BDJ Team
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The ORTHODONTIC workforce

BDA
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CORE CPD: ONE HOUR

Highlights

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NEW APP FOR BRITISH DENTAL CONFERENCE 2015

Delegates at this year's British Dental Conference and Exhibition will find everything they need at the tip of their fingers thanks to a new app specially designed for the event. A first for 2015, the app is suitable for both Apple and Android devices and makes managing your time at the event and getting around even easier than before. The app is available to download now via the Apple App Store or Google Play.

Key features of the new app include:

- A personal agenda feature allowing delegates to browse full programme information and add sessions they would like to attend to their own personalised event diary
- Full speaker bios
- Venue and exhibition maps
- Instant event notifications
- Access to special show offers
- Visitor information from cash machine locations to car parking
- Direct access to Twitter and Facebook allowing users to interact and share views with other delegates and organisers
- Notes section that allows you to save and email notes to yourself.

Linda Stranks, Director of Marketing and Membership at the British Dental Association (BDA), said: 'We have designed this app to make the event experience as simple and smooth as possible. Many of our delegates now carry smartphones so it makes sense to interact with them and provide show information directly into their hands. We want to make the event even more interesting for visitors and more interactive for exhibitors.'

This year's event will take place from 7-9 May at the Manchester Central Convention Complex with many of the sessions of interest to the whole team. However, in addition, there are also a number of sessions which have been designed with particular team members in mind.

Dental nurses

One session that's not to be missed is the Career Pathways presentation in the Training Essentials theatre (Friday, 12 noon). In this special session for dental nurses, BADN President Fiona Ellwood will look at the opportunities that are out there for dental nurses. She will help dental nurses reflect on developing as a specialist practitioner and consider what a new dental contract might mean for dental nurses' future career pathways.

Dental hygienists and therapists

On Friday morning the BSDHT is hosting a must-attend Conference Pass session at which Paul Brocklehurst, Senior Clinical Lecturer/Honorary Consultant, Dental Public Health and NIHR Clinician Scientist, University of Manchester will be looking at the evidence supporting the use of dental hygienists and therapists in primary care.

Another highlight for dental therapists is the Paediatric Prevention presentation in the Training Essentials theatre (Saturday, 11 am) in which Amanda Gallie, Dental Hygienist and Therapist, and DCP Advisor, Health Education England (East Midlands) will look at systems for developing a child friendly hygiene and therapy practice. In total the Training Essentials theatre offers 19 x 30-minute sessions based on the BDA's Training Essentials portfolio. Topics include dealing with emergencies, radiation doses in dental radiography, child and adult safeguarding, infection control and team working.

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Practice managers and administrators

One highlight that's not to be missed is the ADAM team leadership presentation in the Training Essentials theatre (Thursday, 4 pm). In this special session Association Honorary Vice President Tracy Stuart will walk through the steps of building a team rather than a group of people that turn up to the same place of work each day. She will help you understand the many hats you need to wear as a business owner or manager. She will share the changes in marketing, what is working and what isn't and how you can convert calls into patients and treatment plans into solutions the patients wants to pay for without becoming an aggressive sales person.

Further event highlights include a large exhibition featuring the live Demonstration theatre, Speakers' corner and Innovation zone, free advice sessions with BDA advisors and an evening social programme including networking drinks, a Cuban party night. Up to 15 hours' CPD will be on offer with all core CPD subjects covered.

Conference Passes for dental care professionals offer great value with a one day Conference Pass priced at £95 and a full three day Conference Pass just £155. This gives you access to all the lectures as well as the shorter sessions in the Exhibition Hall.

Alternatively, you could attend the event free of charge by registering for your FREE Exhibition Pass which gives you access to the shorter Training Essentials theatre sessions outlined above as well as the other Exhibition Hall sessions. Don't miss out!

Further programme information and booking details for both Conference and Exhibition Passes is available at www.bda.org/conference

Delegates can register online at www.bda.org/conference or by calling 0870 166 6625.

Please note!

The UK general election will take place on Thursday 7 May 2015. If you are planning to attend the event on this day and wish to vote in the election you will need to apply for a postal vote if you cannot attend your local polling stations.

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The twenty-first century ORTHODONTIC workforce

T. Hodge[1] and **N. Parkin**[2] highlight the changes that have taken place in the orthodontic workforce over the past decade and review the roles of various members of the orthodontic team.

Orthodontic workforce planning

Historically, orthodontic workforce planning has proved difficult. In 1985 Stephens *et al.*[1] predicted an oversupply of orthodontists and yet only 13 years later the Task Group for Orthodontics identified a shortfall and recommended a target of 480 general dental service specialist practitioners for the UK. This wide ranging and perspicacious report took into account training mechanisms, European directives and wider drivers from the Chief Medical and Dental Officers. At that time they were mindful of two other unknowns in planning the workforce, the influence of 'grandfathering' onto specialist lists and the potential impact of 'orthodontic auxiliaries' as they were then known.[2]

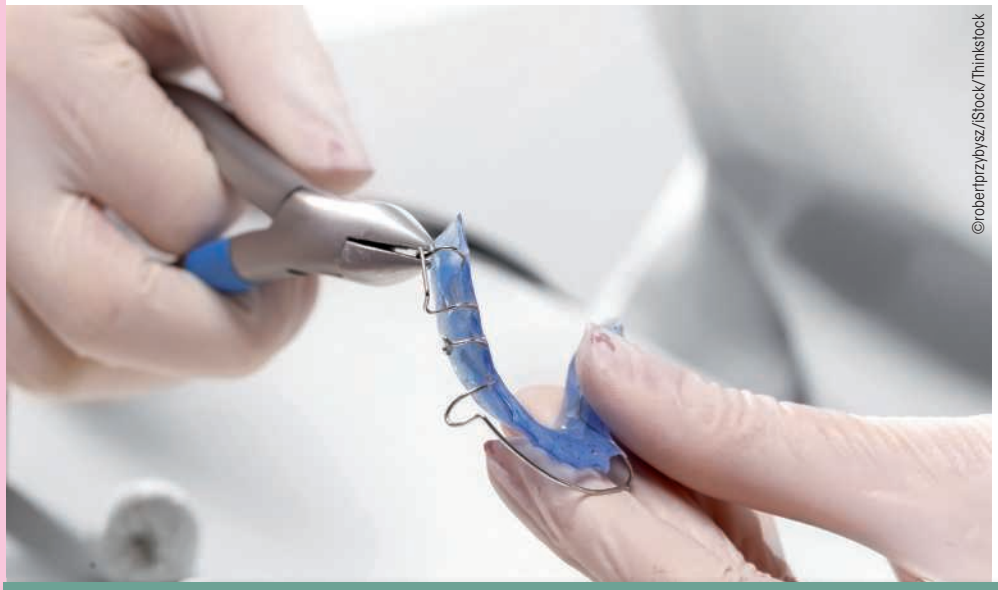
The first complete survey of the orthodontic workforce in the UK was carried out during 2003 and 2004.[3] This survey was commissioned by the Department of Health and carried out by the University of Sheffield. The aim was to assess the existing orthodontic workforce in relation to current and future population needs. It was questionnaire-based and investigated the location of workforce and the ratio of 12-year-olds per whole time equivalent orthodontic provider in each Strategic Health Authority. Type of provider, case mix and productivity (assessed as number of cases treated per year) were also investigated. An orthodontic provider was considered to be a specialist or non-specialist who treated more than 30 cases per year.

Of the 1,660 UK orthodontic providers identified, 919 were General Dental Council (GDC) registered specialist providers. In the hospital setting, 243 NHS consultants and 68 university teachers were identified. Fifty-five worked in a community setting and 221 were in training. The specialist practitioner group was the largest group (548) and the practitioner group (non-specialist providers) represented 26% of the workforce (432). At this time, orthodontic therapists did not exist and attempts were not made to measure their potential impact on workforce need. Several scenarios were presented with the problem of addressing the shortfall in orthodontists and it was emphasised that the demand for increased numbers of providers could be lessened if those patients falling

[1] *Consultant Orthodontist, Leeds Dental Institute;* [2] *Consultant Orthodontist, Charles Clifford Dental Hospital, Sheffield*

into low index of treatment need categories of treatment were not offered orthodontic correction. Following this survey, and the introduction of contracting, for those patients with a dental health component (DHC) score of three and below orthodontic treatment is no longer available on the NHS. An exception to this rule is those who fall in the DHC category three where the aesthetic component scores six or higher. It was also highlighted in the report that there was considerable variation in geographic distribution of providers, similar in fact to the variation shown in the study by O'Brien and colleagues.[4]

In recent years, probably the most significant change to the orthodontic workforce has been the introduction of orthodontic therapists. There is anecdotal evidence that this has already impacted on the employment of some dentists and specialist orthodontists in the workforce and continues to impact on the employment of newly qualified specialists and clinical assistant dentists. Future workforce issues will need to be reassessed by the Centre for Workforce Intelligence, with input from the British Orthodontic Society (BOS). Consideration should be given as to whether potentially smaller numbers of specialists will be needed to be trained in the future or whether there needs to be a reduction in the number of orthodontic therapist training providers. In many ways this latter problem should have been circumvented. The original pilot study to establish training of orthodontic therapists, and conducted in Bristol, made it very clear that a very small number of centres should be involved. It was recognised that it was important to fully evaluate the appropriateness of the training and skills acquired from the initial courses over time before further proliferation of programmes around the UK. At the end of the Bristol pilot it was suggested that there should initially be an establishment of one or two auxiliary training courses in the UK to ensure the development of a national standard, and that further courses would then be seeded from these programme leading to GDC registration.



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'IN RECENT YEARS, PROBABLY THE MOST SIGNIFICANT CHANGE TO THE WORKFORCE HAS BEEN THE INTRODUCTION OF ORTHODONTIC THERAPISTS.'

THE CURRENT WORKFORCE

Orthodontic nurses

In 2000, a survey was undertaken to investigate the delegation of orthodontic tasks and the training of chairside support staff in Europe.[6] At this stage in the UK the role of the orthodontic therapist had not been developed. From the nine tasks investigated, the only one which was permitted to be undertaken by a dental nurse in the UK was the taking of radiographs. This survey highlighted that UK dental nurses were allowed to work without qualifications or formal training. However, currently all dental nurses have to be registered with the GDC. Those employed, but not yet qualified, need to be enrolled within two years of commencing employment or waiting to start on a recognised training

In addition, the clinical duties dental and orthodontic nurses are permitted to undertake have increased. Many nurses not only take radiographs but routinely give oral hygiene instruction, take impressions and clinical photographs. These roles, as with all dental registrants in the team, are laid out in the GDC *Scope of practice* documentation.[7]

Finally, as well as the Certificate in Dental Nursing, the National Examining Board for Dental Nurses (NEBDN) also run additional post-qualification courses leading to certification that many orthodontic nurses undertake in assisting them perform their additional clinical roles competently including the:

- Certificate in Orthodontic Nursing[8]
- Certificate in Oral Health Education[9]
- Certificate in Dental Radiography.[10]

Orthodontic therapists

Orthodontic therapists are a grade of dental care professional (DCP) introduced in 2007. The recommendations for the training and deployment of orthodontic auxiliaries in the UK were based on the experiences of the Bristol pilot study,[5] which provided a foundation for the current training models being used in Bristol and Leeds. These were the first two training centres to qualify orthodontic therapists.[11] It was also the basis for those institutions that subsequently established programmes (Swansea, Edinburgh, King's, Manchester, Preston and Warwick).

