACCORDING TO THE COMMUNITY DOCTORS, ALSO A RISE IN DIABETES AND CARDIOVASCULAR DISORDERS.'

Clinically, the team experienced many cases of severe crowding, carious 6's in very young children and carious 8's in everyone else. Overall the clinic carried out 77 extractions, 19 fillings, 26 prophylaxis and dozens of oral health lessons. St. John Paul II school received toothbrushes and toothpaste to ensure all children would start the year able to brush twice daily.

I'm especially proud of the team for working together with limited resources to achieve so much. By using the triage model and the full skill set of the team we were 100% more effective than a dentist working alone.

The next trip for July 2019 is already in planning and I have begun to establish an organisation called 'Maasai Molar'. We aim to continue visiting Aitong, but also to acquire our own clinic in the area which can employ local staff and provide mentoring for dentists trained in Nairobi. We are also open to applications from other primary healthcare professionals.

Please look for "Maasai Molar" on Facebook. The next expedition to Aitong will be in July 2019, for more details and to register your interest email: maasaimolar@gmail.com or rachaelenglandrdh@gmail.com

Rachael England is a Research Dental Hygienist at University College, London.

Rachael and her chief supporter, Faircare, would like to publicly extend their gratitude to their generous sponsors: Oral B, Beverley Hills Formula, Henry Schein and Colgate.

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What happens when your employer loses their contract?

One of the biggest shake-ups of the last 50 years is underway in the world of orthodontics. **Jasmine Sudworth** and **Russell Abrahams**, lawyers with dental specialist law firm Abrahams Dresden, outline the implications for staff of a change in service provider.

Back in 2006, at the time of the last major shake-up of NHS dental provision, the contracts for NHS orthodontic providers went through fairly smoothly. It was the GDS contracts, mostly for general dentists, which caused the headaches. Roll forward in time and it is the orthodontists who are encountering difficulties. That's because their PDS contracts, by a quirk of European law, are time limited. For some years, most primary care commissioners (Primary Care Trusts for a time) managed the situation by rolling the contracts over. But by last year, it was clear that commissioners in most parts of England were preparing to move to a new system of orthodontic commissioning. They started to invite submissions for orthodontic contracts this year with a view to new contracts rolling out in 2019. Earlier this year, the British Orthodontic Society made its concerns known, stating: 'The BOS considers that, whilst some concessions have been made by NHSE, there remains a significant risk that unintended consequences of the proposals will directly and negatively impact on patients as financial pressures start to build over the contract term.'

Nevertheless, the process is currently underway. Already there are established providers who are losing out to other bigger organisations, sometimes, but not always, tendering at a lower value than the sitting incumbent. This is not always doom and gloom for team members since TUPE - the Transfer of Undertakings (Protection of Employment) Regulations 2006 (the TUPE Regs) - are there to protect you. Nevertheless, these regulations can be confusing and as each contract transfer will be unique and it is advisable that you and/or your employer seek specific legal advice in order to establish whether the TUPE Regs apply to your individual circumstances.

Below Jasmine and Russell answer questions designed to help employees of orthodontic practices who may be unclear about their rights and their options.

What is TUPE?

The TUPE Regs apply to relevant transfers. A relevant transfer can include the situation where activities cease to be carried out by a contractor on a client's behalf and are carried out instead by another person (a subsequent contractor).

In these circumstances the client would be the NHS, the PDS contract holder would be the current contractor/ transferor and the new orthodontist under the PDS contract would be the subsequent contractor/ transferee. If there is a relevant transfer the automatic transfer principle would apply and employees will automatically transfer to the new orthodontist under the PDS contract, who will inherit all rights, liabilities and obligations in relation to the employees.

As mentioned above, each transfer will

be unique and there are certain factors to be considered in order to establish whether the TUPE Regs apply to your individual circumstances. For instance, for there to be a relevant transfer in respect of a service provision change, the employer must have in place a team of employees who are 'essentially dedicated' to carrying out the activities that are to transfer. It could therefore be a complicating factor if the employees at your practice provide a mix of both NHS and private dental work. Similarly, whilst there is no need for the activities carried out by the new contractor to be identical, the contract transferred should relate to 'activities which are fundamentally the same as the activities carried out by the person who has ceased to carry them out'. The extent to which the new activities differ from the old will always be a matter of fact and degree. Finally, there is the possibility that if future services are to be provided by more than one contractor, the services may be considered so fragmented that there is no service provision change.

When should you be told?

The TUPE Regs require both the transferor and transferee to inform and (if appropriate) consult with recognised trade unions or elected employee representatives in relation to any affected employees.

