BDJ Team
MARCH 2017

MEDICAL EMERGENCIES

BDA
British Dental Association

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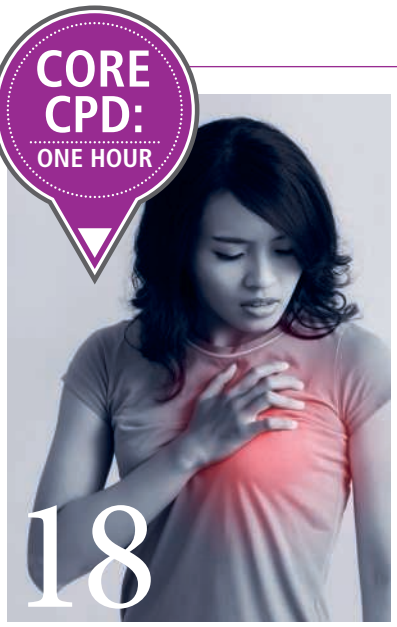
March 2017

Highlights

Regulars

In this issue



CORE CPD: ONE HOUR

Ed's letter

BDJ Team is always keen to present a positive outlook on all aspects of working within the dental industry, which is why I was delighted to interview former dental nurse Kirstie Moons this February at the headquarters of the General Dental Council in London.

'Everyone has a life, and it's just how you manage that I think,' said Kirstie. 'I'm quite a positive person by nature; I think that helps. Even when you're pressured and you're challenged, if you're positive it affects how you respond.' When you have time to put your feet up with a cup of tea, have a read of the full interview with Kirstie in this issue of *BDJ Team* - you might just come out feeling a little bit better about dentistry and your role within it... should you need to!

Medical emergencies & CPD p18

Exclusive interview with Kirstie Moons p13

Tommy: nurse, tutor, trustee. p9

Our CPD article in the February *BDJ Team* was particularly well-received, so I'm pleased to feature another core CPD topic this month: medical emergencies. Refresh your knowledge on what to do if the most common medical emergencies occur in your practice, then head along to the CPD hub (http://bit.ly/2e3G0sv) to test yourself. If you have experienced such an occurrence in your practice, I would love to hear about how it went and how your dental team responded. Drop me a line at bdjteam@nature.com or comment on the *BDJ Team* Facebook page.

Is direct access working? p25

We also spend a day in the life of two Scottish DCPs, one in the Highlands and one in Dumfriesshire. Thank you to everyone who responded to my recent shout-out for volunteers to appear in this feature. Look out for other DCPs taking us through their daily routines in upcoming issues.

With a new research article from the *BDJ* looking at how direct access is working among dental hygienists and dental therapists, book reviews, a global map on sugar consumption and more, read on, and enjoy!

Global sugar consumption p23

Kate

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THE TEAM

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Yorkshire practice *highly commended* for apprentice scheme

Dental practice Michael and Margaret Naylor and Associates have been highly commended at the national final of the National Apprenticeship Awards 2016.

The Awards, now in their thirteenth year, are run by the National Apprenticeship Service and recognise excellence in two areas: businesses that grow their own talent with apprentices and apprentices who have made a significant contribution to their workplaces.

With a small workforce of 37 employees, Michael and Margaret Naylor and Associates dental practice, based in South Yorkshire, have been committed to apprenticeships for almost 20 years – currently employing nine apprentices in different roles across the company.

The practice, who won Yorkshire and the Humber Medium Employer of the Year at the National Apprenticeship Awards, began by offering an advanced apprenticeship in dental nursing. More recently, the ongoing success of apprenticeships at the practice has encouraged the organisation to expand their programme to include level 2 apprenticeships in business administration and customer service.

The practice is committed to investing in apprenticeships. Margaret Naylor, principal dentist, said: 'We find taking on apprentices who are prepared to work hard, alongside studying for a qualification, helps create a motivated and enthusiastic workforce.' This is reflected in an increase in staff retention and loyalty – with over 90% of the practice's full-time staff having progressed into their roles following an apprenticeship.

The advantages brought by apprenticeships to the practice, however, have gone beyond business benefits. They've also had a profound impact upon the local community. Margaret explained: 'Working in a poor socioeconomic area, where the majority of opportunities are in the manual or service industries, the apprenticeships our practice offers can provide a tremendous life opportunity for someone, and the first step on the career ladder.'

Apprentices at Michael and Margaret Naylor and Associates; from left to right Sophie Keady, Ellie Baines, Bethany Gwalter, Alice Kirk and Chloe Kelly

GDC calls for better collaboration in new regulatory plans

On 26 January the General Dental Council (GDC) announced plans for how its approach to regulating dental professionals will be reformed to put public safety firmly at its heart.

In a document entitled *Shifting the balance: a better, fairer system of dental regulation* the GDC said that it will:

- Support and empower the profession through a range of education, learning and development activities
- Support patients to feel confident their concerns are appropriately raised and resolved by the right body at the right time
- Continue its commitment to work better with partners to improve the regulation of dentistry in the UK
- Make it clear how and when it will use its formal FtP enforcement powers to manage serious risk to patients.

Ian Brack, Chief Executive of the GDC, said: 'This is our most significant proposal in a generation and I encourage anyone involved with dental services to engage with our plans.

'We have made it clear from the outset that we cannot do this alone - the proposals require fundamentally better collaboration with others than we have achieved in the past.

'I am confident that our proposals can make the system better for patients and fairer for dental professionals and strengthen public confidence in dental services.'

To read the full document and to comment on the GDC's proposals, visit http://www.gdc-uk.org/Newsandpublications/consultations/Pages/Reforming-dental-professional-regulation.aspx. The discussion document closes on 26 April 2017.

An interview with DCP Kirstie Moons, a member of the GDC Council, is featured this March in BDJ Team

Could you be a Trustee for **NEBDN**?

The National Examining Board for Dental Nurses (NEBDN) is seeking to recruit exceptional people from all areas of dentistry to its Board of Trustees.

NEBDN works throughout the UK and Ireland to deliver high quality qualifications for dental nurses. Its mission is to improve the quality of education and training for dental nurses to promote patient safety and support effective dental practice.

Having recently been through a significant period of change, NEBDN now wishes to strengthen the Trustee Board to support growth and development in a changing external environment. This is an exciting opportunity to get involved in improving dental nurse education and training in the future.

Professor Nairn H. F. Wilson, Emeritus Professor of Dentistry and NEBDN Trustee, said: 'The primary purpose of a Trustee in a not-for-profit charity such as NEBDN is to ensure that the organisation acts in the best interest of the beneficiaries. In the case of NEBDN, these are dental nurses and, in turn, the professions of dental nursing and dentistry. To achieve this goal, Trustees must individually and collectively oversee, in an objective, free of conflict manner, the most efficient and effective use of available resources and volunteer support.

'Thanks to a number of arrangements and circumstances unique to the UK, including the sterling work of the NEBDN, dental teams in Britain are supported by exceptionally well-qualified nurses. Indeed, UK qualified dental nurses are amongst the best in the world.'

Becoming a Trustee for NEBDN is an excellent opportunity, whether you are looking to become a trustee for the first time or you have previous experience of Board-level work.

Trustees are required to commit to around six Board meetings per year held either at the charity's headquarters in Preston, Lancashire or in London. In addition, there are two or three supplementary meetings of the Board or its sub-committees annually and ongoing information exchange, which requires a regular time commitment each month. This is an unremunerated role although expenses will be paid for attendance at meetings.

For further information and to download an application pack visit www.nebdn.org, email Laura Oddie, Executive Assistant to the Chief Executive at laura.oddie@nebdn.org or telephone 01772 429994. The closing date for applications is Friday 7 April 2017.

Will you be in Manchester this May?

This year's British Dental Conference and Exhibition will be held at Manchester Central Convention Complex from Thursday 25 to Saturday 27 May. The three-day event will offer you the chance to gain verifiable CPD, network with your peers and learn about the latest innovations and technologies at the exhibition.

At the Friday night party you and your team can enjoy handmade, rustic dishes and bespoke cocktails at Artisan on Manchester's Avenue North, then dance the night away with a live band.

If your principal is a BDA expert member, you may be able to attend for free. For more information and to book, visit www.bda.org/conference.

New student of the year award launched

The British Society of Dental Hygiene and Therapy (BSDHT) and Henry Schein have announced that they are joining forces to launch a brand new national award that will recognise the personal achievements of a new graduate of either dental hygiene or both dental hygiene and therapy.

The winner of the award, to be presented at the BSDHT Oral Health Conference (OHC) in Harrogate in November, will have demonstrated exceptionally high standards throughout their studies and have gone 'above and beyond' in furthering the profile of the profession.

President of the BSDHT, Helen Minnery, said: 'This is an incredibly exciting opportunity for a newly qualified professional to receive the recognition that they deserve for many challenging years of study.

'The winner of this award will have performed a broad range of clinical skills to an excellent standard and actively recognised where and how they can improve throughout their years of study. Importantly, they will also have demonstrated a high standard of patient care, considering individual patient needs before, during and after the treatment while also creating a safe, clean and patient friendly environment.

'The winning student will also present evidence of a positive attitude to their future in our profession with an ongoing and effective plan for continuing personal and professional development throughout their career.'

For many years, BSDHT has sponsored a prize for each dental hygiene and therapy school in the UK to be awarded to their choice of student who they believe has excelled in their studies. Through BSDHT's new collaboration with Henry Schein, to further enhance and recognise these efforts, one winner from each school will now be considered for the overall 'Student of the Year' award.

The prize will include travel, accommodation and entrance into the BSDHT OHC and the spectacular 'Student of the Year' trophy.

One book, two reviews

Two dental professionals review *Essentials of dental assisting*.

Essentials of dental assisting, 6th edition

This book is written by D. S. Robinson and D. L. Bird and published by Saunders. It has 520 pages and costs £60.99 (ISBN 9780323400640).

This textbook is aimed at either someone who is considering a career in dental nursing, someone who has just begun training or for a dental assistant looking to improve their knowledge.

From the beginning, it must be noted that this textbook is more appropriate to someone either living in America or considering a move to and continuing or beginning a career in dental assisting. This book does not discuss the GDC standards and principles, COSHH or AQC/RQIA. Some of the names given to instruments and materials are also different. As a dental assistant with over 14 years' experience I found it easy to apply the UK standards or names to certain things, however, in my opinion, I wouldn't recommend this textbook to a new dental assistant student studying for their NEBDN exam.

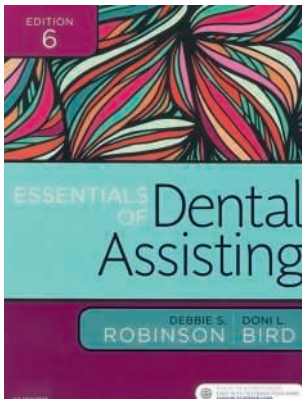
Putting aside that this text would not be applicable to the UK in some instances I must say that I really enjoyed this textbook. When I studied for my NEBDN exam our textbooks were Levison's *Textbook for dental nurses* and Hollins' *Question and answers for dental nurses*. Without question *Essentials of dental assisting* was a huge improvement.

The book is broken down into ten chapters, each with their own overview title. Then each chapter is further sub-divided into smaller topic chapters. Throughout all chapters detailed diagrams and pictures are available. In some chapters there are probably more diagrams than writing but it makes it extremely easy to understand. For example, I'm sure I'm not alone when I think back (and cry silently) to having to learn the facial nerves and bones. In our textbook the picture was rather small (especially when compared to the amount of letters in some of the names) and was black and white. The *Essentials of dental assisting* has wonderful large pictures of the skull, in colour, from different angles and the position of the nerves. (Please do not confuse my enthusiasm with actually wanting to ever think about the palatine nerves!)

At the beginning of each chapter the 'learning objectives' and 'key terms' are outlined. The definition of the 'key terms' are fully explained in the glossary at the back of the book. This makes reading and learning the information in the chapter almost seamless.

> 'Every chapter was well presented and had fantastic diagrams and photographs that would really help anyone visualise a procedure.'

Every chapter was well presented and, as discussed above, had fantastic diagrams and photographs that would really help anyone visualise a procedure. For example, the chapter on endodontics. The procedure was described from the beginning to the end. Every instrument possibly needed for an endo procedure was listed and pictured in great detail (I never fully appreciated the difference in a K-flex file and a Hedstrom). Detailed diagrams showed the accessing of the pulp chamber, extirpation of the root canals, cleaning and widening of the root canals and finally obturation (including the reason why a lateral condenser/ finger spreader is important - it is that detailed).



At the end of each chapter 'procedure guides' are available. These are a detailed description of what you would set out for a certain procedure. (Think of it as the answers to the Record of Experience for the NEBDN.) An 'Icon key' is at the top of each procedure. These icon keys highlight if the procedure is moisture sensitive, if it involves contact with materials that are considered hazardous or potentially infectious materials etc.

The last page on each chapter is multiple choice questions, followed by 'apply your knowledge' questions. These are basically scenarios designed to make you think how you would 'put in practice' your learning.

Essentials of dental assisting starts with the 'history of dentistry and dental assisting' Although it is probably not important to our role today it is great to know that we, as dental assistants, have progressed through the years form the 'lady in attendance' to the amazing people who keep the surgery operating in perfect harmony and keep dentists all across the lands from fleeing in despair.

To close, if this textbook was changed to acknowledge the UK guidelines, GDC, AQC/RQIA etc this would definitely be the perfect textbook for the dental assistants of the UK.

Ciara Doherty
Senior dental nurse and cross infection control nurse, Strabane, Northern Ireland

This is a beginner's guide for dental nurses, primarily aimed at the American student; however, the core clinical knowledge of dentistry is universal. This book has an online interactive study aid with evolve.elsevier.com.

The book is large and heavy with a colourful, eye-catching cover.

The strengths of the book are:

- It is a good overall general guide for dental nurses
- Clear, refreshing layout, good presentation
- Well illustrated - colour pictures and photos
- Comprehensive coverage of some subjects, including
  - Anatomy
  - Endodontics
  - Radiography.

The book's weaknesses are:

- It's written for the American dental student
- Health and safety, safeguarding, mental capacity, Caldicott, Gillick competency and other UK regulations are missing or not extensively covered

'It does not cover the whole of the curriculum for the UK reader'

- It does not cover the whole of the curriculum for the UK and for this reason the claim that the book is concise is false for the UK reader
- The picture of the naked child in chapter 3 page 21 is not necessary to demonstrate anatomy and physiology
- The photos are grainy, the television in the photograph has video built in which dates the photographs, screen shots using windows XP are used rather than quality photos, flat screen television and the latest operating system
- Chapter 13 on medical emergencies would need to be based on the Resuscitation Council guidelines for the UK.