Working under appropriate supervision[12] and following a prescription, orthodontic therapists are permitted to undertake numerous reversible orthodontic procedures. In reality this includes most orthodontic procedures, such as bonding brackets, changing archwires, fitting functional appliances and retainers and debonding appliances.

The exact details of the scope of practice for orthodontic therapists as laid out by the GDC[7] are shown in Table 1 and the specific capabilities of orthodontic therapists can be found in the GDC *Preparing for practice: Dental team learning outcomes for registration* document.[13]

Since the first orthodontic therapists qualified in 2008, 364 of these personnel are now registered with the GDC (as of May 2014). This has significantly increased the orthodontic workforce and in many areas has led to an increase in access to a specialist led orthodontic service. It is expected that therapists will have had a beneficial effect in reducing geographical inequality of specialist

Table 1 Scope of practice of the orthodontic therapist

Orthodontic therapists can:	Orthodontic therapists cannot:
Clean and prepare tooth surfaces ready for orthodontic treatment	Remove sub-gingival deposits
Identify, select, use and maintain appropriate instruments	Give local analgesia
Insert passive removable orthodontic Appliances Insert removable appliances activated or adjusted by a dentist	Re-cement crowns
Remove fixed appliances, orthodontic adhesives and cement	Place temporary dressings
Identify, select, prepare and place auxiliaries	Place active medications
Take impressions Pour, cast and trim study models	They do not carry out laboratory work other than previously listed as that is reserved to dental technicians and clinical technicians
Make a patients's orthodontic appliance safe in the absence of a dentist	Diagnose disease, treatment plan or activate orthodontic wires - only dentists can do this
Fit orthodontic headgear Fit orthodontic facebows which have been adjusted by a dentist Take occlusal records including orthognathic facebow readings Take intra and extra-oral photographs	Additional skills which orthodontic therapists could develop during their career include:
Place brackets and bands prepare, insert, adjust and remove arch wire previously prescribed or, where necessary, activated by a dentist	Applying fluoride varnish to the prescription of a dentist
Give advice on appliance care and oral health instruction	Repairing the acrylic component part of orthodontic appliances
Fit tooth separators	Measuring and recording plaque indices and gingival indices
Fit bonded retainers	Removing sutures after the wound has been checked by a dentist
Carry out Index of Orthodontic Treatment Need (IOTN) screening either under the direction of a dentist or direct to patients	
Make appropriate referrals to other healthcare professionals	
Keep full, accurate and contemporaneous patient records	
Give appropriate patient advice	

Table 2 GDC learning outcomes for dentists – management of the developing and developed dentition

1.13.1 Identify normal and abnormal facial growth, physical, mental and dental development and explain their significance
1.13.2 Undertake orthodontic assessment, including an indication of treatment need
1.13.3 Identify and explain development or acquired occlusal abnormalities
1.13.4 Identify and explain the principles of interceptive treatment, including timely interception and interceptiv orthodontics, and refer when and where appropriate
1.13.5 Identify and explain when and how to refer patients for specialist treatment and apply practice
1.13.6 Recognise and explain to patients the range of contemporary orthodontic treatment options, their impact, outcomes, limitations and risks
1.13.7 Undertake limited orthodontic appliance emergency procedures

care, although this has still to be confirmed in the latest BOS survey expected to be published in the near future.

There have been possible concerns raised about the quality of supervision of this grade of dental registrant.[14] At the outset many, including a number of educational providers, were keen that while DCPs could work independently from a dentist once they had a treatment plan, due to the nature of orthodontics where progress and mechanics were constantly being re-evaluated, an appropriate reassessment schedule would be required every visit. Therefore an orthodontic therapist should never be left unsupervised.[15] Others felt this view was over prescriptive and perhaps such guidelines would be a disincentive to employing therapists.[16] As a result, a working party from all the groups of the BOS convened leading to a set of guidelines being published on the supervision of qualified orthodontic therapists by both the BOS and the Orthodontic National Group (ONG).[12]

Orthodontic technicians

Orthodontic technicians are registered dental professionals who construct custom-made orthodontic appliances to a prescription from a dentist or orthodontist. If they are trained, competent and indemnified they can:

- Review cases that come in to the laboratory to decide how they should progress
- Work with the dentist/orthodontist on treatment planning and appliance design
- Modify orthodontic appliances according to a prescription[7]
- Give appropriate patient advice and carry out shade taking. This may be especially useful mid-treatment when constructing temporary pontics to replace missing units.[17]

With additional training, working alongside an orthodontist, technicians may also assist in the treatment of patients by taking impressions, recording facebows and occlusal registrations, tracing cephalograms and taking photographs. The skill of an orthodontic technician in the orthodontic workforce is probably nowhere more central than in delivering an orthognathic service where accuracy, skill and good communication are crucial for success in treatment outcomes.

General dental practitioners and dentists with enhanced skills

General dental practitioners (GDPs) perform a key role in the orthodontic workforce acting as diagnostic gatekeepers. The GDC *Preparing for practice* documentation[13] it lists the learning outcomes for dentists to be registered with the GDC (Table 2).

Although orthodontics is a very specific area of expertise, and only those registered on the specialist list with the GDC can call themselves a specialist orthodontist, any registered dentist can carry out orthodontics as long as they are competent to do so. Historically, a significant proportion of orthodontic treatment has been carried out by GDPs in the UK. The 2005 report revealed that 17% of orthodontic providers had no orthodontic qualification. The report also highlighted that in some regions, Shropshire, Staffordshire, Trent, North and East Yorkshire and Lincolnshire, the majority of orthodontic provision was carried out by non-specialists. Since 2006 the speciality has seen the end of fee-for-item payments and the introduction of the new individualised contracts. While the majority of these contracts have been made with specialist orthodontic practitioners, contracting has occurred among a group of existing NHS primary care general dentists. Initially known as dentists with a special interest in orthodontics,[18] these clinicians are now known as dentists with enhanced skills (DES). While not being eligible for specialist list registration with the GDC these providers will have gained additional experience and training in orthodontics and can be formally recognised by the commissioners of orthodontic care (known as area teams since April 2013). A DES is expected to treat patients within their competence and refer complex cases to a specialist orthodontist or local hospital service as part of a local clinical network. If this clinical network works efficiently and effectively, the likelihood of population need being met and high quality of care being maintained will be increased. Training of DES often used to take place on two-year orthodontic clinical assistantship schemes but now few, if any, of these remain. Instead, there has been a recent increase in longitudinal general professional training (GPT) schemes for foundation dentists with placements in orthodontic specialist practice or in hospital departments.

Recently, GDPs have increased their presence in the orthodontic workforce by offering short-term orthodontics to adult patients wanting an improvement in their anterior smile aesthetics. While this has caused debate[19] a move away from anterior alignment using a handpiece to reshape teeth together with ceramic restorations has to be welcomed.[20] It should, however, be appreciated by those practitioners offering short-term orthodontics that it provides a relatively limited range of outcomes and frequently a specialist referral for correction of a patient's wider malocclusion may be indicated.

Specialist practitioners

Specialist practitioners work in primary care and are registered as specialists with the GDC. At the time of the introduction of the specialist lists in the late nineties a number of people gained entry to this group via 'grandfathering'. However, entry should now only be on receipt of orthodontic training in other EU member states or in the UK by securing an orthodontic speciality training registrar post. Entry to these salaried posts by UK/EU applicants is competitive with essential criteria for application including the possession of a dental degree, registration with the GDC and completion of a period of dental foundation/vocational training or GPT demonstrating experience in a range of dental specialties. Interestingly, the GDC are currently completing research, including patient and public, stakeholders' and registrants' views on regulation of the specialties and are asking these three questions to gather evidence on the way forward:[21]

- Does regulation of the specialties bring any benefits (potential and/or actual) in terms of patient and public protection?
- Is regulation of the specialties proportionate to the risks to patients in relation to more complex treatments?
- Are the specialist lists the appropriate mechanism for helping patients to make more informed choices about care not seen as falling within the remit of the general dental practitioner?

Many consider that the reason specialist lists are useful is because specialist training and defined standards of practice help to deliver better treatment and improve clinical outcomes for patients who receive specialist dental care. In orthodontics the likelihood that a treatment will benefit a patient is increased if appliance therapy is planned and carried out by an experienced orthodontist.[22]

Orthodontists also spend less time on treatment and achieve better quality outcomes than cases treated by general dentists who have not undergone a specialisation course in orthodontics.[23]

The training programme leading to specialisation in orthodontics in the UK is three years full-time (or part-time pro rata)[24] and involves undertaking a university postgraduate degree at the Masters (MSc, MClinDent, MPhil) or Doctorate (DClinDent, DDS) level and upon successful completion of the programme, eligibility to sit the Membership in Orthodontics examination of the Royal College of Surgeons. The training programmes are currently monitored by the Postgraduate Deaneries and the Specialist Advisory Committee but with national developments through Health Education England these arrangements are likely to change. The workload undertaken by specialist orthodontic practitioners reflects the comprehensive learning outcomes of the specialist training programmes which include being able to diagnose anomalies of the developing dentition and facial growth, carrying out a wide range of simple and complex treatments both interceptive and comprehensive in nature including multi-disciplinary management of a variety of treatments and understanding psychological aspects relevant to orthodontics.

Community orthodontists

The community orthodontic service is a long-established part of NHS provision. In a changing climate of dental provision over recent years, providing orthodontic support for Trust-based 'Personal Dental Services' schemes, under the umbrella of the salaried primary dental care services, has become increasingly important. Community orthodontists are specialist-trained providers who undertake orthodontic treatment for a range of special care patients who have limited access to other, appropriate specialist treatment.

The majority of such patients who are able to receive orthodontic treatment often require close liaison with other health care professionals for a holistic approach to management and not infrequently this service provides a 'safety net' in those areas of the country not well served by specialist practice or hospital orthodontic providers.

Orthodontic consultants

Consultant orthodontists are those specialists that have undergone an additional two years of full-time training (or part-time pro rata), in many cases sub-specialising for example, cleft lip and palate work, who collectively can provide any orthodontic service which the commissioners might require. In addition eligibility for application to these posts is subject to satisfactory completion of the Intercollegiate Speciality Fellowship

Examination Exam in Orthodontics, FDS (Orth), although foundation trusts are in a position to write their own requirements for appointment to a consultant post. While this role can be varied, clinical activity is focused upon the following:

- Working in conjunction with consultant oral and maxillofacial surgeons, plastic surgeons or paediatric surgeons to correct severe skeletal problems by means of combined orthodontic and surgical treatment approaches
- Liaise with other key specialties to provide coordinated care for patients with cleft lip and palate, and other congenital dentofacial anomalies. There is also increasing collaboration with ENT consultants and respiratory medicine to manage patients with obstructive sleep apnoea
- Provide clinical training for undergraduate dental students, career junior staff, future specialists and trainee academics and participate in continuing professional programmes for all trained providers of orthodontic care
- Undertake personal research, innovation and service evaluation including audit
- Working with colleagues in primary care and dental public health as part of a professional network to manage orthodontic services locally.

In summary, the role of the consultant orthodontist is varied but centres on clinical consultation, the treatment of severe and multidisciplinary cases, service coordination, training and research.

DISCUSSION

This article highlights the many varied personnel involved in the delivery of orthodontic treatment in the UK and illustrates how the workforce has evolved in recent years. From the extension of the role of the orthodontic nurse, the introduction of the orthodontic therapist into the team, the mandatory registration of all DCPs and the increase in uptake of short-term orthodontic treatments being offered in general dental practice, much has changed over the past decade.

