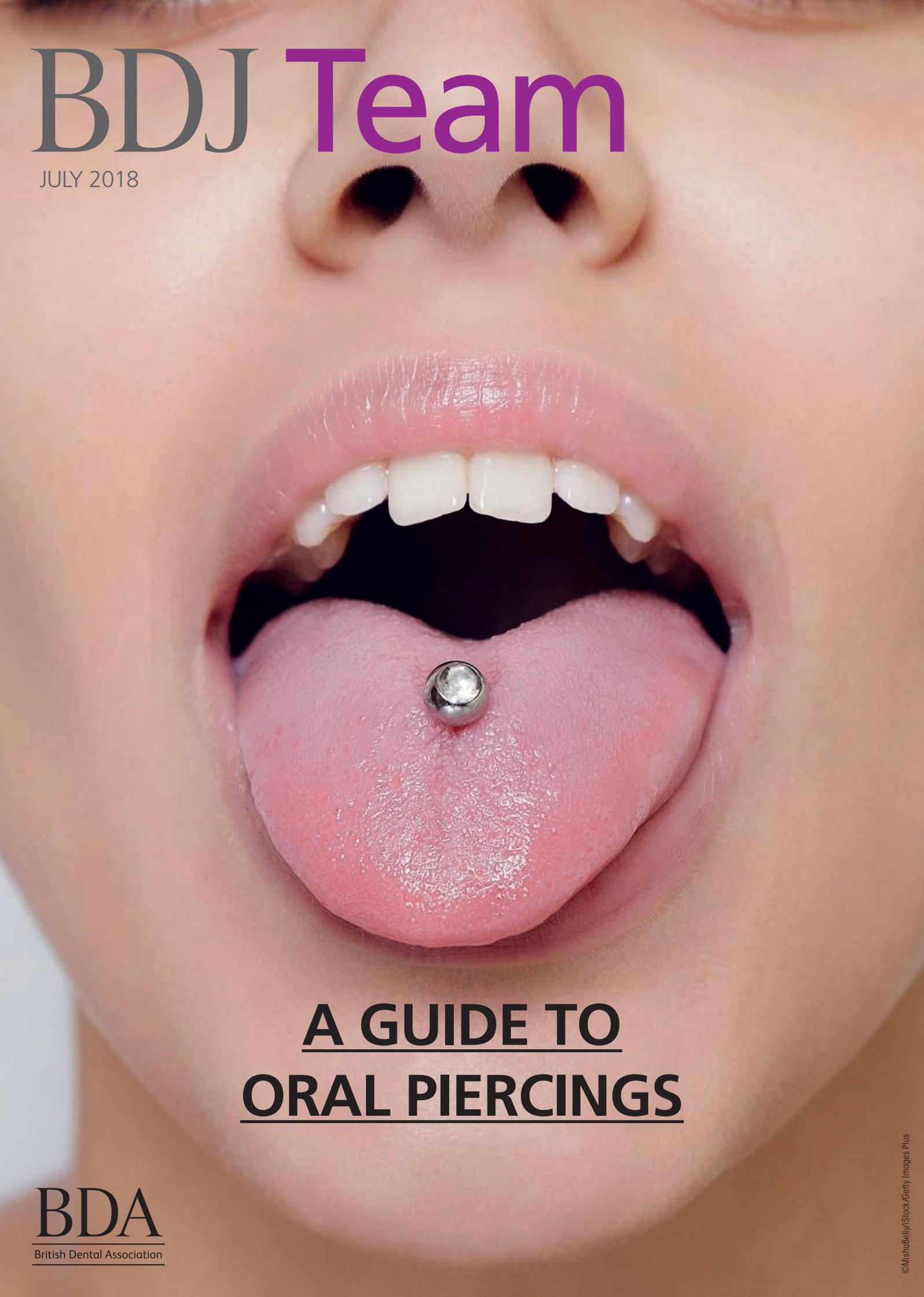


BDJ Team

JULY 2018

A close-up photograph of a person's mouth, showing their teeth and tongue. A silver tongue piercing is visible on the tongue. The background is a soft, out-of-focus skin tone.

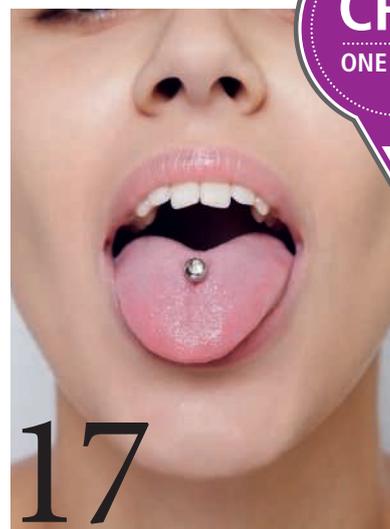
A GUIDE TO ORAL PIERCINGS

July 2018

CPD:
ONE HOUR

Highlights

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A research article investigating oral piercings, their complications and how much the dental profession knows about them.
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Dental nurse and GDC fitness-to-practise panellist, Priya Sharma discusses challenging patient interactions and advises on how best to manage them.
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GETTING YOUR **TEETH** INTO DENTISTRY

A review by **Reena Wadia** of the Wellcome Collection's summer exhibition 'TEETH'

The Wellcome Collection's summer exhibition 'TEETH', is the first exhibition to chart the history of the dental profession that has shaped the way society lives (with or without teeth). The exhibition features over 150 objects that have been assembled from Henry Wellcome, the Northern European collections and the British Dental Association.

From barber-surgeons to professional dentists, the origins of dentistry are explored. The exhibition features the first scientific treatise on teeth. *Le Chirurgien-Dentiste* (the Surgeon-Dentist), 1728, by Pierre Fauchard, which is displayed with examples of early techniques and tools. Dental care for the wealthy is shown through specimens, such as dentures belonging to King William IV and Napoleon's toothbrush. The blacksmiths who performed extractions for the less privileged are depicted in paintings, with caricatures by Thomas Rowlandson contrasting the suffering of the poor.

The progression in the technology behind dental drills, radiographs and

anaesthetic is gradually revealed. The exhibition also displays the changing availability of consumer products such as toothpastes and brushes. The evolving ideas on the importance of oral hygiene are presented through poster campaigns, films and animations.

While walking through the exhibition, it is made clear that the development of modern dentistry has come to represent a great deal more than physical health. Teeth are shown to be intrinsically linked to identity, both individual and cultural. The exhibition considers the language we use around teeth, such as gnashing them, gritting them or lying through them, and examines the tensions surrounding dental care, whether for health, comfort or confidence.

Admission to the exhibition at the Wellcome Collection in London is free. 'TEETH' runs from the 17 May – 16 September 2018, so if you haven't popped in already, it's definitely worth a visit!

More information at <https://wellcomecollection.org/exhibitions>.



NUMBER OF UK ADULTS SEEKING BRACES IS RISING

New figures released by The British Orthodontic Society (BOS) to coincide with National Smile Month, reveal the number of adults seeking orthodontic treatment in the UK continues to rise.

This survey, conducted in March 2018 among BOS members, was designed to gather new data about orthodontics and patient choices in the UK compared to two years ago.

Asked if they were seeing an increase in private adult treatment, 80% said yes. This figure compares to 75% in 2016.

The survey showed that adult patients are most likely to be female and in the 26–40 age bracket. However, the number of men seeking treatment appears to be on the rise. Nineteen percent of the respondents to the survey estimate that half of their adult



patients are male. This compares to 13% in 2016. The most popular system, provided by more than 98% of orthodontists, is fixed braces on the front of the teeth, often referred to as train tracks. This figure reflects the high number of young people treated as NHS patients for whom fixed braces is the most appropriate option.

A quarter of BOS members responded to the survey. Of those who answered the survey, 27% see only NHS patients while 67% see both private and NHS patients.

Dates for your diary

National Dental Nursing Conference

The 2018 National Dental Nursing Conference, to be held at the Blackpool Hilton on 16 and 17 November, will be opened by the Deputy Chief

Dental Officer England, Eric Rooney (pictured).

Mr Rooney will be the Keynote Speaker at the Conference at the Opening Ceremony on Friday 16 November, following the Meet the President Welcome Lunch.

Other subjects on the conference programme include counterfeit equipment and materials, head and neck cancer, alcohol awareness, sepsis, communities of practice, dentistry for the disadvantaged and pride in practice.

Further information and a reservation form is available at www.badn.org.uk/conference.

The future is yours!

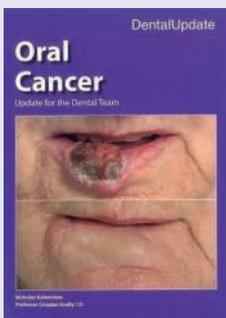
The BSDHT's Oral Health Conference and Exhibition will be held on the 23 and 24 November 2018 at the Telford International Centre. It provides a fantastic opportunity for all dental hygienists, dental therapists and students to update their knowledge, gain verifiable CPD and meet like-minded professionals from across the country.

The theme of this year's event is 'The future is yours', focusing on professional development, empowerment and aspiration. It recognises that BSDHT members are clinical professionals with a huge and mostly untapped potential to develop as individuals and as part of a business.

To make sure you don't miss out, save the dates in your diary!



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ORAL CANCER: UPDATE FOR THE DENTAL TEAM

A book review by Z. C. Sullivan, first published in the BDJ (2018; 224: 477)

This textbook by Nicholas Kalavrezos and Crispian Scully

covers the topic of oral cancer in a concise but detailed manner. The book certainly achieves its aim: to update the dental team, enhancing their knowledge on the many aspects of care and management that oral cancer encompasses. The chapters covering the risk factors for oral cancer will help dental team members to advise and aid patients in the cessation of habits which may prove detrimental to their oral and general health.

The layout of this book provides the reader with the necessary information in a logical manner. The opening chapter introduces the pathogenesis of cancer by introducing the reader to the cellular, histological and molecular changes that occur in the disease process. This is followed by three detailed chapters on the risk factors of oral cancer, which will enrich all clinicians who aim to promote preventative advice. The chapters which cover 'potentially malignant disorders'

and referral guidance assist the identification of lesions which may require referral to a specialist. It also encompasses the UK referral guidelines in a precise manner.

In the chapters that cover oral cancer treatment and the patient care team, the authors efficiently summarise the relevant information to convey the patient journey. Such chapters would be of interest to any dental team member, however, they would be most beneficial to any dental core trainee that was undertaking a post in maxillofacial surgery, in a unit that treats head and neck cancer. The radiotherapy and chemotherapy aspects of oral cancer are also introduced to the reader, along with relevant complications that may present to dental clinicians.

Overall, the book fulfils its purpose entirely in updating the dental team on oral cancer; however, I would say it goes beyond its suggested intention. I feel that the book is probably best suited to those pursuing a career in oral medicine but each member of the dental team has knowledge to gain from reading some or all of this text.

Can dental nurse training provide exposure to both practice and hospital settings?



O. Awojobi,^{*1} S. Movahedi,² E. Jones³ and J. E. Gallagher⁴

Introduction Dental nurses traditionally train in either hospitals or practices. A London pilot scheme provided exposure to both settings to explore the potential for dual training. This evaluation examined the motivation, experiences, career expectations and initial careers of trainees. **Methods** A questionnaire-based survey at two time points during the training. Descriptive and inferential analysis conducted using SPSS version 22. **Results** Overall training was rated highly (7–9) by 100% of trainees with positive views of the concept of dual training. There was also a preference for full-time work in primary care with career decisions strongly influenced by personal factors – financial stability, work-life balance and professional development.

Rotating between settings proved challenging so did perceived low wages; lowest job satisfaction scores were for physical working conditions and remuneration. However, advantages included high levels of preparedness for team-working with most recognising the dental team has shared responsibilities. A high proportion of trainees were employed in primary care (57.8%) post-qualification. Strong interests in gaining further qualifications were reported (92.3%). **Conclusion** The outcome was generally positive with evidence of academic success, employability, commitment to a career in dental nursing and sufficient support for training in multiple settings to be introduced into future dental nurse training.

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Introduction

Dental nursing in the United Kingdom

Dental nursing in the UK currently leads the world in becoming professionalised, requiring dental nurses to be fully trained and registered, following a limited period of training.^{1,2} The General Dental Council had 55,691 dental nurses on its register as of January 2017,³ making up the largest group of registrants at 51%.