In conclusion, this book is a good general guide and useful introduction to dental nursing background and techniques for trainee dental nurses. The authors describe the book as today's most concise, practical guide to clinical dental assisting and in the USA this may be true but in the UK the curriculum covers all aspects of dentistry including the Care Quality Commission's key lines of enquiry (KLOE), health and safety, HTM 01-05 and COSHH.

Sue Denness
Dental nurse, Titchfield

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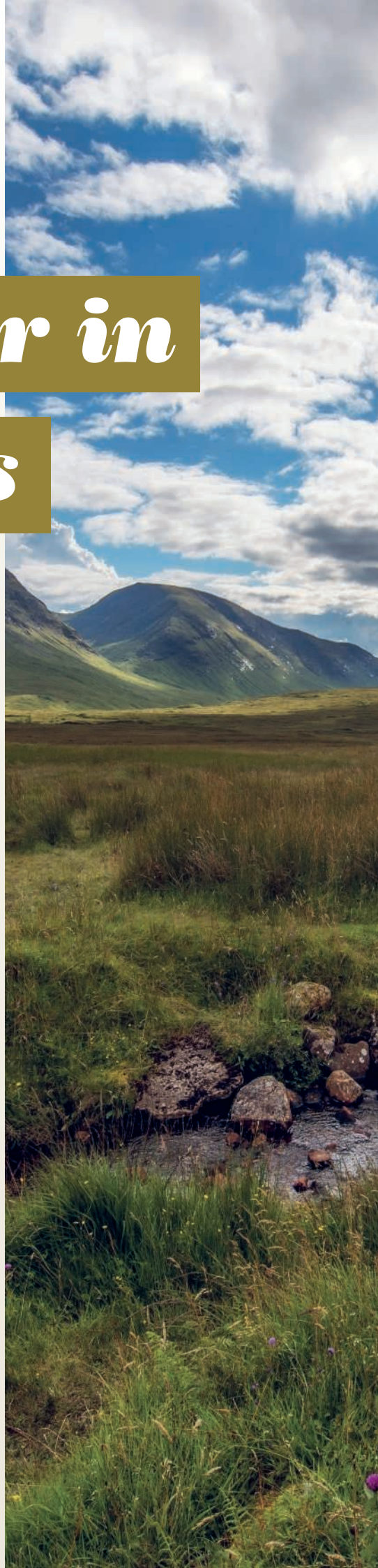
A DCP's life:

The DCP tutor in the Highlands

Tommy MacGregor, 39, qualified as a dental nurse in 1996 and now works for NHS Education for Scotland (NES) as a DCP tutor and CPD advisor. Tommy has also been an NEBDN examiner and is now an NEBDN Trustee.



It depends on what I'm doing workwise but as a general rule I get up at 5 am. I live on my own in a small village called Maryburgh, not far from my hometown of Conon Bridge which is near Dingwall in the Highlands of Scotland. I bought my current house about 14 years ago. I'm very lucky to have family close by. I feel privileged to live in a beautiful part of the country, and with ever improving transport links.

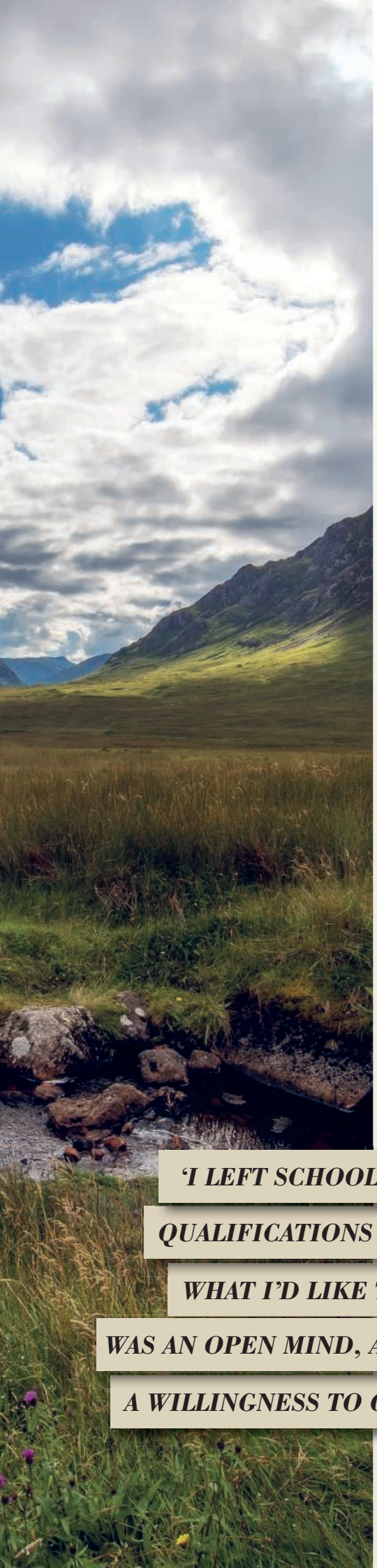
I usually have breakfast at home and what I have varies; I might have a small bowl of homemade porridge/brose or cereal, a cup of coffee with 1% fat milk and a probiotic yoghurt. I've been on a bit of a health kick for about three or so years so I measure out all my ingredients. As a very occasional special treat I'll have a couple of slices of bacon, poached eggs and an avocado. I follow the 5:2 diet, although I see it more as a lifestyle change than a diet.

I work at the Centre for Health Science in Inverness which is 14 miles from home. I take the car when I have to, but I prefer to take the train as it involves a bit of walking. I walk to my local train station and then from Inverness train station to work. It adds up to an additional six miles of walking per day.

Currently I work three days a week within the Clinical Effectiveness work stream as a Dental Tutor in Infection Control. I'm part of the NES Quality Improvement in Practice Training (QIiPT) team; this involves delivering control of infection/decontamination training sessions to dental staff in their practices. Our team also support the delivery of control of infection/decontamination across the other work streams within the directorate such as VT, DCP, CPD etc. I also do one day as a DCP tutor, where I'm involved in the delivery, assessing and internal verification of various DCP courses and qualifications and one day as CPD advisor where I (as part of a national team) assist the development of CPD courses for the dental team.

I left school with pretty limited qualifications and no real clue as to what I'd like to do. What I did have was an open mind, a real work ethic and a willingness to give most things a try.

I never intended to go into dentistry; it was suggested to me by a work experience advisor. Eventually I was taken on by NHS Highland as a trainee dental nurse on the Skills Seekers programme. My intention was to do it for about six months to a year to gain a bit of



experience then move onto something else.

I qualified as dental nurse in 1996; since then I've gone on to graduate from Robert Gordon University in 2001 with an MSc in Health Promotion, De-Montfort University in 2009 with a Pg Cert in Frontline Leadership and Management and in 2014 I graduated from Stirling University with a Pg Cert in Tertiary Education (with a Teaching Qualification in Further Education). I also hold qualifications in assessing and internal verification and completed a range of modules in infection prevention and control from various MSc programmes. Eventually I'd like to go back to university to do further studies, I'm just trying to decide what to do next.

My current roles can involve a lot of travelling so it can involve long days with early starts and late finishes. NES operate a flexi policy so it does balance out. When I'm in the office I do try to stick to office hours.

I like the variety that my posts offer; I'm involved in a lot of different projects. I also enjoy teaching and delivering training out in practice. Juggling all my different roles means that managing my time can be a challenge.

As I have three distinct roles I work with a lot of people. The QIiPT team currently has 13 members strategically placed across the country (ten tutors, a decontamination advisor, an infection control nurse advisor, and very importantly, our administrator who keeps us all right!).

The local DCP team I work with is very small; where I'm based there are another three DCP tutor colleagues along with a Lead DCP Tutor. I also work closely with my other DCP tutors in our other centres.

I was an examiner with the National Examining Board for Dental Nurses (NEBDN) and I recently became a Trustee of the same organisation. As a Trustee I'm currently not allowed to examine but I hope to go back to it once I complete my term of office.

'I LEFT SCHOOL WITH PRETTY LIMITED QUALIFICATIONS AND NO REAL CLUE AS TO WHAT I'D LIKE TO DO. WHAT I DID HAVE WAS AN OPEN MIND, A REAL WORK ETHIC AND A WILLINGNESS TO GIVE MOST THINGS A TRY.'

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When it's not one of my restricted [diet] days I'll take in something I've prepared from home for lunch and I'll either go for a walk or I'll sit and read/listen to music. I try as far as possible to get away from my desk at lunchtime.

To me personal development is incredibly important and CPD is a crucial element of that. My employer gives me time off to do CPD if I apply for it and it is relevant to my role and in my personal development plan (PDP) but I accept that sometimes CPD has to be done in my own time and at my own expense. We are living and working in very challenging times and there aren't pots of money to go around so I think we have to be a bit realistic. As an NHS organisation we use eKSF and iMatter systems to help identify and support our development and organisational needs. At the end of the day I firmly believe that as GDC registrants we are ultimately responsible for ensuring we meet the requirements for registration including CPD.

I try to be home for 6:30 pm but due to the nature of my roles and travel and so on that doesn't always happen. Occasionally I manage to get away at 4 pm.

Outside work I enjoy the usual things most people do, such as cooking and gardening. I also play bowls and I like spending time with my family. The occasional bit of retail therapy doesn't go amiss. I play the drums in a Pipe-band which takes up a fair bit of my time and I'm also involved in children's/youth work.

I like to travel/go on holiday as well. So far I've nothing booked for this year so I think I need to get focussed and a bit more organised!

At the weekend I usually try to go on at least one long walk. I would like to walk the West Highland Way [a 96 mile footpath running from Milngavie north of Glasgow to Fort William in the Scottish Highlands] at some point in the future but I'm not sure if that will be this year, we'll just have to see how it goes…

I am careful with my diet and my oral health regime but I don't think I'm obsessive about them. As I follow the 5:2 diet plan [eat what you want for five days and much less for two], on two days of the week I'm restricted to 600 calories so I'll have breakfast and dinner and nothing in between. The other days I'll eat sensibly but I don't really restrict what I eat, although I do keep an eye on my calories. I use the Myfitnesspal app to keep an eye on my calorie intake and log my food; I also log my exercise and use my phone to count my daily steps. This lifestyle change has helped me to shed quite a lot of weight.

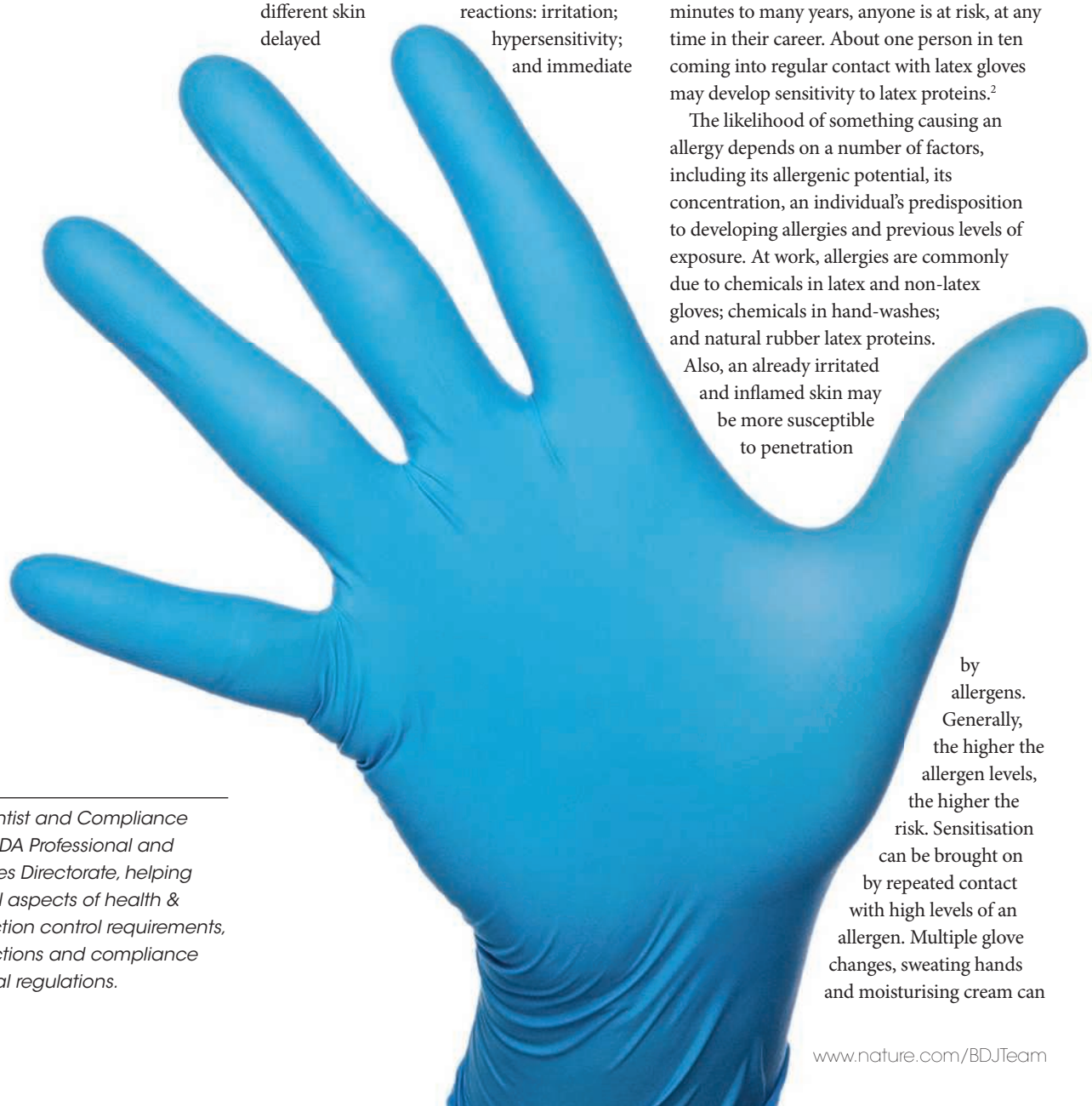
I try to be in bed by 11 pm at the latest.

Are you allergic to LATEX?

Edward Sinclair[1] discusses hand dermatitis and latex allergy among dental workers.

