PERSONAL ACCOUNT

Redeployed as a district nurse

Lwazi Sibanda[1] (pictured) with Vanessa Muirhead[2] reflects on being a dentist redeployed as a district nurse during the COVID-19 pandemic.

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Initially, I was apprehensive about the thought of being redeployed to the district nursing team while working as a dental core trainee (DCT). I was working as a DCT2 in paediatric dentistry, having previously held a DCT1 post in community dental services and oral and maxillofacial surgery (OMFS), as well as having worked in general practice. My first encounter with district nursing was through references I heard whilst working as an OMFS Senior House Officer, when I had to arrange for a patient to have their sutures removed in the community after their discharge. I was unfamiliar with the role that the district nursing team played. Despite any anxieties concerning my new role, I was aware of the great need for support for the NHS during the pandemic, as well as new pressures on the district nursing teams. With support from the dental team, I was fully supported to start my new role.

After undergoing training and completing competencies, I started my new role in the district nursing team. The team consisted of assistant practitioners, community staff nurses, health care assistants, as well as district nurses. Each member of the team had their own unique role with different competencies, working to support the whole team in the most effective way. This began with observing colleagues, followed by assisting and then independently visiting patients and delivering necessary care. My average day is shown in Box 1.

I provided care to patients in their homes, as well as in residential homes, with the majority of patients being housebound and often elderly. Throughout this time, I was able to apply medical knowledge from my dental training. This was applied through taking history when patients had additional complaints and raising this with a senior member of the team. I managed a patient with a low blood glucose reading, recorded and interpreted observations on a NEWS2 [National Early Warning Score] chart and used my knowledge of the aseptic technique from my clinical experience theatres. Wound care accounted for the majority of care for patients. I found that the management of chronic wounds often required primary and secondary dressings, as well as compression (if leg wounds). This was very different from the management of wounds that I had encountered during my OMFS experience, which usually consisted of lacerations that could be closed primarily using sutures. Moreover, the need for flexibility was crucial; this included being able to work in tight spaces in patients' houses.

Daily handover involved discussing the patients we had provided care for, as well as any new referrals or updates to patients. This provided an excellent opportunity to reflect on my assessment and treatment and learn from other members of the district nursing team. As I was working alone, handover served as a reminder that each home visit accounted for the patient's overall plan and a reminder each treatment played a significant part in the patient's comprehensive care.

The handover also provided a culture of celebration within the team. For example, this included celebrating patients gaining more independence with their care, as well as staff members completing competencies. Through presenting my patients during handover, I continued to grow in confidence.

My new role gave me insight into the patient pathway and access to the care provided by the district nursing team. This gave me an appreciation for the multi-agency approach required by the district nursing team, and other community services, general medical practitioners, hospital

departments, care agencies and social services. An example of this included Gold Standard Framework End of Life MDT meetings regarding the palliative patients that the team helped to support. Additionally, having the opportunity to work alongside other redeployed staff from different specialities, within the community, provided an excellent opportunity for shared learning.

Having patient continuity resembled my experience of general practice, while short term care plans resembled my experience of treating patients referred to the dental hospital and oral surgery departments. I thoroughly enjoyed assessing and treating regular patients that required support with their diabetic management or medication prompting. This allowed continual rapport with the patients, their families and their carers.

District nursing is very different from dentistry. However, my redeployment provided me with an invaluable opportunity to continue to carry out a holistic person-centred approach while being mindful of the need to work collaboratively with patients, families, carers and the wider medical team during this challenging time.

This experience highlights the versatility, resilience and adaptability of the dental profession to modify and support the wider healthcare system in the face of a national crisis.[1]

I am thoroughly grateful for the opportunity to have worked alongside the district nursing team and care for vulnerable patients.

Many thanks to the Woodgate Valley District Nursing Team and the Paediatric Dental Department at Birmingham Dental Hospital. ■

Box 1 Average day (average times) working with the district nursing team

1. 08.30–10.00 Early patients (medication prompts, management of diabetic patients, eardrops or eye drops)
2. 10.00–13.00 Treatment including wound care, catheter care, observations, double-up visits
3. 13.00–14.15 Lunch & handover
4. 14.15–15.30 Jobs & responding to messages
5. 15.30–16.30 Late patients (medication prompts, management of diabetic patients, eardrops or eye drops)
6. 16.30 Home.

Reference

1. Sacoor S, Chana S, Fortune F. The dental team as part of the medical workforce during national and global crises. *Br Dent J* 2020; **229:** 89–92.

Looking for writing opportunities?

Would you like to write for the *BDJ*'s sister publication, *BDJ Team*? *BDJ Team* is aimed at UK dental care professionals (DCPs) and published online ten times a year. Editor Kate Quinlan [also the *BDJ*'s News Editor] publishes a wide range of features, news, advice and informative content and is open to submissions or content ideas.

If you think you could write with a 'whole dental team' outlook and focus, there are opportunities for publication in 2021. To discuss your content idea please email k.quinlan@nature.com. *BDJ Team* also has a manuscript submission portal which can be found at https://go.nature.com/3hWlKc1.

To get a feel for the type of content published in *BDJ Team*, which was launched in 2014, please visit www.bdjteam.co.uk.

Russ Ladwa inaugurated as BDA's 134th President

Russ Ladwa took office as the 134th President of the British Dental Association (BDA) on 16 September 2020.

A former Dean of the Faculty of General Dental Practitioners, Russ has chaired both the Federation of London Local Dental Committees and the Dental Vocational Training Authority, and was a board member of the odontology section of the Royal Society of Medicine before being made its President. In 2012, having been a life-long member of the BDA, Russ was elected to its board, serving until 2019.

Russ qualified as a dentist from the London Hospital Medical College in 1975. He returned from a short spell as a civilian dentist in the US Army to work as an associate in an NHS practice in West London in 1977, buying the practice shortly thereafter.

In the 1980s, Russ was involved in establishing the Asian Odontology Group and was a founding member of the Association of Dental Implantology. In 1990, he was one of the first London GDPs appointed as a Postgraduate Dental Tutor, a position he held for 23 years.

Russ' full Presidential address was published in the 25 September issue of the *BDJ* (Volume 229 issue 6).