DENTAL HEALTH

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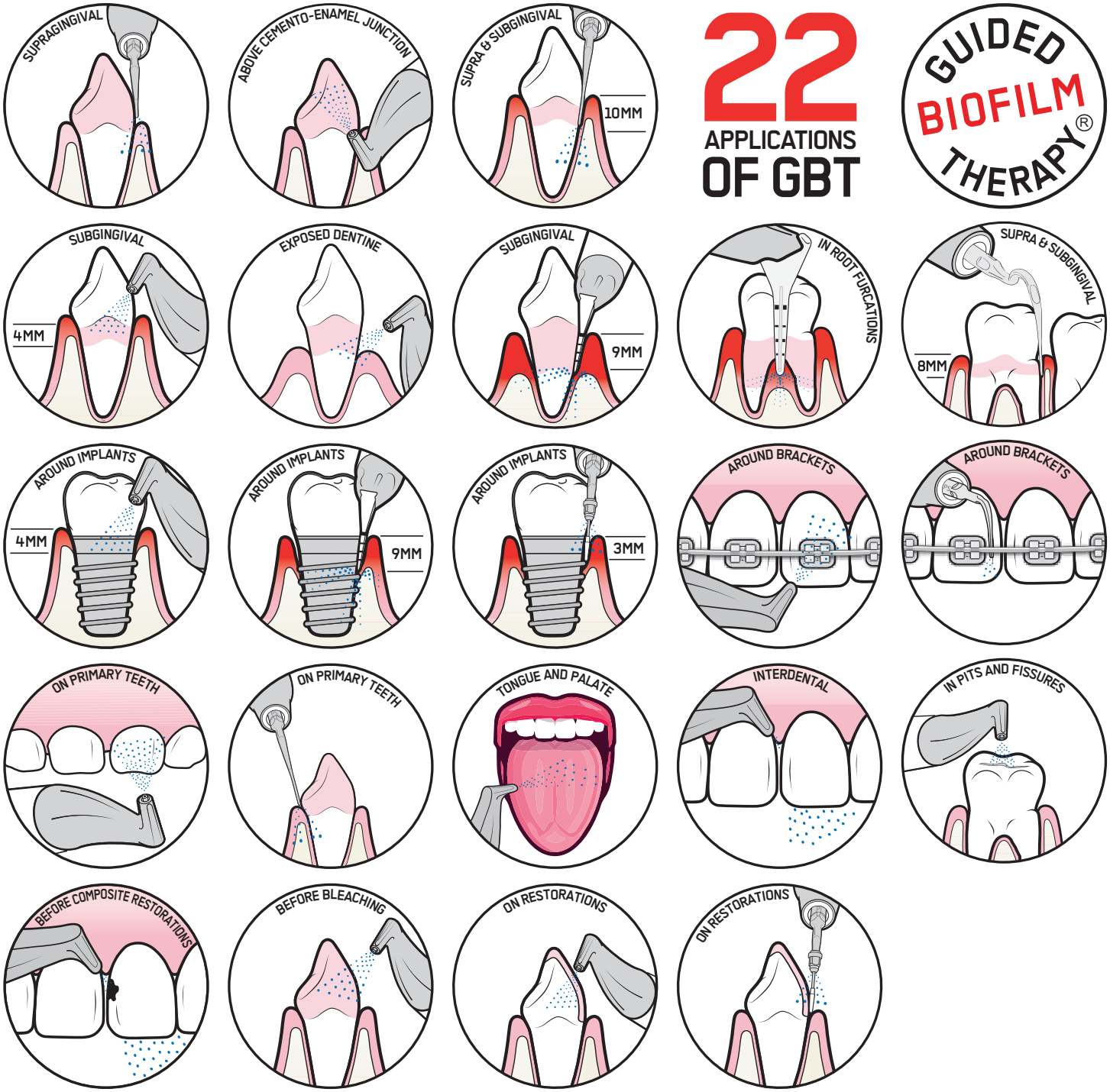
THE JOURNAL OF THE BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY

ECPD
REFLECTION AND THE REFLECTIVE PRACTITIONER

IMPLANTS AND PERI-IMPLANTITIS IN PATIENTS WITH DEMENTIA

FOUNDATION TRAINING
WHAT'S THAT ALL ABOUT?

GUIDED BIOFILM THERAPY



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The mission of BSDHT is to represent the interests of members and to provide a consultative body for public and private organisations on all matters relating to dental hygiene and therapy. We aim to work with other professional and regulatory groups to provide the highest level of information to our members as well as to the general public. The Society seeks to increase the range of benefits offered to members and to support this with a clear business and financial strategy. The Society will continue to work to increase membership for the benefit of the profession.

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Promoting health, preventing disease, providing skills

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DENTAL HEALTH

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GUEST EDITORIAL

Is prevention better than cure?

*The phrase **'prevention is better than cure'** is often attributed to the Dutch philosopher Desiderius Erasmus in around 1500*

Dental hygienists and therapists are, today, practising in times of unprecedented difficulty, given that the COVID crisis has caused a rethink on procedures which involve the use of an aerosol. Use it, and clinicians are subjected to difficult PPE: don't use it, and patients are subjected to a longer scaling or operative procedure. My own preference is for ultrasonic scaling, but, on a recent hygiene visit, I was surprised by how pleasant hand scaling was! (Perhaps due to the empathy and skill of my hygienist!) In that regard, readers, who may have changed their scaling methods to some degree as a result of the pandemic, may therefore be interested to know that the results of one randomised controlled trial indicated that with regard to patient discomfort, with ultrasonic scaling 69.2% felt 'a little uncomfortable' or worse compared with 60% of those undergoing manual treatment[1], but with the majority of patients considering that routine scaling and polishing was beneficial and the majority of patients, regardless of treatment method, experienced some degree of discomfort.