While we may be clearer now as to who does what in the orthodontic workforce, perhaps the next workforce issue that will arise as a result of these changes is how many of these varied personnel will be needed to deliver care and their appropriate training.

The Centre for Workforce Intelligence published a strategic review in 2013 analysing the future 'supply and demand' of the dental workforce in England between 2012 and 2040[25] which revealed that there is likely to be a surplus supply of dentists by as many as 4,000 by 2040. The mechanisms for the derivation of these figures is far from clear and likely to be as hopeless as the information which led to expansion of undergraduate numbers in 2006. It is hoped that the report of the current Workforce Survey Task and Finish Group of the BOS will form the backbone of negotiations with the Centre for Workforce Intelligence, Health Education England and the Department of Health and will be instrumental in shaping the future training of the workforce and delivery of orthodontic services in England and Wales.

'THE IMPACT OF THE CHANGE IN COMPOSITION OF THE WORKFORCE MUST BE TAKEN INTO ACCOUNT WHEN PLANNING FUTURE NEEDS.'

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CONCLUSION

There has been considerable change in the composition of the orthodontic workforce over the last decade. It is hoped that the extension of roles performed by the various members of the orthodontic team will lead to increased accessibility of specialist care.

The impact of the change in composition of the orthodontic workforce, in particular the addition of orthodontic therapists, must be taken into account when planning future manpower needs.

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PROFILE - ORTHODONTIC NURSE

***Ruth Mackenzie**, 34, is a dental nurse at Giffnock Orthodontic Centre in Glasgow. Ruth worked at a specialist orthodontic practice from 2002-2006, at a private general dental practice from 2006-2010, and has been at her current workplace since 2010. As well as her dental nurse qualification, Ruth has a certificate in dental radiography, and enjoys snowboarding, running and travelling.*

What first attracted you to dentistry?

I have always been interested in how braces can make people's teeth move. I had upper and lower fixed appliances myself in the past. I was attracted to working in orthodontics after noticing how much more people would smile after having braces fitted. My interest in orthodontics began when I read a magazine article about clear braces.

I first started working in an orthodontic dental practice in 2002. The general practice that I worked in later on was far quieter. The staff at the orthodontic practice were more involved in the treatment of patients, which I found very appealing.

We treat a broad mixture of child and adult patients. It is very satisfying when patients complete their orthodontic treatment and are happy with the outcome - especially with the patients that were very self-conscious with their smile before treatment.

Have you undertaken a Certificate in Orthodontic Nursing?

No but it is something I am interested in doing and feel I would benefit from greatly.

Would you recommend working in an orthodontic practice to other dental nurses?

Yes, there are many opportunities within orthodontics and it is very satisfying to see patients happy with their smile after treatment.

Do you have any career plans you would like to share with us?

I would like to volunteer in a work placement in a third world country.

PROFILE - ORTHODONTIC THERAPIST

***Fiona Carter**, 53, is an orthodontic therapist at Colchester Orthodontic Centre. Fiona qualified as a dental nurse in 1981 and completed a Certificate in Oral Health Education in 1993, a Certificate in Orthodontic Nursing in 2008, a Diploma in Orthodontic Therapy in 2009, and was PAR calibrated in 2014 (Peer Assessment Rating index). Ruth is a member of the Orthodontic National Group (ONG) and enjoys running, cycling, yoga and vintage shopping!*

What first attracted you to dentistry?

Nursing was my chosen career but when I left school I was too young to begin the SRN (state registered nurse) training. I saw an advertisement for an orthodontic dental nurse so applied, not realising what it entailed, and was successful. That was way back in 1978 and by chance I had found a profession I really enjoyed.

In 1978 there was no recognised qualification for orthodontic nursing so my orthodontist enrolled me on a local NEBDN course. I gained experience in general dental nursing by spending half a day a week working in various local general dental practices to successfully gain the National Certificate. This confirmed that orthodontics was the branch of dentistry that I wanted to continue in.

Fixed appliances were still being made with stainless steel tape so welding and soldering attachments was part of the orthodontic nurse role as was acrylic and wire repairs to removable appliances, preforming arch wires and making EOT face bows which involved learning how to bend wires, a great skill to have as an orthodontic therapist (OT). This was together with all the other duties of running a busy specialist orthodontic practice.

Following a short break after the birth of my two sons I returned to work on a part time basis in a multi-disciplinary dental practice working for an orthodontic specialist. Gaining my Certificate in Oral Health Education in 1993 was a great advantage having a varied patient base and the help and guidance of GDPs.

As my children got older and more independent I had the opportunity to work with the orthodontist I began my career with in 1978 within the local Primary Care Trust, treating a variety of complex orthodontic cases and also dental nursing in a special care dental department. There was a specific managerial element to this position as it involved setting up an orthodontic practice within the community dental department, staff recruitment, department management and carrying out audit, producing the department COSHH manual, Dental Nurse Policy and Protocol, following Trust guidelines and liaising with multidisciplinary departments.

The transition from orthodontic nurse to orthodontic therapist was very exciting; however, it was a change for the whole practice.

> ***'THE MOST SATISFYING PART OF MY JOB IS SEEING HOW DELIGHTED PATIENTS ARE WHEN TREATMENT IS COMPLETED.'***

When did you decide to become an orthodontic therapist?

OTs were being discussed as early as 1978 when I started my career. When the orthodontic therapy course was introduced in 2007 I knew that this was what I wanted to do and that this may be my opportunity! I applied for an orthodontic nurse position and I was lucky in finding an orthodontic specialist who had the confidence in me to support my application and training and was prepared to be my training provider. I studied for the RCS Eng Diploma in Orthodontic Therapy at South Wales Orthodontic Therapy course, based at Cardiff Dental School. It was hard work but also very exciting with excellent course tutors.

Was it difficult to get a place?

I considered myself fortunate to be selected for interview and I was so pleased to be successful at my first interview. My employer/orthodontist also had to be interviewed as a 'training provider'.

Was it straightforward finding employment as an orthodontic therapist?

Yes because you are trained by the orthodontic specialist that you work with. S/he is your 'trainer' and after such a big investment in time, energy and emotion (not forgetting financial investment), successful OTs tend to stay with their trainers/training providers. Having a very supportive team made it easier. Patients had to adjust too but they were all very understanding and encouraging. I am confident working within my clinical capabilities and I am aware of my limitations. CPD is an essential and important part of keeping up to date.

I treat a mixture of both adults and children but a higher percentage of children. I work within the limits of the OT GDC scope of practice and following BOS guidelines.

At Colchester Orthodontic Centre we are a small but very happy team of ten: Gareth Davies, the orthodontic specialist practitioner; two orthodontic therapists; four orthodontic nurses; a practice manager; and two administrative staff.

The most satisfying part of my job is seeing how delighted the patients are when treatment is completed and the self-confidence that this gives them. Not only because they have a fantastic smile but because they realise that have they achieved this through their own hard work. Adult patients may have missed the opportunity to undertake orthodontic treatment as a child and it is rewarding to see the confidence they gain.

What is the future for OTs?

I think OTs are an asset to an orthodontic practice and coming from a dental nursing background OTs are empathetic to the patient and parents. I think it is an excellent career path for an orthodontic dental nurse considering career progression.

bdjteam201531

‘There is a family atmosphere in our lab’

Willette Jean Lati is a 26-year-old dental technician and Clear Aligner Department Assistant Manager at NimroDental Orthodontic Solutions in London.

Dental destiny

When I was at school, like most people, I was quite indecisive about what I wanted to do when I grew up. From a young age till about secondary school it ranged from wanting to be a palaeontologist, doctor, vet, chef, scientist to artist.

I was born in the Philippines but because of my mum’s work we were relocated to Sydney, Australia when I was about two-years-old. After five years, we moved back to the Philippines to further my education for about six years. We moved to London in 2002 where I started at Year 10.

Not doing particularly well during my A-levels (chemistry, biology, maths and psychology), I had to look for an alternative course that catered to my interest in both art and science. A google search turned me to the direction of dental technology. So I guess it was like destiny.

Work experience

To secure a place on a dental technology course is not very difficult providing you have five GCSEs at A*-C (especially in maths, science and English) and don’t mind getting your hands dirty. It may be difficult, however, to find a dental laboratory to take you on as an apprentice if you don’t have any prior experience. Work experience before you start studying is also recommended as it will give you a better idea of what sort of business you’re getting yourself into.

I started work experience at NimroDental in 2007 whilst I was studying my BTEC course in Dental Technology and have been there ever since.

I completed a Foundation degree in Dental Technology in 2009. Both my BTEC and Foundation Degree courses tried to condense the principles and practical techniques of all departments of dental technology (prosthetics, orthodontics and prosthodontics) in a span of three years. But I would say that courses focus more on denture or crown and bridge work.

My class was attended by a majority of girls of a wide range of different ages and backgrounds; there with only two boys among us. But I found that other groups or batches were quite male dominated.

I enjoyed the practical aspect of my foundation course more than the academic as I am more of a hands-on sort of learner. It was interesting to learn and make different sorts of appliances used in dentistry that many would take for granted. I enjoy being able to build, recreate, add detail and finish things with my hands using different mediums.

The academic side of my course was a bit challenging, and also learning to make new appliances - but practice and persistence does help to improve and perfect new skills.

In the lab

At NimroDental I make a fair range of appliances in the lab such as retainers, clear aligners, removable appliances and Inman aligners. I have worked my way up from plaster room technician to assistant manager.

I am currently based on the famous Harley Street although I wasn’t initially aware of its reputation until I started working in the lab. Previously we were located just off Paddington Street; I used to personally do collections and drop-offs of impressions and appliances in the Harley Street area and got to meet or see some of London’s well known dentists and orthodontists. It was fascinating to learn that a small area has such a huge reputation of quality of care and services both from the medical and dental field. It was also nice to bump into the odd celebrity every now and then.

I am currently Assistant Manager of our Clear Aligner Department headed by Agnieszka Horton, specialising in the new digital clear aligner movement system and 3D printed models. I also attend dental tradeshows to raise our company’s profile in the dental and orthodontic industry.

I support my colleague Sophie Cook

'...I HAD TO LOOK FOR AN ALTERNATIVE COURSE THAT CATERED TO MY INTEREST IN BOTH ART AND SCIENCE. A GOOGLE SEARCH TURNED ME TO THE DIRECTION OF DENTAL TECHNOLOGY. SO I GUESS IT WAS LIKE DESTINY.'

(@Nimrodental_SC on Twitter), who is Head of Marketing, with our social media accounts. I would like to make special mention of our mentor Jowita Penkala of Uniqabrand for teaching us the power of social media marketing through Twitter and Facebook since November 2014. I have never used Twitter for personal use but found that it is an amazing tool to connect to all types of people in the dental industry. As a lab it is rare for us to be involved with or to interact with the general public, but we do try to maintain good relationships with our clients such as dentists, cosmetic dentists and orthodontists across the UK and in Europe.

A family atmosphere

Having been at NimroDental for more than seven years, there is an almost family-like atmosphere. We are a continuously growing lab with currently over 30 individuals including the office team.

As a company we enjoy each other's company even after work hours. We organise monthly work drinks at nearby local pubs or bars. A few of us have even been travelling around Europe together.

Regarding my future career ambitions, this may sound cheesy but they are to be the best at what I do and to continue to improve and learn every day, whether it is dental-related or not. I subscribe to a yearly magazine to regularly update my CPD hours and try to attend lectures or find free CPD websites online to keep my skills up to date.