Therefore both your employer and the new orthodontist under the PDS contract are under a duty to inform and (if appropriate) consult in relation to any of the employees who may be affected by the transfer or any measures taken in connection with it.

Please note that for smaller businesses (defined as those with fewer than 10 employees) the rules are slightly more relaxed. The TUPE Regs provide that smaller businesses may discharge their obligations to inform and consult by informing and consulting directly with the affected employees i.e. there is no need to appoint an employee representative.

In respect of timing, affected employees must be given the information required under the TUPE Regs (discussed below) 'long enough before the relevant transfer to enable the employer of any affected employees to consult the appropriate representatives of any affected employees'. This is a fairly ambiguous statement. However, the *Acquired Rights Directive* (the framework document for the TUPE Regs) has suggested that this means within 'good time' prior to the relevant transfer. Ultimately, there is no strict time limit as to when your employer should provide you with this information and much will depend on the extent of any changes which are likely to take place as a result of the transfer.

It is important for your employer to comply with the TUPE Regs, as failure to do so exposes them to liability to pay you compensation equivalent of up to 13 weeks' pay.

This means that you could begin work under a new employment contract with your existing employer. Although, please note that this means that you will lose any rights you had accrued under your previous contract of employment.

'IT IS IMPORTANT FOR YOUR EMPLOYER TO COMPLY WITH THE TUPE REGS, AS FAILURE TO DO SO EXPOSES THEM TO LIABILITY TO PAY YOU COMPENSATION EQUIVALENT OF UP TO 13 WEEKS' PAY.'

How much information should you be given?

You have a right to be told certain information, including:

1. The fact that the transfer is going to take place, approximately when and why. All reasons should be provided where there is more than one reason for the transfer.
2. Any social, legal or economic implications, e.g. a change in location, pay, benefits, or risk of redundancies etc. If the transfer will have no such implications, then the employer should confirm as much.
3. Any measures that your employer expects to take in respect of the affected employees. If there are none then this still needs to be confirmed. Measures should be interpreted broadly to include any 'action, step or arrangement' taken in connection with the transfer.
4. Your employer must also provide information about any measures which the new orthodontist is considering taking which might affect you. Again, even if there are none this will still need to be confirmed.

Can you stay on with your existing employer under a new contract of employment?

Ultimately, yes you can. If you do not want to work for the new orthodontist, you have a right under TUPE to object to your transfer to a new employer.

If you object, your contract of employment and the rights, powers, duties and liabilities under or in connection with it will not transfer to the new orthodontist. However, you should bear in mind that your employment with the existing orthodontist is treated as terminated by operation of law with effect from the transfer date.

What do I need to do to transfer to the new contract-holder?

There is nothing for you to do in order for you to transition to the new PDS contract holder. This will happen automatically. The contracts of employment of those employees affected by the transfer automatically transfer to the new orthodontist on their existing terms from the transfer date.

What happens if your employer agrees to complete the patient treatments already started?

In relation to changes of a service provider, the transfer is regarded as taking place on the grant, assignment, surrender or termination of the relevant operating licence. That is, as soon as there is a change in the legal person responsible for running the economic unit.

Since employees transfer by operation of law the European Court of Justice has ruled that the date of the transfer is a particular point in time, which cannot be postponed to another date at the will of the transferor or transferee i.e. even if your current employer and the new orthodontist agree an alternative transfer date this will not be effective. This means that the affected employees will transfer to the new orthodontist as soon as the PDS contract is granted to them. Accordingly, your current employer cannot agree to continue to employee the transferring employees until the relevant orthodontic work has been finished and they may need to consider using agency staff and/or locums in order to fulfil this arrangement.

Of course, if you object to your transfer to the new orthodontist, you will be able to assist your employer in finishing any ongoing orthodontic treatment under your new employment contract.

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Straight to the point:

considering sharp safety in dentistry

A. Imran,[1] H. Imran[2] and M. P. Ashley*[3]

All members of the clinical dental team face a daily risk of a personal sharp injury. A wide range of sharp instruments are used, some of which are specifically designed to easily pierce the skin and mucosa. The instruments are placed, moved, passed between colleagues, used for treatment, replaced and cleaned, all in relatively confined areas. The clinical dental workplace and the decontamination unit are both therefore sharp-risk environments. There is a clear risk of a sharp injury and the potential consequences of occupational exposure to blood-borne pathogens are at least inconvenient and at worst, career and even life threatening. However, good sharp safety is not universally understood and practised throughout the dental profession. This paper considers the risk of sharp injury in dentistry and discusses some of the methods used to improve sharp safety.

In this context, a sharp can be defined as any dental instrument that has the potential to cause a penetrating injury to the skin. When contaminated with body fluids, a percutaneous injury is classed as a sharp injury.