While investigating to whom the title phrase of this editorial should be attributed, I uncovered a 2018 UK Government publication of the same title[2]. It starts by stating that the UK has a rich history of preventing ill health, for example, with Edward Jenner having developed the first smallpox vaccine in 1796. The introduction added: "Today, we remain at the cutting edge of prevention. We are already global leaders in scientific advances that could see life-threatening viral outbreaks stopped before they start." Perhaps the politicians may be embarrassed when they read this - it is indeed easier to get into print than it is to get out of it! I scanned the 37-page document and noted only three sentences which might be relevant to prevention in dentistry, a "low sugar diet" (this was in a section on childhood obesity), one mention of dentists (page 16) and one mention of improving dental health in children (page 20). Given that discussion on how to achieve a preventive mindset among clinicians has been taking place for, it seems, decades, it is the ultimate kick in the teeth (pardon the pun) for dentistry and dental health to have such minimal input to this document. Perhaps the reason for this is the uncertainty of who will pay for prevention? This is not only a UK problem, but one which has not been addressed by governments worldwide. The majority remain hooked on the principle of not paying for what they cannot see. And, hence, if prevention works, then the patient and clinician see – nothing! No demineralisation, no cavity, nothing but sound enamel.

At a time when there has been much unresolved head-scratching regarding aerosol production, the alternative approach, already proposed by myself and my co-authors[3], is to utilise procedures which don't involve an aerosol, but the alternative proposal is to concentrate even more on prevention. Have all our patients been taught an effective method of plaque control? I am sure that the patients of BSDHT members have, but what is their compliance with instructions?

Capitation, as a method of payment, works for motivated patients, because some take the preventive message on board because they are, in effect, paying for it. Keeping the patient off the traditional chain of events when restorative treatment is first carried out is important. The dental restoration is a treatment, but unfortunately a preventive session is not seen as treatment by some. It is time for this to change and for the UK Governments to start valuing prevention as a means for stopping the drill philosophy in the long term. In that regard, readers may find the recent Dental Update article by Timms and colleagues on Silver Diamine Fluoride (fast becoming "flavour of the month") of value[4].

The title of this editorial asks an increasingly relevant question. The US version of it is: *"an ounce of prevention is worth a pound of cure"*. Readers will all be aware that it is better to stop something bad from happening than it is to deal with it after it has happened. The paucity of mention for dentistry in the UK GOV document means that it looks like we are on our own in seeking to encourage a preventive mindset in our patients. Therefore, keep up the good work!

Trevor Burke
Emeritus Professor
University of Birmingham
Editorial Director Dental Update

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FROM THE PRESIDENT

As a professional membership organisation, our members are encouraged to participate in the many and varying roles that play such an important part in maintaining momentum within the society. However, earlier this year I realised that you are not always aware of how you can become actively involved in BSDHT.

The roles are often voluntary, so why would a member choose to give up their valuable time?

Well, not only is this an opportunity to give back to an organisation that supports you, and strives for positive change within our profession, it is also an opportunity to learn and develop new skills aside from clinical practice. There is also an element of fun and the chance to form new friendships, working and supporting each other as team - a true sense of camaraderie!

Ambassadors

BSDHT ambassadors are personable and enthusiastic and are tasked with: spreading the word to the wider profession and public about the work BSDHT does; inspiring fellow professional colleagues to become members; introducing dental hygiene and therapy students across the country to the benefits of becoming a BSDHT student member; promoting and encouraging attendance at regional group study days and the annual Oral Health Conference.

Ambassadors serve an initial term of two years and are eligible to re-apply annually. If you are interested in this role then look out for the email invitation inviting you to apply, later this month.

Regional groups

The primary role of the regional group committee is to plan and host their study days. The committees consist of five elected positions: chair; secretary; treasurer; trade liaison officer; and regional group representative on council. To keep regional groups current, some groups have already implemented new roles within their committees of student representative and social media representative. Elections take place at the autumn study day during the Regional Group AGM. Any member can express an interest in standing for a committee position by contacting a member of the current committee.

Regional groups are a really good introduction into how the society works and often a stepping-stone for members aspiring to become involved at national level on council or the executive.

Elected member to council

My first active role with BSDHT was as an elected member to council: I was so proud to be on council and be involved in the discussions which help to shape and direct the society. Elected members are often involved in various current projects and occasionally asked to attend external meetings. Three members are elected to council each year at the BSDHT Annual General Meeting, nominations open in the autumn and all full members are eligible to be nominated.

Working and advisory groups

Working and advisory groups are small groups of members with a special interest or knowledge of specific areas relating to different aspects of the society, our careers and working lives. These groups are an opportunity for wider participation, offering members a chance to make a difference, while developing their own skills and learning new ones. To date we have an Education Group, Diversity, Inclusion and Belonging Advisory Group, Social Media Group and Student Representative Group, with others including a Research Group to follow later in the year.

There are many wonderful examples of ambassadors, who stepped into other roles such as: Jo Downs, Chair of the South East Regional Group, and member of the executive committee; Alison Edisbury, North West Regional Group Representative on Council; Anna Middleton, London Regional Group Acting Treasurer; Nina Lord, Midlands Regional Group Representative on Council; and Vicki Griffiths, North West Regional Group Treasurer.

If you are enthusiastic, have a desire to learn and are feeling inspired then the sky's the limit!