The vast majority of registered dental nurses have trained within the UK (>99%), and 5,140 qualified nurses were added to the register in 2015.⁴ The scope of practice of dental nurses is clearly defined,⁵ including core functions and additional skills that may be developed post qualification. In 2008, it became mandatory for all dental nurses working in the UK to register with the General Dental Council,² except student dental nurses on an accredited training course who are not required to register until after qualification. All dental nurses are also

required to undertake continuing professional development (CPD) once they are qualified and registered with the GDC.⁶ Proponents of compulsory registration argue that it raises the profile of dental nursing whereas opponents feel it may have added to the existing recruiting and attrition problems.^{7–9}

The dental workforce, once trained, is an important resource and it is necessary to understand the motivation and career expectations of each section of the workforce; however, there is limited published research on the dental nursing workforce.^{10–13} There is some evidence that the motivation for their choice of a career in dentistry has parallels with the dental profession as a whole, whereby 'features of the job' form an important element.^{10–12} Innovation in training to provide experience across both sectors of dentistry in their training will provide dental nurses with broad training experience and should increase their preparedness to work across settings and thus



enhance their future career prospects. Research among hospital-employed dental nurses suggests that 'opportunity to progress in dental sector' was the greatest influence on their career decision.¹² Evidence on career expectations from surveys of existing programmes suggest that dental nurses wish to work across primary and secondary care settings, within the NHS and private sectors,^{10,13} and there is strong interest in further professional development,^{12,13} sometimes leading to dental hygiene and therapy.¹³ Retention of dental nurses, as with general nursing, is a professional challenge, with the GDC experiencing significant turnover in this sector of the dental profession.^{14–16} Evidence from a survey of preregistered dental nurses in Scotland suggests that there may be a mediating role for work engagement and personal accomplishment in their stability of remaining in the job.⁷ Lack of job satisfaction has also been shown to be a key determinant of intention to leave.¹⁷

There is great emphasis on professional teamwork across healthcare in general, and dentistry in particular. The General Dental Council guidance on 'Preparing for Practice: Dental Team Learning Outcomes',¹⁸ places great emphasis on coherence of education across dental team members, including dental nurses. Inter-professional education may improve professionals' abilities to work more effectively in a team.^{19–22} Furthermore, the role of the dental nurse is expanding within the dental team to include elements of clinical care, notably the application of fluoride varnish.^{5,23} As the role of dental nurses has developed and their jurisdiction expanded,^{5,24} so it is necessary that their education and training develops in parallel. This is the case for the whole dental team and recent changes have seen dental

students increasingly training across primary and secondary care settings.^{25,26} Theoretically, this should also prove beneficial for dental nurses.

Current arrangements allow for training in one setting only, either dental hospital or dental practice, with little or no exposure to other settings. However, the vast majority of potential employers are currently based in primary care. Training in primary care may not always include any exposure to the varying team and complex cases more commonly found in secondary care. Health Education England (HEE), which leads on dental education across London, established a pilot dental nurse training scheme to address the issues highlighted by a single-setting training. This was a shared training pilot between primary dental care practices and a hospital trust in North East (NE) London which have been accredited to run National Examining Board for Dental Nursing (NEBDN) training courses and comply with the new NEBDN regulations.²⁷ Trainees worked part-time at a dental practice and part-time at the hospital provider; alternating between sites weekly. Trainees spent one day per week on didactic training at the hospital provider. The aim of the pilot, as outlined by London's Postgraduate Dental Dean, was 'to provide trainees with a broader training programme with exposure to the rich but varying experiences that can be found in the different settings and help to produce a workforce that is better prepared'. It proposed to provide better value for money by doubling the number of trainee posts available. Ultimately, the pilot hoped to increase partnership between primary and secondary settings in order to produce a workforce that will improve patient care and experience, with nurses fit to work in

all settings and taking on board the changes to the delivery of dentistry by the future workforce. Further details on the scheme will be published in due course.

Aim and objectives

The aim of this research was to examine the motivation, experiences, initial careers and career expectations of dental nurses trained through this pilot scheme, over the course of their training. Stakeholder views on the pilot training initiative itself are reported elsewhere.²⁸

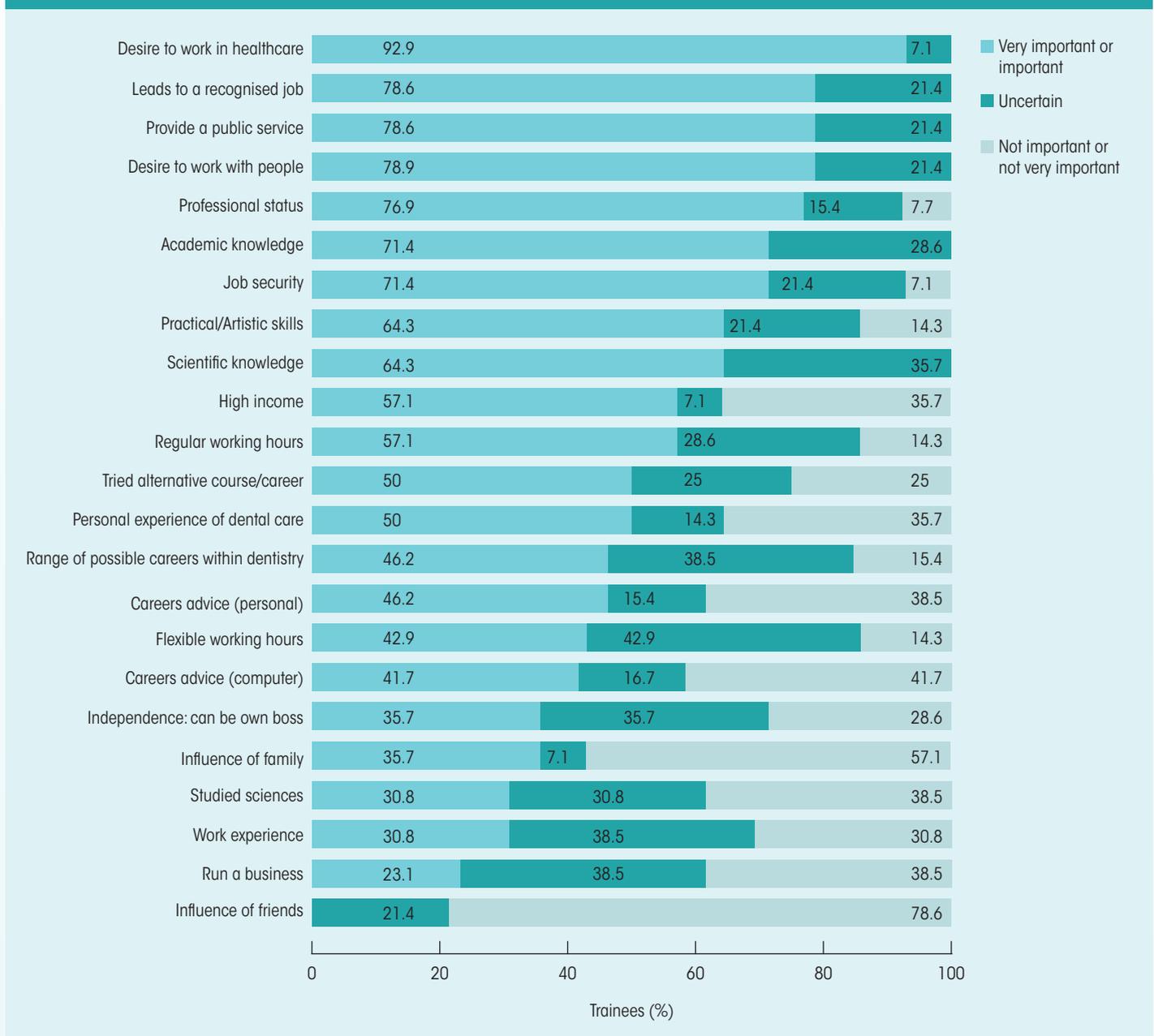
The main research questions were:

- What are the motivations, career expectations and career decisions of the dental nurse trainees entering the pilot scheme and over time?
- What are their experiences of the training and education, preparedness for team working, their job satisfaction and views on retention following the pilot scheme?

Methods

This was a quantitative research study using a cross sectional survey looking at the dental nurse trainees cohort longitudinally. This approach was informed by previous dental workforce research.^{10,12,29–31} It sought to explore the feasibility of training dental nurses across different settings. Ethical approval for the study was obtained from King's College London (BDM/14/15–15).

All dental nurse trainees on the pilot scheme were invited to take part in the research study in the first term of their training. Trainees were sent personally addressed letters from HEE inviting them to take part in the study along with the information sheet. A researcher (OA) attended a session with the trainee in their first term to answer questions, obtain consent and to administer baseline questionnaires. Based on previous research, the questionnaires explored their motivation for a career in dental nursing,^{10,29,30,32} career expectations and influences: short- and long-term,¹² amended in light of current GDC guidance on additional skills,⁵ retention³⁴ and job satisfaction,¹⁷ team working views^{21,22} using the Readiness for Interprofessional Learning Scale (RIPLS)³⁴ modified for use in dentistry and the Dental Roles and Responsibility Scale,²² and demography.^{10,29,30,32} Follow-up questionnaires were distributed to trainees immediately after qualification in order to investigate possible changes in their views over time; linked using a unique identifier code to help maintain anonymity. Data were entered and analysed using Statistical Package for Social Sciences (SPSS) software. Descriptive and inferential statistics were used to examine the data given the small sample size.

Fig. 1 Motivation for a career in dental nursing (Term 1)

Results

Thirty trainee dental nurses were recruited onto the pilot scheme which commenced in August 2014. Thirteen trainees departed the scheme during the course of the year due to personal circumstances, pay and working conditions, and illness among other reasons. Of the 17 remaining trainees, two of them did not complete their Records of Experience (ROE) by the deadline and were therefore not entered into the examination. Fifteen trainees were entered into the final NEBDN examination, all of whom passed the written exams at first attempt (100%) while fourteen of them passed the practical exams at first attempt (93.3%).

Over half of trainees who qualified (57%; $n = 8$) work in primary care with six employed at their training practices; one at a wholly

private practice and one in a mixed NHS/private practice. A further 14% ($n = 2$) were employed in a dental hospital, 14% ($n = 2$) work with a dental nursing agency and there was no information on the destination of two trainees (14%).

Demography

Fourteen students participated in the survey in term 1 and 13 students in term 3. Eleven students participated in both surveys. Participants were mainly mature students (average age 32 years) who had caring roles living with their partner/children or in their parental home. The group had an array of qualifications and previous careers. Half of respondents were black African and a quarter were Caucasian.

Motivation for a career within dentistry

The most notable factors which influenced their choice of a career within dentistry was their desire to work in healthcare and with people, to provide a public service and that it leads to a recognised job with professional status (Fig. 1). Over the course of the training the most prominent influencing factor changed from the desire to work in healthcare to job security.

Education and training

Overall training and the educational element both had notable improvements in ratings over time; with 100% ($n = 13$) of trainees rating both seven and above in term 3. Training at dental practice scored lowest initially followed

Table 1 Readiness for interprofessional learning scale (RIPLS)

Scale and subscales (/Max)	Mean (SD)	
	This study	Colonio Salazar (2016)
Total RIPLS score (/95)	74.64 (6.27)	80.36 (6.25)
1. Teamwork and collaboration (/45)	37.42 (3.34)	40.73 (3.64)
2. Professional identity (/35)	27.00 (3.57)	28.67 (3.14)
2a. Negative professional identity	11.08 (2.78)	11.50 (1.98)
2b. Positive professional identity	15.67 (2.67)	17.17 (1.90)
3. Roles and responsibilities (/15)	10.31 (2.02)	10.58 (1.73)

by hospital training, however, these also had improvements over time. Trainees' written views of the scheme in term 1 highlighted good elements of the concept and the valuable experience gained across two different settings but focused largely on the problems that needed addressing. Their views were more positive in term 3, paralleling the shift in training ratings.

Team working

Measured using the Readiness for Inter-Professional Learning Scale and the Dental and Dental Care Professionals Roles and Responsibilities (Dental R&R) scales (Table 1).

The mean scores for the RIPLS scale as well as the subscales within it suggest positive attitudes towards inter-professional learning and these results are similar to those from another study.³⁵ The majority also provided an expected response in line with their scope of practice while recognising some responsibilities are shared by the dental team

including building a rapport with patients and giving advice.

Job satisfaction and retention in dental nursing

A score of five or more on the seven-point scale indicates job satisfaction; 67% of trainees were satisfied with their job (mean 5.27). Mean score for the overall satisfaction domain was 5.38, while the two lowest mean scores were for remuneration (2.93) and physical working conditions (4.85) (Fig. 2). The majority (84.6%; n = 11) reported that they did not often think of quitting their job nor did they plan to change jobs within the year following the survey (92.3%, n = 12) and their long-term intentions were positive (69% said they did not intend to leave dental nursing for a different career).

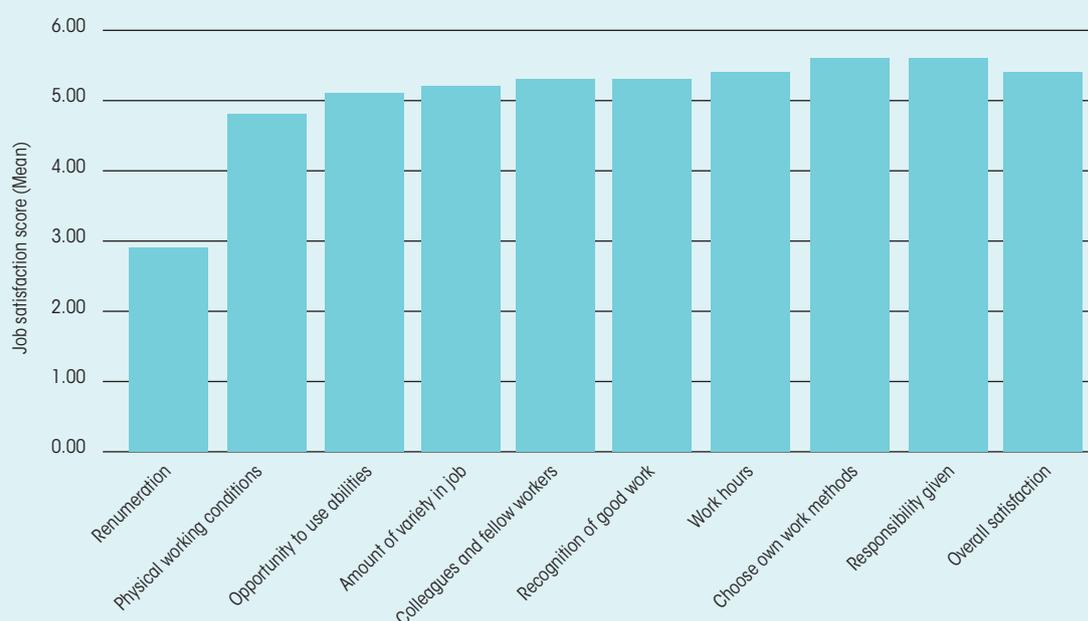
Career expectations

The majority of trainees knew what they planned to do at the end of the training, both

in term 1 (85.7%, n = 12), and term 3 (91.7%, n = 11) with no significant difference over time. In term 1, 85.7% of trainees wanted to work in hospital and 28.6% in primary care. This changed to 61.5% and 53.8% respectively by term 3. There was also a trend for trainees to be more certain of their overall career plans over time; with a preference for full-time work in primary care. Their career decisions were strongly influenced by both personal and career-related factors for example, financial stability, work-life balance and professional development. Trainees also had a strong interest in gaining additional skills mainly in oral health education and prevention, such as the application of fluoride varnish.