An estimated 40,000 sharp injuries are recorded annually across the UK medical profession. The true figure is likely to be much higher, however, as the majority go unreported.[1] The National Centre for Infectious Diseases[2] estimates a 0.3% risk of HIV transmission following a sharp injury contaminated with HIV-infected blood. Their report also suggests a 2% risk associated with Hepatitis C and 5% risk from Hepatitis B infected patients (if affected members of the clinical team are not vaccinated).

Health and Safety law applies to risks from sharps injuries. In the UK, the Health and Safety at Work Act 1974,[3] put into law a responsibility for employers to protect the health, safety and welfare of their employees and anyone affected by their business. Subsequent legislations, such as the Control of Substances Hazardous to Health Regulations (COSHH) 2002,[4], have been introduced which require employers to implement measures to prevent the exposure of biological hazards in the workplace. This includes safety-engineered devices and providing protective equipment to employees (COSHH).

More recently, in 2013, the UK government implemented EU Council Directive 2010/32/EU, the 'Health and Safety (Sharp Instruments in Healthcare) Regulations'[5] – a legislative framework agreement on prevention of sharps injuries in hospitals and the healthcare sector.

These regulations include specific information regarding using safer sharps (incorporating protection mechanisms) – regulation 5(1)(b):

'*The employer must substitute traditional, unprotected medical sharps with a 'safer sharp' where it is reasonably practicable to do so. The term 'safer sharp' means medical sharps that incorporate features or mechanisms to prevent*

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or minimise the risk of accidental injury. For example, a range of syringes and needles are now available with a shield or cover that slides or pivots to cover the needle after use.'

It also includes information and training that employers must provide for employees.

The information provided to employees must cover:

- The risks from injuries involving medical sharps
- Relevant legal duties on employers and workers
- Good practice in preventing injury
- The benefits and drawbacks of vaccination
- The support available to an injured person from their employer.

The training provided to employees must cover:

- The correct use of safer sharps
- Safe use and disposal of medical sharps
- What to do in the event of a sharps injury.

The regulations apply to all employers, contractors and workers in the healthcare sector. NHS Trusts, independent healthcare businesses, such as dental practices and other employers whose main activity is the management, organisation and provision of healthcare are subject to the regulations.

Sharp injuries within the UK dental profession are recognised as a problem. In 2014, the British Association of Dental Nurses[6] carried out a survey to which over 1200 dental nurses responded. Eighty-seven percent of the respondents had been working for more than five years. Over half (51%) had had a sharp injury and of these, 60% had had more than one sharp injury. Eleven percent of respondents had had a sharp injury within the previous year. Of note, 41% of injuries incurred by nurses were after use of the sharp but before its disposal and a further 22% was during or after disposal. It is the duty of whoever is using the sharp, to dispose of it as soon as its use is complete, as advised by Safe Management of Healthcare Waste Guidelines.[7]

We can report a simple survey of student dentists and recent dental graduates, undertaken in 2016/2017. The aim was to assess the sharp injury experience among a sample of colleagues in the early years of their clinical careers in dentistry. Participants were foundation dentists from the Thames Valley and Wessex deanery and student dentists in years 3, 4 and 5 at Newcastle University and at the University of Manchester. Participants received an invitation to take part in the anonymous, voluntary, on-line survey, through a variety of social media platforms and university postgraduate mailings lists. The survey was open to participants for a four-month period.

A total of 164 participants responded to the survey. Almost a third (51) reported already having had a sharp injury within their clinical careers and of these, just less than a half (23) had had a sharp injury within the previous year. Half of the respondents (83) knew of at least one sharp injury reported by a colleague from their own clinical team, within this period. Needlestick injuries (32%) were the most commonly reported sharp injury, with 19% of these occurring while using a re-sheathable needle system. Dental burs (26%) and matrix bands (24%) were also frequently reported as the source of the injury. Twelve percent of respondents admitted to not reporting a sharp injury.

Approximately 20% of respondents did not feel confident in managing a sharp injury, with over 12% not having received training in over a year and 3% reported to have never received any sharp safety training. Although the majority of respondents felt their sharp safety training was either adequate (71%) or excellent (22%), 7% still felt inadequately trained. This indicates that not only is training very varied but also inadequately refreshed, resulting in reduced confidence among new graduates.

Advice regarding the management of a sharp injury is contained in Box 1.

The risk of sharp injuries to the dental team has been long recognised and we can report the outcomes of incident reporting at the University Dental Hospital of Manchester, over a twelve-year period (Table 1). The method for incident reporting a sharp injury was improved and simplified twice, in 2008 and 2011 and the increased number of injuries reported each year reflects these changes. Rather than more incidents occurring, it became easier for student and staff members to report the incidents.