In other news…

Mentorship programme

After a few false starts due to Covid-19, the 20 members taking part in the Coaching and Mentoring Short Course at the University of Kent, is underway. Laura McClune BSDHT Honorary Treasurer and I have been working with a small group of members who are qualified coaches and mentors to set up the mentorship programme. I hope this will become an integral part of the society, offering support and guidance

for members throughout all stages of their careers. There will be much more news about the launch over the summer.

Dental nurse support

One of our elected members to council, Christina Chatfield, has been involved with a dental nurse apprenticeship scheme in her practice. This facilitates a high standard of training for dental nurses, and is also a means of providing chairside dental nurse support for all clinicians working in her practice. However, there is more work to be done, but this could be a potential solution to the ongoing issue of chairside dental nurse support.

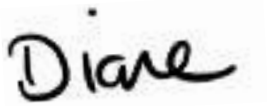
BSDHT student representatives

Claire Bennett, BSDHT Ambassador, and a past student representative on council, has been working hard contacting all the UK dental hygiene and therapy schools to invite a student to become their BSDHT representative. Claire has some big plans to further integrate student members as they are the future of the society and profession.

OHC 2021

The plans for the OHC2021 continue at pace. A big 'thank you' to Miranda Steeples, President Elect, for putting together a fantastic programme - there really is something there for everyone - so make sure you start planning your trip to Glasgow this November. I feel a sense of excitement and positivity that we will hopefully be meeting once again face to face.

Enjoy the summer months and stay safe.



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READERS' FORUM

Do you need support?

These have been, and continue to be, difficult times for the dental profession. Thankfully, our mental health and wellbeing is recognised as being equally important as our physical health and we are all encouraged to talk more.

So how is our physical, emotional, spiritual and mental health. How is our wellbeing? Do we need to talk to someone about how we are feeling, about our concerns and worries? Would it help to talk to another dental professional? In matters of faith and work, would it help to talk to a Christian dental colleague?

There are many good listening and counselling services out there specifically for dental professionals. In addition, the Christian Dental Fellowship has a pastoral care scheme, manned by dental professionals, and whilst we are not a professional counselling and listening service, we are happy to listen to and talk with any member of the dental profession about any matter, and sign post where appropriate to other services. Prayer is optional but we believe a problem or situation shared and prayed for is a powerful thing.

Enquirers do not need to be a member to access the scheme and all enquiries are welcomed, dealt with in confidence and free to all.

The Christian Dental Fellowship is recognised as a faith group in the recently published *Wellbeing Support for the Dental Team* document.

Karen Paterson

CDF Pastoral Care Scheme Coordinator

Christian Dental Fellowship

Enquiries to: christiandentalfellowship@gmail.com

website: cdf-uk.org.

CHRISTIAN DENTAL FELLOWSHIP

A life-saver

I bring to your attention the diligent care and excellent skills of our dental hygienist, Julie Green, in Tavistock, Devon. We wish to praise her!

Some months ago, during a regular check-up, she spotted a small abnormality on the underside of my husband's tongue. He was quickly referred to the hospital by the dental practice for whom she works (Andrew Brown Dental Ltd).

Two operations later and he is making a good recovery from cancer of his tongue.

The surgeon at the hospital was impressed that Julie had spotted the abnormality as it was so difficult to see. It was a great shock to us when it was diagnosed as cancer of the tongue. My husband had no pain, discomfort, or any other indicator that something was badly wrong.

I feel Julie's skills and care may have saved my husband's life. If she had not spotted it, and acted upon it, this probably would have continued to grow unnoticed and turned into something more invasive and life-threatening.

We remain very grateful to Julie, Mr Brown, and all his team.

Perhaps this letter may also help to raise awareness of the benefits of regular dental check-ups and hygienist appointments.

Yours sincerely

Christine and Jim McKay

UNSUBSCRIBED?

You may be missing out on regular updates from BSDHT!

Contact: **enquiries@bsdht.org.uk**

In practice

The president elect, Miranda Steeples, responds to member enquiries sent into head office. Below is a selection of your current hot topics.

At the time of writing, member enquiries are dominated by questions about working within Covid guidelines and the associated standard operating procedures (SOP): at the time of writing (mid-May), there have been no updates. Any updates to SOP will be disseminated to you via email and social media as soon as they become available.

Q: I started a new job and was told I would have dental nurse support, but now it is only to be occasional. What evidence is there to say I need this?

A: At the present time, there is no evidence for this. BSDHT would always advocate dental nurse support to be the norm, but this is not currently the case. If you look on the BSDHT website you will find a copy of our position statement and a risk assessment tool that you can use in the workplace. Last year BSDHT commissioned research into the considerable benefits of full-time nursing support for dental hygienists. This has now been published: Harris M, Eaton K. A survey to establish the extent of dental nurse support for dental hygienists who are members of the British Society of Dental Hygiene and Therapy. *The Annual Clinical Journal of Dental Health* 2021;10:5-10. BSDHT is in ongoing dialogue with the GDC and BDA about this subject.

Q: I have a patient who is having treatment for lung cancer, they take an immunosuppressant, is it ok to treat them?

A: This question and answer could apply to numerous medical problems that patients present with. There are no fixed guidelines about when a patient should, or should not, attend for dental treatment, because every patient needs an individual approach.

In my experience, if a patient's specialist does not want them to attend for dental treatment, they are usually very aware. In the instance you describe, I would contact the patient's consultant directly and ask them how they would like you, the dental hygienist, to proceed. It is clear that in a patient having immunosuppressant therapy you would want to reduce the risks of a bacteraemia occurring, however, it should be noted that they are likely to create this themselves every day while toothbrushing or during eating. It is also clear that if they have lung cancer, then they would benefit from having reduced oral bacteria, and thus a reduced risk of inhaling these bacteria into the lungs.