Discussion

This pilot contributes to knowledge in this field as it reports on issues relating to an innovative dental nurse training scheme. This scheme seemed to attract an older cohort of trainees than usual and more of them had caring roles (as spouses, partners and parents) which seemed to have an impact on their ability to remain on the course especially from a financial viewpoint. Although it is unclear why, it may be related to how the scheme was advertised and perhaps some confusion about what it entailed. Nevertheless, everyone passed written exams and all but one passed the practical exams at the first attempt; these are considered better than the national averages which sit at around 80–85%. While the course can be viewed as having supported this success, the high rates of attrition at the beginning may also have meant that only the more committed trainees remained in the programme and of course numbers are small.

Fig. 2 Job satisfaction in Term 3

It was interesting to note the increase in the proportion of those wanting to work in primary care over time. This highlights a possible benefit to dual training. Trainees' experience of working in primary care as part of this scheme may have demystified primary care employment and addressed pre-existing misconceptions. This is advantageous especially in the context of there being more jobs for dental nurses in primary care. Moreover, Sembawa *et al.*¹³ found that solely hospital-trained dental nurses were more inclined to only want to work within the hospital. Trainees' divergent views on the training they received also became increasingly positive towards the end.

Trainees in this study support the view that inter-professional learning is beneficial in line with recent research.³⁵ However, it must also be recognised that professional identity and its development are issues that should be given full consideration by educators who are developing initiatives that involve inter-professional education.²² This is because some professions may feel threatened by

showed strong interest in additional skills and qualifications which is positive for long-term retention within dental nursing as a career. These views are generally more positive than those reported by Turner *et al.*,¹⁷ who found negative attitudes towards retention among qualified dental nurses in the UK. It is possible that this may be associated with the length of time those nurses had spent in practice (a mean of 15.7 years), therefore they may have encountered more challenges to their desire to remain in the profession compared with trainees from this scheme who were new to dentistry. Most importantly, recent changes including the introduction of compulsory GDC registration for dental nurses and expansion of their scope of practice mean that the future is potentially more positive for a career in dental nursing. With regards to career development, the majority of pilot trainees had plans for additional qualifications which could be as a result of being in hospital and possible exposure to additional, extended skills being used widely by the dental nurses in hospital.

nurses trained on an innovative scheme that took place in London therefore findings from this study may not be transferable as the implementation of this exact model of training may not necessarily be transferable. Nevertheless, as a study that explores the feasibility of the concept of training dental nurses across settings, it has shed light on the experiences of trainees and gives insight into various outcomes. Similar to our findings that support the concept of training across more than one site, a recent evaluation³⁸ of a pilot scheme to train foundation dentists across two sites rather than the traditional one site, reports that trainees had positive perceptions of the concept and that it enhanced their learning experience.

Conclusion

While the introduction of this pilot which involved several dental practices and a dental hospital, presented a number of challenges, the outcome was generally positive with evidence of academic success at the final examinations, employability, commitment to dental nursing as a career, and sufficient support for this concept to be embraced in future training initiatives.

Conflicts of interest declaration

Two of the authors (EJ and SM) had the shared vision, developed and delivered this concept of training dental nurses in London across both primary and secondary care settings. Furthermore, EJ was the former Postgraduate Dental Dean for Dentistry at Health Education England, London when HEE funded this pilot scheme. HEE also commissioned this evaluation which was undertaken by TA and JEG at King's College London. Both EJ and SM were interviewed as part of the stakeholder group associated with this pilot (findings reported elsewhere). Finally JEG was chair of the Dental Workforce Advisory Group for Health Education England and Honorary Consultant in Dental Public Health for Public Health England. The views expressed in this paper are those of the authors and do not represent the views of these organisations.

Acknowledgements

The concept of this dual training was conceived, developed and delivered by Mrs Sana Movahedi and Mrs Elizabeth Jones at Health Education England. The authors would like to thank all the pilot scheme trainees that took part in this study along with Ms Rebecca Parr and the Dental Nurse Training Staff and Management at the hospital provider, HEE Representatives, Population and Patient Health research administrative staff at KCL, and Ms Shiho Kino.

Study limitations

This study involves a small number of dental

the idea and may not see its value, thereby undermining a future in which a team-based approach to healthcare is vital.

Retention of dental nurses has been highlighted as an important dental workforce issue in the past with high staff turnover reported.^{36,37} Research has shown that the development of work engagement among dental nurses (for example, helping them feel inspired by their work), job resource beliefs (for example, beliefs in their ability to use their skills in practice) and personal accomplishments (for example, positively influencing people's lives) may help them feel they are integral to how the team operates and reduce intentions to leave the job.⁷ While the initial retention rate for trainees was poor, with almost half departing following early experiences relating to pay and working conditions, this stabilised over time. In the short-term, most trainees did not intend to find another job or change jobs, they also

Implications for future practice and research

Future dental nurse training should consider the concept of exposure to a variety of settings even if a large proportion of training is undertaken in a single setting as this has been shown to have a positive overall impact. It is important for future research in this area to collect comparative data regarding single-site trained dental nurses (dental hospital only or dental practice only) across all relevant domains simultaneously in order to ensure more detailed comparison and highlight benefits or otherwise of this multi-site training initiative. Additionally, this study like others,^{22,35} highlights the inadequacies of the roles and responsibilities subscale of the RIPLS instrument. This instrument therefore requires further work.

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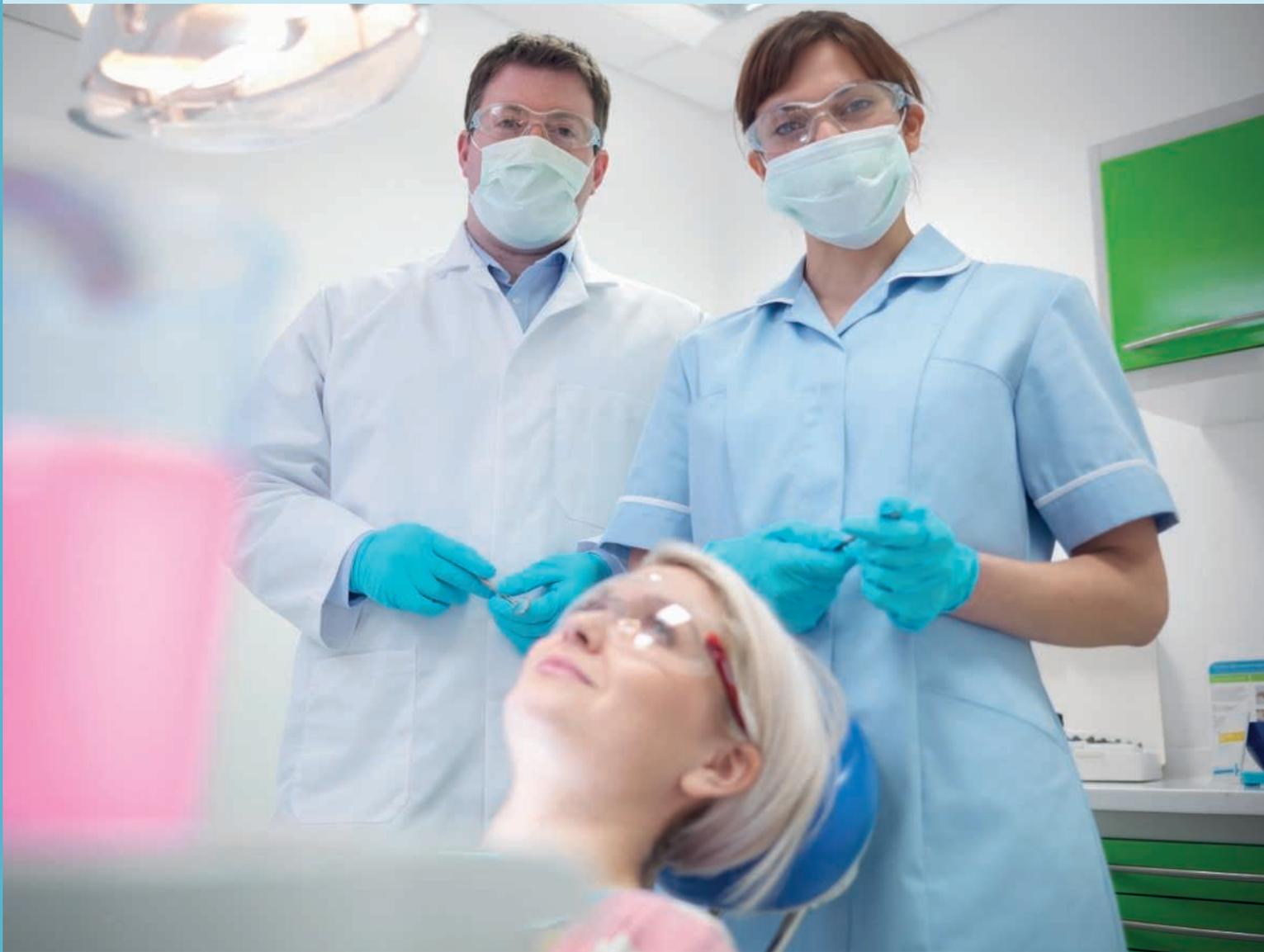
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bdjteam2018102



Scope of practice: dental nurses

An up-to-date focus on the scope of practice of one group of dental care professionals (DCPs), as described by the General Dental Council (GDC).

'Scope of practice' means what you are trained and competent to do. It describes the areas in which you have the knowledge, skills and experience to practise safely and effectively in the best interests of patients. The GDC's full document on the scope of practice of all dental registrants, published in 2013 and updated in 2017, can be found at <https://www.gdc-uk.org/professionals/registrars/reg-types>.

Dental nurses

Dental nurses are registered dental professionals who provide clinical and other support to registrants and patients. As a dental nurse, you can undertake the following if you are trained, competent and indemnified:

- Prepare and maintain the clinical environment, including the equipment
- Carry out infection prevention and control procedures to prevent physical, chemical and microbiological contamination in the surgery

or laboratory

- Record dental charting and oral tissue assessment carried out by other registrants
- Prepare, mix and handle dental bio-materials
- Provide chairside support to the operator during treatment
- Keep full, accurate and contemporaneous patient records
- Prepare equipment, materials and patients for dental radiography
- Process dental radiographs

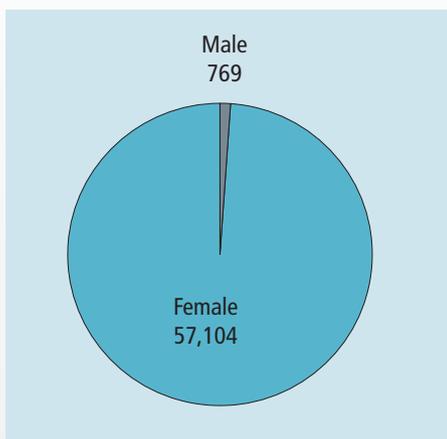


Fig. 1 Dental nurses on the GDC register (March 2018)

- Monitor, support and reassure patients
- Give appropriate patient advice
- Support the patient and their colleagues if there is a medical emergency
- Make appropriate referrals to other health professionals

Additional skills dental nurses could develop include:

- Further skills in oral health education and oral health promotion
- Assisting in the treatment of patients who are under conscious sedation
- Further skills in assisting in the treatment of patients with special needs
- Further skills in assisting in the treatment of orthodontic patients
- Intra- and extra-oral photography
- Pouring, casting and trimming study models