Dental workers are particularly at risk of hand dermatitis because of continuous glove use and frequent washing of hands. In all it can affect up to one in three healthcare workers.[1] Hand dermatitis is a general term describing three different skin reactions: irritation; delayed hypersensitivity; and immediate hypersensitivity. Irritant contact dermatitis is by far the most common reaction. Of the allergic reactions, delayed hypersensitivity is more common than immediate, although immediate hypersensitivity is potentially much more serious. Because allergies are preceded by a period of sensitisation, ranging from a few minutes to many years, anyone is at risk, at any time in their career. About one person in ten coming into regular contact with latex gloves may develop sensitivity to latex proteins.[2]

The likelihood of something causing an allergy depends on a number of factors, including its allergenic potential, its concentration, an individual's predisposition to developing allergies and previous levels of exposure. At work, allergies are commonly due to chemicals in latex and non-latex gloves; chemicals in hand-washes; and natural rubber latex proteins. Also, an already irritated and inflamed skin may be more susceptible to penetration by allergens. Generally, the higher the allergen levels, the higher the risk. Sensitisation can be brought on by repeated contact with high levels of an allergen. Multiple glove changes, sweating hands and moisturising cream can



[1] *Edward is a dentist and Compliance Adviser in the BDA Professional and Advisory Services Directorate, helping members on all aspects of health & safety law, infection control requirements, practice inspections and compliance with professional regulations.*

liberate latex proteins increasing risk of allergy due to cutaneous exposure. However, once allergic, someone may experience reactions at much lower levels.

Seek help

If you suspect hand dermatitis or latex allergy seek medical advice from your medical practitioner, local occupational health expert or dermatologist. This is particularly important if you think you may have become sensitised to latex. Latex allergy can be potentially life-threatening and expert advice must be sought immediately.

Management usually depends on the cause and severity, and medical advice is required to confirm a diagnosis and decide the best way to manage the problem. Various tests can be used to determine whether dermatitis is allergy-based. Failure to identify an allergen may then mean looking at potential skin irritants for the cause.

Risk assessment

Latex allergy and contact dermatitis should be included in your practice COSHH risk assessments. There is no need to have a separate policy on latex allergy as long as you have carried out a proper assessment that identifies exposure to latex and ways in which exposure can be prevented or controlled.

Practices should not scrimp on glove quality. Lower quality gloves are more likely to cause allergy. Gloves should have the lowest levels possible of chemical accelerators; if latex is worn the levels of extractable proteins should be <50 µ/g. However, it is imperative that there is a non-latex alternative in terms of gloves available to staff that can be used whenever required. Potential alternatives include nitrile and neoprene. Practice managers should ensure that those ordering stock are aware of the types of gloves to be ordered. In addition, staff should be trained not only in identifying latex allergy risks but how to deal with anaphylaxis in an emergency.

'MULTIPLE GLOVE CHANGES, SWEATING HANDS AND MOISTURISING CREAM CAN LIBERATE LATEX PROTEINS INCREASING RISK OF ALLERGY DUE TO CUTANEOUS EXPOSURE.'

Many other latex containing products are used in the dental surgery; this includes rubber dams. A non-latex alternative should be used in these situations, whenever possible. Contrary to some reports, the risk of latex allergies from local anaesthetic carriages is minimal. Some have been manufactured with latex diaphragms and plungers can also contain latex. However, given the lack of evidence, it is difficult to directly attribute this particular source of latex to allergies within the dental surgery.

In theory, there could also be some cross reactivity with *gutta percha* material. Again, this is only theoretical given both materials have common sources. There is no evidence in the literature to substantiate such a comparison. In patients known to have a latex allergy, it may be prudent to allergy test for *gutta percha* sensitivity.

With your patients around 1-6% of the general population are thought to be potentially sensitised to latex. Control measures to prevent allergy to latex include taking an excellent medical history, considering co-morbidities that may increase the risk of latex allergy and the use of barrier protection from contact with latex containing materials. It has been suggested that early morning appointments could be helpful in preventing patient exposure to allergens that have become aerosolised.

Full national guidelines *Latex allergy – Occupational aspects of management*, are published by the Royal College of Physicians; visit https://www.rcplondon.ac.uk/guidelines-policy/latex-allergy-occupational-aspects-management-2008.

1. Flyvholm M A, Bach B, Rose M, Jepsen K F. Self-reported hand eczema in a hospital population. *Contact Dermatitis* 2007; **57**: 110-115.
2. Allergy UK. Rubber Latex Allergy. Available at: https://www.allergyuk.org/rubber-latex-allergy/rubber-latex-allergy (accessed February 2017).

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Kirstie Moons[1] qualified as a dental nurse in Cardiff Dental Hospital in 1990 and is now Associate Director for DCP Education within the Wales Deanery at Cardiff University. In 2013 she was appointed to the 12-member body that leads the General Dental Council.

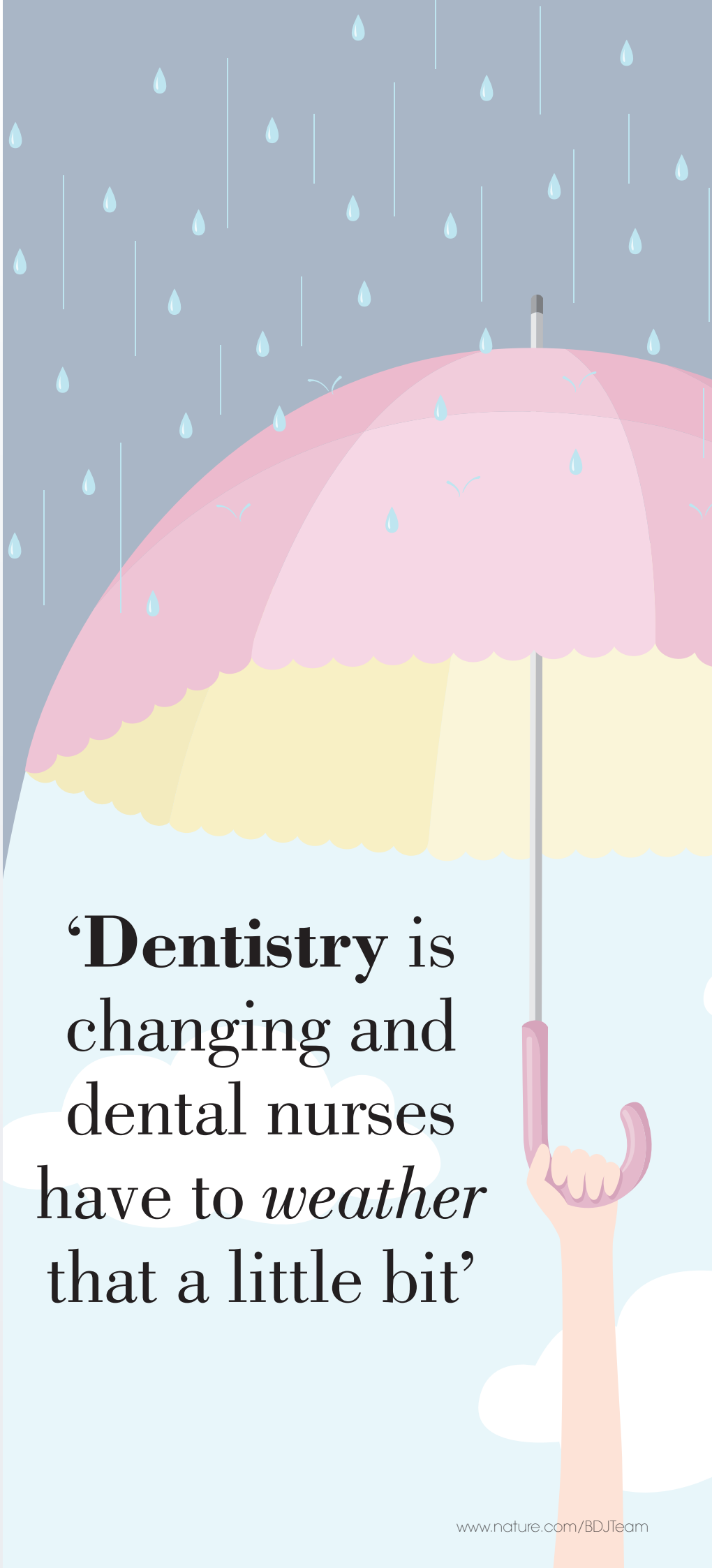
What originally attracted you to dental nursing?

I was studying A-levels in French, English and Spanish at sixth form college - languages were always my thing - and enjoyed college but I wanted to do something a bit more practical. So my dentist said 'why don't you come and work with me for a couple of weeks and see how you feel?' I was 17. He was quite a good friend and we'd been seeing him since we were children, so I said 'okay then'.

I went in for a couple of weeks and had some work experience and I really enjoyed it. So I applied to the dental hospital for the dental nursing programme and got in and did the two years training. The way the programme was set up at that time was that you were employed as a salaried trainee while you got your hospital certificate.

Going from the South Wales Valleys into Cardiff and working there every day, it was really good. When you cast your mind back, you can see how far you've come; I can remember being in one of the early seminars and the tutor talking to us about molars and I remember the girl sitting next to me saying 'what's a molar?'

I qualified as a dental nurse and got a job on the oral health clinic which housed all the undergraduate students and trained them in 35 surgeries. I worked there for a few years



'Dentistry is changing and dental nurses have to *weather* that a little bit'

and had a great time; there was great social interaction. I lived the student life without being a student! I shared houses with students who are now consultants. I became a senior nurse in charge of the clinic a few years later.

What did you enjoy about dental nursing?

I enjoyed all of it but particularly the interaction with dental students - because you knew you were making a difference, you were helping them. I really enjoyed the education side of it. As well as undergraduate dentists we had trainee dental nurses, hygienists and therapists, so we had the whole team and I really enjoyed being part of that.

I was 19 when I qualified and it was a great social atmosphere but I did like the interaction with patients too - you'd see the same patients, they'd come back and you'd get to know them. That was the big driver for me I think.

I liked the science side of it and all the biology too. I've always had a natural curiosity - I always want to learn, and that's what has driven me on.

How did your career develop from there?

I have wondered why I didn't stop at being a clinical dental nurse, and it was because I wanted to do a bit more. I think I've been quite lucky in being championed - when you get to certain parts of your career and certain people champion you. You don't realise at the time that that's what they're doing, it's only when you reflect, and so particularly when I was a senior nurse, one of the executive directors at the time got me on to this NHS All Wales Widening Horizons staff programme. It was probably a bit early in my career really, but it opened a lot of doors for me, it made me think about things differently and do things a bit differently. So I think career wise, maybe I just got lucky, or maybe it's not luck, who knows? I also put the work in.

The Widening Horizons programme took 12 people. It was quite a competitive programme; you went to an assessment centre for two days and sat various tests ... and I was offered a place. I remember thinking 'oh that's exciting'. So we went away for these weekend residential blocks and I would meet people who were, for example, directors of strategy, and I was a senior dental nurse, aged 23 or 24. I remember some chief executives came to talk to us, people who I wouldn't naturally have been interacting with at that point, but it was great. I've always been quite comfortable talking to people and I think that's part

[1] *Kirstie qualified as a dental nurse in Cardiff Dental Hospital and went on to work as both a trained and senior dental nurse in the hospital before moving to a training role. During her time as Dental Nurse Training Officer she oversaw and managed the training programme and an external inspection.*
Following this Kirstie moved into the role of Dental Nurse Manager for the hospital where she led and modernised the dental nurse workforce. She followed this with a six month secondment as Directorate Manager for the Dental Hospital and then as Directorate Manager for the Community Dental Service.
In 2008 she started the role she currently holds within the Deanery overseeing postgraduate education for DCPs in Wales.
Kirstie also holds a seat representing DCPs on the Welsh Dental Committee. She has a PG Certificate in Education and a Diploma in Management and she is currently working towards an MSc in Advancing Healthcare Practice with the Open University.

of training in a hospital, you learn very quickly that they may be a consultant or a professor but we're all people! I've always been comfortable with people in any capacity really. The Widening Horizons programme was a big turning point for me.

How did you move into a training role?

The hospital has always trained dental nurses and they've always looked for tutors. Teaching people how to do things, the right way, was something that I quite enjoyed and I think I was reasonably good at it - students seemed to enjoy how I would interact with them. I went and did the Certificate in Education at the University of Wales and absolutely loved it - the lesson plans, objectives: all of it. That enabled me to become a tutor, in quite an informal capacity to begin with, and then you applied for jobs if they came up, so I became a dental nurse tutor.

The hospital ran the NEBDN course. Then in 2001 it changed to the NVQ City and Guilds course which required lots of changes. So they created a new job as Training Officer which I applied for and got. It was my role to set up the new course in its entirety: train staff, get the infrastructure set up, organise the transition from the old courses to the new. Although difficult and a real learning curve, it was great.

I think training in the hospital environment just gives you a different perspective; you see things differently. You see all the different levels of education, the committees, the governance structure, the corporate side and so on. You are exposed to a lot more things than you would if you were training in a dental practice.

I have worked in a practice though, with colleagues on an emergency service, but not for any length of time.

Were you pleased when GDC registration was introduced for dental nurses?

I've always been a big advocate of registration. I always thought that it was a good thing for the profession and that registration would take us forward.

While I was Dental Nurse Manager we had to get about 120 dental nurses at the hospital on board with registration. It was a new concept to many of them. Many came into dental nursing just wanting to be a dental nurse - they don't want to do anything else and that's fine - but for those people it was harder to get their head around what registration meant and why it was different. Some people were really on board with registration and got on with it, others were asking why and saying 'I don't want to pay money, what's that going to give me, I don't want to be a registrant'.

We had actually set up a local BADN group and were trying to get dental nurses to all meet up in the evenings and we did that for a couple of years and I chaired it for a bit [prior to registration]. We were trying to encourage dental nurses to recognise that there was strength in numbers and that the more you engage, the better it will be.

We're nine years into registration now and people have accepted it; they get it and understand why the team is registered. Since registration has come in there's a much better understanding of the dental team. It used to be that there were dentists and DCPs and dentists were king. I'm not saying that dentists aren't still 'king', but there's a much greater understanding of the value of teams than when I originally came into the industry.

Dentistry is constantly changing and evolving. There are currently plans for contract reform and extending the use of DCPs.

Do you think that dental nurses now have the professional status that they deserve?

I think things are better. I think dental nurses are more recognised than they were, and that's a generalisation I make there. I think there is still some way to go. Salaries are one issue: dental nurses are not reimbursed for the responsibility they have in the team.