To consider which clinical procedures may be most likely to result in a sharp injury, the results for each year reveal around two thirds of injuries occurred in restorative dentistry clinics, although it is recognised that proportionally more patients are treated and a wider range of instruments are used for treatments in these clinics. One fifth of injuries occurred in oral surgery clinics.

A feature of the incident reporting system is the personal narrative that can be added. These highlight the factors that can lead to a sharp injury (Box 2).

To manage the issue of sharp injuries and partly in response to these incident reports, a novel Risk Assessment Tool for Sharps (RATS) has been developed and used at University Dental Hospital of Manchester. The approach is to pro-actively assess the risk of a sharp injury occurring in advance, rather than recording those sharp injuries that are reported, after the event. The RATS method is based on a simple examination of the clinical environment and recording the presence of any of the six known highest risks for a sharp injury.

Box 1 Instructions to manage a sharp injury

1. Don't suck the wound to make it bleed
2. Bleed the wound gently under running water
3. Wash with soap and water
4. Dry the wound and protect with a plaster
5. Identify source of contamination for example, patient details
6. Seek urgent medical advice (for example from your Occupational Health Service or Accident and Casualty Service) to assess the risk and take appropriate action. Effective prophylactic medications are available
7. Document and report the incident locally to your employer.

Table 1 The number of sharp incidents reported per year, at the University Dental Hospital of Manchester

Year	Number of incidents reported
2005-6	22
2006-7	12
2007-8	19
2008-9	27
2009-10	24
2010-11	29
2011-12	38
2012-13	33
2013-14	31
2014-15	34
2015-16	36
2016-17	19
2017-18	23

Box 2 Comments taken from sharp injury incident reports

'While attempting to give patient a second dose of LA, I managed to stab myself with the needle.'

'The dental student received a needle stick to their right forearm from a Cavitron scaler.'

'I pricked my left index finger through my gloves with a size 10 K file.'

'When searching for an instrument on the tray, I scratched my arm on a bur in the fast hand piece.'

'I lent down to pick something up and cut my head on the exposed scaler tip above my right eyebrow.'

'I received a dirty sharps injury to my right thumb. I was assisting during adjustment of an orthodontic appliance. The wire was retained within the cutting instrument after it had been used to trim a small wire within the patient's mouth. The wire perforated my glove and my thumb, which in turn drew blood.'

'Scraped forearm on denture bur when it was in hand piece sat in bracket table. Bur had been used to modify dentures after they had been in the patient's mouth. Stopped using bur after it scraped me, told nurse and tutor.'

'Two nurses have sustained sharps injuries, breaking the skin, with clean instruments not packaged safely, penetrating through the outer packaging.'

'Superficial skin wound from scaler tip to post graduate endodontic student.'

'Bur in fast handpiece in bracket table slot, hit into left arm, above the elbow.'

'Clearing up instruments after the patient had left after receiving dental treatment, I pricked the upper palm of my right hand slightly with the needle following a local anaesthetic. The cover that protects the needle slipped down and caught me. I removed my gloves and although I saw no blood I began to milk the wound under warm water and once dried it was then I noticed a small pin prick that slightly bled.'

'Using sonic scaler, turned round and cut elbow on the tip.'

1. Re-sheathing or re-sheathed needles
2. Bur packs left open
3. Bur left in the hand piece in the bracket table slot
4. Unprotected or unnecessary sharps such as matrix bands and endodontic files left on worktops or bracket tables after use
5. Untidy bracket table
6. Ultrasonic scaler tip left in the handpiece in the bracket table slot.

The RATS method has not yet been validated. The relative risk associated with each of the six risks has not yet been quantified and other factors such as experience of the clinical team are also likely to have an effect. However, the RATS method is a useful clinical audit tool and is a way for any member of the clinical team to identify a potential problem and act to reduce the risk immediately. To adopt this system does not require a lot of time or effort. With practice, the use of the RATS system can be a simple method to identify risks before, during and after treatment and for dental team members to immediately address the risks identified.

'The risk of sharp injuries to the dental team has been long recognised and we can report the outcomes of incident reporting at the University Dental Hospital of Manchester, over a twelve-year period'

Each clinical area is rapidly examined for the six sharps risks and the total number of risks is recorded:

three or more risks identified = high risk of sharp injury, one or two risks identified = medium risk of sharp injury, 0 risks identified = low risk of sharp injury.

Information gained from the incident reports show that introduction of a safety needle injection system immediately altered needle stick injuries from the most common to the least common of the six reported causes of sharp injury. Similarly, introducing a pre-tied matrix band, to be used in preference to the Siqveland or Tofflemire matrix band systems, has notably reduced the frequency of sharp injuries related to the need to tie or untie the metal band, before and after each.