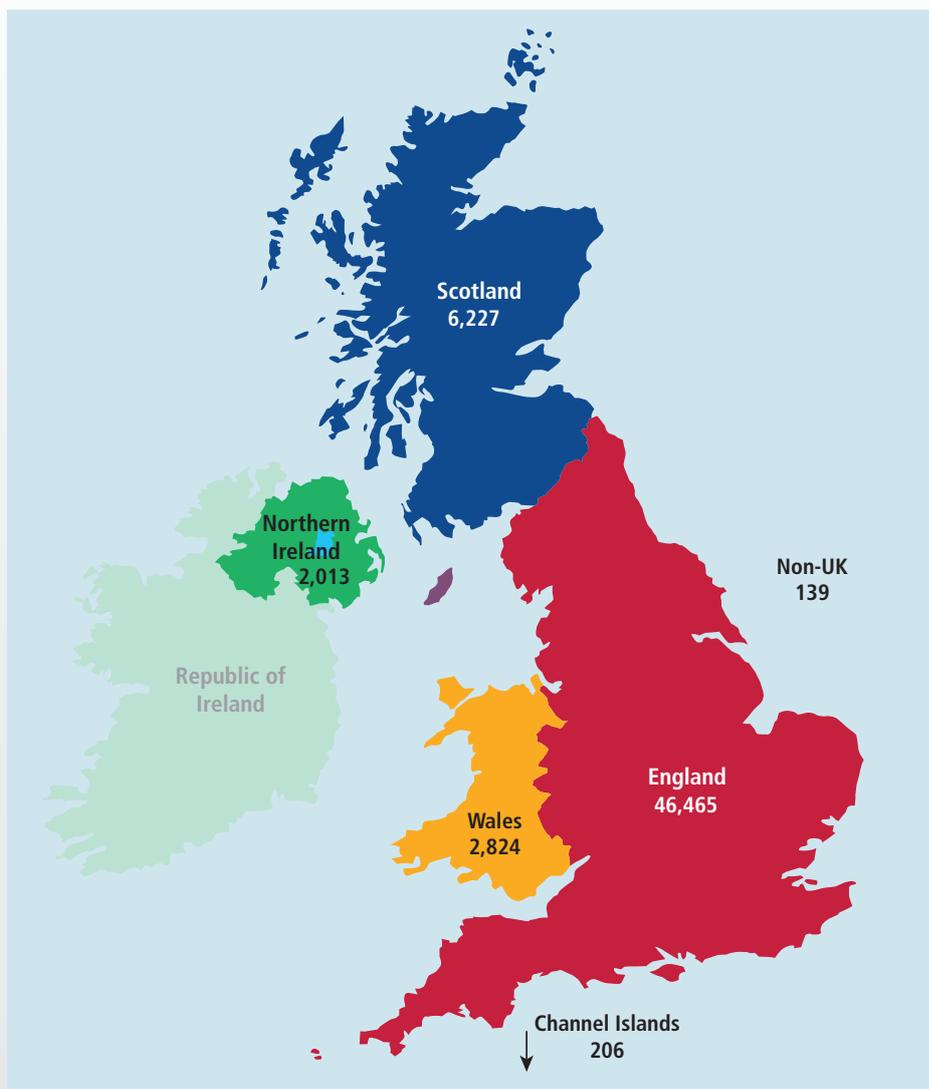


Fig. 2 Dental nurses by UK region (March 2018)

‘DENTAL NURSES CAN APPLY FLUORIDE VARNISH EITHER ON PRESCRIPTION FROM A DENTIST OR DIRECT AS PART OF A STRUCTURED DENTAL HEALTH PROGRAMME’

- Shade taking
- Tracing cephalographs.

Additional skills carried out on prescription from, or under the direction of, another registrant:

- Taking radiographs
- Placing rubber dam
- Measuring and recording plaque indices
- Removing sutures after the wound has been checked by a dentist
- Constructing occlusal registration rims and special trays

- Repairing the acrylic component of removable appliances
- Applying topical anaesthetic to the prescription of a dentist
- Constructing mouthguards and bleaching trays to the prescription of a dentist
- Constructing vacuum-formed retainers to the prescription of a dentist
- Taking impressions to the prescription of a dentist or a CDT (where appropriate).

Dental nurses can apply fluoride varnish either on prescription from a dentist or direct as part

Table 1: Dental care professionals with more than one title (March 2018)

	Dental Nurse
Clinical Dental Technician	3
Dental Hygienist	1,035
Orthodontic Therapist	558
Dental Technician	0
Dental Therapist	711

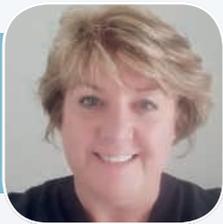
of a structured dental health programme.

Dental nurses **do not** diagnose disease or treatment plan. All other skills are reserved to one or more of the other registrant groups.

bdjteam2018103



'My years of experience in all aspects of dentistry affords me incredible autonomy in the practice'



Experienced dental nurse, tutor and mum of two **Karen Robinson, 54**, tells *BDJ Team* exactly what it's like to walk a mile in her shoes...

I was born into a 'dental' family in the idyllic, picturesque harbour town of Burry Port in South West Wales. My late father was a dental technician and my brother, eight years my senior, was a dentist. It was always presumed that I would follow in the footsteps of my brother and become a dentist too... I, however, had other ideas!

My brother was the golden boy, graduating from Bristol winning the gold medal. I really did not fancy the idea of spending my time in university studying and living in his shadow. Little did I know there was an alternative. Half way through sixth form in an all girls' grammar school I took it upon myself to switch from the sciences to the arts. You can imagine the furore that created at home!

Fast forward a few years: I did not manage to escape the dental grasp in the end. Taking a year's sabbatical following my A Levels to work in my brother's dental practice, I ended up staying. He did not give up trying to make me

do dentistry, so I married his associate instead. A half-way-house compromise, I guess.

I qualified as a dental nurse in 1984 and worked with my brother and consequently my husband. I was always keen on helping patients improve their oral health knowledge and skills. Both my husband and brother were quite ahead of their time, as back in the eighties, most dentists regarded their 'assistants' (as we were known then) to be silent suckers and cleaner-uppers! My brother and husband believed a nurse's role should be far more integrated – talking to patients, giving instructions and dishing out oral health advice. To them and to me a nervous patient is far more likely to listen to a nurse who is not about to pick up a needle or carry out a procedure that might be uncomfortable. Plus, the patient could be given the advice while sitting up, not laying in a very vulnerable supine position – hardly a position conducive to taking on board important information.

So, here I am in 2018. I am 54 years old going

on 18, with two married children: Joshua, a post-doctoral biomedical engineer at Oxford University, and Louisa, who is a television assistant at the British Film Institute in London and has almost completed her Master's Degree in Creative Writing.

Since 2005, I have worked in a busy, three-surgery NHS/Private practice in Pontarddulais, on the outskirts of Swansea, as the senior nurse/oral health educator. It always brings a smile to my face to read patients' notes from the 60s, when writing dental records was succinct, shall we say? 'Recall, NAD, 6/12' sufficed! The General Dental Council would have a field day in 2018.

We have two dentists: David, a specialist in prosthodontics, and Anne, who has a special interest in oral surgery. There's a hygienist, a part-time practice manager, three qualified nurses, one trainee nurse and two receptionists. We are a dental foundation (DF) training practice, so enjoy the challenges that brings. I work with the DF trainee on Wednesday



are usually filled. My years of experience in all aspects of dentistry affords me incredible autonomy in the practice. I am the triage nurse, entrusted with establishing the possible cause of an emergency and can arrange the appropriate appointment. If a patient calls in with a fractured denture, I will decide if an impression is required, or if it can be taken straight down to the laboratory. If an impression is needed, I can take it, saving the dentist's time. It is also very helpful when working with the DF as again, I can be relied upon to give constructive advice. However, my knowledge also gives me the ability to know when to call a halt to the proceedings and call for the trainer to intervene, if the DF hasn't already.

Having worked there for so long, I feel I have developed a very good rapport with the patients, so much so, when I began working in the University, David threatened to have his scrubs embroidered with the words 'She's in Cardiff today', as he was sick of answering the questions – 'Where is she then?' 'Where's your sidekick?'

Having had years of experience as a tutor, and loving every second, it is down to me to organise staff training and the continual professional

problems. I have been nick-named 'Mummy Karen' on more than one occasion!

I believe our profession is a true vocation, a calling and not a job that entails clocking in and out at the exact second. The patients come first and it makes me so cross at five o'clock when I see nurses strutting around the practice taking out the clinical waste bags, or worse, congregating around the reception, impatiently waiting for the last patient to come out of the surgery. The last patient of the day is just as important as the first. How awful must that person feel if the nurse is busying him/herself closing down the surgery as the dentist or hygienist completes the treatment.

The role of the dental nurse is, of course, to facilitate the clinician, but more importantly, we are there to ensure the patient is supported and cared for. By our attitudes and encouraging words, we can be completely instrumental in transforming initially terrified people, whose fear can manifest in them being belligerent, taciturn and even sometimes quite aggressive people, and whose names we dread to see on the day list, into our favourite patients. This transformation takes skill, which only comes

and Thursdays. I love this part of my job very much – seeing them develop and grow in confidence and, of course, bringing them around to allow the nurse to take more responsibility.

I have gained almost all of the extended duties and was thrilled to achieve the prestigious Stafford Miller Award for the most outstanding candidate for the Certificate in Oral Health Education. I recently retired from the part-time post of dental nurse tutor in Cardiff University and returned to work in the practice on a full-time basis.

In 2000, I changed my marital status from that of being a dentist's wife to being married to a dental technician! Kevin owns a busy laboratory so is up and out of the house before six, which means I am an early bird, too. Consequently, I am normally the first member of staff in the practice and like to check on everything before the official working day begins.

I go through the day list, planning everything, to ensure we run smoothly and to time; checking the laboratory work is there and switching on the central sterilising unit and validating the machines. David is the dentist I work with the most, and because of his specialism, we get a fair share of very rewarding cases. He is a meticulous planner and can estimate to the second how long each appointment will take and is always correct.

We have two emergency slots each day, which

'BACK IN THE EIGHTIES, MOST DENTISTS

REGARDED THEIR "ASSISTANTS" (AS WE

WERE KNOWN THEN) TO BE SILENT

SUCKERS AND CLEANER-UPPERS!'

development (CPD) sessions. I will deliver some sessions myself. I firmly believe that knowledge is the key and if we want to be taken seriously and treated as vital members of the team, we must possess the underpinning knowledge to accompany our clinical skills so we can be allowed to have more responsibility and trust. I feel quite honoured when the dentist turns to me for my opinion or advice on a treatment plan, or looking at a radiograph – but I couldn't do this without years of continual clinical development.

Lunch times, the staff sit together and discuss the day. It is during our lunch break that we have a practice meeting, or a CPD session. We work well as a team, all helping each other when we can. Over the years, there have been dramas, as in all establishments where there are several employees. Some days, it almost feels like I am a social worker rather than a dental nurse, with other members of staff crying on my shoulder, or indeed patients confiding the most intimate

with knowledge, experience and highly trained staff. We have to be chameleons, changing our colours to suit each patient. I use humour to break the ice, but it has to be professional and appropriate. I try to encourage the other nurses in the team to follow suit.

Being part of a dental practice is being part of a team and is very much give and take. David and Anne are very generous in repaying the team for their hard work and regularly organise meals out or trips. We have been to London and Disneyland Paris for weekend breaks. At the end of June we are going to Tenby for a well-earned rest and some team building fun!

Do I regret not going to dental school? Well, hindsight always comes with twenty-twenty vision. If I had taken that route, my life would be different, but not necessarily better.

Interview by David Westgarth

bdjteam2018104



Keeping the peace in the practice



Priya Sharma¹ discusses challenging patient interactions and the best ways for the dental team to manage them.

Patients are often incorrectly labelled as 'difficult' or perhaps 'high maintenance'; this is true of the healthcare realm and perhaps particularly so in dentistry. There is a vast amount of literature, case

studies, continuing professional learning and anecdotes citing the 'difficulty' these patients pose and how best the dental team can manage these situations.

The fact remains that at some point these patients are wrongly labelled and to a certain extent stigmatised when they arrive at the practice, in turn unfortunately creating a stereotypical view of these patients. It is prudent to remember that the patient is not 'difficult' but the interaction poses a challenge. Categorically labelling patients as 'difficult' leads to a 'blaming the patient' point of view. Additionally it will colour all future interactions with a particular patient as 'difficult'.

Generally people hope that all their daily interactions, including ones with the dental team, will be smooth and uneventful. However, often many patient factors are interwoven within these interactions such as unrealistic expectations, not taking

responsibility for their own dental health, medical health conditions, assumptions, cultural/language barriers and confusion, among others.

Often the first points of contact for a patient is a dental care professional (DCP), therefore it is important that they confidently manage to de-escalate the challenging interaction. It will not be easy but if handled appropriately all parties will be satisfied with the conclusion.

At the heart and soul of a successful DCP and patient interaction is transparent and seamless communication; this includes both verbal and non-verbal. Be mindful that each interaction will be unique hence a general paintbrush approach cannot be used for all challenging interactions

Active listening

The first element of a successful interaction, whether challenging or not, is to actively listen to the person. You must give your full

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attention to them respectfully at all times. Use positive communication skills such as ‘May I suggest to you...’ or ‘I realise there was a lot to take in...’ as opposed to ‘You did not...’ or ‘You should have...’. This will ensure that the patient does not become reactive, leading to a calmer interaction.

It is vital not to change the degree of active listening, especially if the conversation is longer than perhaps you had anticipated. It is possible to attempt to politely re-focus the conversation to the original issues.

Verbal communication

At no point interrupt the flow of the patient and obviously do not argue or be defensive.

It may be that you feel you need clarification; if so, ask open-ended questions encouraging honest feedback. Be mindful not to raise your voice; remain polite and neutral whilst taking professional control without superiority of the interaction. Both parties are equal in the interaction; DCPs should not assume that they are somehow superior. Do not attempt to be demanding or lay the blame on the patient.

Empathy will play a key role and most DCPs will find if the patient truly feels that they have been listened to they in turn are more willing to listen to what you have to say.

Non-verbal communication

At all times be fully aware of your own non-verbal communication. Often it is what you do not say that the patient will remember the most, for example visual cues such as facial expressions and gestures (kinesics) and the distance between both parties (proxemics). Making every effort to be conscious of your non-verbal behaviour will ensure that you are not communicating mixed messages.