I usually finish work around 5 pm but stay a little longer on busier days. To relax or let off steam after work I sometimes go to the gym to swim or train, do a bit of hot yoga or even just spend a couple of minutes in the sauna.

To be honest, I haven't got a clue what I would have done if I hadn't become a dental technician! Wherever the wind had taken me I suppose. I don't have a set path and just take any opportunities that come my way.

If you are good with your hands and have an interest in science, then I would definitely recommend a career in dental technology to others.

What three things can Willette not live without?

1. My iPhone to connect with people
2. The Internet to connect with the world
3. Sour candies/sweets because I have a bit of a sweet (sour) tooth which is a naughty thing in my profession!

bdjteam201532

Needlestick safety for the whole dental team

By Rebecca Allen[1]

Consider the risk

As part of the dental team, needlestick safety is something you should be acutely aware of in your day-to-day role. A survey of 1,216 dental nurses from the UK and Ireland conducted in conjunction with the British Association of Dental Nurses (BADN) in 2014 found that 51.2% of respondents had received a needlestick injury at some point throughout their career, with 60% of those saying they'd received more than one. When you then consider the risk of infection following a needlestick injury is estimated to be one in three for Hepatitis B virus (HBV), one in 30 for Hepatitis C virus (HCV) and one in 300 for HIV (for healthcare workers worldwide), it is vital that safety procedures are put in place in all dental surgeries.

The use of sharps

Following the introduction of The Health & Safety (Sharps Instruments in Healthcare) Regulations 2013, all healthcare facilities must ensure that:

(a) The use of medical sharps at work is avoided so far as is reasonably practicable

(b) When medical sharps are used at work, safer sharps are used so far as is reasonably practicable

(c) Needles that are medical sharps are not capped after use at work unless:
   i. that act is required to control a risk identified by an assessment undertaken pursuant to regulation 3 of the Management of Health and Safety at Work Regulations 1999 (a)
   ii. the risk of injury to employees is effectively controlled by the use of a suitable appliance, tool or other equipment

(d) In relation to the safe disposal of medical sharps that are not designed for re-use:
   i. there should be written instructions for employees
   ii. clearly marked and secure containers should be located close to areas where medical sharps are used at work.

Health and safety law has always placed general responsibilities on the employer to provide their staff with a healthy working environment. However, this legislation now puts further emphasis on prevention. In reality it would be difficult, if not impossible, to remove all sharps from a dental practice, so the next best thing is to assess the risk correctly, use devices

[1] *Rebecca is Category Manager at Initial Medical (http://www.initial.co.uk/healthcare-waste/). She has worked in the healthcare sector for the past 13 years and was a Research Chemist with Bayer Cropscience prior to joining Rentokil Initial in 2003. She keeps up to date on all developments within the clinical waste management industry and is an active member of the CIWM, SMDSA and BDIA.*

which limit the risk of injury and dispose of all sharps in a safe manner.

Top tips for needlestick safety are shown in Table 1.

Cradle-to-grave rule

It's important to remember that when it comes to hazardous and infectious waste such as syringes and other sharps at a dental practice, the cradle-to-grave rule applies. The producer of waste will always be held responsible for the safe and legal disposal of it, even after it has been passed onto the waste carrier collecting it. This is why it's important to work with comprehensively trained sharps waste disposal experts who will advise on the correct products that comply with both the UK and EU legislation and safely and securely dispose of sharps. Health and safety law is criminal law and healthcare organisations can be subject to enforcement action if they fail to comply with the legal requirements. There is also always a threat of civil law action if an employee is injured due to insufficient practices and technologies being in place.

'EVERYONE HAS A ROLE TO PLAY IN THE PREVENTION OF SHARPS INJURIES, FROM TRAINEE STAFF WHO ARE LEARNING THE ROPES, TO PRACTICE OWNERS WHO WILL HOLD LEGAL OVERALL RESPONSIBILITY FOR THE WELLBEING OF THEIR STAFF.'

Staff wellbeing

Everyone has a role to play in the prevention of sharps injuries, from trainee staff who are learning the ropes, to practice owners who will hold legal overall responsibility for the wellbeing of their staff.

Another quick and simple way to reduce the risk of needlestick injuries is to use innovative solutions such as InSafe syringes – a safety system providing comprehensive protection for clinical staff from the beginning of the procedure through to the disposal of the needle. InSafe's syringe and sharps box ensure that the contaminated needle is never exposed except during the actual injection. It feels and aspirates just like a traditional syringe so there will be no interruptions to the dental practice when introducing the protective system. When the injection has been administered, the protective sleeve locks securely into place over the needle, protecting clinical staff and patients when not in use. The needle can then be safely disposed of using a sharps container. Specially developed sharps disposal bins are designed for such waste and comply with all EU and UK regulations and directives, and there are companies available that provide a dependable and safe collection service.

bdjteam201533

Table 1 Top tips for needlestick safety

Always dispose of used sharps directly into an approved sharps container
It is essential that your sharps are segregated and disposed of correctly based on their medical contamination. The lid colour and label on the container relates to how the waste should be treated and disposed of.

Where possible, place the sharps container at the point of use
This avoids the need to walk anywhere with a needle, which creates higher risk of an injury occurring.

Do not re-sheath needles
When the Health & Safety (Sharps Instruments in Healthcare) Regulations 2013 came into place, the recapping of needles was banned, so it is now against regulations to do so. The purpose of this is to prevent needlestick injuries from occurring when removing the needle. You should use a safer sharps device to remove needles from your syringe.

Do not leave sharps lying around
Although this may seem obvious, sharps injuries are still known to occur as a result of sharps being left lying around, when other people are not aware that they are there, so it is extremely important that they are disposed of immediately after use.

Report all sharps injuries immediately
If a sharps injury does occur, you need to ensure you follow the below steps:

- Encourage bleeding from the wound
- Dry the wound and cover it with a waterproof dressing
- Seek urgent medical advice
- Report the injury and ensure all details are reported in your practice's accident reporting book.

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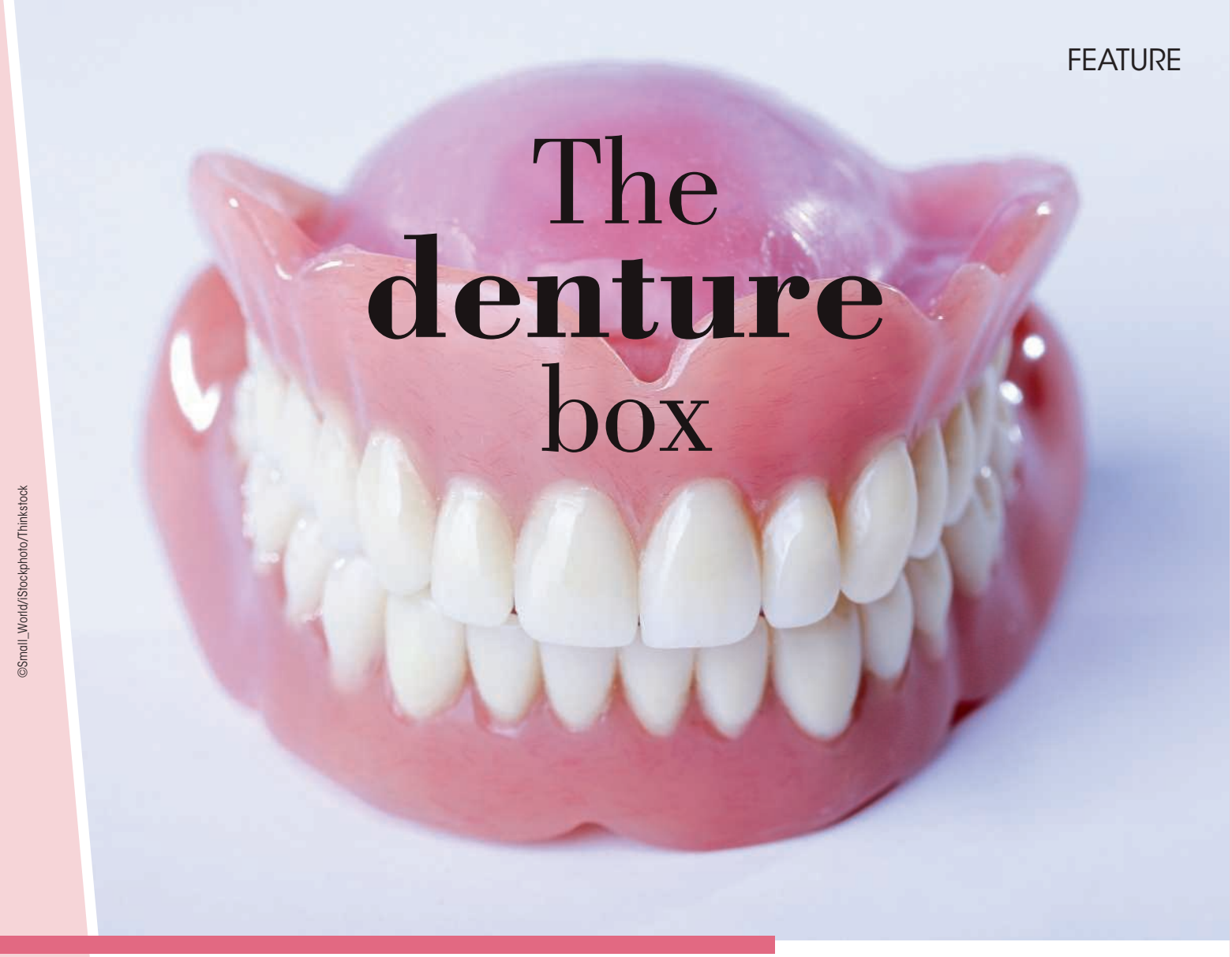
The denture box



M. J. Faigenblum[1] explains how the denture box facilitates denture hygiene, reduces the chance of accidental damage and acts as a means of identification.

Patients or their carers need to maintain as low a level of denture biofilm as possible. This article notes that the handling of dentures is unpleasant to carers and suggests a method of reducing this contact to a minimum yet allowing efficient cleaning by means of brushing. It also highlights the potential damage that can occur due to mishandling or accident. The denture box acts as a safe storage unit and its 'footprint' allows accurate recovery in an institution where dentures can be inadvertently mingled.

[1] *UCL Eastman Dental Institute*

Edentulous patients

The programme for the 2013 British Dental Association's conference contained some 60 lectures, none of which dealt with the treatment of edentulous patients. This reflects the subject's relative absence from the literature and reinforces the perception that the need for complete dentures is waning. Nonetheless, as recently as 2009, 6% of the combined population of England, Wales and Northern Ireland were edentate and in need of prostheses.[1] Most of them are 'elderly', that is 75+, and in consequence a proportion are likely to be in care homes or incapacitated to a greater or lesser degree.

The York consensus[2] declared that for the edentulous mandible the minimal standard of care is the provision of an overdenture supported by two implants. However, in the recent update on guidelines for the provision of such treatment under the NHS,[3] the authors note '…funding for implants on the NHS is likely to be a precious resource.' They suggest, 'the decision to provide implants needs to be balanced against alternative modes of restoration, their ease of provision, longevity and outcome rates'.

An alternative mode of restoration is the provision of optimal dentures, if necessary, at the hands of an experienced dentist. This might preclude the need for surgical intervention and is especially relevant for patients who are not amenable to surgery.[4] An added benefit is that if correctly designed, the denture(s) can act as a stent for implants if they are subsequently required.