As part of the reflection on the lessons learned from the incident reports and of the outcomes of clinical audits undertaken using the RATS method, the six common causes for sharp injuries have been discussed and simple advice is offered to all members of the clinical team.

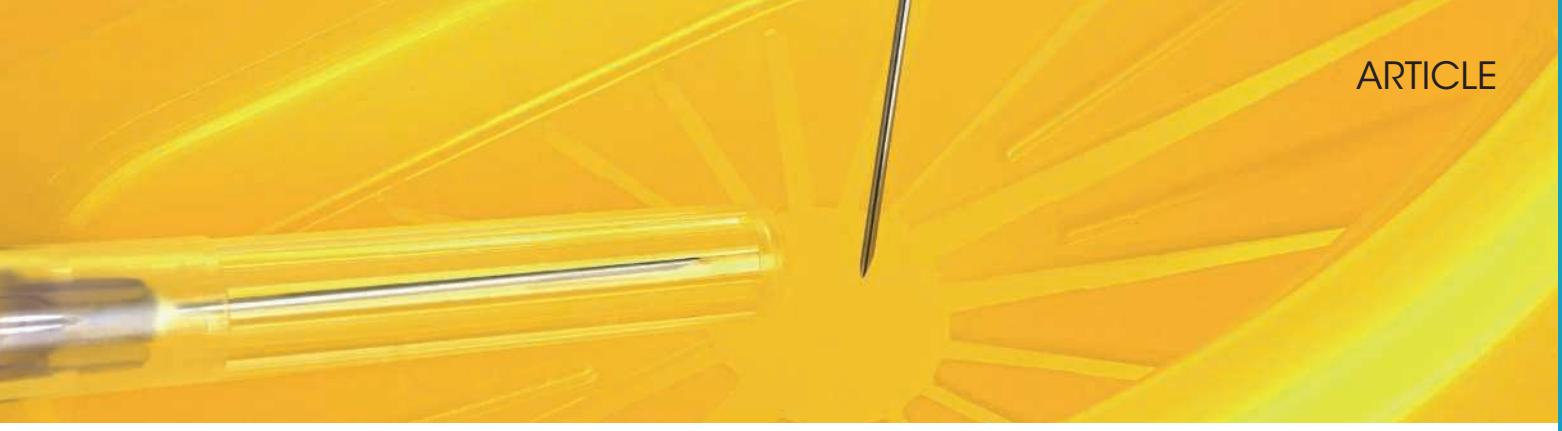
Dental burs are usually presented in a bur pack with the sharp end upwards, within containers with removable lids. These bur packs are often placed on the bracket table, within easy reach of the dentist. The open bur pack is a clear sharp risk but can be simply managed by only opening the lid when a bur is being removed or replaced and keeping the lid closed on the bur pack at all other times.

Handpieces with burs and ultrasonic or sonic-powered dental hygiene instruments are commonly replaced into the slot on the bracket table whenever not immediately required, during and after a procedure. This leads to sharp injuries to the hand, the arm and the leg. To avoid this risk, a hand piece containing the bur or scaler tip should never be put into the slot but rather be rapidly detached from the coupling and placed safely on the bracket table until required again. Furthermore, the habit of inverting the handpiece or scaler instrument within the slot not only maintains the risk of sharp injury to the leg, but also risks contamination from an unclean area of the work surface.

A small effort to maintain a tidy bracket table reduces the risk of sharp injury occurring when instruments, such as matrix bands and endodontic files, are left on the bracket table during a procedure. It is the shared responsibility of the dentist and the dental nurse to maintain a tidy and safe clinical environment.

The consistent occurrence of sharp injuries in a university teaching hospital and in dental practices, affecting all clinical members of the dental profession, strongly suggest that the problem is multifactorial and reducing sharp incidents is a significant challenge for the dental profession. Improvements in equipment and technology, such as the ready availability of sharp safety bins and safety needle injection systems, have been effective.

The use of a new product, such as a safety needle injection system, requires a level of understanding and for the techniques to be learned and actually implemented. Without this, sharp injuries can persist, as demonstrated



by our survey of foundation dentists and student dentists.

Education of all members of the dental team occurs throughout our careers, through a range of methods, such as didactic teaching during our undergraduate years and continuing professional development. However, when education is delivered to support the introduction of improved safety systems, dramatic improvements can be demonstrated. This is supported by the paper by Zakrzewska *et al.*,[8] which highlighted the 'vitally important role of education in the effective implementation of the change to safety syringes'. They used the unit of number of needle stick injuries per 1,000,000 hours worked per year. Education contributed to the reduction from 11.8 to 0.