Eye contact for a few seconds at a time ensures that you are engaged with the patient, but do not stare at the patient as they may feel confronted or intimidated. In addition, maintain comfortable personal space so they do not feel threatened.

Issue identification

It is mandatory to identify the issues succinctly which is probably the first time in the entire interaction that a bridge is created. Remain neutral, that is, state the patient's concerns and do not accept liability or blame. Acknowledging how they feel does not equal agreeing with them. This will be a very helpful step in the entire interaction.

Apology

Never underestimate the power of an apology. Simply saying sorry for the inconvenience

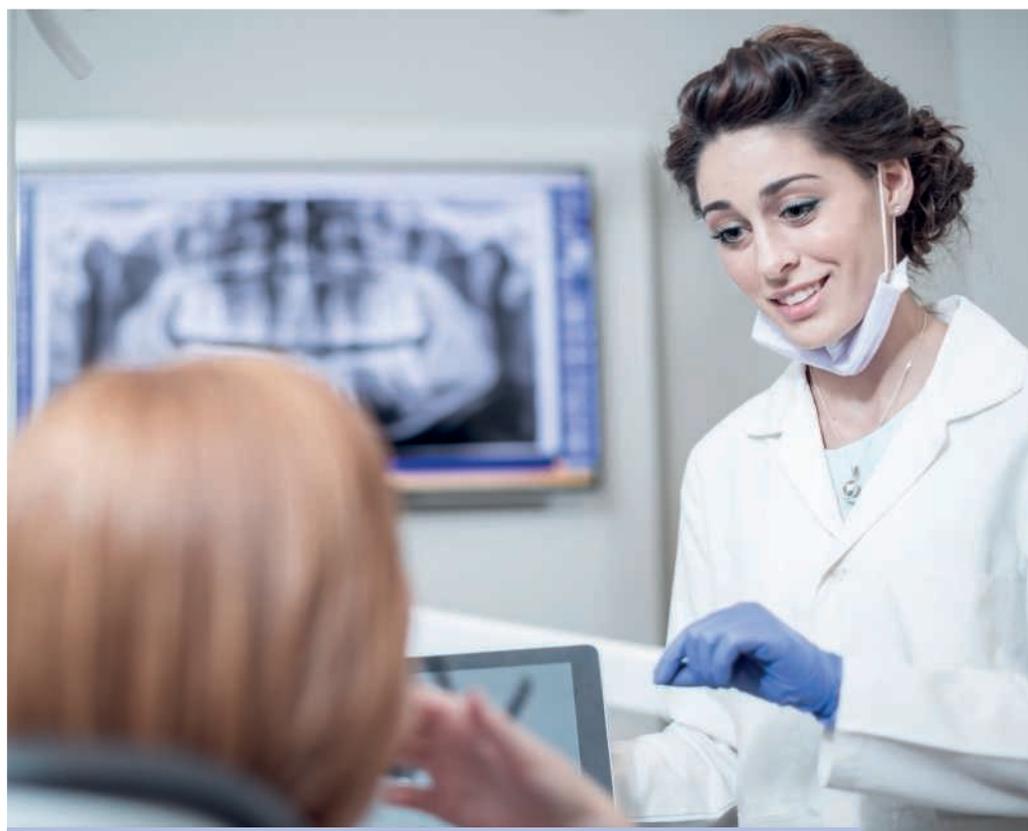
caused will often put the patient at ease. It does not mean that the patient is right and a dental member was wrong but it does show the respect of the DCP and in the patient relationship.

Asking the patient how they would like the issue to be resolved will prove to be insightful and may actually result in a simple solution. Often it is just pure acknowledgement of the miscommunication and a simple apology which resolves the matter.

ensure that the patient's best interest is central in the interaction.

Albeit a very demanding interaction, professionally, consider it to be a learning experience. Reflect on the interaction and take away learning points that will improve future interactions.

As Albert Einstein said ‘In the middle of every *difficulty* lies an *opportunity*’.



**‘AT THE HEART AND SOUL OF A SUCCESSFUL
DCP AND PATIENT INTERACTION IS
TRANSPARENT AND SEAMLESS COMMUNICATION;
THIS INCLUDES BOTH VERBAL AND NON-VERBAL.’**

Patient complaints

Remember that the vast majority of patient concerns will not lead to formal patient complaints. However, be prepared that if a patient would like to file a formal complaint, have the practice policy on complaints to hand. All members of the dental team should be trained in how best to manage complaints.

Future

The end of the conversation will demand possible options going forward. This must include the patient's perspective. At all times

Want to know more?

To find out more about dealing with complaints, why not read Priya's BDJ Team article 'The professional approach to handling complaints' from February 2017 - <https://www.nature.com/articles/bdjteam201730>

bdjteam2018105



A guide to oral piercings

CPD questions

This article has four CPD questions attached to it which will earn you one hour of verifiable CPD. To access the free BDA CPD hub, go to <https://cpd.bda.org/login/index.php>

E. M. King,^{*1} E. Brewer² and P. Brown¹

Introduction The prevalence of oral piercings in the UK is increasing. Consequently, the dental profession is encountering an increasing number of complications associated with piercings. Providing patient preventative advice regarding piercing complications is important, however the level of advice offered by UK dentists is currently unknown. **Aims** The aim of this survey was to establish the current knowledge, attitudes and behaviours of dentists regarding advice provided to patients with oral piercings. **Methods** A questionnaire was sent to 200 dentists across Wales with questions regarding perceived confidence in providing advice, type of advice provided, the sources dentists use to acquire knowledge and the perceived

need for further professional information. **Results** Fifty-three dentists responded. Only 24.5% were very confident discussing piercing complications. The advice provided varied markedly, with the majority (73.6%) reporting they had acquired knowledge through experience alone. Only one dentist reported providing written information and 83% responded that they would like to have access to printed information directed at patients. **Conclusions** The results of this survey suggest that dental professionals are not fully confident discussing risks and preventative advice with patients. To address this, patient information leaflets have been developed to encourage dentists to discuss complications associated with oral piercings with patients.

Introduction

Body modification, the purposeful alteration of normal human anatomy to achieve a desired appearance, is a popular practice that has led to a rise in the prevalence of oral piercings. In 1992, the first report relating to oral piercing appeared in the dental literature titled 'Tongue piercing: a new fad in body art'.¹ However, rather than a fad, oral piercings have become increasingly popular. Common sites for oral piercings include the tongue (Fig. 1) and lips (Fig. 2) however piercing of alternative anatomical sites

such as the cheeks (Figs 3 and 4) and frenulae (Fig. 5), is becoming more prevalent.^{2,3} Oral piercings have been a recent topic of debate in the Welsh Government, and in May 2017 a new Public Health (Wales) Bill was accepted by the National Assembly for Wales to ban all intimate piercing, which includes tongue piercing, before the age of 18. To establish the current attitudes of the dental profession towards oral piercings, a national survey was conducted among General Dental Practitioners (GDPs) across Wales. Furthermore, a literature review was conducted to establish the current global trends in oral piercings and discuss the potential complications resulting from such body modifications.

Legislation

Following the death of a Sheffield teenager from septicaemia caused by a lip piercing in 2002, the risks of body piercing were discussed in the House of Commons.^{4,5} As a result, a voluntary code of practice was implemented for piercers which included guidance regarding the practice of body piercing, specific recommendations for hygienic procedures, checking medical history before piercing and the prevention of piercing individuals below 16 years of age unless parental consent is given. This code of practice is summarised in the document 'Advice and Safe Practice for Body Piercing – Guidance for Operators' produced by the British Body Piercing Association.⁶ It is unknown how many

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piercers have adopted this code of practice and therefore compliance can vary between establishments.

Currently the legislation for licensing and registration of piercing establishments varies between local authorities. In England and Wales, local authorities have the power to apply the Health and Safety at Work Act 1974 to impose infection control and safety requirements.⁷ Furthermore, there are specifications stated in the Local Government (Miscellaneous Provisions) Act 1982 and the Local Government Act 2003 for local authorities in England and Wales to require the registration of individuals providing body piercings.⁸ The Local Government Act 2003 also stipulates standards of cross infection control. With the aim of preventing transmission of infectious diseases, the Health and Safety Executive have produced the SR12 publication to help piercers comply with the Control of Substances Hazardous to Health Regulations (COSHH) 2002.⁹ Local authorities can choose whether to adopt and enforce these guidelines in addition to their own byelaws; therefore piercing standards vary across the UK.

While many piercing establishments enforce their own age restrictions, there are currently no laws restricting piercings for minors in England. Many local authorities have developed licensing frameworks that make it possible to state a minimum age; however there are inconsistencies across the UK. Some local councils prohibit cosmetic piercing under 16 years of age whereas some state 18 years of age.¹⁰⁻¹² In Scotland, individuals under 16 are required to have parental consent before undergoing any piercing. In Northern Ireland, the piercing of nipples and genitalia of children under the age of 16 is regarded as indecent assault under sexual offences legislation, and can lead to prosecution.

The Welsh Government has raised serious concerns about the medical implications associated with intimate piercings, and the potential vulnerability of young people receiving such piercings. In 2015, the Welsh Government introduced a Public Health (Wales) Bill which included a clause to ban all intimate piercing before the age of 18. The Welsh Dental Committee (WDC) responded to the consultation and strongly suggested that intimate piercing should include tongue piercing, and as a result tongue piercing was added to the list of intimate piercings. The Public Health (Wales) Bill was accepted by the National Assembly for Wales in May 2017 and the age for intimate piercing, including tongue piercing, has been raised to 18 years old. This is now in keeping with similar legislation such as tattooing of minors and

Fig. 1 Midline tongue piercing with stainless steel tongue bar (barbell)



Fig. 2 Lip piercing (also termed labret) with a titanium lip bar

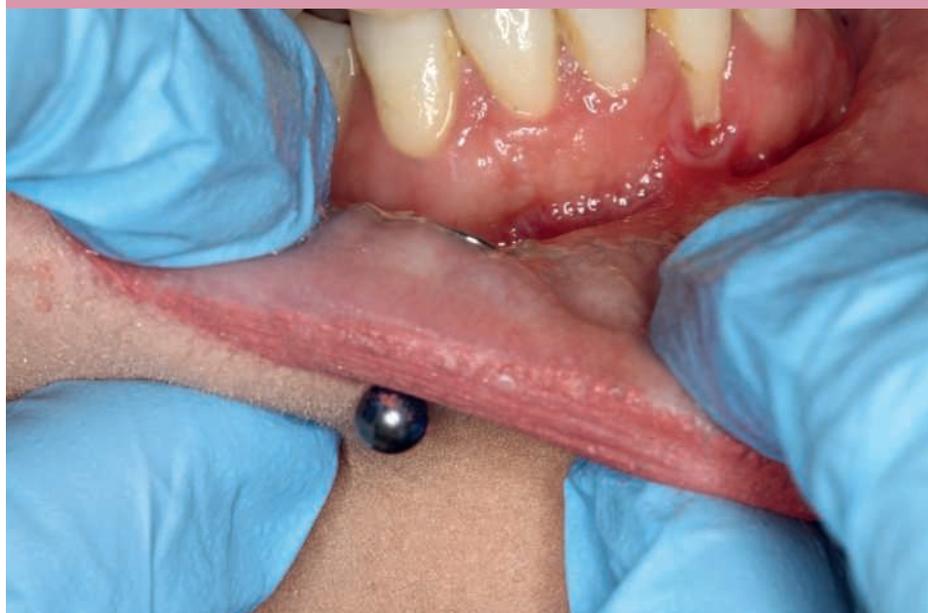


Fig. 3 Cheek piercing viewed intra-orally with titanium bar *in situ*



Fig. 4 Cheek piercing viewed extra-orally



Fig. 5 Piercing of the lingual frenulum with stainless steel bar in place. Note the accumulation of plaque on the ball ends of the piercing



**'TONGUE PIERCING WAS THE SECOND
MOST COMMON BODY PIERCING
RESULTING IN COMPLICATIONS
(FOLLOWING THE NAVEL).'**

female genital mutilation. The age increase will help to avoid circumstances where young people are placed in potentially vulnerable situations, particularly where there is risk to the developing body.¹³

Complications

Unsurprisingly, oral and peri-oral piercings are associated with numerous complications. The UK incidence of complications associated

with oral piercings is reported by Bone *et al.* (2008).² In 16–24-year-olds, 50.1% who had tongue piercings and 20.5% who had lip piercings experienced complications. Tongue piercing was the second most common body piercing resulting in complications (following the navel). This finding corroborates other studies which state that complications are most prevalent with tongue piercings, followed by lip, cheek and gingivae.^{3,14,15}

It is currently unknown how many patients with oral piercings attend for emergency treatment in the UK. In 2006, a UK-based survey of 126 piercees reported that 99% had problems with their tongue piercing, 7% of which required healthcare following the piercing.¹⁶ A US study of 100 emergency departments has reported an estimated annual presentation rate of 3,494 injuries associated with oral piercings.¹⁴ In this study, patients aged 14 to 22 years old accounted for 73% of the emergency visits.