There is always merit in giving a patient an intense session of oral hygiene instruction and a supragingival scale would still be of benefit in reducing the bacterial load in the mouth and facilitating interdental cleaning. It would also make their mouth feel clean and help them maintain some normality and control in their life.

Q: What would I need to have in place, and what treatment could I provide, if I wanted to offer domiciliary visits?

A: This would depend on what treatment you might be expected to provide, which will be limited unless you have a portable powered unit with suction and handpieces. In the first instance, one would want to be sure that it is safe to be visiting a patient at home and that there was an adequate light source and good ventilation.

You will need to ensure you have the facility to take your clean instruments with you, to dispose of clinical waste, and to take away your used instruments safely. An emergency drugs kit, oxygen and defibrillator are essential so you can respond, as you would in surgery, should a medical emergency arise. You will need to obtain patient consent and to ensure access to clinical notes, diagnoses, treatment plan and charts, medical history, and any available radiographs.

CQC offer this guidance: https://www.cqc.org.uk/guidance-providers/dentists/dental-mythbuster-24-medical-resuscitation-equipment-domiciliary-dental and this is an interesting article https://www.nice.org.uk/sharedlearning/residential-oral-care-sheffield-rocs-domiciliary-dental-care-scheme-to-improve-oral-healthcare-for-patients-in-care-homes

BSDHT

APPEAR ON OUR 'FIND A MEMBER' PAGE

BSDHT would like to offer members of the public the chance to find a DENTAL HYGIENIST or DENTAL THERAPIST in their local area.

For you and your practice to appear on our list, please fill out our permissions form. To obtain your form **please visit: www.bsdht.org.uk/find-a-dental-hygienist-therapist/register**

or scan this quick code with your mobile camera

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References

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LIVING WITH LONG COVID

Alison Chapman

January 2021

Following the Christmas break, I returned to work in January and decided to take a lateral flow test, as a member of my household had been admitted to hospital where a fellow patient was diagnosed Covid-19 positive. Happily, my test result was negative. However, two days later, while at work, I began to feel poorly. A second test once again gave a negative result.

That night I woke feeling more unwell than I had ever felt but was convinced it was not Covid-19, having tested negative twice. I had a temperature but did not have a persistent cough and I was not breathless. The following day, both my husband and my son were also unwell. Nonetheless, I thought we all had a cold virus.

Following the test, I had been reporting daily using the Covid Zoe app and was sent an e-mail asking me to take a PCR (polymerase chain reaction) test. We all went for the test later that day. I was still feeling generally unwell - aching and very tired - and I had a slight cough.

At 7.00am the next morning we all received texts and e-mails to say we were positive for Covid-19. Feeling shocked and worried I contacted my dental practice. They could not have been kinder and more reassuring, telling me to look after myself.

During the first week that followed life was hard. I could not get out of bed, and despite taking paracetamol regularly, I continued feeling very unwell. My whole body ached - muscles, bones and joints and I had severe stomach pains and diarrhoea. I shivered when I moved, had a temperature, mild cough and was slightly breathless. I was unable to concentrate and was not really interested in food. There was also a great concern about how ill any of us might become.

Covid-19 is so new and the way people react is so varied. The statistics were frightening and I was concerned about how it would affect us. Unlike a normal flu virus, the course of the illness differs from day to day. When you have a day feeling better it does not necessarily follow that you will continue to improve. On a good day you learn not to push yourself, as the exhaustion kicks in stopping you getting out of bed for the following few days. There is no definite pattern and with so little information it is trial and error.

March 2021

The majority of those infected recover after about 10 to 14 days, which is what happened to both my husband and son. I was not so lucky. Still exhibiting symptoms, I became much worse about eight weeks after diagnosis. I called 111 for advice and was advised to call an ambulance. I could not believe that after so long I was getting worse not better. My temperature was up and my oxygen levels low. I was back in bed unable to get up. Fortunately, I did not need hospitalisation and another PCR test proved negative.

The symptoms vary from day to day - the most debilitating is the exhaustion and moving becomes so difficult. Each weekend I would be optimistic that I could get back to work. However, the following Monday morning, as I struggled to get up, I would admit defeat. Luckily, I only work part-time and on a number of occasions my colleague has been able to see my patients.

Speaking to a physiotherapist, she stressed I should not consider going back to work until I was able to get up at my normal time. She also advised me to avoid going to sleep until bedtime. At that point, it was taking me several hours to get out of bed in the morning. My body felt like I was moving through thick mud with a heavy weight on my chest and I had to sleep for an hour after breakfast or showering. I limited myself to do one thing each day, be it going for a short walk or putting the washing on, but I was unable to cook a meal.

I am normally a happy positive person but Covid-19 has taken its toll. It is hard to be positive when you cannot see an end to it.

May 2021

I have spoken to my doctor several times and on 22 April 2021 she referred me to a post Covid syndrome clinic set up through Gloucester Hospital. Although I have e-mailed to check, and they have acknowledged receipt of my details, I am still awaiting their support. They have advised me that they are inundated with calls for help. However, they did send the following link: https://www.yourcovidrecovery.nhs.uk

For anyone reading this who is suffering, or knows of someone suffering, there is some useful advice on the site and it has helped me accept my condition.

I have been writing a diary of my activities and symptoms and can see I am improving, albeit very slowly. My practice has been incredibly supportive and we have agreed that I will keep them informed of my progress but not set a date for my return. My colleague works increased hours where she can and they have also had a couple of locum dental hygienists helping out.