A well-made but retentively compromised complete upper denture can be stabilised with the judicious use of a dental fixative[5] and severe bone resorption of either jaw too is not necessarily a barrier to a successful outcome. The effect of a resorbed, mobile maxillary ridge can be ameliorated by a careful impression technique.[6] Similarly, in

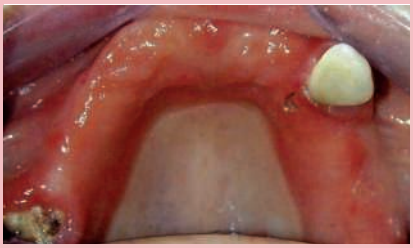
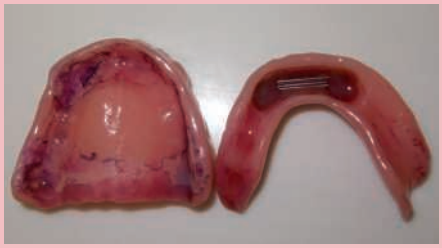


Fig. 1 Denture induced stomatitis under an acrylic partial denture

Fig. 2 Angular cheilitis associated with the stomatitis in Figure 1



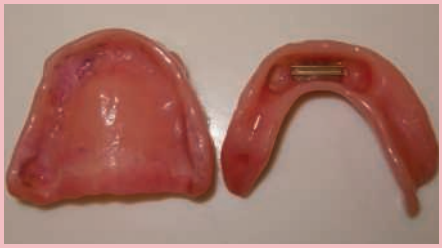
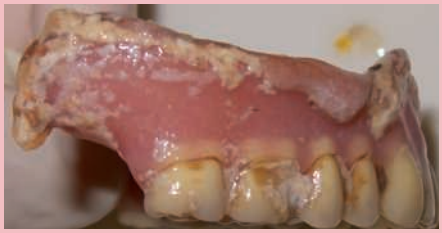
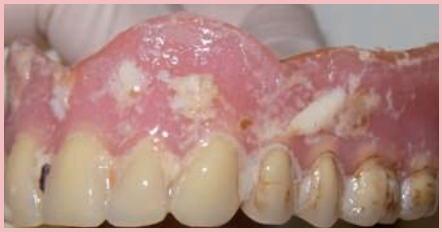


Fig. 3 Using a plaque disclosing liquid and the result of simple cleaning with a brush and detergent





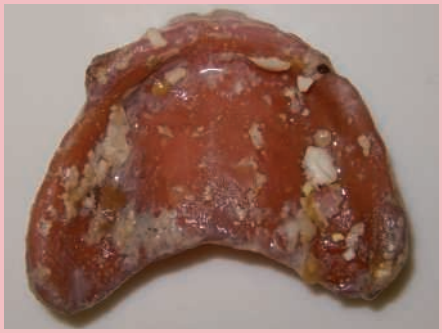


Fig. 4 Probable cause for a carer's reluctance to handle a denture

the mandible a skilful technique can provide a stable denture that can be soft-lined if discomfort cannot be eliminated. The updated report[3] makes provision under the NHS for patients who are intolerant to such treatment and where the implant retained or supported overdenture[2] would then be treatment of choice.

The edentate state is most often the result of a lack of awareness of the importance of oral hygiene. It is therefore unlikely that attention to this will be radically altered when the teeth are replaced by dentures. Even if this is not always the case, patients may not be aware of the potential harm of the denture biofilm.

maxillary denture it produces a bright red imprint of the outline of the denture on the underlying mucosa (Fig. 1). Due to a lack of symptoms, its presence is frequently unnoticed by the patient and by the dental professional.

Not infrequently, DS is associated with AC described as a usually bilateral erythematous fissuring of the corners of the mouth (Fig. 2). The poor appearance that this produces

'THE IMPORTANCE OF CONTROLLING DENTURE PLAQUE FOR THE PREVENTION OF ASPIRATION PNEUMONIA CANNOT BE OVEREMPHASISED.'

Denture biofilm

Denture plaque (DP) differs in its constituents from the normal dental biofilm.[7] In the physically healthy individual it can be aesthetically objectionable with a build-up of materials found in the mouth that can produce an unpleasant odour.[8] They can also induce mucosal inflammation that is, denture stomatitis, and a potentially disfiguring angular cheilitis (AC).[9,10]

Denture stomatitis (DS) can appear in different forms. Found typically under a is exacerbated by deep labial folds that encourage maceration of the corners of the mouth with saliva. These folds are often present when the vertical dimension is significantly reduced but is not a cause of the cheilitis.[11] AC can sometimes be a result of vitamin and iron deficiency anaemias.[12]

Removal of denture plaque is therefore important. The film may not be visible but its presence can be demonstrated to the patient by the use of a plaque disclosing agent (Fig. 3). The two main denture cleaning methods of brushing with a non-abrasive paste or soaking in chemicals have been reviewed.[13] The authors found that there was a lack of evidence to suggest that one method was superior to the other. In the author's opinion the demonstration of the removal of disclosed plaque by brushing is preferred to simply advising chemical soaking. However, without assistance brushing becomes a problem when the patient is unable to use one hand, for example due to injury or a stroke. A possible solution is suggested below.

The healthy individual can be expected to respond to oral hygiene advice but this may not be the case with patients who are seriously infirm and/or residents in care establishments, and this can pose a serious problem. It is now recognised that dental and denture plaque allow the colonisation of respiratory pathogens.[14] 'Dentures should be considered an important reservoir of organisms which could colonise the pharynx, and the importance of controlling denture plaque for the prevention of aspiration pneumonia cannot be overemphasised.'[15] Where rigorous oral hygiene procedures have been instituted a reduction in the rate of pneumonia and deaths has resulted.[16]

Oral care assistance

A Swedish study[17] compared the differences in attitude to the maintenance of oral health

Fig. 5 A denture box

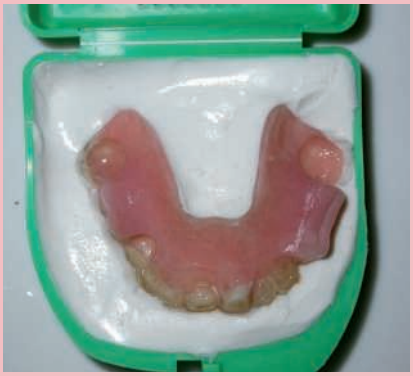


Fig. 6 Denture lightly impressed into the laboratory putty

Fig. 7 Impression left by the denture

in dependant elderly and severely disabled patients in a group of 398 health workers. They were asked regarding a) personal oral healthcare habits b) experience and attitudes in assisting oral care and c) willingness to assist patients/residents with their daily oral hygiene. This study revealed that oral care assistance is viewed as more disagreeable than other nursing activities.

Another study[18] found that nursing staff considered oral care the most distasteful aspect of their work (Fig. 4). They said they would '*rather clean up after bowel movements or attend to urinary incontinence accidents than brush a resident's teeth*'.

The denture biofilm attached to removable partial dentures (Fig. 12) will place teeth at risk, in particular the abutment teeth.[19]

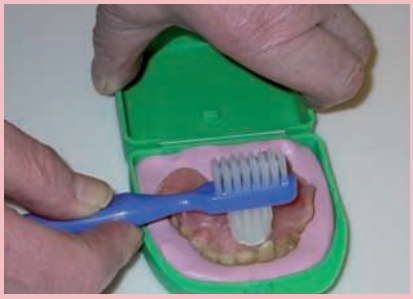


Fig. 8 The patient is able to steady the box with his left hand

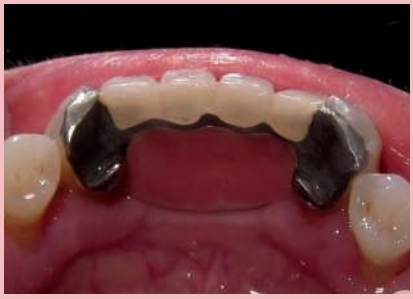


Fig. 9 Resin bonded bridge with cingulum rests

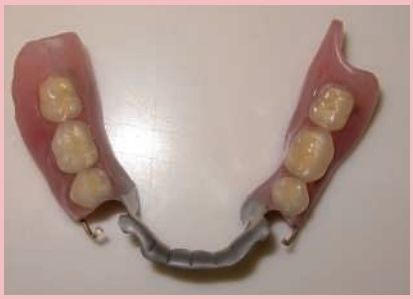


Fig. 10 Kennedy Class 1 denture with a cingulum bar major connector

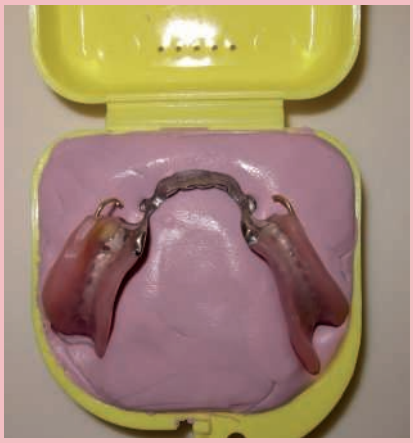


Fig. 11 Kennedy Class 1 denture replaced into the silicone impression to avoid accidental damage when cleaning

Acrylic resin partial dentures, as with complete dentures, are prone to fracture if dropped onto a hard surface whereas metal-based dentures are more resistant to this danger, but nonetheless can distort after being dropped or by mishandling during cleaning. This is most likely to occur with a mandibular denture[20] with a lingual or cingulum bar major connector.[21] As with complete dentures, cleaning partial dentures may be left to a carer with the possibility of neglect or damage.

As has been stated, for most individuals the simplest way to remove the denture biofilm is by mechanical cleaning with a toothbrush and a non-abrasive paste, at least once a day. As an adjunct to this, the denture can be soaked twice a week in 0.1% hypochlorite solution or chlorhexidine solution for 15-30 minutes.[22] Long-term nocturnal use should be discouraged.[23] According to Manfredi *et al.*[22] leaving dentures to soak overnight is counter to 'hygienic logic' because organisms that inhabit the biofilm do not survive prolonged drying out. There is no evidence to support the view that leaving them to dry overnight will cause warpage of the acrylic.[22]

To summarise, both complete and partial dentures require careful removal of the denture biofilm. However, this may not be carried out because:

- The patient is unaware of the need to do this
- The patient is unable to physically carry out the cleaning
- The carer finds the process unpleasant and may do this perfunctorily or even avoid it
- In the process of cleaning, the denture may be prone to fracture or distortion if mishandled.

The denture box

This is a simple device to hold the denture in place during cleaning (Fig. 5). It reduces the risk of fracture and distortion of a prosthesis. It will also allow a carer minimal handling of the denture and allow its storage with reduced risk of 'getting lost'. In an institution its 'footprint' will make positive discovery of the owner certain.

One half of an orthodontic retainer or denture box (or a soap box) is filled with activated laboratory putty (Fig. 6). The occlusal surface of the denture is pressed into the putty sufficiently deeply to produce firm retention. The denture can be replaced in the negative impression and the surface rigorously cleaned with a brush. Where the patient has the loss of the use of a hand, the box can be steadied while brushing or it can be secured on its base with a suction pad or a fabric fastener.

The occlusal surface of the denture can be similarly displayed, following an imprint of the intaglio surface in the lid of the box if it has sufficient depth (Fig. 7).