Several investigations have aimed to identify the prevalence of the different complications associated with oral piercings (Table 1). Commonly reported acute complications include pain, swelling, haemorrhage, infection and masticatory and speech impairment. Less frequently reported immediate complications include haematoma, delayed healing, puncture wound, laceration, dental trauma, allergy, dysphagia and hypersalivation.^{14,15,17–21}

Commonly reported chronic complications include pain, infection, swelling, bleeding, tissue hyperplasia, soft tissue trauma, gingival recession, dental trauma, dental pain, speech impairment, taste disturbances and ingestion of piercing. Less frequently reported chronic complications include masticatory/eating impairment, gingivitis, plaque accumulation (Fig. 5), hypersalivation, galvanic reaction, tooth migration and dysphagia.^{14,16–21} Complications have been shown to be more common in patients who habitually play with their piercing.¹⁵

Several rare and sometimes serious oral piercing complications have been reported (Table 2).²² Prior to the enforcement of COSHH regulations, it was hypothesised that oral piercings could increase the risk of transmission of blood borne viruses such as HIV and hepatitis B and C.²³

It is essential that all professions who encounter oral piercings are properly informed and able to provide advice regarding oral piercing complications. The level of advice offered by UK dental professionals regarding oral piercings is currently unknown. There is no current consensus among dental professionals regarding the type of complications that should be discussed with patients. There many easily available advice leaflets developed for the piercing industry, however similar documentation does not exist for the dental profession. To investigate the current knowledge, attitudes and behaviours of UK dentists regarding advice provided to patients with oral piercings, a survey was distributed to GDPs in Wales. The results are discussed, and advice is provided for dental professionals treating patients with oral piercings.

Table 1 Commonly reported complications of oral and peri-oral piercings in the dental and medical literature (cont. on p22)

Study	Number of patients	Number of piercings	Frequency of oral piercing complications			
			Acute	%	Chronic	%
De Moor <i>et al.</i> 2005 ⁷ Patient questionnaire + examination	50	55 (47 tongue; 8 lip)	Swelling	22	Speech impairment	14
			Pain	14	Eating impairment	10
			Haematoma	4	Soft tissue trauma	2
			Infection	2		
			Delayed healing	2		
			Haemorrhage	2		
Levin <i>et al.</i> 2005 ⁹ Patient questionnaire + examination	79	79	Swelling	52.9	Gingival recession	26.6
			Haemorrhage	45.7	Dental trauma	13.9
					Bleeding	13.9
					Infection	11.4
					Gingivitis	5.1
Chadwick <i>et al.</i> 2005 ¹⁸ Dentist questionnaire	227	–	Not reported		Dental trauma	100
					Gingival recession	42.6
					Swelling	35.8
					Infection	34.7
					Speech impairment	30.6
					Pain	23.8
					Plaque deposits	22.7
					Tissue hyperplasia	18.2
					Bleeding	9
					Tooth migration	2.8
					Hypersalivation	2.3
					Dysphagia	2.3
					Galvanic reaction	2.3
	Ingest piercing	1.1				
Stead <i>et al.</i> 2006 ¹⁶ Patient questionnaire	126	126 (tongue)	Swelling	90	Ingest piercing	29
			Pain	69	Dental trauma	28
			Eating impairment	63	Plaque deposits	26
			Speech impairment	43	Speech impairment	9
			Haemorrhage	42	Swelling	7
			Ingest piercing	5	Eating impairment	2
			Dental trauma	4	Pain	1
			Plaque deposits	4	Bleeding	1
Vieira <i>et al.</i> 2010 ²¹ Patient questionnaire + examination	39	42 (37 tongue; 5 lip)	Haemorrhage	69	Pain	92.2
			Pain	52.4	Soft tissue trauma	64.3
			Faint	4.8	Swelling	61.9
					Infection	38.1
					Dental pain	33.3
					Tissue hyperplasia	31
					Bleeding	28.6
					Gingival recession	4.8
		Dental trauma	2.4			

Table 1 Commonly reported complications of oral and peri-oral piercings in the dental and medical literature (cont. from p21)

Study	Number of patients	Number of piercings	Frequency of oral piercing complications			
			Acute	%	Chronic	%
Hickey <i>et al.</i> 2010 ¹⁵ Patient questionnaire + examination	201	201 (106 tongue; 88 lip; 7 cheek)	Eating impairment	78.3	Gingival recession	14.8
			Speech impairment	67	Taste disturbance	12.3
			Swelling	51.7	Dental trauma	7
			Dysphagia	28.4		
			Hypersalivation	20.4		
Gill <i>et al.</i> 2012 ¹⁴ Retrospective epidemiological study	24,459	24,459 (10,341 tongue; 11,197 lip; 2,921 other)	Infection	42	Not reported	
			Puncture wound	29		
			Laceration	10		
			Haemorrhage	7		
			Dental trauma	7		
			Haematoma	1		
			Allergy	1		
Plessas <i>et al.</i> 2012 ²² Patient questionnaire + examination	110	161 (51 tongue; 110 lip)	Pain	57.7	Ingest piercing	48
			Eating impairment	49	Gingival recession	39.7
			Speech impairment	33.5	Bleeding	33
			Haemorrhage	4.3	Dental trauma	32.3
					Plaque deposits	21
					Dental pain	13
					Hypersalivation	9.3
					Taste disturbance	6.8
		Galvanic reaction	3			

Table 2 Rare complications of oral and peri-oral piercings²²

Complication	Number of case reports
Periodontitis	11
Endocarditis	8
Hypotensive collapse	1
Loss of insertion needle	1
Ludwig's angina	1
Fatal herpes simplex hepatitis	1
Thrombophlebitis of sigmoid sinus	1
Atypical trigeminal neuralgia	1
Bifid tongue	1
Airway obstruction	1
Cerebral abscess	1
Tetanus infection	1

Fig. 6 Example of questionnaire sent to GDPs

Q1. How confident are you when discussing oral piercing advice with patients?

Very confident
 Moderately confident
 Not confident

Q2. Do you warn patients about common complications for oral piercings? If yes please tick the relevant box.

Pain <input type="checkbox"/>	Tissue hyperplasia <input type="checkbox"/>
Inflammation <input type="checkbox"/>	Speech impairment <input type="checkbox"/>
Masticatory impairment <input type="checkbox"/>	Tooth fracture/wear <input type="checkbox"/>
Ingestion of bar/stud <input type="checkbox"/>	Puncture wounds <input type="checkbox"/>
Infection/abscess <input type="checkbox"/>	Gingival recession <input type="checkbox"/>
Haemorrhage <input type="checkbox"/>	Dentine hypersensitivity <input type="checkbox"/>
Haematoma <input type="checkbox"/>	Galvanic current creation <input type="checkbox"/>
Allergy <input type="checkbox"/>	No Advice Given (go straight to Q3) <input type="checkbox"/>

If other, please specify _____

Q2a. How are the warnings about the complications provided?

Verbal (Go straight to Q3)
 Written (Please provide a copy)

2b. If written advice is given how is this produced?

In house at the practice
 Printed leaflets from another source please specify _____
 Please attach a copy of all written advice provided

Q3. What advice do you give patients with oral piercings?

Removal of bar/stud
 Discuss potential complications
 Advise patient to attend dentist regularly to monitor potential complications
 Discourage patients to 'play' with their bar/stud
 Piercing hygiene advice
 Emergency advice (e.g. inhalation/swallowing of piercing)
 If other, please specify _____
 No advice given (go straight to Q4)

Q3a. When providing this advice to patients, how is this information provided?

Verbal (go straight to Q4)
 Written

Q3a. If written advice is given how is this produced?

In house at the practice
 Printed leaflets from another source please specify _____
 Please attach a copy of all written advice provided

Q4. Do you give advice on where to seek treatment if complications arise?

Yes
 No

4b. If yes, where do you advise patients to seek help?

Return to piercing studio Dentist
 Doctor Emergency department
 If other, please specify _____

Q5. Where have you acquired the information that you give to patients?

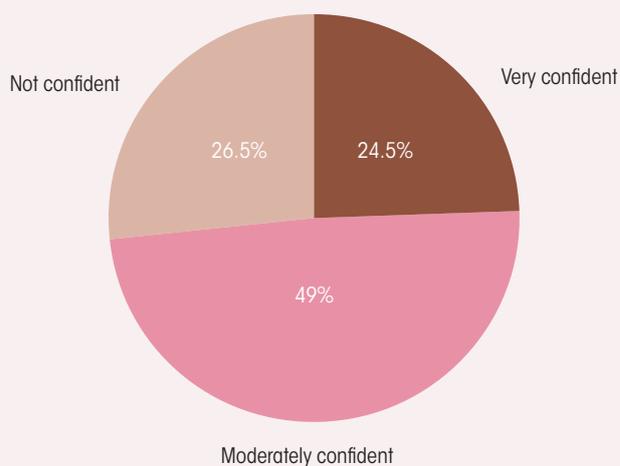
During training
 Reading up-to-date publications
 Local authority / CIH toolkit
 Learned from experience
 If other, please specify _____

Q6. What support would you like from your Local Authority/Health Board in providing patient advice to help minimise complications?

Training courses with verifiable CPD
 Information aimed at professionals (e.g. leaflets)
 Information aimed at patients (e.g. leaflets)
 If other, please specify _____

Q7. Do you feel the Health & Safety Executive publications are sufficient regarding aftercare instructions?

Yes
 No
 If no, please state reasons _____

Fig. 7 GDP confidence in delivering orofacial piercing education to patients

Methodology

A multiple-choice questionnaire was developed with the aim of documenting dentists' perceived confidence in discussing oral piercings, information provided to patients regarding complications, methods used to provide patients with information, sources dentists are using to acquire their knowledge and whether further support or information is required. An example of the questionnaire is presented in Figure 6.

Inclusion criteria consisted of GDPs working in primary care in the Betsi Cadwaladr University Health Board (North Wales) and the Bro Taf Health Authority (covering Cardiff, Merthyr Tydfil, Rhondda Cynon Taff and the Vale of Glamorgan in South Wales). The questionnaire was sent via electronic mail using Microsoft Office Software.

Results

Two hundred GDPs were approached to complete the questionnaire with a total of 53 GDPs (26.5%) returning completed surveys. Results were collated and analysed using Microsoft Excel.

GDP confidence

When asked how respondents felt about discussing oral piercing advice with patients, 24.5% (N = 13) replied very confident, 49% (N = 26) were moderately confident and 26.5% (N = 14) not confident (Fig. 7). Information provided to patients has predominantly been acquired from experience (N = 39, 73.6%), and to a lesser extent from dental training (N = 9, 17.0%). As part of their Continuing Professional Development (CPD), some GDPs have also read

published literature on the topic (N = 15, 28.3%) and one had researched their local authority publications.

Complications

Warnings of piercing complications are given by 50 (94.3%) of the respondents, all of whom given verbal advice only. The three GDPs (5.7%) who do not offer any information had also answered that they were not confident in discussing advice with patients.

There were 15 complications described in the survey, illustrated by Figure 8. None of the respondents offered additional examples. Understandably the most common complications discussed were trauma to teeth (N = 46), gingival recession (64.1%, N = 34), and dentine hypersensitivity (22.6%, N = 12). Aside from dental-related trauma, GDPs tend to warn of acute complications such as infection (52.8%, N = 28), inflammation (37.7%, N = 20), and pain (28.3%, N = 15). Chronic complications, such as scarring/ tissue hyperplasia (16.9%, N = 9), are described less often.

When complications arise, 19 GDPs (35.8%) would advise on where to seek treatment. In the first instance, the majority (24.5%, N = 13) recommend seeking treatment from a dentist. Secondary to this, patients are directed to either return to their piercer (13.2%, N = 7), attend with their general medical practitioner (11.3%, N = 6), or seek attention from their local emergency department (13.2%, N = 7).