I think, and I say this because I am a dental nurse and I talk to large groups about

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'I THINK WE HAVE A WAY TO GO YET, TO FULLY APPRECIATE REGISTRATION AND ITS BENEFITS. I DO THINK THE STATUS OF DENTAL NURSES IS BETTER THAN IT WAS'

professional standards, I see this as quite an immature profession. I don't mean that disrespectfully - I just think that we have a way to go yet, to fully appreciate registration and the benefits it brings, and why we are registered. I do think that the status of dental nurses is better than it was and that we are on a path.

Do you think there is a lot of pressure on dental nurses in 2017 with paying the ARF and for indemnity, CPD and so on?

Absolutely, and increasing pressures in terms of regulation, because quite often it is dental nurses who are being given the lead for decontamination or radiation - positions of responsibility to take forward. Yet I'm not sure that their roles have been elevated to reflect that.

As I say it's constantly evolving. There's been movement - *Scope of practice* was significant, it enabled dental nurses to take impressions, train to take radiographs, apply fluoride varnish - with the appropriate training dental nurses can do a much broader range of things. *Scope of practice* was quite pivotal for dental nurses to be able to develop.

When I first started in dental nursing there weren't many routes you could take. You could become a tutor and that was it. Now there are a lot more doors open: treatment coordinators, practice managers - more doors even than 10-15 years ago. It has changed fairly significantly in quite a short time. And I think the profession recognises it; dental nurses may not be rewarded appropriately but there is more recognition than there was.

We have had a number of articles about dental nurse wages in BDJ Team which have caused quite a storm on our Facebook page, with a lot of dental nurses saying they are not paid enough for the amount of responsibility they have. Are you in favour of a national pay scale?

I think there are pros and cons to a national pay scale. I think it would be useful in terms of setting a baseline, but there are risks associated with it as well. There are employers out there - more and more increasingly - that want to reward their staff appropriately. Their staff are handsomely rewarded and those employers retain their staff. So naturally, they are the dental nurses that stay. The staff that aren't recognised move on. Dentistry is a small world and people know.

So I think having a national pay scale, there are some benefits but you wouldn't want people to use it as a tool to say 'I won't pay you any more than that'. That's the risk of the minimum wage isn't it; it can become a double edged sword. It becomes something that people say 'this is the norm'. And there are so many variables depending on where you are around the country, the type of patients you see, the type of practice, and so on.

What would your advice be to a dental nurse who might be feeling a bit disillusioned about their role?

There are always those good employers out there. Dentistry is changing; the industry is changing and evolving and dental nurses just have to, in a sense, weather that a little bit. And sometimes it's about finding your place, finding where you're happy. I mean you can work anywhere and not be happy; it's not all about the money is it. Sometimes it's about the recognition and the knowledge that you're doing a good job and making a difference. And to be fair to the dentists, let's not tar them with a brush, they are bound by so many competing things, that quite often how their nurses are feeling is way down their agenda - but that is not their fault necessarily, it's just that they have competing priorities that they are already trying to juggle.

Were you proud to join the GDC Council in 2013 as a voice for DCPs?

I was. I wasn't the first DCP on the current sort of Council. The composition of the Council changed in 2013 so prior to that it was much bigger and had a dentist as a chair, whereas now we have a lay chair, six lay members and six registrants. I'm not the only DCP on the current Council but the only dental nurse; there is also a dental technician, David Smith. There are two of us banging the DCP drum which is great.

Again it was one of those things that happened. People had said to me 'you should consider applying for this', 'you should go for this', and I wasn't sure. I said I'm quite happy with what I'm doing, I have two kids (boys aged six and 12) and I'm busy. But then I thought, oh well, I've got nothing to lose, so I put the application in and thought I'll see how it goes.

Then I came for interview, trotted up to London [it was the first time I'd been on the tube!] and thoroughly enjoyed it, bizarrely. I had a good chat with the four people on the panel. We had to do a five minute verbal presentation then were interviewed. I came away thinking I enjoyed that, it was good, a discussion about regulation and about where things are... so if it doesn't come to anything, so be it. Then I had a phone call a while later to say they'd like to offer me the position. I was a little bit taken aback! I wasn't expecting it. You don't know who you're up against.

'I LOVE THE FACT THAT I CAN BE DOING SOMETHING REALLY MUNDANE ONE DAY AND THE NEXT DAY IT'S SOMETHING ENTIRELY DIFFERENT. I THRIVE ON THAT.'

I've really enjoyed it so far. It's been a challenging time but also very rewarding on a personal level, I like being involved and able to influence things, to be able to see how things are evolving. I have great conversations with colleagues (dentists) who don't always get the full picture and it's great to be able to paint the picture and explain what's going on and what's behind it. It's a position of privilege for me. If I'm making a difference, however small that might be, that's a good thing.

Is it difficult juggling this with your other roles?

I have a very, very, very supportive husband, bless him, he's great. And the children know now, 'oh Mum's going to London again'. Attending the meetings is the easy bit. It's the reading papers in between meetings which is difficult. So my evenings and weekends are frequently taken up by reading. 'Mum why do you work all the time?' my kids say and I reply 'to buy you toys!'

I love the variety in my work. I love the fact that I can be doing something really mundane and boring one day and the next day it's something entirely different. I thrive on that.

My work ethic has always been, if you're going to do something, do the best you can. Don't do half a job. I wouldn't think about going into a meeting and not having prepared. That's my choice to give up my time to do that. But everybody's busy; I'm no exception.

Everyone has a life, and it's just how you manage that I think. I'm quite a positive person by nature; I think that helps, to have a positive outlook. Even when you're pressured and you're challenged, if you're positive it affects how you respond. That makes a big difference.

With the launch of the Shifting the balance *document recently, the GDC encouraged all dental professionals to engage with its plans and said that it wants to work more collaboratively. How can DCPs practically engage with the GDC?*

We've had some good conversations about this. We're about to recruit to Council, potentially up to two registrant members, so one of the things that the organisation is trying to put in place is workshops, so we'll try to get DCPs to come along.

We want DCPs to engage and apply for these positions. They might not think that they can or have the experience or the exposure. We want to try and open that door for them, say 'look, it's not as scary as you might think, come and have a look, come and have a chat with us and see'.

A professional forum has been set up and all of the professional organisations are involved. We have good links and networks that we can access. But it is an on-going challenge to engage DCPs because they don't have a single platform. Dentists have the BDA, they have that platform. Not all DCPs are members of the individual associations. David and I, the other DCP on Council, have an on-going mission to try and get DCPs more engaged.

I go out with my Deanery hat on and always try and engage DCPs, and DCPs always say 'oh I really enjoyed that, you really made it sound straightforward and sensible'. And the GDC communications team are also doing a great job. They are in tune with using appropriate platforms to reach DCPs. For example I think DCPs are more engaged online than dentists. Engaging DCPs is not difficult, it's just reaching them. We will keep chipping away at it.

Do you think the future is bright for the dental team?

A lot of people are afraid of change, but I think change is an opportunity. It is not something to be scared of. Change doesn't mean it's bad. Dentistry has been through such a storm as an industry and there has to be a period of stability. Everyone is feeling battered by the various requirements. It's not just one single area within dentistry; they've all got their pressures. I think there is much more of a team ethos and that will continue to develop. The corporates are an interesting area as they have a large part of the market now and that continues to grow. We need to get more familiar with their models and how they work as a team.

One of the things I'm involved with in my Deanery job is a research project looking at skill-mix and dental teams, therapists in particular but also dental nurses, and we're looking at how dental therapists work in practice and the barriers and then doing some work with GDPs to educate them. Part of the reason dentists don't take therapists on is because they don't understand their roles and how a therapist might work for their practice. With appropriate use of skill-mix a dental practice's profits and output can increase in less time... There are lots of things happening in dentistry and I do feel that 'spring is coming', for want of a better analogy.

What are your interests outside dentistry?

I love reading and of course all of my spare time is taken up by my children, spending time with my family. My husband was an electrician by trade but he gave up work when we had our second child. This has allowed me to go and do all the things that I have. He has retrained now as a teaching assistant so he can work round the school holidays. I can go home and switch off from dentistry which is great.

We are very involved in parkrun (adults run 5K and children run 2K on weekend mornings in parks all over the country) so we do that every weekend.

Yes, juggling can be a challenge. You've got to have a good relationship and a supportive partner. My husband's got to be willing to have the children for two nights and get them ready for school and so on when I'm in London. He's quite well trained now!

I respond well to stress. You've just got to be positive and get the balance right in whatever you're doing.

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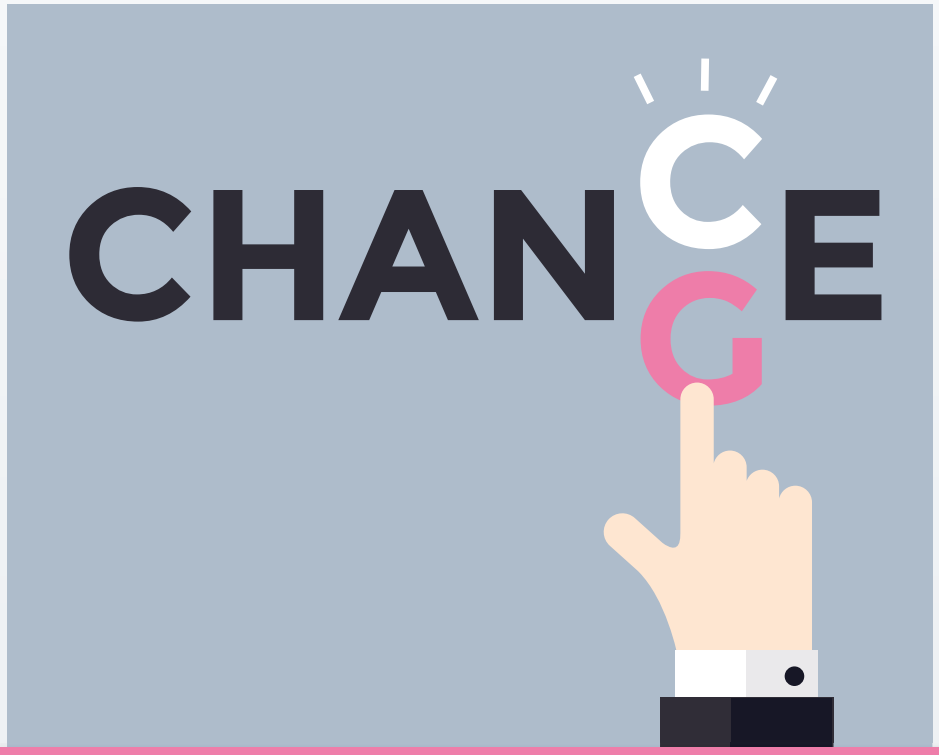

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'A LOT OF PEOPLE ARE AFRAID OF CHANGE, BUT I THINK IT IS AN OPPORTUNITY. DENTISTRY HAS BEEN THROUGH A STORM AND THERE HAS TO BE A PERIOD OF STABILITY.'

CORE CPD: ONE HOUR

Medical emergencies:

refresh your knowledge

By **Jon Kyle Anderson**[1]

CPD questions

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

What are the common medical emergencies?

- Anaphylaxis
- Angina pectoris
- Asthma
- Choking
- Fainting (syncope)
- Heart attack (myocardial infarction)
- Hypoglycaemia
- Seizure.

Anaphylaxis

Description

A severe, life-threatening, generalised or systemic hypersensitivity reaction – the extreme end of the spectrum, occurring when the body's immune system reacts inappropriately to the presence of a substance that it wrongly perceives as a threat.

Presentation

Characterised by rapidly developing life-threatening airway and/or breathing and/or circulation problems usually associated with skin and mucosal changes:

- Life-threatening **A**irway: swelling of the face/throat/tongue, hoarse voice, stridor, difficulty swallowing
- Life-threatening **B**reathing: increased respiratory rate, wheeze, cyanosis
- Life-threatening **C**irculation: pale skin, clammy, low blood pressure, faintness, drowsiness, collapse.

[1] *Jon Andersen is the sole proprietor of ST4 Training and personally delivers courses to a range of healthcare and non-healthcare organisations. Prior to ST4 Training, Jon was a Paramedic, Operational Station Officer, Aircrew Paramedic (one of the first six in Sussex), Advanced Exercise Referral Instructor, and Phase IV Cardiac Rehabilitation Exercise Specialist. Jon also holds a City & Guilds 7303 teaching qualification. You can contact Jon on 07710 988628 or visit www.st4training.co.uk*

Jon will be running the Brighton Marathon in 2018 to raise money for Breast Cancer Care. http://www.justgiving.com/Jon-Andersen1

Treatment

- Phone 999 or 112 and say 'anaphylaxis'
- Adrenaline (intramuscular - IM) using a blue needle (or a green needle if the person is obese). The dose is repeated if necessary at five minute intervals according to the patient's condition (Table 1)
- Adrenaline auto-injectors
- Oxygen - 15 litres per minute with a non-rebreather mask and reservoir
- Patient positioning – a patient with an airway or breathing problem should sit up. However, any patient who collapses, or is shocked, or who feels faint or light-headed, must be laid flat (with legs raised) and kept in that position until his/her blood pressure has returned to normal.

Angina pectoris

Description

Angina pectoris occurs when one or more of the coronary arteries become narrowed.

Presentation

A manifestation of angina pectoris is chest pain on exertion. The signs and symptoms are similar to a heart attack:

- Pain in the chest/arm or arms/back/throat and lower jaw
- Breathlessness
- Feeling dizzy or sick
- Looking pale/grey/blue.

Treatment

- 300 mg aspirin (unless allergic)
- Rest – ask the patient to sit down
- GTN spray - administered under the tongue and the patient should then close his/her mouth to retain the spray. The initial dosage is 1 or 2 metered sprays (400 micrograms per dose spray) then the patient should be reassessed after five minutes. This dosage can be repeated every 5-10 minutes as clinically indicated
- Phone 999 or 112 if the patient's condition deteriorates or does not improve (this may now be a heart attack).

Asthma

Description

Asthma is characterised by a narrowing of the small airways with or without excess mucous production.

Asthma UK recommends the following steps to patients in the event of an asthma attack:

1. Sit up – don't lie down. Try to keep calm
2. Take one puff of your reliever inhaler (usually blue) every 30-60 seconds, up to a maximum of 10 puffs
3. If you feel worse at any point while you're using your inhaler OR you don't feel better after 10 puffs OR you're worried at any time, call 999 for an ambulance
4. If the ambulance is taking longer than 15 minutes you can repeat step 2.

NOTE: This asthma attack information is not designed for people using a SMART or MART medicine plan.

(From www.asthma.org.uk.)