Fig. 12 The disposition of plaque on the denture is shown with a disclosing solution

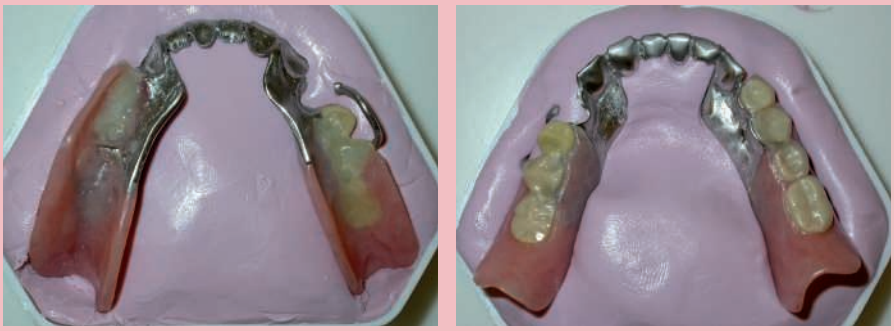


Fig. 13 The occlusal surface of the denture is placed in the base of the denture box. The fitting surface is impressed in the lid

Case history 1

An 80+ male patient in indifferent health had suffered a recent stroke that prevented the normal use of his left hand. He was provided with an acrylic partial overlay denture, primarily to replace his upper front teeth. The denture was embedded in the silicone putty and he was able to steady the box with the left hand allowing the right hand to brush (Fig. 8).

Case history 2

The patient has been provided with a resin-bonded bridge to replace the lower incisor teeth with wings on the canines (Fig. 9). Cingulum rests have been added to the canine wings to receive the cingulum bar major connector of the Kennedy Class 1 denture (Figs 10 and 11).

Case history 3

The cingulum bar connector does not impinge on the gingival margins but the abutment teeth, in the presence of plaque, are still prone to damage (Figs 12 and 13).

Storage

The denture box provides a secure method of storage particularly in an institutional environment where it is not unusual for dentures to be wrapped in tissue and inadvertently discarded. In addition, where the denture is not marked for identification, it is possible for the ownership of a denture to be confused with others. The imprint of the denture being unique to the individual can be used to reclaim it to its owner. The imprint can be kept clean by washing under a tap and, if required, a small amount of chlorhexidine gluconate can be left *in situ* when stored.

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bdjteam201534

Rules

for shared parental leave

By **Alan Pitcaithley**, practice management consultant

Parents will soon be legally entitled to share statutory leave following the birth or adoption of a child. This 'shared parental leave' will apply to eligible parents of babies due, or children placed for adoption, on or after 5 April 2015. It allows employees to break their absence from work into separate blocks and to share some of the leave with their spouse or partner. Potentially, eligible parents, in the first year of a child's birth or adoption, will be able to dip in and out of their job, taking time off to provide care for the child.

Greater flexibility

The idea is to allow greater flexibility for new parents in setting their work-life balances in their child's first year. This will have an impact on employers and there are, therefore, precise procedures to be followed.

The mother would normally be able to take up to 52 weeks' maternity leave. Shared parental leave allows a mother to turn her maternity leave into shared parental leave. The actual amount of shared parental leave available depends on how much maternity leave is taken.

Since a mother must take at least two weeks' compulsory maternity leave following the birth of their child, there could be up to 50 weeks of shared parental leave available. Any week or weeks of maternity leave taken by the mother before the birth of the child or after the two weeks of compulsory maternity leave reduces the shared parental leave available by a corresponding amount. The remaining amount of shared parental leave can be used by either the mother or her spouse or partner to take time off work to look after the child.

It is the mother's initial choice whether or not to opt for shared parental leave, but once that choice has been made the couple must agree when they should take leave. They may choose to take time off at the same time, consecutively or alternately. Whatever their decision, shared parental leave must be taken by the child's first birthday – any unused leave at that date would be lost.

Table 1 Who can share the leave?

A mother must:

- Be an employee entitled to maternity leave or self-employed and entitled to maternity allowance
- Have given notice to end her maternity leave and take shared parental leave.

A partner must:

- Be the mother's spouse, civil partner or partner (who is a person in a long-term relationship with the mother and living with the mother and child), or the child's biological father (even if they are not in a stable relationship with the mother)
- Share the primary parental responsibility for the child with the mother at the time of the birth
- Be an employee, who is entitled to paternity leave.

Written notice

To use these rights, eligible parents (Table 1) must give their employer proper written notice; in fact, three different notices.

First, the mother must give notice to end her maternity leave and change over to shared parental leave. Second, both parents must give their employers a *notice of entitlement* letter that sets out their basic eligibility (Table 2). Finally, each must provide a *notice of leave* letter that specifies the actual dates that the employee wishes to take as shared parental leave. It should include the start date, end date and overall amount of leave to be taken, which must be in full weeks. Each notification fulfils a specific purpose but the employee could combine them all into one letter.

Time limits are important. Eight weeks' notice must be given, both by the mother to switch over from maternity leave and by either parent before the start of a period of shared parental leave.

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Continuity

A major change introduced by shared parental leave is the facility to divide leave into separate blocks, where a parent can return to work between blocks and go back on leave later on. Each block must, however, be made up of full weeks. This could cause difficulties for an employer, so how a practice responds to a *notice of leave* letter will depend on if the employee is asking for a continuous period of leave or a series of separate blocks.

If a continuous period of shared parental leave is requested, this request must be agreed. But if the employee asks for two or more separate blocks of leave – which would be interspersed by periods back in work – this is subject to the approval of the employer.

If you have an objective business or operational reason to refuse a request for leave to be taken in blocks you can. But you must respond in writing, setting out your reason within two weeks. In this situation, the employee's overall amount of requested leave defaults to a single period of leave to begin on the original start date for their intended first block of leave. You should ensure that your employee understands these default provisions because they can change the start date by amending their notice of leave or could withdraw their request altogether.

Being able to refuse a request for shared parental leave to be taken in separate blocks would seem to negate the employee's new right but an employee can submit three separate notice of leave letters within the year. If each one asks for a continuous block of leave then, as currently understood, each of these three blocks of leave would have to be agreed. But this provision has given rise to the misconception that shared parental leave can only be taken in three distinct blocks. While this is the default situation where an employee gives you three separate *notice of leave* letters, they could in any of these requests ask for their leave to be split into many more parts. It is therefore theoretically possible that an employee could take 25 blocks of shared parental leave, working one week on and one week off up to the child's first birthday. This pattern of shared parental leave would require an employer's agreement but in some job roles could occur under the new arrangements.

Shared parental pay

Most mothers taking maternity leave will be entitled to Statutory Maternity Pay (SMP), which is available for up to 39 weeks. If an employee opts into shared parental leave then the Statutory Maternity Pay remaining becomes available as Shared Parental Pay (ShPP). This can be claimed by either partner while on shared parental leave. The eligibility for each partner is based on the same earnings criteria for Statutory Maternity Pay and Statutory Paternity Pay.

If both parents qualify for ShPP, they must decide who will receive it or how it will be divided. Each must inform their respective employers of how much ShPP each parent intends to take and when they expect to take ShPP. They must also include a declaration from the employee's partner confirming their agreement to the employee claiming their amount of ShPP. It is expected that this notice would be given at the same time as a *notice of leave* letter.

> *'THE IDEA IS TO ALLOW GREATER FLEXIBILITY FOR NEW PARENTS IN SETTING THEIR WORK-LIFE BALANCES IN THEIR CHILD'S FIRST YEAR. THIS WILL HAVE AN IMPACT ON EMPLOYERS AND THERE ARE, THEREFORE, PRECISE PROCEDURES TO BE FOLLOWED.'*

Another way to SPLIT it

The concept of Keeping-in-Touch (KIT) days that apply to maternity leave has been extended to shared parental leave. This allows an employee to attend work during a period of leave for training purposes or just to stay up to date with what is happening in their workplace.

Under shared parental leave these are known as Shared-Parental-Leave-In-Touch (SPLIT) days; up to 20 SPLIT days are available overall to be shared by the parents. The employees should contact their employers to discuss the date or dates of SPLIT days that they wish to work, though there is no obligation on either party to agree to a specific date.

Table 2 Notice of entitlement letter

A *notice of entitlement* letter must include the following:

- The date that the child is expected or their actual date of birth
- The spouse's or partner's name
- The spouse's or partner's address and National Insurance number
- Confirmation that the spouse or partner shares childcare responsibility
- The amount of shared parental leave available overall for both parents
- The dates of any maternity leave that will be, or has been, taken
- The amount of shared parental leave that the employee intends to take
- The amount of shared parental leave their spouse or partner intends to take
- A personal declaration that the employee meets the eligibility criteria for shared parental leave and that all the information provided is accurate
- A signed declaration from the employee's spouse or partner that they meet the eligibility criteria for shared parental leave.

Sharing adoption leave

The right to opt into shared parental leave also applies to employees who are on adoption leave. From the end of a compulsory period of adoption leave, that is two weeks after the placement of the child, the adopter can opt into shared parental leave and share some of this with their partner or co-adopter. The same rules and procedures apply to giving notice, taking leave and claiming ShPP.

More details

Shared parental leave is a new system and exactly how it will work for businesses, employers and employees remains to be seen. If your principal is a BDA member, the BDA Advice *Employees maternity and parental leave and pay* (see www.bda.org/advice) provides further information.

bdjteam201535

Are you addicted to sugar?

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As a dental professional you often advise patients to cut down their sugar intake, but are your own sugar cravings under control? asks **Laura Thomas**[1]

Practising what you preach

You know that your patients' sugar habits end up costing them greatly in terms of dental treatment and you're regularly dealing out low sugar lifestyle advice to help them. However, sometimes you find yourself craving sugar and succumbing to a few more chocolates than you'd like. Keen to live by your messages, what can you do to get more control over your own sugar cravings and protect your own health from the white stuff?

Other impacts of sugar

In addition to attacking teeth and enamel, an excess of sugar has all sorts of other detrimental impacts on your body.

Refined sugar, whether in its raw form or in a processed food like a tomato sauce, is made up of 50% glucose and 50% fructose. You need to know that fructose is metabolised *very* differently to glucose - it's processed exclusively by the liver. Consuming an excess of fructose (sugar) puts serious strain on this vital organ which can lead to a number of ailments including non-alcoholic fatty liver disease and elevated levels of uric acid (contributing to gout). It's also worth noting that excess fructose consumption over a sustained and long period of time can increase the risk of the serious chronic diseases (eg diabetes) that are plaguing the Western world today.

Sugar also plays havoc on your blood sugar management, impacting on your sleep quality, concentration and energy levels. It weakens your immune system and speeds up the ageing process.

Finally, sugar is addictive. Over time, a gradual increase in consumption can start to negatively affect your behaviour. This can result in you needing more sweet food to satisfy your sweet tooth.

Reminding yourself of these reasons can help motivate you to take consistent actions to reduce the sugar in your diet.

So what can you do to shift your taste buds away from sweet?

Stop drinking sugar

It's likely that because you know about the detrimental impacts of sugary soft drinks on teeth and enamel, you aren't chucking back half a dozen fizzy drinks during the day. However, it's worth being aware of the more covert sources which may be exposing your palate frequently to the sweet taste that drives cravings.

The sweetener in your tea, the smoothie drink on the go or that tonic water in your gin tipple are all still sweet drink sources that you may not realise have become somewhat habitual in your routine or lifestyle. Seek to identify those last few places where you are drinking sugar and work to eliminate sugar in all liquid forms. Adapt to unsweetened tea or coffee; use fresh lemon or lime to flavour water [editor's note - but use a straw to protect your tooth enamel!] and opt for the whole fibre rich fruit instead of a sugar condensed smoothie.

Lower sugar substitutes of your favourite foods

Quite often there can be a big difference in sugar content between brands of the same food. Spending a little time researching and finding the ones that don't have as much added sugar shaves off a few grams that can make a difference if you're eating these products daily. Muesli, sauces and dressings are all good items to do this with. By doing this you're also becoming aware of the great lower sugar products that you can easily recommend to your patients.