Piercing advice

A large proportion of GDPs offered additional guidance (94.3%, N = 50), demonstrated in

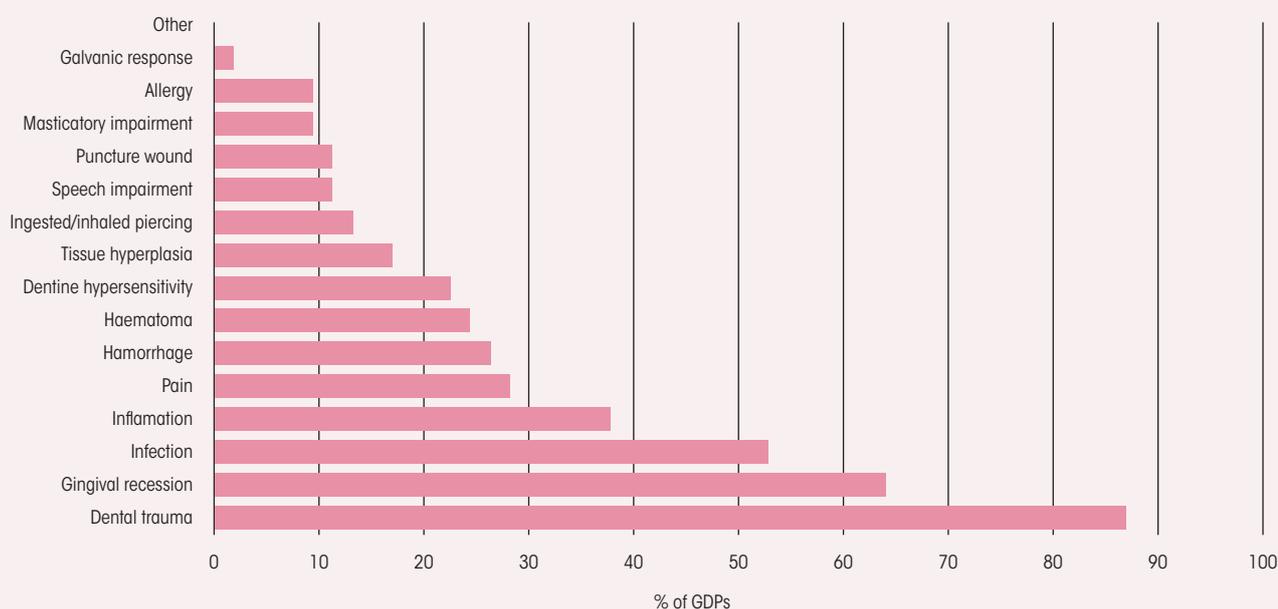
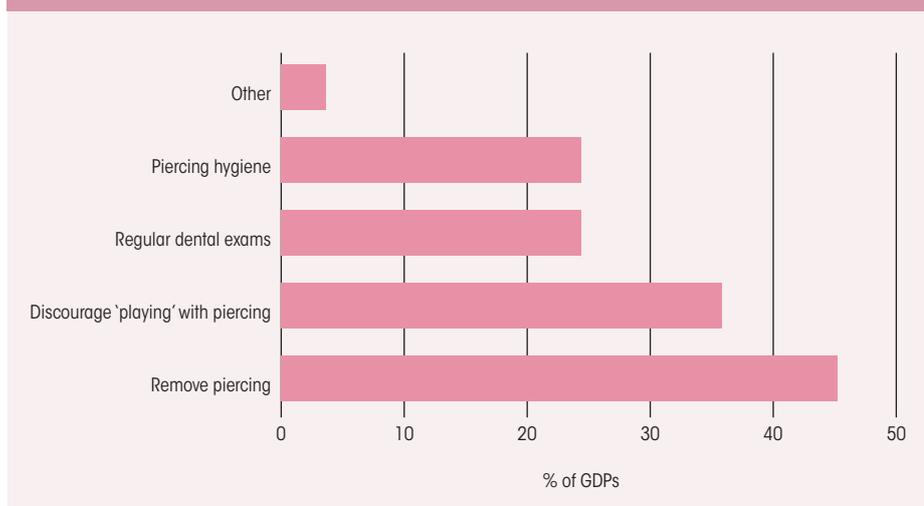
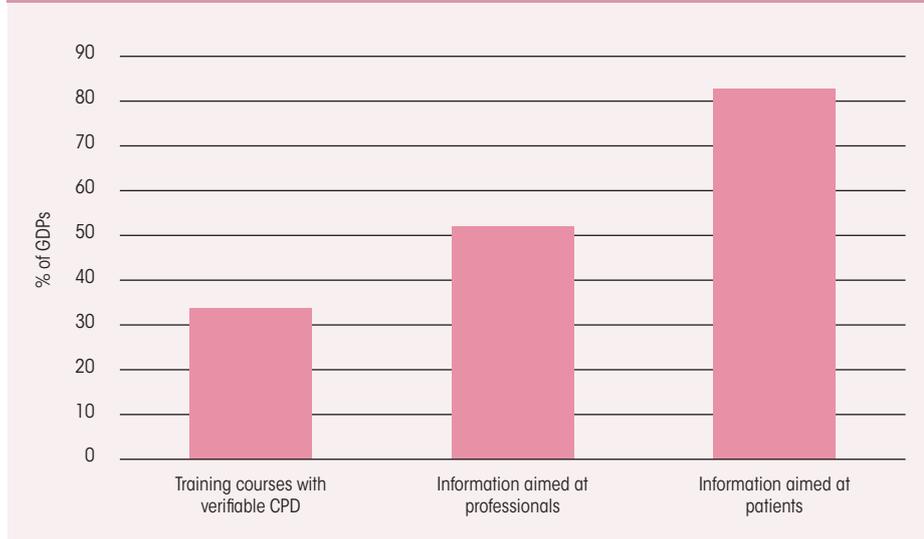
Fig. 8 Orofacial piercing complications described to patients by GDPs

Fig. 9 Orofacial piercing advice given to patients by GDPs**Fig. 10** Advice GDPs would like to receive in relation to the management of orofacial piercings

GDPs reporting they developed knowledge through formal training or reading dental Figure 9. The three GDPs (5.7%) who lacked confidence acknowledged that they do not discuss oral piercings with patients.

Advice is largely based on minimising the risk of trauma to intra-oral tissues, hence GDPs often advocate removing piercings (45.2%, $N = 24$). Two respondents who offered 'Other' information recommend replacing metallic components of piercings with plastic alternatives, particularly if there is 'evidence of damage to the lower anterior teeth.' A quarter of GDPs advise that patients attend for regular dental examinations to monitor potential problems (24.5%, $N = 13$). Where piercings are kept *in situ*, patients are discouraged from regularly 'playing' with or touching/rotating the piercing (35.8%, $N = 19$). Hygiene guidance is provided by 13 (24.5%) respondents.

Again, the preferred method of delivering advice is verbally ($N = 44$, 83.0%). One

respondent (1.9%) stated that they offer written information, which is produced in-house at the practice. A copy of this written advice was not offered on return of the survey. A number ($N = 8$, 15.1%) of GDPs did not specify how their advice is delivered.

GDP support

GDPs were asked what advice they would like to receive in relation to managing oral piercings in dental practice, summarised in Figure 10. Largely, respondents preferred printed information directed towards patients ($N = 44$, 83.0%). Just over half of GDPs indicated that they would like printed information aimed at professionals ($N = 28$, 52.8%), and 18 (34.0%) would like training courses that provide verifiable CPD.

Lastly, GDPs were asked their opinion of existing publications relating to oral piercings. Of the responses, 20 (37.7%) felt that available publications are sufficient; however,

observations were made that materials are not readily accessible. One individual remarked that they 'could not find information on where to seek help if serious infection occurred.' A total of 13 (24.5%) respondents felt that current publications are insufficient, with two commenting that they hadn't seen piercing-related documents before this survey. Two GDPs specified that patient information is inadequate. A proportion of GDPs were unfamiliar with any publications (15.1%, $N = 8$).

Discussion

Prevalence

The increasing incidence of oral piercings appears to be a world-wide phenomenon. A 2012 systematic review studied the prevalence of oral piercings in young adults from the United Kingdom, Canada, Brazil, Spain, Israel, the United States of America, New Zealand, Germany and Finland. The results revealed that 5.2% of the 9,104 young adults had an oral piercing.³ The trend for such piercings was higher in women (5.6%) than men (1.6%) (M:F = 3:11), with the most popular piercing being the tongue (5.6%) followed by lips (1.5%) and cheeks (0.1%). Oral piercings are most common in 16–30 year olds.^{2,3} Alarming, several studies report oral piercings in individuals as young as 11–14 years of age.^{3,14,17,24}

Bone *et al.* (2008)² published the only study that estimates the prevalence of body piercings in the United Kingdom. This survey of 10,503 adults found that 2.1% had a piercing of the lip or tongue. When looking specifically at 16–24-year-olds, 9.2% reported piercings of the lip and/or tongue. Females (2.5%) were more likely than males (1.5%) to opt for these types of piercings (M:F ratio 3:5). Most piercees received their piercing at a dedicated studio. Similar evidence suggests around 80% of piercings take place in piercing establishments.²⁵

A 2016 survey was conducted by the Oral Health Foundation, an independent UK oral health charity, to establish the current trends of oral piercings in the UK.²⁶ Of 214 respondents, tongue piercings were the most commonly reported (43%), followed by lip (33%). Additionally, other anatomical sites were described: frenulum (7%), cheek (3%) and sites such as gingival piercings. 13% of people with oral piercings had more than one intra-oral site pierced, highlighting their existing popularity among the UK population.

The increased prevalence of oral piercings has not gone unnoticed by the dental profession. A UK survey of 227 dentists in South Wales revealed that 99% of dentists had treated a patient with an oral piercing, over three-quarters (77.5%) had seen a

patient for a complication caused by the piercing, and over half (52.9%) had treated an oral piercing complication.¹⁸ The British Dental Association (BDA) released a position statement in 2009 which advises against oral piercings, and recommends that individuals with a piercing should regularly visit a dentist and self-monitor the piercing site for complications.²⁷ Although the prevalence of oral piercings is on the rise, the results from this survey suggest that the confidence and knowledge within the dental profession regarding oral piercings is not evolving with this trend. It is therefore felt by the authors that more should be done to educate the dental profession about oral piercings.

Awareness

Piercee awareness of potential oral piercing complications varies. One study of 110 piercees reported 70.9% were unaware that oral piercings could affect their general health and 26.4% were unaware of potential dental complications.²⁴ Similar studies have reported that around 46–57.8% of piercees are unaware of the complications associated with oral piercings.^{19,21}

Information should initially be provided by the establishment performing the piercing, both before consenting an individual and after performing the piercing. Encouragingly, a recent UK survey of piercers in South Wales reported 100% of piercers provided advice regarding oral piercing complications, with 57% giving both verbal and written warnings, 36% giving verbal only, and 7% providing written warnings only.²⁸ However, warnings given by piercing studios were diverse and no one piercer discussed all relevant complications. Interestingly 79% of piercers reported that further information aimed at both piercing professionals and piercees would be beneficial.

Confidence among the dental profession

It is evident from the results of this survey that only a quarter of GDPs are very confident in discussing with patients the nature of oral piercing complications and necessary preventative advice. In comparison, a similar UK survey conducted by Chadwick (2005)¹⁸ reported that nearly 88% of dentists felt they could give adequate advice regarding possible complications to patients who were considering having an oral piercing. This suggests confidence among the profession has fallen, which may be a result of the increased prevalence and complexity of oral piercings.

Most respondents disclosed that their knowledge regarding oral piercings was learnt from experience, with only a small number of

Fig. 11 Advice leaflet developed for dental professionals to discuss oral piercing complications with patients. Courtesy of 1000 Lives Service Improvement Dental Team

Background
Oral and peri-oral piercings are increasingly popular. They include piercing of the tongue, lip, cheeks and frenula. This guidance will help dental teams to advise patients on the risks of oral piercing and how to care for the piercing if they have them.

Annual 80% of piercings take place in tattoo establishments. Sanitisation methods vary, few piercers are aware of correct oral anatomy and good piercing advice is variable with many piercers omitting hygiene advice. A survey of piercing establishments in Cardiff showed that the 14 establishments who responded either instructed about piercing hygiene, healing times and acute complications and most provide written and verbal aftercare. However this good practice is not replicated in other studios.

A Cardiff study showed that 99% of 227 dentists have treated patients with oral piercings and 78% had seen patients for complications relating to oral piercing.

There has been one report of a death in Wales following tongue piercing and one death in England associated with lip piercing.

Law to improve and protect the health of the nation
The Public Health (Wales) Bill 2017 is a radical piece of legislation which will improve and protect the health and wellbeing of the nation.

The Bill will protect children from the harms of second hand smoke and the dangers of intimate piercing while anyone undergoing a special procedure will be able to have confidence that the person carrying it out has safe working practice.

The Bill will protect children from harm with age restriction for intimate piercing being raised from 16 to 18 years of age. It is therefore unlawful to provide tongue piercing to persons under 18 years.

Complications of oral and peri-oral piercings

Common short-term complications	Reported Frequency
Pain	52%
Inflammation	48%
Difficulty with eating	48%
Difficulty of piercing	48%
Infection / abscess	42%
Haemorrhage	4%
Haematoma	2%
Allergy	1%

Common long-term complications

Complication	Frequency
Those hypothyroid (muscular wastage)	3%
Speech impairment	33%
Teeth fracture/loose - temporally	10-32%
Puncture wounds	29%
Gingival recession	1%
Chronic hyperemesis	19%
Chronic current generation	4%

Rare complications

Parotiditis	11 case reports
Stomatitis	8 case reports
Aggravated cellulitis	1 case report
Loss of maxillary incisor	1 case report
Ludwig's angina	1 case report
Fatal herpes simplex hepatitis	1 case report
Thrombotic thrombocytopenic syndrome	1 case report
Mucosal hypertrophic overgrowth	1 case report
Waldenström	1 case report
Always obstructive	1 case report
Coronary abscess	1 case report
Neural infection	1 case report

Guidance:
As the prevalence of oral and peri-oral piercings is increasing it is important that dental professionals understand the associated risks and are able to provide patients with comprehensive and consistent advice.

- Encourage patients with piercings to remove them altogether because of the risk of harm to teeth and soft tissue.
- If patients will not remove their bacterial plastic version may be less likely to fracture teeth.
- Medically compromised patients (e.g. immunodeficiency or cardiac disease) should be strongly discouraged from having oral or peri-oral piercings to prevent serious health complications.
- If serious complications are suspected (e.g. airway obstruction, systemic illness, tracking abscess) immediate referral to an emergency department is required.

Immediately post piercing - patients should avoid:

- Smoking - this reduces healing.
- Alcohol or aspirin - this increases risk of bleeding.
- Excessive talking, playing with the bar/disk, chewing gum or other objects - this can damage the skin around the piercing.
- Clipping using the tongue and oral sex - this increases risk of infection.
- Swimming - this increases risk of infection.
- Always wash hands before touching the piercing.
- Clean the bar/disk with a salt water solution every day until the area has healed.

Routine care for patients with piercings

- Oral hygiene advice including twice daily tooth brushing, interdental cleaning, use of alcohol-free mouthwash, rinsing after meals.
- Patients should be discouraged from 'playing' with the bar/disk to prevent soft tissue erosion and tooth damage.
- Advise patients with oral/peri-oral piercings to keep dental appointments to monitor and maintain oral health.