However, education alone clearly does not lead to adoption of sharp safe habits in daily clinical practice. It is worth considering some of the perceived barriers to this and methods used to improve the situation.

Using new versions of equipment, such as safety needles: these are now readily available and proven to reduce the risk of sharp injuries. The cost associated with using these single use items is marginal compared to the financial implications of a sharp injury occurring. Introducing a proven method to reduce risk is required by law.

Lack of regulation to 'force' clinical teams to act in a sharp safe manner: the current regulations can, in part, be interpreted so that individuals can continue to use unsafe habits in the clinical environment and perhaps need to be addressed in any future updated guidelines.

Lack of education and training: all members of the dental team who train in a university teaching hospital or who join a dental practice require induction training, which will include sharp safety training. This is a requirement that is stated in the recommendations within the HTM01–05 document. More rigorous guidance on sharps injury training and use of safer sharps as a requirement would be beneficial.

Lack of awareness of the scale of the problem and learning from others' incidents: reflective learning from reported incidents and clinical audits are useful educational methods. Sharing of experiences and learning associated with sharp injuries, such as the twelve-year sharp incidence reporting data and the use of the RATS method from the University Dental Hospital of Manchester, provide information to raise awareness in other dental teams and lead to reflection of their own clinical behaviours. Effective local incident reporting processes will allow increased numbers of incidents to be reported, shared and safety lessons learned within the clinical team. The incident reporting method should be immediately available, be simple to use, contain a personal narrative section and be handled by a member of staff with responsibility for risk management, who will feed back to the affected colleague and to the wider dental team.

'It is likely that the main reason for failure to adopt sharp safe methods routinely is related to all members of the dental team accepting repeatedly unsafe habits and behaviours.'

It is therefore likely that the main reason for failure to adopt sharp safe methods routinely is related to all members of the dental team accepting repeatedly unsafe habits and behaviours. The dental team may, of course, be as small as one dentist and one dental nurse, working together regularly. If sharp safe habits are not expected of each team member, the risk of a sharp injury increases.

A quotation attributed to Aristotle: 'We are what we repeatedly do. Excellence then is not an act, but a habit.' To adopt the quotation to this context emphasises that, despite working with sharp instruments in a sharp-risk environment, the dental team can achieve and maintain levels of excellence by habitually using sharp safe methods.

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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.

BICKIEPEGS SUPPORTS POSTERS FOR DENTAL PRACTICES

In support of the BSPD's #DCby1 (Dental Check by One Campaign) dentists are being encouraged to remind parents that NHS dental checks for children are free in England and the recommendation is to get all babies into the dentist's chair before their first birthday.

The Office of the Chief Dental Officer, England, has created new attention-grabbing public awareness posters using a "Little Monsters" theme. This is in support of BSPD's DCby1 campaign. Bickiepegs Healthcare, experts in baby oral health for over 90 years, have joined with the OCDO team to print and distribute 500 posters to dental practices in the South of England.

RADIOLOGY SOLUTION - UPGRADE WITH PROPACS

PROPACS from PRO Diagnostics UK is the perfect solution to seamlessly and quickly manage your diagnostic imaging workflow with the touch of a button. PROPACS automatically stores a copy of your diagnostic image library within the UK.

The system also has a unique dental radiology reporting service. In just 24 hours, your radiographs could be analysed by dedicated dental radiology specialists, saving you time and ensuring that you have all the necessary information you need to create an effective care plan for your patient.

The benefits of PROPACS are that you:

- Save time on radiology reporting.
- Lower your medical legal liability.
- Comply to the recently upgraded GDPR requirements!

For more information, please visit www.prodentalradiology.com or email sales@prodiagnostics.co.uk

TIME TO REJUVENATE YOUR PATIENT DENTAL CHAIRS?

Meditelle-Dental provides a specialised onsite service to re-upholster all brands and models of patient dental chairs, across the UK.

To ensure your equipment is not out of service for any length of time and to minimise downtime all procedures are carried out at your surgery, so you can get a fresh new look for your dental chairs in just a few hours. Our visiting expert upholsterer has over 20 years' upholstering experience, so you can be assured of a professional finish.

Re-upholstering your patient chairs 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 risk. Meditelle's re-covering service will ensure that your patient chairs are hygienic and the safety of your equipment is maintained in line with CQC requirements.

Meditelle offers you a wide range of over 20 vinyl colours to choose from, all are medical contract grade vinyl's and contain an antimicrobial additive to provide long-lasting effectiveness even after regular cleaning. They are also effective against the spread of MRSA, E coli and other bacteria on its surface.