Presentation

A severe asthma attack is one that comes on very quickly and worsens very quickly. Signs of **life-threatening asthma** include any **one** of the following:

- Blue tinges at the extremities/lips/earlobes
- Exhaustion
- Confusion
- Decreased level of consciousness
- Poor respiratory effort
- Little or no response to inhaler therapy.

Treatment

- Phone 999
- Oxygen - 15 litres per minute with a non-rebreather mask and reservoir
- Salamol inhaler - Administer up to 10 doses of Salamol (using a large-volume spacer device if the patient is unable to use the inhaler effectively) and repeat every ten minutes if necessary.

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'A PATIENT WITH AN AIRWAY OR BREATHING PROBLEM SHOULD SIT UP. ANY PATIENT WHO COLLAPSES, OR IS SHOCKED, OR WHO FEELS FAINT OR LIGHT-HEADED MUST BE LAID FLAT (WITH LEGS RAISED)…'

Choking

Description

Complete airway obstruction.

Presentation

The patient:

- May put their hands up to their chest or throat
- Will panic
- Will use their accessory muscles of respiration.

Treatment

- Confirm choking by asking 'Are you choking?'
- Position the patient by leaning them forward
- Deliver: back blows – up to five, then abdominal thrusts – up to five (repeat as necessary). Use back blows and chest thrusts in babies less than one year of age
- Unconsciousness: if the patient becomes unconscious, phone 999 or 112 and start CPR.

'THE GOLDEN RULE OF ANDERSON IS IF YOU HAVE A HIGH INDEX OF SUSPICION THAT SOMETHING IS CLEARLY WRONG, THEN PHONE 999 OR 112 AND SAY SO!'

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Fainting (syncope)

Description

Fainting is a defence mechanism employed by the brain, when the blood and oxygen supply to the brain becomes too low. A trigger causes the nervous system to temporarily malfunction, leading to a drop in heart rate and blood pressure.

Presentation

The person may:

- Feel light-headed or dizzy
- Become very pale
- Have ringing in their ears
- Yawn
- Feel weak
- Give little or no warning at all!

Treatment

- Oxygen - 15 litres per minute with a non-rebreather mask and reservoir
- Keep the person on the floor (consider the recovery position)
- If a person feels faint (but hasn't fainted) lay the person down and raise the legs
- After fainting, the person should return to normal fairly quickly
- Phone 999 or 112 if the person does not recover after a few minutes
- Repeated episodes of fainting need medical follow-up.

Check for the presence of a very slow heart rate (<40 per minute) which may drop the blood pressure. This is usually caused by a vaso-vagal episode. The drop in blood pressure may cause transient cerebral hypoxia and give rise to a brief seizure.

Heart attack

Description

A heart attack occurs when one or more of the coronary arteries become blocked.

Presentation

No two heart attacks are the same, and not everybody will present with all the signs and symptoms below:

- Pain in the chest/arm or arms/back/throat and lower jaw
- Breathlessness
- Feeling dizzy or sick
- Looking pale/grey/blue
- A sense of 'impending doom'.

The **Golden Rule of Andersen** is if you have a high index of suspicion that something is clearly wrong, then phone 999 or 112 and say so!

Treatment

- Phone 999 or 112
- Aspirin - 300 milligram dispersible tablet to be chewed, given crushed or swallowed with a small amount of water **unless contraindicated**
- Oxygen - 15 litres per minute with a non-rebreather mask and reservoir, but only if the person is cyanosed or has a reduced level of consciousness
- GTN spray.

Hypoglycaemia

Description

Hypoglycaemia is a blood glucose <3 millimoles per litre, although some patients may show symptoms at a higher blood sugar level.

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Table 1 Adrenaline dose

Age	Volume	Dose
Adult	0.50 ml	500 micrograms
Child more than 12 years	0.50 ml	500 micrograms
Child 6-12 years	0.30 ml	300 micrograms
Child less than 6 years	0.15 ml	150 micrograms

Table 2 Glucagon dose

Age	Volume	Dose
Adult	1 ampoule	1 milligram
Children >8 years old or >25kg	1 ampoule	1 milligram
Children <8 years old or <25kg	0.5 ampoule	500 micrograms

Table 3 Midazolam dose

Age	Dose
Adult	10 milligrams (mg)
Above 10 years	10 milligrams (mg)
Child 5 to 10 years	7.5 milligrams (mg)
Child 1 to 5 years	5 milligrams (mg)

Presentation

Other signs and symptoms include:

- Shaking/trembling
- Sweating
- Headache
- Difficulty in concentration/vagueness
- Slurring of speech
- Aggression and confusion/seizures
- Skin pale and clammy.

Treatment

- **GlucoGel** can be given if the patient is co-operative and has an intact gag reflex. Twist off the cap and squeeze the gel into the mouth and swallow. Alternatively, GlucoGel can be squeezed inside the cheek and the outside of the cheek then gently rubbed to aid absorption. Repeat after 10-15 minutes if necessary
- **Glucagon** is given when the patient is uncooperative/does not have an intact gag reflex/is unable to swallow safely/has an impaired level of consciousness. Administer IM into the upper arm or into the antero-lateral aspect of the thigh **(single dose only)** (Table 2). If any difficulty is experienced, or if the patient does not respond, then phone 999 or 112.

Seizure

Description

An epileptic seizure is the result of a sudden burst of excess electrical activity in the brain.

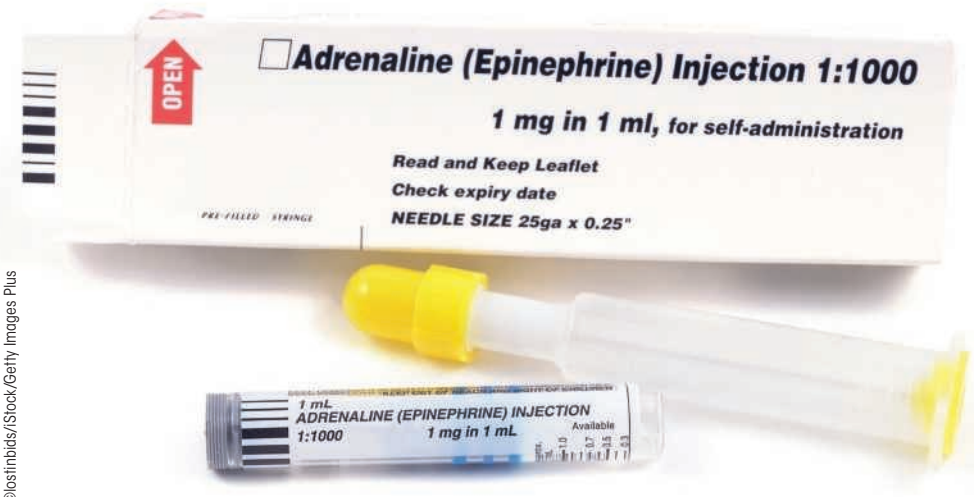
Presentation

Signs and symptoms of a **tonic-clonic** seizure are:

- The body stiffens (tonic stage)
- If standing, the person may fall (usually backwards)
- The muscles relax and contract rhythmically, causing the convulsion (clonic stage)
- Breathing may become laboured (ie difficult or noisy) and may stop for up to 40 seconds. The person may become cyanosed.

Treatment

- Time the seizure - note the time the seizure started and stopped
- Phone 999 or 112 if:
  - The seizure has already lasted five minutes, and is continuing
  - There is a slow recovery or you have any concerns
  - It is the person's first seizure
  - The person is injured.
- Oxygen - 15 litres per minute with a non-rebreather mask and reservoir (during an active convulsion)
- Buccal midazolam – for a tonic-clonic seizure that fits the criteria highlighted in red above. (Table 3.) Single dose only (even if the patient vomits) into the buccal sulcus.



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CPD questions

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bdjteam201743

A DCP's life: Juggling work and family life

Susan Cameron, 42, is a Senior Dental Nurse with NHS Dumfries and Galloway.

I usually get up at 6 am. I live in Annan, a town in Dumfriesshire in the south-west of Scotland, with my husband Philip and children Chloe, 16 and Andrew, 13. Breakfast is usually a rushed bowl of bran flakes with coffee. I live a 30 minute drive away from work. I work 37.5 hours a week from Monday to Friday (flexible working), but usually from around 8.30 am to 4.30 pm.

I left school to become a dental nurse in 1990; at this time I attended college and gained dental surgery assistant qualifications. When GDC registration came about in 2007 these were no longer recognised; I had however noted this and completed NEBDN training in 2006 because I wanted to undertake post certificate training (I hold a Certificate in Dental Sedation Nursing [2013]). I trained as a dental technician between 1992-1995, working in laboratories and part time as a dental nurse in general practice, but then went back to full time dental nursing when I had my children and commenced a role in NHS secondary care services.

As Senior Dental Nurse my job currently includes large amount of admin tasks, staffing rosters, payroll and risk management. I am not in clinic as much as at the start of my career but am required to maintain sedation cases to enable IV and IS techniques as current. I also oversee a prison dental clinic and schedule nurse support for general anaesthetics sessions in hospital.

In my workplace I am managed by a Dental Services Manager supporting three dentists providing sedation treatments; I also work with a dental therapist, five advanced skills dental nurses who support a full range of treatments under secondary care referral and within the prison dental clinic; and we are supported by three receptionists and a dental business administrator. I coordinate regional dental officer visits to Dumfries providing nursing support.

We see a wide variety of patients but mostly those who require anxiety management and are medically complex. We look after child and adult patients with incapacity and using general anaesthetics.

The best part of my job is the people I work with. I also enjoy providing chairside support and engaging with patients within a whole range of different treatments, supporting patients' specific needs.

In addition to my day job, I have assisted NEBDN as an examiner with the post certificate sedation qualification, and I now assist on their sedation committee as well as coordinating our own post certificate accredited training in Dumfries.

Managing a work and home life balance is challenging: my daughter is currently recovering from brain tumour resection and is not at school full time; my son is at school full time.

I usually get home between 5 and 5.30 pm. I attend keep fit classes twice a week and enjoy running. I am currently training for the Glasgow 10K in June, raising money for brain tumour research.

For fun I like to attend social events with my friends; the most recent one was a night away to Edinburgh for rugby.

I am currently planning a big party on 22 April this year with my daughter to be held at Dumfries Cairndale Hotel, to raise money for The Brain Tumour Charity and Ronald McDonald House Charities; it's going to be fun with two live bands and some brilliant raffle prizes.

In the evening I always cook meals using raw ingredients and my spice racks. I like to try to eat healthily and we never buy bottled sauces. I love Italian food.

I usually go to bed late, around 11 pm.

https://www.justgiving.com/Susan-Cameron5

bdjteam201744

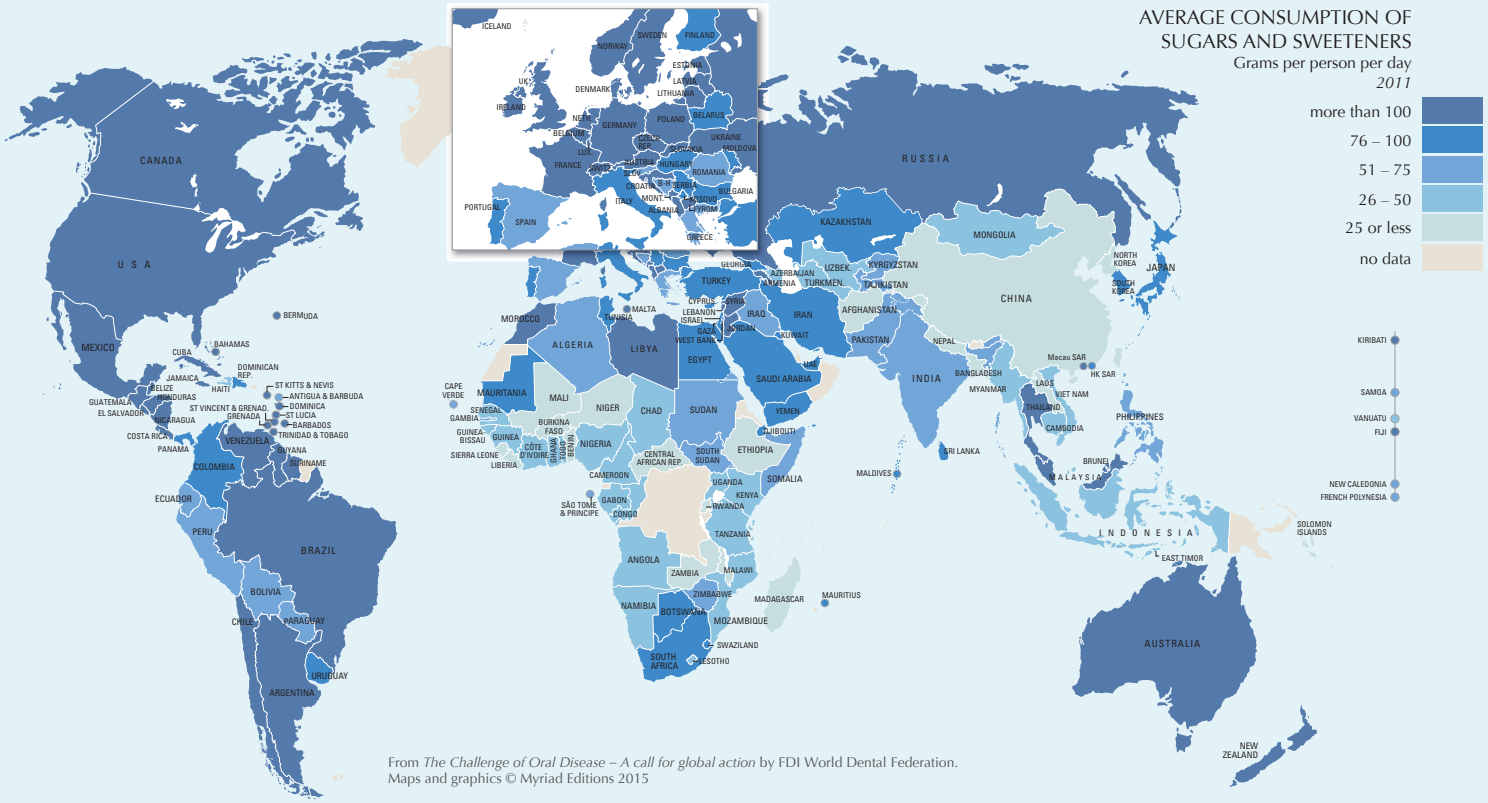
A global outlook on sugar

Sugar is rarely out of the headlines at the moment, whether it is in reference to the number of children having rotten teeth extracted under general anaesthetic; the quantity of soft drinks consumed by teenagers; or our very British love of cakes to celebrate every occasion. How does our consumption of sugar compare to that of other countries across the world? The following content is taken from the second edition of *The Oral Health Atlas* published by the FDI World Dental Federation.