Today, I can report some improvement in my symptoms although I still get exhausted easily, become breathless if I move too fast and have regular bouts of gastric pain and diarrhoea. I have tinnitus in my right ear, which gets worse as I tire. Now able to walk to my local shops as well as do some shopping, I can also swim 14 lengths and I have been able to cook a few roast dinners by myself! I still only undertake one major activity each day. I really hope to return to work in the next few months and intend to try an afternoon to begin with. Working in full PPE is exhausting when healthy so I will see how it goes.

Author: Alison has been an active member of BSDHT since qualifying, acting as secretary for the South East and South West and South Wales regional groups as well as being an observing member of council. She was a student supervisor at Bristol Dental Hospital for 10 years, where she also undertook research projects. Running courses teaching oral health education for 12 years Alison is co-author of the book, A Basic Guide to Oral Health Education and Promotion. It has recently had its third edition published by Wiley Blackwell.

Correspondence: alisonchapman@btopenworld.com

STUDENT PERSPECTIVE

TOP TIPS FOR NEW STUDENTS

Sophie Jackson

Last August I was thrilled to finally begin my studies in Oral Health Science at the University of Manchester. However, similar to many other courses, I am yet to enjoy the complete university student experience and remain at home in Surrey, studying remotely. A strange and disappointing reality for a new student!

Semester #1

In the first semester we studied a wide range of subjects including human biology and physiology. The study of anatomy was particularly intense and self-directed, which was to be expected at university level. I very quickly realised that I needed a variety of revision techniques to help me retain all this new information and keep on top of my workload.

Semester #2

At this point in our course, we were delighted to finally be allowed to attend university for clinical skills teaching every Tuesday. I had been desperately looking forward to becoming more hands on and it was so lovely to finally meet the tutors and my university friends in person, for the first time.

Despite the great distance, I decided that I would commute from Surrey to Manchester once a week. I made good use of my time

during this eight-hour commute and studied on the train. This was enormously helpful and ensured that I was on track with my revision timetable.

Motivation

I never put pressure on myself to revise. I have found that by keeping on top of my work, and being organised, is the key to staying motivated. My habit of making 'to do' lists also really helps me. By prioritising my workload, I commit to my studies.

TOP TIP: File and organise your revision from the start so that your notes are in easy reach when it comes to revising. I use a desk expander which I bought online.

The following really work for me:

Taking notes

- I complete any required pre-reading material
- I attend the lecture and make digital notes using my laptop
- I then re-write and expand my notes later that day
- I create flash cards as prompts to aid my learning

Revision techniques

- Flash cards: I use Quizlet
- Handwrite notes using different colours and highlighters
- Youtube is a great resource: short videos help my understanding of many topics
- 'Immersify Dental Education' app is fantastic for learning and testing your knowledge
- A3 Pad: I use this to make colourful posters with diagrammes, which I position randomly around the house during exam season
- Recall method: I write a list of questions and recall the information

Essential revision tips

- Start preparing early to prevent feeling overwhelmed
- Write a list of all topics which have been taught
- Use a timetable for revision
- Set up a tidy study space
- Set aside time for self-care
- Schedule time to do activities and see friends and family
- Take regular breaks
- Try and enjoy the process. You have worked so hard to get where you are!

Good luck to everyone at university, or currently applying. I wish you all the best.

Author: Sophie Jackson is a first year BSc Oral Health Science Student at the University of Manchester.

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DENTAL HEALTH

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The BSDHT Publications Team is responsible for the producing Dental Health, The Annual Clinical Journal of Dental Health and DH Contact online.

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INVITATION TO BECOME BSDHT

COUNCIL OBSERVERS

BSDHT

BSDHT Council would like to invite any interested BSDHT members to apply for the role of council observer.

It has been agreed that the work of the BSDHT Council would be more transparent to members if meetings were open to invited observers.

A number of members of the Society may attend full Council meetings purely as observers. Applicants will be accepted on a first come basis and no expenses will be paid.

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Self-care

looking after ourselves is just as important as looking after our patients

Amber Ojak

The last year has been taxing on all of us. The combination of new guidance, extra PPE, and back logs of patient appointments, means that sometimes remembering to take some time to look after ourselves has taken a back seat.

Many of us have been so focused on getting our patients back on track, we have not given ourselves any time to get back on track too. Taking some time for self-care is a wonderful way to recharge your batteries and press reset.

Self-care is about taking time to work on our own well-being and happiness, especially during times of stress.

Here are a few methods of self-care that we can all tap into:

Take some exercise

It has been proven many times that physical activity improves your body's capability to use oxygen and improve blood flow, as well as increasing the production of endorphins (chemicals that relieve stress). Over lockdown, many of us have exercised more regularly. Personally, I have found that setting a target of 10,000 steps a day is a wonderful way to switch off from the stresses of everyday life. Setting goals or exercise targets may give you the motivation to achieve these in your everyday activities and pose as a distraction, along with boosting the 'happy hormones'.

Time off social media

The use of social media appears to be growing exponentially. I have first-hand experience of how, in the last 12 months, more and more professionals are creating social media profiles and it is all too easy to get caught up in this. Taking time off from social media can really help, and some apps allow you to create a time limit for online activity. Limiting how long you spend on social media gives you more time for other activities.

Beauty routines

Face masks and bubble baths are for everyone! This is a great way to switch off and unwind from your thoughts. There are many different face masks available for all skin types. We all deserve a good pamper with home beauty treatments and due to the increase in mask-acne, it is very important to look after our skin.

Practising mindfulness

Activities such as yoga or meditation can help tap into mindfulness. Mindfulness is all about being in the moment and relaxing with actions such as breathing techniques. Yoga and Pilates can also increase core strength to help with your posture and positioning at work, so benefit the muscles, as well as the mind.