At the same visit you can also have a 'made-to-measure' scuff guard fitted to your newly upholstered dental chairs and opt to have your operator seating re-covered in the same matching vinyl.

Flexible onsite appointments are availble to work around your practice's busy schedule with early time slots prior to opening.

Obtaining a no-obligation quotation couldn't be easier, just email Meditelle a full image of your chair front and back along with your postcode location. For more information, www.meditelle-dental.co.uk

NEW MICROBIOME-BALANCING TOOTHPASTE LAUNCHED IN THE UK

Zendium is a toothpaste that works differently. In addition to fluoride, its unique SLS-free formulation contains natural enzymes and proteins which boost the natural salivary defences[1] and balance the oral microbiome. A landmark study, published in 2017, showed that over 14 weeks' use, Zendium significantly increased health-associated bacteria and significantly reduced disease-associated bacteria.[2]

These findings complement a growing expert consensus which recognises that it is the overall balance of the oral microbiome which is key to oral health rather than the simple presence or absence of a specific pathogen.[3]

Two further studies now demonstrate the clinical benefit of Zendium's balancing effect. In a 13-week controlled clinical trial, 83% of Zendium users experienced improved gingival health with Zendium showing superiority vs control across all three clinical indices measured.[4] Supporting these results, a real-world study of over 300 people in Denmark revealed that long-term Zendium users had significantly better gingival health than those using regular toothpastes.[5]

Zendium can be bought on Amazon.

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ZENDIUM COMPLETE PROTECTION REVIEW

By Kishan Patel, dental therapist

Zendium is a toothpaste brand that has been developed in Scandinavia over the past 40 years where it is also one of the toothpastes most recommended by dental professionals[1]. Zendium contains active enzymes and proteins that are found in saliva, with the aim of boosting the body's natural defences to keep the mouth's microflora balanced. This results in a reduction in the number of disease-associated bacteria and an increase in the number of health-associated bacteria [2], therefore antibacterial agents such as triclosan are not required to reduce bacterial numbers. Fluoride is present at 1450ppm in the form of sodium fluoride, aiding remineralisation of enamel and providing protection against cavities[3].

All Zendium toothpastes are free of sodium lauryl sulphate (SLS). SLS is a common foaming agent which has been known to cause aphthous stomatitis and irritations to mucosa in the mouth[4]. SLS is also known to alter taste for a short period after use and may cause xerostomia[5].

As Zendium is SLS free it can also be used together with products containing chlorhexidine digluconate if required. SLS reduces the antiplaque effect of products containing chlohexidine digluconate[6]. Zendium products are also paraben free.

Zendium Complete Protection has a mild, subtle peppermint taste with a minimal cooling effect, not leaving the mouth overwhelmed with a minty taste, as found with many other toothpastes. It lightly foams in the mouth but significantly less than toothpastes which contain SLS, and is also not abrasive in texture. I appreciate its method of delivering protection for a healthier mouth through the addition of active enzymes and proteins. Zendium is limiting chemicals (SLS, parabens and triclosan) which have been known to be harmful and is keeping mild ingredients in its formulation. This would appeal to those who know these ingredients may be detrimental to their health.

Zendium Complete Protection would appeal to:

- Those who suffer from aphthous stomatitis, irritations of the mucosa or xerostomia linked to SLS
- Those who suffer from sensitive gingiva and/or suffer from gingivitis or periodontitis
- Those who prefer a mild tasting toothpaste
- Those who use a chlorhexidine digluconate product during their oral hygiene routine
- Those looking for a paraben free and/or SLS free and/or triclosan free toothpaste which contains fluoride

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HELP PREVENT BIOFILM BUILD-UP

Aspirmatic cleaner from schülke – experts in infection prevention and control – is designed for cleaning dental suction systems and spittoons. Regular use helps prevent the build-up of biofilm.

During routine use of the suction unit, organic and inorganic substances can be deposited which may dry in the tubes potentially leading to contamination and the risk of cross infection for staff when changing the filter. Aspirmatic is effective against bacteria (including salmonella and legionnella), fungi and viruses (including HCV, HBV, HIV) in 30 minutes.

Extensive testing of Aspirmatic in dental practices has shown the non-foaming formulation is quick and easy to use, with a broad spectrum of efficacy. Aspirmatic has a three in one action and cleans, disinfects and deodorises in a single application.

A two litre bottle reconstitutes to 100 litres, helping to save on storage space as well as cost.

To find out more visit www.schuelke.com or contact: schülke UK, Cygnet House, 1 Jenkin Road, Meadowhall, Sheffield, S9 1AT / 0114 254 3500 / email: mail.uk@schuelke.com

THE POWER OF A HEALTHY SMILE

UK parents are keen to invest in improving the smiles of their children. That's according to a new survey[1] of over 2,000 adults. Responses reveal that fixing their children's teeth would be high on the priority list if they won £5,000 to spend on future-proofing their children.