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More information:
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'MORE SHOULD BE DONE TO EDUCATE THE DENTAL PROFESSION ABOUT ORAL PIERCINGS...'

literature. This suggests there is a lack of access to information and training available for dentists in the UK. Furthermore, a large proportion of respondents reported they would like information leaflets available for their patients. Many reported they would like to receive further information aimed at dentists and felt that there is a need for CPD courses for dental professionals. This highlights an area of dental education which may currently be insufficient for dental professionals to feel confident giving oral piercing advice and treating complications.

It was reassuring to discover that the majority of GDPs are providing patients with verbal advice regarding oral piercing complications. As one would expect, GDPs responded that they regularly discuss dental related complications. Other common acute and chronic complications appear to be discussed much less frequently. This concurs with the UK study by Chadwick (2005),¹⁸ whereby tooth fracture and recession were the most commonly discussed complications between GDPs and patients.¹⁸ It is apparent that in over ten years there has not been any development in the information provided by GDPs to patients regarding oral piercing complications. As a visit to a dental

professional is an opportune moment for patients to receive oral health advice, it is felt by the authors that more needs to be done to empower dental professionals to discuss the range of complications associated with oral piercings.

Encouragingly, almost all GDPs reported the provision of preventative advice to avoid oral piercing complications for their patients. However, the advice regarding how to prevent complications and where complications should be treated varied among GDPs. It is currently unknown how frequently piercees in the UK seek medical or dental attention for oral piercing complications. Considering an estimated 2% of adults in the UK have an oral piercing, it is likely that a large proportion of this group of patients will require some level of medical or dental care at some point.² This therefore emphasises the importance of the provision of clear and comprehensive preventative advice for patients to reduce the likelihood of complications.

As GDPs feel that current publications are insufficient and have indicated that they would like further information available for patients and dental professionals, the authors of this article, together with 1000 Live Wales, have developed patient information leaflets which have been distributed to GDPs in Wales to enable them to discuss complications with patients and provide written advice (Fig. 13). It is important that all dental professionals possess

the appropriate skills and knowledge to treat patients with oral piercings and are confident to provide the correct advice.

Limitations

As with all studies, there are certain limitations that need to be recognized in this survey. Firstly, the low response rate of 26.5% meant that a large proportion of dentists' experiences and opinions were not captured in the data which may have affected the results. It is possible that contacting dentists via email led to a poorer response rate than that which may have been achieved by using a printed version of the survey sent via post. It is also possible that due to the large number of surveys dentists receive, the GDPs targeted in this study may have experienced 'survey fatigue' which affected response rates. The variation in prevalence of oral piercings in the different Welsh regions targeted for this survey is unknown. It is therefore possible that the GDPs who responded may see a low number of patients with oral piercings which may explain the low confidence and experience treating piercing related complications.

Conclusion

Oral piercings are associated with numerous complications, and it is possible that the incidence of complications may increase as the prevalence of oral piercings rises in the UK population. It is important that dental professionals can provide patients with appropriate advice and manage oral piercing complications that may arise. The results of this survey suggest that dental professionals are not entirely confident discussing risks and preventative advice with patients. To address this issue, patient information leaflets have been developed to encourage dentists to discuss complications associated with oral piercings with patients.

Acknowledgements

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UNIQUE INSIGHTS INTO THE NATION'S BRUSHING HABITS

Award-winning dental care innovation Brushlink has passed its 10,000 sessions milestone, showing that since its soft launch in November last year it is already having positive impact on the oral health of the nation. The 10,000 sessions equate to around 12 million individual brushing data samples, which together give a unique insight to the brushing habits of Brushlink users while providing them with feedback on how to further improve their brushing technique.

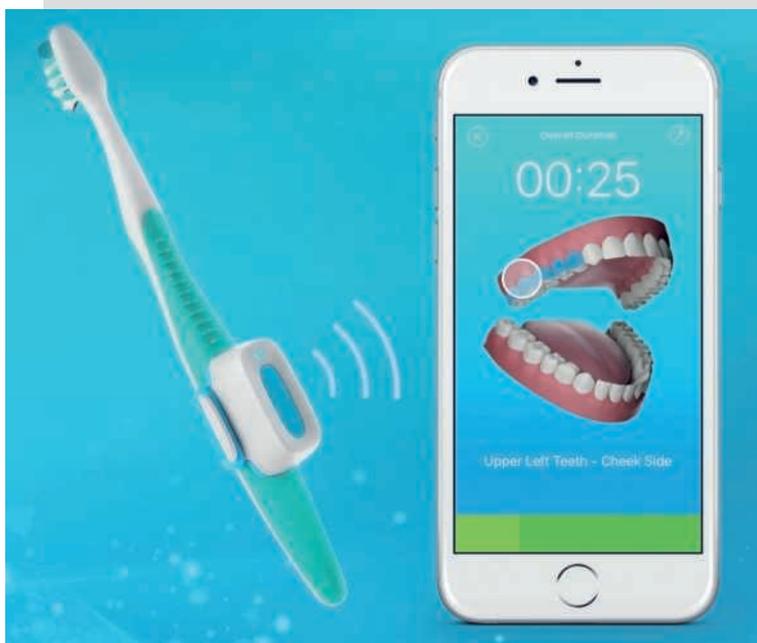
Brushlink is the first device of its kind that can track and coach people on brushing frequency, duration and angles while making this data available to dentists if consented – and it works with any toothbrush, manual or electric. Brushlink has also been built to provide a brushing score each time it is used, which makes it

great for families – parents and kids can compete with each other to see who is the 'best brusher'. The score is displayed along with 'in-brush' coaching tips and hints via a Bluetooth connection to a smartphone app; however, it also stores data for up to three months in case the user does not have a phone in the bathroom.

The data collected by the device is used by the user's dentist to create a bespoke dental hygiene plan based on their brushing habits. The care plan is automatically uploaded to the device, helping to make brushing even more effective and efficient and thereby improving oral health.

Dr Dev Patel, CEO and Founder of Brushlink and an award-winning dentist, commented: "The amount and quality of our data is giving us a real insight into the brushing habits of the nation – showing

where they are with their brushing routine at a certain point and how they are improving their technique over time. We are working on research relating to the data we are gathering, and early indications show that using Brushlink can reduce dental plaque (the cause of dental decay) by as much as 40 percent."



A STAGED APPROACH

At the British Dental Conference and Dentistry Show, Philips supported a main-stage lecture by Dr Ben Atkins – a champion of protection – who has been conducting an early trial of the new Sonicare ProtectiveClean brush amongst 70 of his patients. He was joined by dental hygienist Anna Middleton and together they presented the findings of a countrywide trial, demonstrating the strengths of Sonicare technology and what this means for the continued improvement of patients' oral hygiene.

The new affordable range fits well with his inclusive ethos as Dr Atkins runs oral healthcare initiatives amongst patients from all walks of life, including homeless individuals and very high-needs patients, and so accessibility is at the heart of all he does. His award winning Revive group of dental practices in the north west of England have developed a traffic light scheme to identify patients who need to tackle their oral health status and they are encouraged to adopt a better oral health routine by being provided with Sonicare brushes at cost price – because in the opinion of Dr Atkins 'You can't put a price on good oral health and I am not looking for a means of profiting from patients' improved oral status'.

For more information, visit www.philips.co.uk/dentalprofessional or call 0800 0567 222.

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

STRONG TEETH MAKE STRONG KIDS



Oral-B is on a mission to support UK parents and carers to adopt appropriate home-based oral health behaviours and thereby reduce the number of children with toothache and dental problems – all through its #StrongTeethMakeStrongKids campaign. The oral health experts from Oral-B and the University of Leeds, have launched a research and education programme to give dental professionals and parents the right support to prevent these dental health issues from now on.

‘We are working closely with the UK’s dental professionals by aiming to provide up to 20,000 dental professionals this year with simple and engaging educational materials for parents and their children during routine check-ups. Oral-B is committed to take on this challenge to sustainably improve the situation in the UK’, says Jane Kidson, Oral-B Professional Team Leader UK and Ireland.

Combined with the right dental care products, these positive oral health messages

are designed to encourage parents to lead the way, so they can see that these oral health issues are mostly preventable with simple changes to their families’ daily oral care routine.

Here is a snapshot of the brand’s educational materials that dental professionals can use to support the conversations that they are having with parents and carers:

1. Brushing from first tooth to five years
2. Friends and family can support healthy habits
3. Make brushing fun for children
4. Healthy eating can help protect teeth.

Maintaining good oral health and establishing the right healthy habits early on will help children progress along the key ‘Strong Teeth’ milestones. They include their first dental visit, the arrival of their first tooth or teeth, and then the first time they use an electric power toothbrush (from the age of three onwards).

DENTAL PARTNERS: MAKING A DIFFERENCE WITH DENTAID

Dental Partners is a growing network of practices with an ethos of supporting its staff and charities operating within the dental sector. The opportunity to combine both these aspects of support presented itself last month when Jess Hague, a dental nurse from one of its latest acquisitions, High Green Dental Practice in Sheffield, became a volunteer for Dentaaid.

As one of the world’s leading oral health charities, Dentaaid’s vital work involves supplying refurbished dental surgeries and oral healthcare to projects in many different countries. This includes sending teams of volunteer dental professionals from the UK to countries where there is an acute shortage of dental care across a variety of settings including schools, prisons, orphanages and refugee camps.

Along with three volunteer dentists, Jess spent a week in May at a Syrian refugee camp on the Greek island of Samos, where she helped refugees who had no access to dental care. The team provided vital dental treatment along with toothbrushes and oral health products.

Jess said: ‘I’ve never experienced anything like this before, seeing so many people in desperate need of dental treatment – it really opened my eyes to the amazing work Dentaaid’s volunteers do.’

Find out more about Dental Partners at www.dentalpartners.co.uk or email contact@dentalpartners.co.uk.

NEW OPPORTUNITIES FOR EVERYBODY TO CAMPAIGN FOR BETTER ORAL HEALTH

The Oral Health Foundation has relaunched its website, with the focus on giving its supporters more opportunities to be actively involved in raising awareness of important causes.

The new online platform not only allows visitors to support all the charity’s campaigns and activities, such as National Smile Month, but also gives many more the chance to participate in them. The website also houses its own dedicated fundraising

platform, which means that individuals and groups can create and share their own fundraising efforts and raise money for a series of charitable causes related to oral health.

Visitors can also read about the latest oral health news, take an interest in a series of new blogs and read the charity’s digital magazine.

The redesigned website is live now at www.dentalhealth.org.



Dental Nurse Jess Hague receives a Dentaaid donation from Dental Partners’ CEO Neil Lloyd

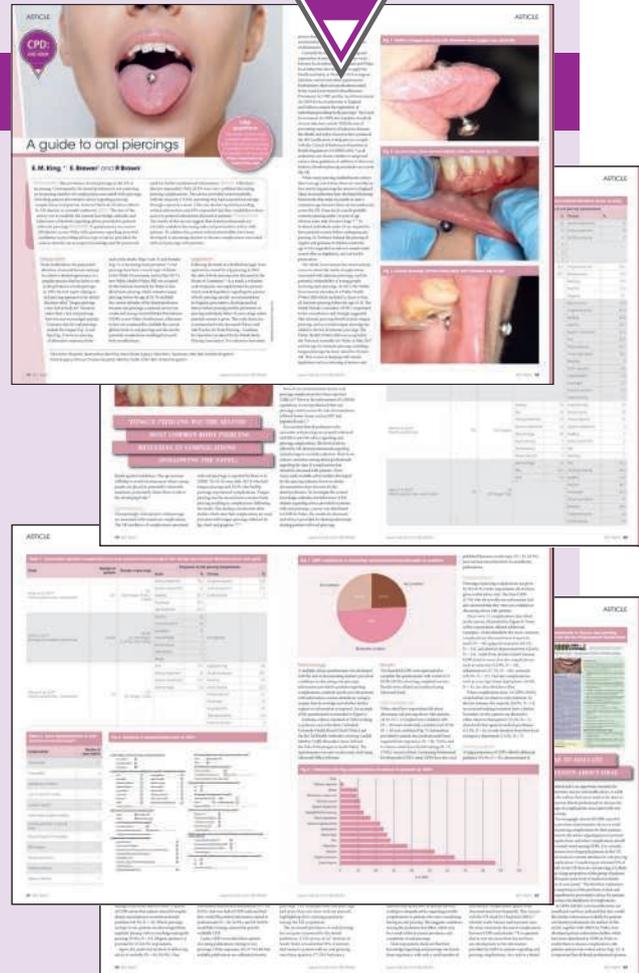
BDJ Team CPD



CPD questions: July 2018

A guide to oral piercings

- According to the British Body Piercing Association code of practice for piercers, at what age can piercing be provided without parental consent?
 - 21 years of age
 - 18 years of age
 - 16 years of age
 - 14 years of age
- Which of the following are commonly reported chronic complications associated with oral piercings?
 - speech impairment
 - infection
 - dental pain
 - all of the above
- Complications resulting from oral piercings have been shown to be more common in:
 - patients with cheek piercings
 - patients who habitually play with their piercing
 - patients wearing studs
 - patients with geographic tongue
- According to a review discussed in the article, oral piercings in young adults are more frequently in:
 - women than men, with the most popular piercing site being the lingual frenulum
 - women than men, with the most popular piercing site being the tongue
 - men than women, with the most popular piercing site being the tongue
 - men than women, with the most popular piercing site being the lips



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.