Sugars are part of the bigger family of sweeteners – substances that are either naturally part of or added to food and drinks and create the sensation of sweetness. They are an important, essential source of daily energy intake, but their excessive consumption has severe consequences. As part of a high-calorie diet, they have increasingly been recognised as causes for major non-communicable diseases (NCDs) such as diabetes and obesity.

The nomenclature used for sugars and sweeteners is complex. Free sugars – all sugars added to foods by the manufacturer, cook or consumer, plus sugars naturally present in honey, syrups and fruit juices – are the only cause of tooth decay in children and adults. Sugar consumption shifts the healthy mix of bacteria present in the mouth towards bacteria that convert sugars into the acids that demineralise tooth enamel. Repeated episodes of sugar intake throughout the day increase the frequency of acid attacks and the risk of developing tooth decay. Sugar consumption is influenced by many biological, behavioural, social, cultural and environmental factors. Worldwide consumption has tripled over the past 50 years, and this increase is expected to continue, particularly in emerging economies. To curb the growing epidemic of tooth decay and other NCDs, the World Health Organisation (WHO) recommends limiting the daily consumption of free sugars to 5% or less of total energy. This is equal to 25 grams

'WORLDWIDE CONSUMPTION HAS TRIPLED OVER THE PAST 50 YEARS, AND THIS INCREASE IS EXPECTED TO CONTINUE'



SUGAR FACTS

Sugar consumption	WHO-recommended daily sugar intake for children and adults	Sugar content per 100g of various foods
Average sugar and sweetener consumption per person per day in 2011: **109g** global; **166g** USA	**Strong recommendation** No more than 10% of total energy intake: ~50g or 10 teaspoons. **10%**	Chocolate-coated biscuits **45.8g**
Only **19** countries consume less than **25g** per person per day. **<25g**	**Additional recommendation** No more than 5% of total energy intake: ~25g or 5 teaspoons. **5%**	Frosted cornflakes **37g**
65 countries consume more than **100g** per person per day. **>100g**		Tomato ketchup **27.5g**
		Stir-in sweet and sour sauce **20.2g**
		Salad cream **16.7g**
		Fruit yoghurt **16.6g**
		Coca-Cola **10.9g**
		Sweetened fruit juice **9.8g**

or five teaspoons of sugar per day.
A number of measures are being explored to reduce global sugar consumption. These include additional taxes on products with high sugar content, reducing the overconsumption of sugar-sweetened beverages, limiting sugar content of foods and drinks, introducing regulations for transparent labelling of food ingredients, and constraining the marketing to children and adolescents of food high in sugars.

bdjteam201745

FDI World Dental Federation recommendations

Policies for sugar reduction

1. Enforce higher taxation on sugar-rich food and sugar-sweetened beverages
2. Ensure transparent food labelling for informed consumer choices
3. Strongly regulate sugar in baby foods and sugar-sweetened beverages
4. Limit marketing and availability of sugar-rich foods and sugar-sweetened beverages to children and adolescents
5. Provide simplified nutrition guidelines, including sugar intake, to promote healthy eating and drinking.

Direct access: how is it working?

Stephen Turner[1] and **Margaret Ross**[1] conducted a survey of dental hygienists and therapists working in direct access practices in the UK to find out how they were functioning, which treatments were involved, and the barriers they had encountered.

Introduction

It is now approaching four years since the General Dental Council (GDC) abolished the requirement for a referral from a dentist before a patient could see a dental hygienist or therapist for treatment.[1,2] However, there is evidence that many dentists remain concerned about certain aspects of direct access. A survey conducted in 2014 among a representative sample of dentists found that most held unfavourable views with regard to hygienists and dually qualified hygienist/therapists undertaking diagnosis and treatment planning, risk assessments, referral decisions and, for therapists, restorations, despite the fact that these activities were within their respective scope of practice.[3] These findings mirror those of an earlier study which indicated that dentists were concerned about the education, competence and ability of hygienists and therapists to undertake treatments which had been previously viewed as only within the scope of practice of dentists.[4] However, studies in the UK and elsewhere suggest that such fears may be ill-founded.[5-8]

There remains a lack of information on how widespread direct access has become in the UK, or how it is operating. The aim of this study was therefore to investigate how hygienists and therapists working in direct access practices were functioning within the new system, which treatments were involved, and what barriers they had encountered. For brevity the terms 'dental hygienists' and 'dental therapists' are used here, although the dental therapists of today are dually qualified in dental hygiene and dental therapy.

Method

The study used a purposive sample of hygienists and therapists working in practices offering direct access. Such practices were identified by conducting a 'Google' search using the terms 'dental direct access', 'dental hygienist direct access', 'dental hygiene direct access' and, 'dental therapist direct access'. The particulars of UK-based practices so identified were then noted, and the website of each practice was searched in order to obtain names of hygienists and therapists employed there. Although it would have been possible to email these practices requesting cooperation, it was felt to be preferable to use the individual hygienists' or therapists' email address when requesting participation. These addresses were obtained by referencing the UK GDC Register, to which the authors were given access under strict conditions of use and confidentiality. Where two or more hygienists and/or therapists were found to be working at the same practice address, one was selected using an online random number generator (https://www.random.org/). This search was supplemented by reference to the 'Hygienist Direct' website, which lists a number of stand-alone clinics or dentist-led practices offering direct access (http://www. hygienistdirect.co.uk/).

A questionnaire was developed and piloted. As the survey was targeted at all known hygienists and therapists offering direct patient access, it was not possible to draw a pilot sample without reducing the number of potential respondents. A number of colleagues at Edinburgh Dental Institute were therefore asked to access and complete the online survey. The design and content of the questionnaire was guided by previous surveys of general dental practitioners conducted by the authors.[3,4] It used both closed

[1]*University of Edinburgh, Edinburgh Dental Institute, 4th Floor, Lauriston Building, Lauriston Place, Edinburgh, EH3 9HA*

and open-ended questions, and covered issues relating to direct patient access to hygienists and therapists within the context of their respective scope of practice, including periodontal and preventive treatment, oral health advice, referral for treatment by a dentist and, for therapists, restorative treatment. Opinion questions were investigated using five-point scales ('very favourable, quite favourable, neutral, quite unfavourable, very unfavourable'; or 'very much agree, somewhat agree, neither, somewhat disagree, very much disagree', plus 'can't say'). A validated measure of job satisfaction was included.[9] The survey may be accessed through the link provided at the end of this article.

In November 2015 those hygienists and therapists identified as working in direct access practices were sent an email introducing the study which contained a hyperlink unique to that individual through which the online questionnaire could be accessed.[10] An email reminder to non-respondents was followed by a mailed paper questionnaire sent two weeks after the original communication, and a final reminder/thank you email was sent in early January 2016 to all included in the original communication. Analysis was conducted using SPSS V22.11 Differences in views between hygienists and others were tested using the chi-square, the Mann-Whitney test or student's t test at the P = 0.05 level. Where none were found, results for both hygienists and therapists are reported together.

Results

The initial search identified 243 individuals working in practices offering direct access.

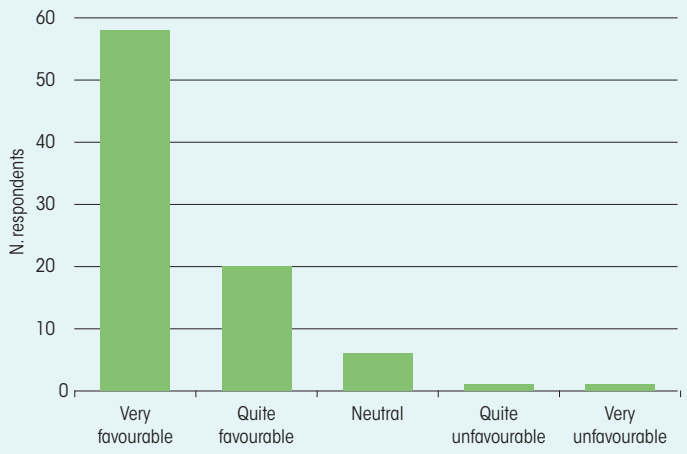


Fig. 1 View of GDC decision

While many practices appeared to be stand-alone businesses, a number were part of a corporate group of up to 50 practices all offering direct access dental hygiene services. Where a practice at a unique address listed more than one hygienist/ therapist, one was randomly selected as described above. This gave a total of 179 potential respondents. Sixty online and 26 postal responses were received, representing a response rate of 48%.

The 86 respondents included 52 singly qualified dental hygienists (60%), 32 dually qualified hygienist/therapists (37%), and two singly qualified therapists (2%). This breakdown closely reflects the make-up of the GDC register, where singly qualified dental hygienists represent 68% of UK-based dental hygienists and therapists.

The majority of respondents, 74 (86%), worked in England, three (6%) in Scotland, and seven (8%) in Wales. Forty-three (50%) worked full time (including one who only ran an oral hygiene website), 42 (49%) worked part time (ie four days or less), and one (1%) was not currently working. Fifty-seven (66%) reported that they worked in all or mainly private practice, 23 (27%) worked in practices that were 50/50 private and NHS, and two (2%) worked in mainly or all NHS practices.

Views on direct access

A large majority of respondents (58, 73%) reported that they were very favourable in their view of the GDC decision to allow direct access (Fig. 1). When asked whether they thought there were any advantages or disadvantages of direct access for patients, 83 (96%) said there were advantages, and 36 (42%) stated there were disadvantages (Fig. 2). A large majority (70, 81%) also thought there