The survey – conducted on behalf of Align Technology, the global company behind Invisalign clear aligners – sought parents' attitudes towards investment in their children's future, as well as their own. A quarter (24%) of parents cited teeth straightening as an investment of choice.

When asked what troubled their children the most about their appearance, 21% of parents revealed their child often felt their teeth and smile concerned them, compared with 19% sensitive about the condition of their skin and 17% worried about weight.

Respondents said they would happily help their children improve their smile in a bid to boost confidence (40%) – with teeth straightening deemed the most acceptable procedure to embrace in order to change their facial appearance (39%).

Parents were also keen to address their child's crooked teeth if it meant putting paid to potential bullying (23%) or raising the bar for long-term life success, with 15% happy to pay for teeth-straightening treatment to boost their kids' school achievements (15%).

Align Technology has tailored its Invisalign product to meet the needs of teenagers as the system includes a number of features to help orthodontists treat younger patients – including its latest mandibular advancement options.

The aligner series work incrementally - changed every one to two weeks - as teeth are gently repositioned into alignment. Because they are removable, the aligners have little impact on speech, eating and drinking and socialising. Plus, if wearers have a major event coming up, they are easily removable for short periods of time – although the optimum wear time is 22 hours a day.

According to the survey, if given £5,000 to spend on themselves, parents were more likely to fix and whiten their own teeth. These treatments were more popular than Botox, lip fillers, a facelift, nose job, a tattoo or a nose piercing – with the majority citing their smile as the part of their appearance about which they were most self-conscious. Align Technology designs and manufactures the Invisalign system and iTero intraoral scanners. For more information, please visit: www.invisalign.co.uk.

1. Investing in the Future – conducted for Invisalign The survey of 2002 UK adults, 50% male and 50% female took place between 20th-23rd April 2018. Participants came from 12 regions in the UK and were from a variety of socio economic backgrounds. A (10%), B (27%), C1 (17%), C2 (15%), D (9%), E (22%). 81% of participants had 1 or more children, 83% of those children were aged 10 or more. Participants were asked a range of questions based on their attitudes to investing in the future for themselves and their children.

DENTAL ELITE CAN HELP

As concerns mount over recruitment issues and impaired growth of dental businesses, assistance from a specialist agency with dental experience is more vital than ever.

Dental Elite has many years collective experience across the team, and with a customer rating of 4.8 out of 5, it is one of the profession's must trusted agencies, covering recruitment, sales and acquisitions, valuations and finance.

'I would definitely recommend Dental Elite to others, and would certainly give them a call if I ever needed to find another job in the future,' says associate Justin George.

STEAMLINING CLINICAL SOLUTIONS

Manufacturer W&H has got several new solutions in its range to help streamline clinical procedures. Among them are the Lisa type B vacuum sterilizer, featuring Eco Dry technology that adapts the drying time to the mass of each load. For dental practices which provide implants, they have the Osstell Beacon handheld device, which identifies when an implant is ready for loading, thereby improving osseointegration.

Assistina TWIN handpiece care and maintenance unit provides a cost-effective solution to extending the working life of handpieces

These innovative products make up an exciting catalogue of high quality dental technology, that also includes the Piezomed unit and the award-winning Synea Vision range of powerful handpieces.

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

BDJ Team CPD

CPD: ONE HOUR

CPD questions: October 2018

Feeding in the First Year of Life

1. The government recommends a daily supplement of Vitamin A for children aged 6 months to 5 years unless:

A) They are being given cow's milk to drink

B) They are consuming over 500ml of infant formula per day

C) They are receiving enough daylight

D) Their diet includes smoothies

2. What drinks are recommended for babies between meals

A) Milk and baby juices

B) Freshly squeezed oranges and milk

C) Diluted tea with sugar

D) Milk and water

3. Which two statements are new to the SACN on nutrition in 2018

A) Discourage bottle feeding from 12 months

B) All infants from birth to 1 year of age who are exclusively or partially breastfed should be given a daily supplement containing 8.5 to 10µg of vitamin D

C) Unmodified cows milk should not be given to infants

D) Foods containing hen's eggs and peanuts can be introduced from six months of age

4. A decreased risk of caries is associated with:

A) Vitamin D

B) Breastfeeding for the first year of life

C) Soya milk formulas

D) Unmodified cow's milk

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 still 10 hours of free *BDJ Team* CPD on the CPD Hub from 2017, in addition to this year's CPD hours.

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

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