Meeting up with friends

Happily, we can safely meet up with people again. Ensuring that we spend some time with our friends can help remind us we are not alone. Having a cup of tea or coffee and a chat can let us reconnect with people we may not have seen for a long time, and allows us to talk about how we have all been coping. Equally, it is fine if you do not feel ready to meet up with people just yet. We have all processed the last year differently, and we all need to come out of it at our own pace too, and that's okay!

Whatever you do, some self-care will help you meet and manage the challenges that still lie ahead!

Author: Amber is an award-winning dental therapist working in Edinburgh. She qualified in 2018 from the University of Edinburgh. She is a BSDHT Ambassador as well as an elected council member and member of the Scottish regional group. Amber is a keen advocate for oral health and has written multiple articles.

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Foundation training
What's that all about?

Dee Dyer

Dental therapy foundation training (DTFT) had always been a known option for me post university, but I never really knew what this involved or if I was suited to it. My university provided some information and luckily one of the tutors kindly shared her experiences with us. However, as a student, I would have really liked to have heard from someone who was currently experiencing the scheme, and get their perspective.

I would therefore like to share my experience of foundation training so far, in the hope that it helps any students who may be considering this. It is always helpful, I feel, to collate as much information as you can regarding what is involved, if it sounds suitable for you, and what you can possibly get out of it before making the decision.

Covid has affected so many of us in the profession and completing university in the midst of the first lockdown had its challenges. I believe many practices had to opt out of the DTFT schemes which obviously limited the number of student places, making the schemes even more competitive than they already were.

She had me at brownies

I was lucky enough to be accepted onto the North East Scheme, which had always stood out to me because of their additional unique enhanced programme making it a full-time salaried position. Coincidentally, the North East is my home! All trainees received a presentation about the Educational Supervisors (ES), their practices and the particular enhanced programme that was attached. We then had the opportunity to rank our preference. Once again, I was extremely lucky to get my first choice. My ES did mention that she bakes brownies in her 'about me' section so I was pretty much sold after that.

The fundamentals

My working week consists of three days at my primary care practice and two days at my enhanced programme locations within The Newcastle upon Tyne Hospitals NHS Foundation Trust.

My ES, who is based at my primary care practice, has been invaluable to my professional development. Discussions have been held on a regular basis and have addressed my learning needs and lengths of appointments, which have both altered as I have progressed. There has been a real focus on equipping

me with everything I need in order to grow from a 'safe beginner' to an 'independent practitioner' and prepare me for practice before I finish my training.

I have made it a mission to get as much as I possibly can out of this year whilst someone is theoretically holding my hand, and that includes taking any opportunities that arise. For example, within my practice I am taking part in an NHS pilot programme for opportunistic blood pressure readings and atrial fibrillation (AF) detection, in primary dental care settings, for the Office of The Chief Dental Officer for England. The objective of the pilot is a proof of concept for opportunistic case finding for hypertension and AF in NHS, HEE dental training practices. NHS dental teams see 12 million over 40's a year, which creates an amazing opportunity to 'make every contact count' and help reduce cardiovascular disease.

At first I was afraid

The first half of my enhanced programme was located at the Child Dental Health (CDH) department at Newcastle Dental Hospital (NDH). I chose this placement option because frankly I was petrified at the thought of treating paediatric patients! It turns out they are not that scary. I'm a bit of a dab hand at pre formed metal crowns as I placed over 80 whilst I was there, and I survived! I also grasped the opportunity to observe sessions

of inhalation sedation and general anaesthetic. I have also recently just delivered an oral presentation at the Northern British Society of Paediatric Dentistry members' communication evening, an opportunity I sought through CDH. I do hope that by being the first ever dental therapist to work within the CDH department at NDH, and loving it, I have represented the profession well and that many more of my peers will follow.

The second half of my enhanced programme involves working within special care dentistry, where once again I have demonstrated an unfaltering keenness and managed to be involved in student supervision, monthly joint clinics and sedation. I chose this placement as I thoroughly enjoyed my community placement at Aldershot whilst at university. The dental therapist who supervised me was fantastic and highlighted the possibility of a career in special care. Every single day is challenging and allows me to encounter something new.

Study days, assignments and one keen bean

As part of the foundation training there are a certain number of study days that occur throughout the year which cover a mixture of topics. The North East study day programme was heavily front-loaded, with the majority of them happening in the first six months. This was extremely beneficial considering the break between laying down my instruments for the last time at university and picking them back up for the first time in practice. Assignments - if you're anything like me, these were not my favourite nor my strongest part of university - are a mandatory aspect of foundation training, and I have spent many hours on them.

I realised I have been an extra keen bean this year, and the foundation training is fundamentally about supporting newly qualified dental therapists during their transition into the primary dental care workforce, and even without all of the additional opportunities I have experienced, I feel it has accomplished this.

Thank you

I would just like to thank all members of staff within all my placements. I have been welcomed, utilised, guided and supported and consider myself very lucky to have had such a positive start to my career.

Author: Dee Dyer graduated from Portsmouth University in 2020 with a First-Class Honours degree in Dental Hygiene and Dental Therapy. She was a BSDHT Student Representative 2019-2020 and a Student Ambassador for Portsmouth Dental Academy 2017-2020.

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The Annual Clinical Journal of Dental Health 2022

The editor is currently accepting submissions for the next issue of the journal.