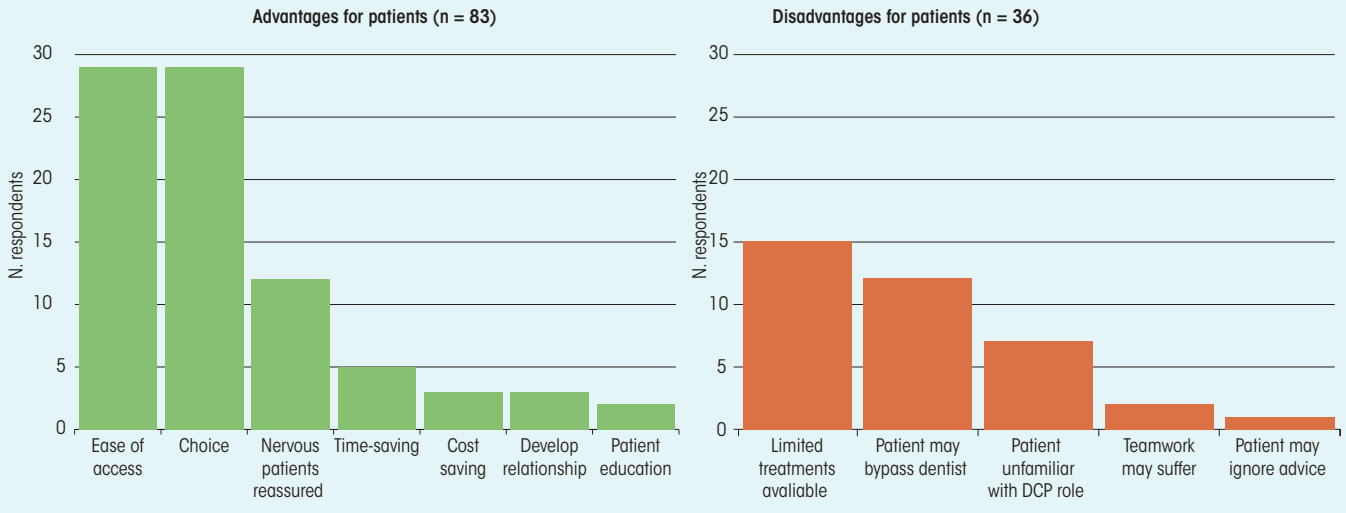


Fig. 2 Advantages and disadvantages of direct access for patients

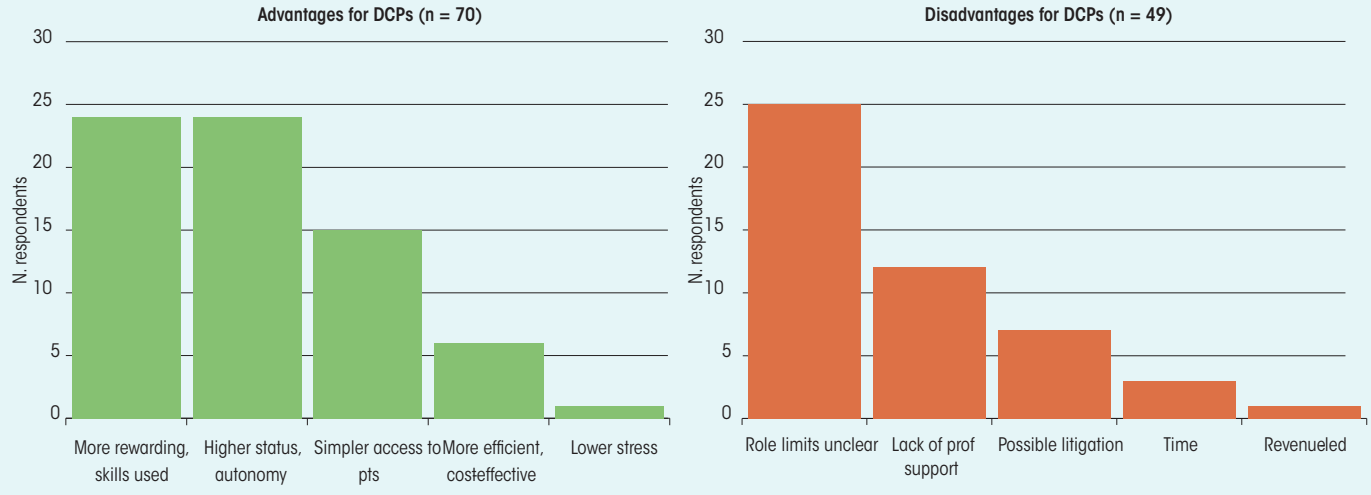


Fig. 3 Advantages and disadvantages of direct access for DCPs

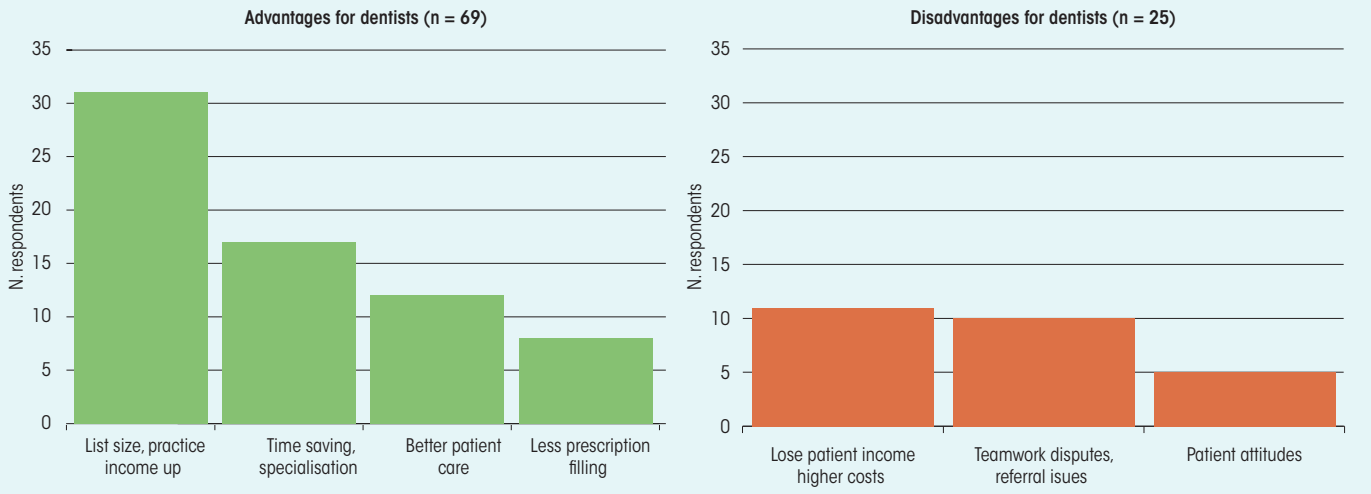


Fig. 4 Advantages and disadvantages of direct access for dentists

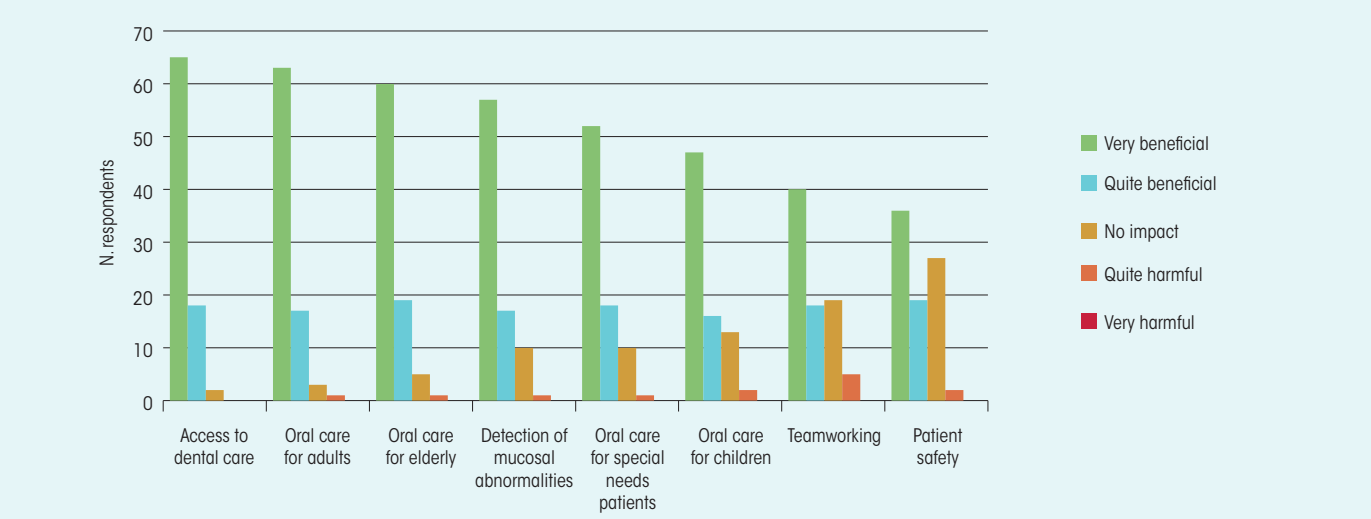


Fig. 5 View on likely impact of direct access on eight aspects of care (n = 85)

Table 1 Arrangements for independent practice and direct access (n = 9)

Independent practice (4)	
I set up in 2007 and used a dentist to write written scripts	My practice is hygiene owned so just easier to take hyg only without having to go through my associates.
I advertise my services and have my own stationery and treatment brochures. I have developed a treatment 'menu' for some services. I now rent a room and provide my own materials.	Some I see at a specialist practice (are) advised to see me by their outside dentist or from my website. I use the fees set and get paid a % set by them. I also have my own practice.
Other arrangements (5)	
Consent forms are different, they are informed beforehand that I will only offer treatment for gross scale and polish, if any treatment needed they have to see a dentist to get treatment plan.	I always require my direct access patients to be first thing in the morning or first after lunch so I can extend the appointment times to give me time to go over medical history and general dental history.
I am employed so to be honest don't really benefit from direct access in any way! It's more hassle, paper work, stress etc I do it because it's the right thing to do, I believe all pt should be able to access a hygienist.	My direct access assessment appointments require longer appointments to ensure I comply with regulations and good note keeping.
	Yes - I have a consent form and different fees.

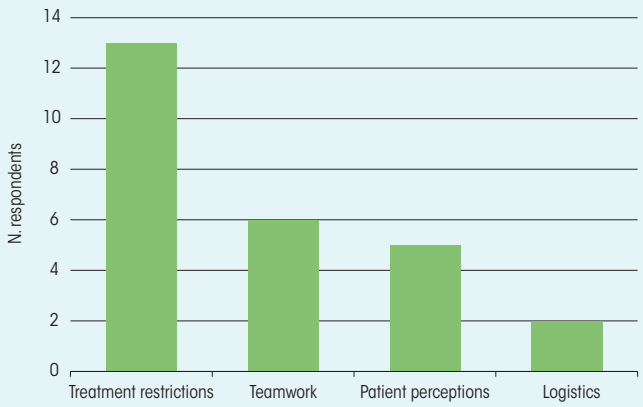


Fig. 6 Barriers to providing direct access care (n = 26)

were advantages for hygienists and therapists (Fig. 3). Similarly, most (69, 80%) thought there were advantages for dentists (Fig. 4). Respondents were then asked their views on the likely impact of direct access on eight aspects of dental care (Fig. 5).

Experience of direct access

Six (7%) of the respondents reported that they did not currently offer direct access care, although, all but one of these said they planned to do so in the next two years. The remaining 80 were asked a series of questions about their practice.

For the large majority (72 of 80, 90%), direct access patients formed a small minority of their caseload. Sixteen (21%) reported they saw less than one direct access patient per month, and another 42 (54%) estimated that they saw between one and nine per month. At the other extreme, 10% (8) stated they saw 40 or more direct access patients per month, with a maximum of 220 reported. The mean number seen by the 78 who were able to estimate the number of direct access patients they saw per month was 13.1. There is some evidence that numbers seen may have built up over time. The 31 who said they had been offering direct access for over two years reported seeing a mean of 18.0 patients per month, compared to a mean of 5.4 among the 46 who had started direct access more recently ($t = 2.17$, $df\ 33.58$, $P = 0.04$).

There is also evidence that direct access patients may include considerable numbers who were not previously registered with a practice. Of the respondents, 27 (34%) said that half or more of new direct access patients were not registered with a practice, and only 17 (21%) said that all or most of their new direct access patients were already registered with the practice where the hygienist or therapist was working.

Practising arrangements

Practising arrangements were unchanged for the majority of respondents (60 of 80 – 75%), while 11 (14%) had established a direct access list within their current dentist-owned practice, six (8%) had their own set of fees, and four (6%) were in independent practice. Nine (11%) described these arrangements (Table 1).

Participants were asked how patients were referred to a dentist for treatment outside their own scope of practice. Sixty one (86%) said they referred to a dentist within their practice, 55 (64%) advised the patient to attend their own practice without making a formal referral, and 11 (13%) had a formal arrangement with an outside dental practice. Eight (10%) made comments about their referral arrangements.

Treatment was mainly restricted to periodontal work, irrespective of whether the respondent was singly or dually qualified. Twenty one of 33 (64%) dually qualified hygienist-therapists and 37 of 53 (70%) singly qualified hygienists said their direct access work was only periodontal in nature.

Barriers

Twenty-six of the 80 (33%) respondents reported encountering barriers to successful practice (Fig. 6).

As these reports of barriers encountered may be particularly helpful in regard to the future development of direct access, Table 2 shows the comments in full under the four headings given in Figure 6.

Training and support needs

Eighteen (21%) felt their education and training had not prepared them sufficiently to see patients under direct access. Seven comments referred to training in diagnosis or screening skills, while 11 made more general points about training to improve the skills needed to work more independently. However,

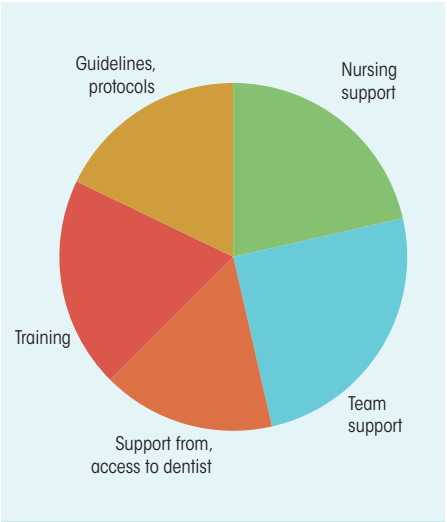


Fig. 7 Types of support needed in providing direct access (n = 57)

there was no difference between the eight hygienists who felt unprepared for direct access by their training in terms of the number of years since they had qualified or the level of confidence they felt undertaking treatments without a dentist's prescription. However, the ten therapists who were critical of their training in this respect reported a significantly lower level of confidence undertaking ten specified treatments (diagnose and treatment plan – perio, apply fissure sealants, administer local analgesia, assign recall intervals, take radiographs, diagnose and treatment plan – restorative, restore primary teeth, restore permanent teeth, extract primary teeth and undertake risk assessments) without a dentist's prescription than those who were uncritical of their training ($t = 2.69$, $df 31$, $p = 0.01$).

Fifty-five (64%) felt that hygienists and therapists working under direct access arrangements needed additional support, and made 57 comments between them (Fig. 7).

Patients' views

Respondents were asked what they felt their patients' views of direct access were, using a five point scale from very favourable to very unfavourable. Fifty two (65%) said their patients were very favourable, and another 21 (26%) said they were quite favourable. No unfavourable views were reported.

NHS List numbers

Asked their view on whether the current restriction on hygienists and therapists accessing an NHS List Number, 54 (63%) felt this restriction should be removed, five (6%) said it should not, and 26 (30%) were unsure or had no view.

Skills and job satisfaction

Asked if working under direct access arrangements had any impact on their clinical skills, 16 (20%) stated these had been enhanced considerably, 20 (25%) said they had been enhanced a little, and 42 (52%) said there had been no impact. Twenty (25%) reported that direct access had enhanced their job satisfaction by a lot, 31 (39%) by a little, and 25 (31%) said it had no impact. Two (2%) felt it had decreased their job satisfaction a little.

On a 7-point scale, with one representing extreme dissatisfaction and seven extreme satisfaction with their job, 67 of 80 (84%) scored five or more. Across all respondents dental hygienists had a higher mean job satisfaction score than therapists (5.92, n = 50; 5.30, n = 33: p = 0.02). However this was not the case when the analysis was restricted to those 80 providing direct access (5.89, n = 47; 5.37, n = 30: p = 0.06).

Discussion

As far as is known, this study represents the first review of direct access in the UK since the GDC reform of 2013. Responses were qualitatively very rich. The main weaknesses to this study are the survey frame and the response rate. Use of a web search to identify direct access practices employing hygienists and therapists is likely to yield few false positives but may have led to an unknown number of false negatives if reference to direct access on practice websites was scant. Given that direct access appeared to be concentrated in private practice, with strong incentives to attract income from new patients, it is possible that the internet search method used may be less likely to miss eligible practices than if the same approach was adopted if and when direct access is extended to NHS dental services. It could also be argued that only including hygienists and therapists in the survey, and excluding dentists and patients, gives an incomplete picture of the impact of direct access. The authors hope to address this point in future work, which will build on the study of dentists' attitudes to direct access completed in 2014.[3] The justification for focusing on hygienists and therapists exclusively at this point is that these are the clinicians most directly involved in the reform, and their experiences will inform future work involving dentists and patients.

A response rate of 48% (86 of 179) to a mixed methods survey may be considered reasonably good compared with similar recent surveys and research findings on the subject.[12–16] It is possible that monetary incentives and/or telephone follow-up may have increased the response rate further, but these options were ruled out on resource grounds.[17,18]

The initial August 2015 search identified almost 250 individuals working in direct access practices. If the 80 direct access-active survey respondents are representative of this larger number, their experience suggests that by the end of 2015 at least 3,000 patients were being treated every month under direct access arrangements. In a recent review, Brocklehurst *et al.* suggested that the purpose of direct access type reforms remained unclear: 'Is it to expand access, reduce inequalities in access, improve quality of care, improve population health, or reduce costs?'

Comments from respondents in this study refer to all these potential benefits. For example, responses reviewed in Figure 4 and Table 1 on attracting new patients to the practice suggests that direct access may indeed be able to stimulate the dental market, or change the consumer profile of service users by bringing new or reluctant patients into the surgery on a regular basis. However, a smaller number also referred to the possibility that some patients may be deterred from continued attendance if their treatment is poorly managed between team members.