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[1] *Laura Thomas is a certified health coach and the founder of Happy Sugar Habits, an organisation working to educate and support individuals to reduce their sugar consumption, and feel a sense of control over their sweet cravings. Laura runs a successful Mentor Me Off Sugar detox programme and speaks nationally about sugar, emotional eating and the practicalities of a low sugar lifestyle. Laura was the former the presenter of The Sugar Diaries radio show for UK Health Radio, has written for* The Telegraph *and the* Daily Mail *and has recently been featured in* Elle *and* Grazia *magazines. Find out more at www.happysugarhabits.com.*

Being mindful of total sugar (especially fructose)

As mentioned earlier, fructose is the more dangerous part of sugar. Although fruits and natural sources of sugar have nutritional benefit and are healthy in many respects, they are still sweet and you're likely to still experience powerful cravings if you're consuming them excessively.

To keep cravings at bay, be mindful of the total amount of sweet food in your diet (including fruit), the quantities you're consuming and how often you're eating it. Be particularly wary of dried fruit products and fruit purees that tend to be very concentrated sources of sugar. If something says 'refined sugar free' always check that it's not just been jam packed full of 'natural' dried fruit sugar.

Avoid hidden sugar

It goes without saying: avoid sugar that you don't know you're eating. Double check sauces, dressings, cereals, soups etc. Look to make your own where you can and cut back on processed foods as much as possible.

Consider your use of sugar

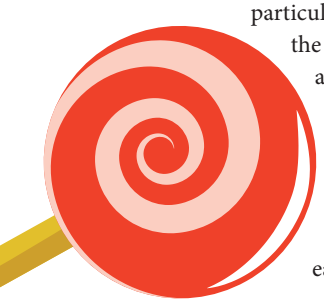
It's very common for people to use sugar as a stress coping mechanism. It's accessible, cheap, quick and easy. Take note if you're consuming sugar in response to emotional hunger. Seek to build in other coping mechanisms that don't involve sweet food eg some yoga or a run, something relaxing like a walk or a simple breathing exercise.

Embrace the savoury foods you love

To avoid the doom and gloom feeling of eating less sugar, embrace your favourite savoury foods in all their forms. Try new combinations of them, be more experimental with foods and try to enjoy the process of finding savoury alternatives that you really get excited about.

Work through social challenges

Often it's the social side of sugar that can be particularly challenging: the birthdays, weddings and numerous annual occasions that are closely associated with excessively sugary food. Seek to understand if you're eating sugar because everyone else is, or if it's closely tied to the joy you feel at these events and celebrations. Building awareness of your sugar habits in social situations is the first best step to adjusting them.



For more tips, recipes and a free low sugar snack guide to get control over sugar cravings visit and sign up for updates at www.happysugarhabits.com.

RECIPE: Savoury olive & almond flapjacks

These have all the satisfaction of a flapjack but with a savoury twist and no sugar in sight. Great as a quick breakfast bar or as a substantial snack. The pumpkin and chia seed topping is optional to simply boost the nutritional count and make them look pretty!

Makes 8 large bars or 16 smaller bites

Ingredients

200g rolled oats (2 cups)

300ml milk (1½ cups)

75g almonds (½ cup)

20g parmesan cheese (⅓ cup, grated)

60g black pitted olives (½ cup)

½ tsp salt

2 tbsp dried oregano

2 tbsp ground flaxseed

1 tsp cumin seeds

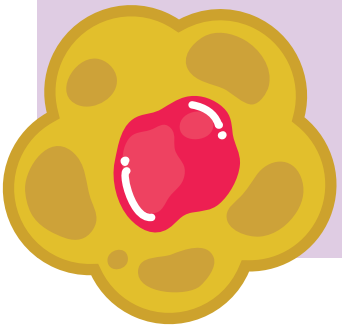
1 tsp chilli flakes

1 tbsp chia seeds (optional)

1 tbsp pumpkin seeds (optional)

Method

- Preheat the oven to 180C and line an 8-inch square tin with parchment paper
- In a medium bowl, mix the oats, salt, herbs and spices together with the ground flaxseed
- Add the milk and leave it to soak for 10 minutes whilst you prepare the rest
- Roughly chop the olives, almonds and grate the parmesan cheese
- Add these ingredients to the mixture, stir well
- Pour the mixture into the tin and spread evenly
- Sprinkle over the chia seeds and pumpkin seeds
- Bake for 45 minutes, remove and let cool
- Slice into bars or squares
- Keep refrigerated in an airtight container for up to 3 days



Have you had a go at this recipe? Let us know how your flapjacks turned out and send a photo of the results to bdjteam@nature.com or upload it on the BDJ Team Facebook page www.facebook.com/bdjteam.

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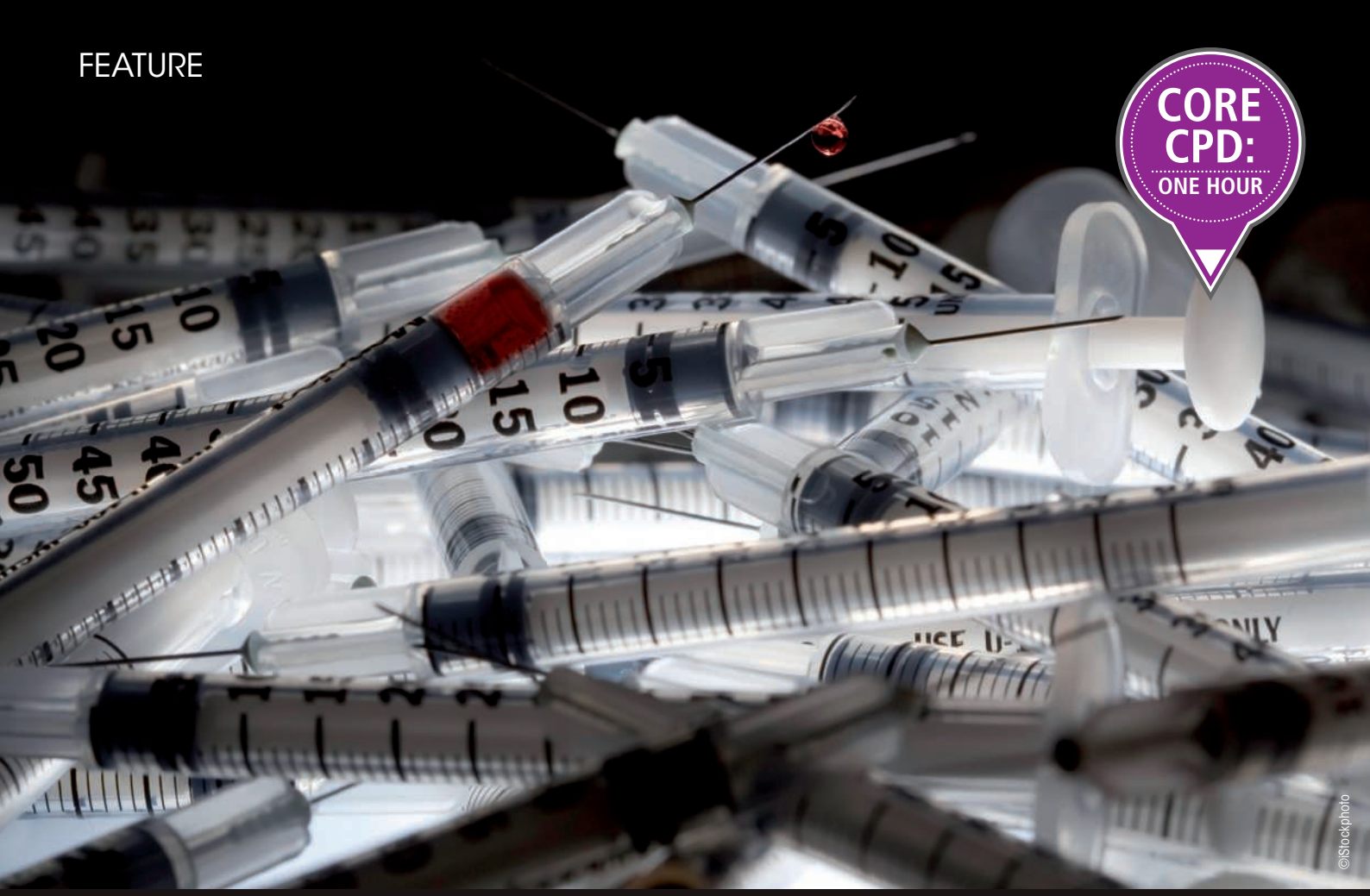

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How to dispose of hazardous WASTE

Do you know what constitutes hazardous waste and how to dispose of it correctly? **Mhari Coxon RDH** discusses waste segregation and management in dentistry.

The aim of this article is to give a practical approach to the subject of waste management and segregation in general practice. It is my intention that this could be used as a tool in practice to develop the waste management and segregation protocol and policy. It can equally be used for an individual's development as verifiable CPD in the core subject of infection control.

Waste produced as a result of any healthcare activity, like dentistry, is classified as clinical waste. Health Technical Memorandum 01-05 (HTM 01-05) states that:

'The Registered Manager is solely responsible for ensuring that waste is:

- Correctly segregated
- Stored safely and securely away from areas of public access within the premises
- Packaged appropriately for transport
- Described accurately and fully on the accompanying documentation when removed
- Transferred to an Authorised Person for transport to an authorised waste site
- Appropriately registered, with necessary records and returns at premises.

The Registered Manager should also ensure that all staff are trained and aware of the waste procedures.'

Most of the requirements can be found in HTM 07-01 (*Safe management of healthcare waste*) which is followed for England, Wales and Scotland but not Northern Ireland.

Clinical waste

Clinical waste is any waste which consists wholly or partly of human or animal tissue, blood or other bodily fluids, excretions, drugs or other pharmaceutical products, swabs or dressings, syringes, needles or other sharp instruments, being waste which unless rendered safe may prove hazardous to any person coming into contact with it.

Also, any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it.

It is vital that ONLY staff members

who have a certified Hep B immunisation should be handling clinical waste. Cleaners should NOT touch it unless they have been immunised and are aware of the protocols and polices and have had adequate training.

Correct segregation

Is the waste a healthcare waste? Table 1 shows us how we can define and categorise our waste in practice.

Hazardous waste must be disposed of without endangering human health or the environment and be capable of being traced from the point of production to the point of disposal (Table 2).

Colour description for bagging day to day waste

Orange bags – infectious or anatomical waste which requires incineration.

Yellow bags with black stripes – continence pads and other waste produced from human hygiene (urine, faeces, sputum, tears, nasal secretions, vomit). Disposed equipment that does not pose a risk of infection (inhalers, gowns, gloves, and plaster casts).

Purple cytotoxic and cytostatic waste (waste which requires treatment to be 'rendered safe'. Unlikely to find this in a dental environment but you should recognise the danger of these waste bags or buckets).

Black Domestic waste for landfill – also most authorities have recycling bags you can buy as a business which vary in colour.

White Amalgam waste for recovery (includes extracted teeth with amalgam present and cages from suction if amalgam was removed).

Red Healthcare waste for special recovery eg X-ray processing chemicals.

Lead foil

Lead foil is now classified as non-hazardous waste and there is no longer any need for it to be collected by licensed contractors.

Sharps waste

Sharps are items that could cause cuts or puncture wounds – including needles, syringes with needles attached, broken glass ampoules, scalpels and other blades or infusion sets.