For further information, author guidelines or to submit your work please email: editor@bsdht.org.uk

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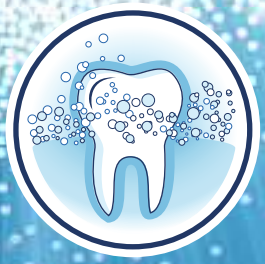

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1. Putt MS, et al. J Clin Dent 2008;19(4):111-9. 2. Thong S, et al. J Clin Dent 2011;22:171-8. 3. Sabharwal A, Scannapieco FA. JADA 2017;148(11 suppl):15-9.
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The BSDHT student representative initiative

Claire Bennett

There are currently 20 dental schools across the United Kingdom providing education and training for a career in dental hygiene or dental therapy. I am constantly amazed by the standard of work, commitment and dedication of talented dental hygiene and dental therapy undergraduate students. You only have to pick up the last edition of *Dental Health* or scan social media to view this generation of students' latest posts, showcasing and embracing the digital social media world.

Supporting students

The BSDHT has been a devoted supporter of undergraduate students within the society. For many years, BSDHT has sponsored a prize for each dental hygiene and therapy school in the United Kingdom to be awarded to their chosen student who they believe has excelled in their studies. Madeleine Pearce won the very first national student of the year award when it was introduced in 2017. Since then, the BSDHT has set up the Student Room: a space just for students on social media to connect and ask questions. It has grown from strength to strength with over 600 students. There are regular Friday quizzes, study tips, motivational posts and revision topics. As you have to be a current student, it feels like a safe space to join in and ask questions.

Many students are now joining the BSDHT, attending regional study days and the annual Oral Health Conference. In 2020, the BSDHT published the *Preparing for Practice Toolkit:* a guide designed to support undergraduate students with a smooth transition into practice. This essential publication is another additional benefit to student membership. You may also be aware that the society has five student ambassadors working alongside some established well-known names in the profession, all promoting the society and encouraging students to get involved.

BSDHT student representatives

I am delighted to announce the formation of a brand-new student committee to represent undergraduate dental hygienists and dental therapists within the society. The first virtual meeting was held in June. There is an exciting year ahead for the first committee, and we cannot wait to share our achievements with you.

It has always intrigued me how unique each dental school's approach is to training the next cohort of students and how we can learn from each other. The BSDHT hopes to continue to build strong links with the dental schools and ensure that we as a society represent the interests of undergraduate members. The society will of course continue to work to influence positive change in the profession and provide information to the public.

Virtual platforms

Last year brought so many changes to how we work and train in dentistry. Access to digital platforms has become easier and this has ensured that we have been able to attend virtual meetings, study days and lectures. With the easing of lockdown and the return of face-to-face meetings, it would be easy to forget the convenience of reaching out and connecting to larger audiences. I for one intend to continue to take full advantage of digital platforms whilst making the most of face-to-face contact. The BSDHT student representatives will be able to access these platforms to hold quarterly meetings at no additional cost to the society.

Student authors

In each edition of *Dental Health*, we aim to bring you articles and content created by students from each dental school. We hope this will interest and inspire every member. The student committee hopes to bring you an insight into the current topics of interest at the undergraduate level, ideas and the latest training initiatives. Writing for *Dental Health*, for many students, is their first writing experience and hopefully not their last!

In the words of Heather Lewis, Editor of *Dental Health*, "We all have a vested interest in the next generation of dental hygienists and therapists – YOU are the future of our amazing BSDHT".

If you would like help or support to contribute to the journals, or submit your final year dissertation for publication, do get in touch with your school's BSDHT student representative or email me at: studentrep@bsdht.org.uk.

Author: Claire graduated in 2021 from Cardiff University. She won National Student of the year 2020 and is the BSDHT student representative co-ordinator.

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TikTok

Harnessing social media as an educational tool

Maya Samuel

If the pandemic has taught this profession anything, it is that social media can have a positive part to play in patient education.

The measures taken to reduce the spread of coronavirus initially hit dentistry hard but, for some out-of-the-box thinkers, from adversity came reinvention!

With practice doors closed in the first three months from March 2020, Maya Samuel was among those inventive dental professionals who plugged the socially distanced gap by going digital with her oral health messages – and, from this, 'thehygenie' was born.

On the Instagram page of her aptly named account, she now regularly shares dental-related TikToks. For the uninitiated, TikTok is a 'short-form, video-sharing app that allows users to create and share 15-second videos on any topic'. And it's proving a huge hit for Maya, whose unique (and humorous) approach is reaching a rapidly growing number of followers.

An ever-evolving profession

Quick to adjust with the times when COVID-19 struck, Maya

moved online so she could continue her oral health education.

She says: 'I set up my Instagram account at the tail-end of lockdown 1.0. I was previously too busy to manage a social media page but I was missing my work life. I wanted to connect with patients beyond my practice and, with so much spare time, there was no better moment.'

Her focus was to educate followers, primarily driven by the plethora of posts by non-dental professionals extolling the virtues of various – and often dangerous – acts of DIY dentistry.

'Scrolling through my feed, very often a "dental trend" popped up – the most shocking was one recommending the use of hydrogen peroxide solution as a mouthwash to whiten teeth. TikTok works via algorithms so some videos have the potential to go viral – sadly, this was one of them,' she says. 'So, I started filming short informative videos in my bedroom. Within weeks, I had a few hundred followers and was overwhelmed at the positive response and feedback I received.'

One year – and more than 2.6k followers later – she could not be more pleased.

She says: 'I wasn't familiar with TikTok to begin with. My sister introduced me to it when I caught her filming dances in her bedroom and I was intrigued. I was getting ready to meet some friends one day and, scrolling aimlessly through TikTok, I came across a funny voiceover and had the bright idea of using it to convey an oral health message.

'To stand out from the masses of dental profiles cropping up daily, I needed to do something different. So, I filmed it, posted it and forgot about it. When I returned a few hours later, it had received more than 1.5k views – and that's when I knew how to capture my audience.'