Direct access to dental hygienists has been available in the US on a state by state basis since the 1980s.[20] Similar arrangements are well established in New Zealand, the Netherlands and elsewhere. Northcott *et al.*, in a qualitative study of direct access arrangements in the Netherlands, reported similar concerns regarding teamwork, public perceptions and referral arrangements etc as those voiced by the hygienists and therapists in the present study.[21] In the example of how patients are referred by hygienists and therapists if required, the GDC has not issued prescriptive guidance but suggests individual practices establish their own procedures:

'Dental hygienists and dental therapists offering treatment via direct access need to have clear arrangements in place to refer patients on who need treatment which they cannot provide. In a multi-disciplinary practice where the dental team works together on one site, this should be straightforward. In a multi-site set-up where members of the dental team work in separate locations, there should be formal arrangements such as standard operating procedures in place for the transfer and updating of records, referrals and communication between the registrants.'[1]

Direct access is not currently possible within the terms of the NHS GDS contract without changes in either regulations (England and Wales) or primary legislation (Scotland and Northern Ireland),[22] which require a full oral health assessment to be carried out by a dentist. A majority of the hygienists and therapists in this study felt this restriction should be revoked. For direct access to function in the NHS and to completely fulfil its original purpose, there

Table 2 Barriers to direct access (n = 27)	
Treatment restrictions (14 comments)	
Clarity is still required with regard to radiographs.	Rx LA/fl
Limitation of the use of prescription only medicines (mainly LA).	Still need prescription for LA/fluoride etc
Limitation to Rx able to do due to not having the help, not being able to prescribe and issue prescriptions.	The inability to provide local anaesthetic without a prescription.
Not being able to diagnose, treatment plan.	The necessity for a local anaesthetic prescription.
Prescribing radiographs and reporting,fluoride application and la's	The work I carry out prescribed is a good mix of perio and restorative, I don't know how I go about covering myself for restorative if it is not prescribed due to diagnosis issues.
Prescribing rights. One of the four practices I work with has rejected direct access patients' prescription.	PGD - set up c a Pharmacist????? POMS
Unable to administer any local anaesthetic without the patient visiting a dentist for a prescription.	LA and application of fluoride varnish and high fluoride tp.
Teamwork issues (6)	
Dentists refusing nurse support.	And reluctance of independent pts GDP's to correspond with me. And occasionally pt GP's reluctance to correspond about medical history or referral.
Unhelpful attitude of dentists.	With the dentist as they prefer to do all the restorative work.
Dentists pushing direct access in the hopes of gaining extra income without supporting the hygienist eg I was told just give them a scale and polish when I sought advice about a patient who had extensive periodontal and restorative problems with so much calculus, I didn't know where to begin.	Dentists think it will negatively impact on them financially. Ludicrous.
Patient perceptions (5)	
Pt who refuse restorative treatment, even though it is severely affecting their oral and general health. Pts tend to be new to the practice and often expect a lot from their visits. Difficult to meet expectation and often pts reluctant to have routine care. A lot want one-off quick fix.	Not enough public knowledge of direct access and what it means.
When a patient had an area [sensitive] to scaling code 3 hadn't got radiographs suggested ref to see a dentist for exam or /and rads either at our practice or externally patient refused I wasn't happy to continue to see under direct access thought it would be best to discharge from my care .....big patient complaint continues.	The only patients who want to be seen just want a clean and not proper care.
	Patient not understanding what the appointment entails. Reception giving out false hope - ie telling patients that they will have all staining removed. Patients being unhappy at being told they need several appointments to tackle perio. Patients being unhappy that I have declined to treat them until they see a dentist.
Logistics (2)	
Building up my patient book is taking a long time	Feel that new patients need longer appointment to complete all relevant paperwork, history etc and reception do not always allow for this.

is a need for hygienists and therapists to be allocated NHS list or provider numbers as a matter of urgency. Until this is addressed, direct access will only function in a limited way and deny professionals the autonomy they deserve, and patients the right to choose who carries out their treatment. Such a reform would permit a great expansion in the numbers of practitioners providing treatment under direct access, and greatly increase the gateway to dental services among many in the population, whether or not they are currently registered with a practice. Another fundamental barrier is the inability to prescribe medicines, particularly local analgesia and fluoride. This restriction dictates that hygienists and therapists will never have complete autonomy in terms of treatment provision although still working as part of a team, which was the purpose of direct access in the first instance. Under the current regulations, these clinicians will have to rely on individual prescriptions from dentists or patient group directives to administer these essential components of everyday patient treatment and care.

Individual comments made by respondents were enlightening and sometimes rather worrying. The lack of allocation of dental nurses to hygienists and therapists was highlighted, as was the unavailability of periodontal treatment under NHS regulations in some areas. A comment of concern was made in relation to the length of appointment times in order to write notes in enough detail and comply with GDC Regulations (Table 2). Anecdotally, ten to 15 minute appointments are routine for many hygienists and therapists, and often nursing support is not available. It is clearly not in the best interest of either the patient or clinician to have to work under these circumstances. Conversely, many participants reported that they were satisfied with their employment arrangements, demonstrating that skill mix can be successful if utilised to its full extent. If the clinical abilities of hygienists and therapists were to be underused, there is a risk of them becoming deskilled, representing a huge waste in terms of resources, and a demoralising and frustrating situation for the individual. The survey found that much work with direct access patients was periodontal in nature, one result of which may be the lower job satisfaction reported by dental therapists in this study.

Conclusion

This survey revealed strongly positive views regarding direct access among hygienists and therapists practising under the new arrangements, tempered by some frustration in respect to the level of referrals, the nature of the clinical work they had to undertake, and a certain lack of recognition of their contribution and potential by dental colleagues. Dangers of de-skilling and demoralisation are evident. However, the barriers they report are not insurmountable, given professional and political commitment. Direct access for patients may be the most radical reform to have ever taken place in dentistry in the UK, and it is clear that it requires time and support to become embedded on our healthcare system for the future benefit of the population. As one respondent to the survey commented: 'There are many patients who as a result of DA have better oral health and are also more likely to then go on to receive further treatment. Seems to be a win-win decision'.

Declaration of interests: MR was involved in the lobby for direct access by the British Society of Dental Hygiene and Therapy. She is also a past President of the same Society.

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Product news

Product news is provided as a service to readers using text and images from the manufacturer, supplier or distributor and does not imply endorsement by *BDJ Team*. Normal and prudent research should be exercised before purchase or use of any product mentioned.

A **NEW SOLUTION** TO DRY MOUTH

The Oralieve Dry Mouth Relief product range has been formulated with a unique combination of bioactive ingredients and enzymes to provide effective, long-lasting relief from dry mouth.

Oralieve Moisturizing Mouth Gel is a saliva substitute with intensive moisturisers to soothe and lubricate for long lasting relief. Ideal for use at night, Oralieve Moisturising Mouth Gel can be applied as often as required. Oralieve Moisturising Mouth Spray is ideal for use during the day providing on-the-go relief from dry mouth, and freshness.

Oralieve Ultra Mild Toothpaste contains no SLS and its mild flavours and ingredients are gentle on the mouth. An alcohol-free fluoride mouth rinse is also available.

Patients who are at risk of developing dry mouth include those with diabetes, on multiple medications, with Sjögren's syndrome or who have suffered from head and neck cancer.[1,2] The impacts can make chewing, swallowing and talking difficult as well as leading to oral health complications such as caries and gingivitis.

www.oralieve.co.uk

1. National Institute of Dental and Craniofacial Research. Dry mouth (xerostomia). Available at https://www.nidcr.nih.gov/oralhealth/topics/drymouth/ (accessed 20 December 2016).
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WHAT **RED** MEANS IN WASTE MANAGEMENT

When considering 'red' in the best practice waste management colour coding system, here's what you need to know:

- 'Red' is the colour used to code anatomical waste
- Red waste can be hazardous or non-hazardous and includes any waste generated from the body
- Examples for this waste stream include body parts (excluding extracted teeth), blood bags, blood preserves and animal parts.

For obvious reasons, few dental practices will generate any 'red' waste, but it remains important to know what it means in order to complete the colour code.

Once waste containers (coded any colour) are full, they should be sealed and stored in a private location. It is necessary to work with a licenced contractor you can trust, such as Initial Medical, who will safely and legally collect the waste and dispose of it in the correct manner.

All Initial Medical technicians have undergone the required ADR training and they strive to always provide outstanding customer service.

Don't forget, if you or any member of your team has a question about safe and effective waste segregation and disposal, the experts at Initial Medical would be more than happy to help. For further information visit www.initial.co.uk/medical.

NEW APP LOOKS AT DIET AND THE TEETH

FoodForTeeth is a prevention based app designed by young dentists Prateek Biyani and Jasneet Gulati. The app officially launched on the iOS platform in November 2016 and has already been prescribed to patients in primary care.

The aim of FoodForTeeth is to educate patients about the causes of dental disease and how our diet is so crucial for our oral health. This is achieved by promoting the use of digital diet diaries as a dietary investigation, as well as through a traffic-light system database of common foods and drinks with their risk of caries and erosion.

The app is designed to be used very closely with the patient's dentist/DCP, so that the patient can present their diet diary via the FoodForTeeth app and engage in conversation about their diet. This can then allow tailored, specific dietary advice to be given as part of the preventative regime for the patient.

The app has been checked and edited by expert nutritionists and the dietary advice has been designed to be holistic, as much of the dietary factors that lead to caries are also linked to diabetes and obesity.

The designers of the app hope that *BDJ* readers will use FoodForTeeth as a diet investigation tool with their patients, and would welcome feedback to help improve the free app. Visit http://www.foodforteeth.com to find out more and to leave feedback.

NEW ALCOHOL-FREE HAND DISINFECTANT FOAM

Dentisan are delighted to introduce a new non-alcohol post wash skin disinfectant foam to their product portfolio. New DentiSure is an important addition to Dentisan's already comprehensive range of hand care products and dispensing solutions, providing a non-alcohol alternative for those who prefer this option.

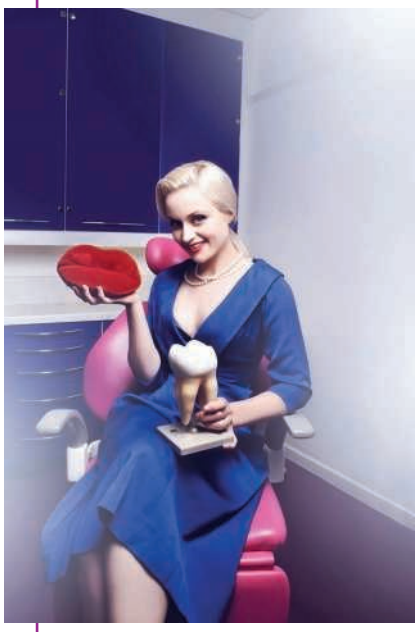
Hand hygiene is one of the most important measures in reducing the risk of infection transmission and all dental practices have a duty of care to ensure they are managed in accordance with current regulations and guidelines regarding hand hygiene. DentiSure makes an important contribution to this work, being fully compliant with HTM 01-05 and having been microbiologically tested to British Standard BS EN 1500.

DentiSure is supplied in a 1 litre ready-to-use format and should be applied to the hands after washing and drying, and rubbed in until fully dispersed. It can also be used on clean skin between washes to minimise pathogen transmission. This complete coverage of the exposed skin provides additional protection from pathogens for those working within dental practices.

DentiSure is available in a ready to use 1 litre foam pump dispenser, and can be ordered exclusively from Henry Schein Dental on 0800 023 2558 and Kent Express on 01634 878787.

www.dentisan.co.uk

FOR THE *LOVE* OF A DENTAL CHAIR



Between September and December 2016, dental practices up and down the country have been sharing their love of Belmont Dental chairs taking pride of place in their surgeries as part of the latest #MyBelmontChair campaign.

Centred around the important role of colour within the modern dental practice, and in relation to the patient experience, the #MyBelmontChair campaign celebrates just how special, functional and colourful Belmont chairs and treatment centres look in practice.

By simply posting or tweeting a picture of their chair in all its glory across Facebook and Twitter using the hashtag #MyBelmontChair, and with the chance to win a top prize, the response has been amazing. From sophisticated black and grey, through shades of calming blues, greens and purples, to stunning red and vivid pink, it's easy to see how a colourful Belmont chair can take centre stage in the treatment process.

With such a high standard of entries it has been no easy task to pick a winner. However, congratulations go to Phil Eisenberg, owner of Sparklysmile Dental Practice in Blackheath Village, London who is delighted to have won £250 in High Street vouchers (entry pictured).

To see all the entries or to find out more about Belmont chairs and pick up some colourful practice design tips along the way, visit www.mybelmontchair.co.uk.

FLEXIBLE, COMFORTABLE AND *STYLISH* UNIFORMS

Made in Italy, the quality Pastelli uniforms available from RPA Dental encapsulate the essence of dental attire.

Flexible, comfortable and durable, Pastelli garments are everything that dental professionals desire from a work garment.

Not satisfied with just offering what is needed, however, the Pastelli range from RPA Dental places high importance on style, use of colours, stitching and monitoring quality control. The result? High-end tailoring that is elegant and fashionable. And when you look great, you feel great.

With over 40 pages, the brochure is now available to download from www.dental-equipment.co.uk/uniforms.

It features both traditional and modern uniforms for both genders in a range of colours, sizes and fits. A range of stylish and comfortable shoes are also available, as well as staple accessories such as hats and belts.

To see how RPA Dental can transform your dental practice, call 0800 0933 975 or visit www.dental-equipment.co.uk.

BDJ Team CPD

CPD questions: March 2017

CORE CPD: ONE HOUR

Medical emergencies: refresh your knowledge

1. Swelling of the face/throat/tongue, wheezing, difficulty swallowing. What medical emergency might present like this?

A) severe asthma attack
B) angina pectoris
C) anaphylaxis
D) seizure

2. Select the **false** statement.

A) in adults who are choking use back blows then abdominal thrusts
B) no two heart attacks are the same
C) chest thrusts can be used for a 10-month-old baby who is choking
D) fainting occurs when too much blood is supplied to the brain

3. a) A sudden burst of excess electrical activity in the brain. b) Aggressive, confused behaviour. What might these describe/indicate?

A) a) epilepsy; b) hypoglycaemia
B) a) epilepsy; b) heart attack
C) a) hypoglycaemia; b) epilepsy
D) a) syncope; b) hypoglycaemia

4. Which of the following is **correct**?

A) glucagon dose for a child weighing over 25 kg is 500 micrograms
B) a 45-year-old woman should be given 300 micrograms of adrenaline
C) children over 10-years-old should be given the same dose of midazolam as adults
D) if a patient vomits after being given buccal midazolam, they should be given another dose

BDJ Team is offering all readers **10 hours of free** *CPD a year on the BDA CPD hub! Simply visit* **http://bit.ly/2e3G0sv** *to take part!*

How to take part in *BDJ Team* CPD

BDJ Team CPD can be found on the BDA CPD hub. This site is user-friendly and easy to use. There are now **ten hours of free BDJ Team CPD a year** on the CPD hub, and currently there are ten hours from 2016 and three hours from 2017!

To take part, just go to http://bit.ly/2e3G0sv

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