Orange lidded sharps bins are for hazardous sharps not contaminated by prescribed medicines. This bin would include extracted teeth with no amalgam in them and scalpels.

Yellow lidded bins are suitable for local anaesthetic cartridges and botox ampules as they are for sharps, including infectious sharps, for incineration only. Marked with 'Medicinal Sharps'. For use with sharps waste including those contaminated with medicines other than those which are cytotoxic/cytostatic.

Again, not likely to be in general practice, purple lids are for those medicines and sharps which are cytotoxic/cytostatic.

Table 1 Defining and categorising waste in the practice

Hazardous waste	Non-hazardous waste
Infectious waste (eg sharps, anatomical waste, implanted medical devices). Any waste which poses a known or potential risk of infection.	Offensive/hygiene waste (eg human incontinence and other human hygiene, sanitary waste, nappies, stoma bags). Waste which may cause offence to those coming into contact with it.
Cytotoxic and cytostatic medicines	Non-cytotoxic and cytostatic medicines (expired, unused, spilt and contaminated pharmaceuticals, bottles and boxes with residue, masks, connecting tubing, syringes, drug vials, vaccines, medicinal patches and sera).
Health care chemicals and hazardous properties	Domestic waste (uncontaminated paper towels, flowers, materials which are unsuitable for recycling).
Batteries (single-cell or Ni-cad batteries)	Packaging waste
X-ray photo chemicals	Recyclable materials (cardboard, non-confidential paper, drinks cans, bottles, plastic, toner/ink cartridges, cooking oil).
Mercury (from dental amalgam, spillage from thermometer/ sphygmomanometer, from electrical switch/battery or fluorescent discharge lamps).	Confidential paper waste
Other chemicals eg paint, solvents, some cleaning materials, laboratory chemicals	Grounds waste
Radioactive waste	Food waste
Contaminated furniture or equipment	Uncontaminated, unwanted or broken furniture or equipment
Asbestos and some construction/ demolition waste	Construction/demolition waste following risk assessment

Waste handling

NEVER:

- Throw bags
- Carry close to body
- Empty one bin into another
- Attempt to retrieve items from waste
- Leave waste areas unsecured
- Overfill bags or containers
- Allow waste to build up – contact Environmental Manager if additional collection is required.

ALWAYS:

- Apply Standard Infection Control Precautions
- Wear Personal Protective Equipment (PPE)
- Carry out hand hygiene
- Provide patients with a waste receptacle
- Dispose of waste immediately at point of use
- Label and secure correctly
- Give information to patients/carers on appropriate waste disposal.

Storage of waste

Within the clinical area:

- Solid sided, foot operated bin
- Bags not more than three-quarters full
- Segregation of waste streams

Table 2 Instructions for disposal of waste

Type of waste	Instructions for disposal
Anatomical waste	Must be placed in appropriate UN approved container, labelled and sealed for incineration. Container must not be placed inside a bag.
Equipment and furniture	If contaminated, contact waste contractor. If decontaminated must have a certificate before disposal.
Radioactive waste	Contact Radiation Protection Supervisor or Environmental Manager for advice.
Dental waste	Teeth are non-anatomical infectious waste – orange stream Teeth with amalgam must be segregated into white rigid container with mercury suppressant Dental practices must have an amalgam separator
Mercury	Areas where mercury is in use must have a spillage kit. Staff within the area must know how to use the kit. Instructions should be looked at at intervals as a team.
Medicinal waste	Expired prescription drugs should be handed in to a local pharmacy for disposal
Chemical waste	Any chemicals in use within healthcare must have a COSHH risk assessment. Staff in areas where chemicals are used/disposed must know how to handle and dispose of them appropriately.
Surgical instruments	Must be transported in designated, correctly labelled rigid, locked container to/from decontamination area.

> 'All staff handling waste must have access to appropriate PPE.'

- Not left in corridors or public spaces
- Disposed of as soon as possible
- Tied securely
- Bins kept clean inside and out.

After removal from clinical area:
- Securely away from public access
- Safe from pests and animals
- In locked wheeled bins (available from your contractor)
- Away from other items
- In an area where hand hygiene facilities are close by (could be wall mounted hand disinfectant).

Sealing and tagging

Bags must be:
- No more than three-quarters full
- Release air to avoid bursting bag
- Secure the bag using tags or double tie method
- Label with department/surgery in which the waste was generated (for audit purposes) and with correct European Waste Code.

European Waste Catalogue (EWC) codes are mandatory for all waste documentation – ie it is necessary for the documentation which accompanies the consignment of waste containers to state what the waste is, including its classification per the EWC (Table 3). Contaminated sharps could fit into any one of approximately ten EWC codes dependent on particular circumstances. If the container label includes the EWC code, then there is a likelihood either that the code will be wrong or that a substantially greater number of containers will be required. This is why it must be written on by the clinician and initialled again for audit purposes.

Table 3 EWC codes

18 01 01	Sharps (except 18 01 03) LA cartridges for example
18 01 02	Body parts and organs including blood bags and blood preserves (except 18 01 03)
18 01 03	Infectious waste
18 01 04	Offensive waste
18 01 08	Cytotoxic and cytostatic medicines
18 01 09	Medicines other than those mentioned in 18 01 08
18 01 10	Dental amalgam waste

Personal Protective Equipment

ALL staff handling waste must have access to appropriate PPE. In most instances disposable gloves and an apron will suffice. Heavy duty gloves must be available for use if required.

If uniform/clothing becomes contaminated they must be changed immediately.

Training

It is essential that every team member handling clinical waste be aware of how to segregate, label and dispose of waste safely. Training should be reviewed annually and audited at intervals. The staff members should accept responsibility for how to manage themselves in this regard once adequate training has taken place.

Paper trail of safe disposal

It is essential that all documentation to and from your registered waste collection company is kept on file. Your waste collection company will also be able to give you a copy of their licence and policies for your file.

This article was originally published in Vital *in 2011 as* The whys and wherefores of waste. *To take part in the verifiable CPD questions associated with this BDJ Team article, visit www.nature.com/bdjteamcpd (free subscription required).*

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HELPING YOU IDENTIFY ACID WEAR

The results of ESCARCEL, the first and largest pan-European Epidemiology study to assess the prevalence and risk factors for acid wear, offers unparalleled insights into the condition.

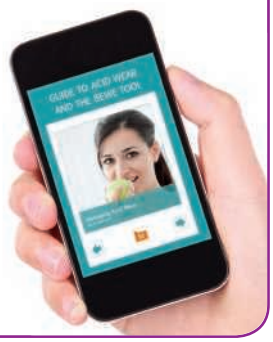
The study revealed just how widespread acid wear is in young adults across Europe, with one in three exhibiting clinical signs. Of particular concern is the evidence that this figure is significantly higher in the UK.[1]

ESCARCEL found that those aged 26-35 years were most affected by acid wear, and exposed to what extent conditions such as frequent heartburn or acid reflux contribute.[1]

Acid wear is an irreversible condition. The best way to manage it is prevention.

As identification of the early clinical signs is the first step in helping to protect patients from further damage, the BEWE (basic erosive wear examination) tool can help support your understanding. Developed with Professor David Bartlett, Head of Prosthodontics from King's College London Dental Institute, the tool is split into three simple steps which can help you to assess patients' level of risk and ultimately aid your treatment decision.

GSK has launched the Pronamel BEWE and acid wear mobile app to help support you in detecting acid wear. Use the simple app on-the-go as an easy reference guide for the background to the condition, the BEWE tool and tips for patient management. Download the app from the iTunes App Store now, just search 'bewe'.



1. Bartlett D W, Lussi A, West N X, Bouchard P, Sanz M, Bourgeois D. Prevalence of tooth wear on buccal and lingual surfaces and possible risk factors in young European adults. *J Dent* 2013; **41:** 1007–1013.

TAKE ACTION AGAINST PERIODONTITIS

New from oral healthcare specialist Curaprox is the perfect pocket minimiser for the treatment of chronic and aggressive periodontitis.

Adjusan combines the active ingredient doxycycline with a novel design for easy subgingival application, high tolerability and optimum efficiency. The effective and uncomplicated single administration is easily applied via the practical cylinder cartridge. The local antibiotic has the ability to kill key microorganisms whilst remaining safe for the patient.

Adjusan's most impressive characteristic is its innovative gel-like consistency. The initial flowable form allows you to reach the deep areas of the periodontal pocket, remaining in place as its viscosity increases in the aqueous environment. The active ingredient is released continuously over at least 12 days, enabling pocket depth to be reduced and attachment level enhanced.

For more information call 01480 862084 or visit www.curaprox.co.uk

CELEBRATING THREE DECADES OF TALKING POINTS

GSK, manufacturers of Aquafresh, Corsodyl, Poligrip, Pronamel and Sensodyne, is inviting dental professionals to join them to celebrate 30 years of Talking Points in Dentistry. The postgraduate lecture series first launched in 1985 and is open to all members of the dental team.

This year in celebration of the 30-year heritage of the programme we ask: 'Who will be the patient in 2045 and what will they want?' The lectures will reflect on the changes that have occurred in the dental industry over the last 30 years and how delivery of dental care will continue to evolve in the future.

Over the last 30 years more than 60 industry experts and professionals have delivered lectures to thousands of delegates. Many things have evolved during that time, but the core focus has remained to provide topical and thought provoking content.

The lecture series will visit five venues across the UK during May:

- 12 May 2015 – Titanic Belfast
- 14 May 2015 – Dynamic Earth, Edinburgh
- 18 May 2015 – National Motorcycle Museum, Solihull
- 20 May 2015 – National Museum, Cardiff
- 27 May 2015 – Royal Institute, London.

To book your place at your nearest venue simply visit www.gsk-dentalprofessionals.co.uk. Tickets are allocated on a first come, first served basis and limited to a total of six per practice, so book now!

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BDJ Team continuing professional development

CORE CPD: ONE HOUR

CPD questions – March 2015

CPD ARTICLE: How to dispose of hazardous waste

1. Which of the following is categorised as hazardous waste?

A. grounds waste

B. ink cartridges

C. nappies

D. sphygmomanometer spillage

2. According to HTM 01-05, who is responsible for ensuring that waste is described accurately and fully on the accompanying documentation when removed?

A. the cleaner

B. the Registered Manager

C. the bin men

D. whoever is last to leave the practice

3. Which of the following is **incorrect**?

A. red bags are for healthcare waste for special recovery

B. yellow bags with black stripes are for infectious or anatomical waste which requires incineration

C. extracted teeth with no amalgam in them should be placed in orange lidded sharps bins

D. after removal from the clinical area waste bags should be kept in locked wheeled bins

4. What is the correct European Waste Catalogue code for a body part or organ?

A. 18 01 08

B. 18 01 10

C. 18 01 02

D. 18 01 01

How do I take part in *BDJ Team* CPD?

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Topics covered so far

➤ April 2014: **Disposing of clinical and dental waste**

➤ May 2014: **Emergency oxygen therapy in the dental practice**

➤ July 2014: **Needlestick and occupational exposure to infections**

➤ August 2014: **Medical emergencies: the drug box, equipment and basic principles**

➤ October 2014: **Radiation protection in dental X-ray surgeries**

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3. I am answering the CPD questions in the _____ issue (PLEASE ENTER MONTH):

	A	B	C	D
Q1	☐	☐	☐	☐
Q2	☐	☐	☐	☐
Q3	☐	☐	☐	☐
Q4	☐	☐	☐	☐

4. Please add any comments or feedback that you might have below or email bdjteam@nature.com.