Her funny videos are sometimes personalised to fit song lyrics, frequently dispel common dental myths and often see her exasperated with her 'patients'.

'Would I react the same way to some of the things my real patients say? No, I would not. There is a time and a place and I believe you need to be careful and considerate with how you portray information when done in a humorous way. I appreciate not everyone will find it funny, but it is a great way to bust those myths, as well as inform and educate.'

'Instagram is a brilliant place to convey key messages,' she adds. 'Particularly when they are repeated by different professionals. I guess we all just hope that by posting enough from multiple sources, it'll eventually stick.'

TikTok has come in for a lot of criticism since its inception, mostly because of its irrelevant content, failure to censor inappropriate posts and often misleading information – especially among younger users. However, it recently reframed itself as a 'home of educational content'. And, whilst Maya agrees it can be a 'wonderful platform to learn from', it does have its limitations.

'Communication skills, compassion and empathy are all key elements of working in dentistry and nothing beats tailored face-to-face care. I believe these traits are what make me a "people person" and enable me to have such good relationships with my patients.

'I consider myself a bit of an extrovert and I love being around people, which is fantastic as I work in multiple practices. As for the nerdy stuff, I may not always explain gum disease on a cellular level to my patients, but at least I know what goes on behind the scenes. The science supporting my explanations makes me feel more confident in the treatment and advice I'm providing.'

As a key opinion leader for Oral-B, Maya also shares videos of their toothbrushes and toothpastes, which has proved an effective way to raise awareness of the products than can help patients maintain their oral health during lockdown.

She says: 'For someone like me who wholeheartedly believes in Oral-B products, and recommends them on a daily basis, the opportunity to work with them is an absolute dream come true. Their toothbrushes produce consistent results and, since advising my patients to make the switch to electric, their hygiene has never been better. Depending on my patients' needs and wants, I recommend anything from the Pro 2000 all the way up to the iO, discussing the different functions available on different brushes and their different heads, as well as the different types of toothpastes (including anti-bacterial and anti-sensitivity ranges). I can tailor the range to each of my patients as they offer solutions for everyone.'

With the growing number of dental professionals reaching out to patients online, thanks partly to the pandemic, companies that collaborate with those who have direct patient contact and an understanding of the science behind their products is a fantastic way of reaching a target audience.

Maya concludes: 'In an online world where there is much misinformation about oral health care, recommendations from a trusted, registered professional places more confidence in a brand from a patient's perspective. I also hope my TikToks go some way to help fight the tide of those incorrect, unsubstantiated and reckless dental posts.'

TikTok top tips

TikTok has exploded in popularity, especially since the first lockdown – so how can dental professionals use the app to educate their patients?

- People want to see movement, colour and noise in short, snappy video clips, which makes key oral health messages easy to digest.
- Video content usually elicits much more engagement than static posts, blocks of text and photos, so get active.
- Often a voiceover or a certain song may "trend" on TikTok. With a bit of creativity, you can match your messages to incorporate the most popular.
- Social media works well alongside the more traditional clinical setting and face-to-face communication, so find the right balance.
- Don't be afraid to put yourself out there. Filming yourself can be a bit daunting but have faith. Ask a colleague or a friend to give you feedback before posting.
- Make sure you're not insensitive to anyone or unprofessional.
- Find some dental TikTok pages for inspiration, get creative and have fun!

Author: Maya practises as a dental therapist across multiple practices in central London and Hertfordshire.

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**Source: A survey of 201 dental hygienists in the UK, Ipsos, (2019).

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The year of pandemic a student's perspective

Umara Javed

From the compulsory use of face masks to meeting loved ones at a distance, the 'new normal' has definitely left its imprint on daily life and the world of dentistry. As we have worked our life around rules and guidelines, the last year has been a particular challenge for students.

Clinics

My first day as a student on clinic last year involved a double cleaning routine for each bay, a constant reminder to COVID screen all patients, and nestling under copious layers of PPE!

With increased difficulties in patients being able to visit a dental hygienist or therapist, and struggling with their dental care during lockdown, there was an even greater importance placed on oral health education. However, reduced patient availability and an increase in cancellations soon became a weekly occurrence.

I was timetabled for three afternoons each week dedicated to practising and perfecting my clinical skills. The dental school was well prepared by ensuring we used this valuable clinical contact time to practise our techniques on the phantom heads when we were not treating patients.

Working with different students had also proved a challenge due to the group 'bubbles' which allowed for greater social distancing. When not treating patients or assisting my fellow students, I worked collaboratively with my peers discussing proposed treatment plans and consolidating our clinical knowledge. For final year students, who have been seriously impacted by the missed clinical experience, their busy schedules have involved Saturday clinics.

Now in my second year, I hope to gain ample clinical hours with each patient I treat enabling me to grow as a clinician ready for the world of work!

Lectures

As a commuter, the daily journey became less of a burden as I was only in the dental school three days a week. Lectures, seminars and tutorials were attended and completed from the comfort of my own home. Many of the lectures were pre-recorded and seminars and tutorials were carried out on Microsoft Teams. This shift in the delivery of content has been advantageous, as it allows for greater flexibility. I find I am less fatigued learning this way with the hours I dedicate to studying more productive.

However, I have struggled with my motivation to continue studying, and found long hours reading on a screen exhausting. I have found it useful to allow myself regular breaks and go for a short walk. It is also helpful just to change my environment: a different room helped me to concentrate for longer periods of time and make online learning more enjoyable. However, the battle with technology is an inevitable one: from Wi-Fi issues to crashing webpages, I can only hope the internet works during the exam period!

Life after the pandemic

As the restrictions begin to ease and we anticipate the return to normal, I hope that the dental school will continue with blended learning.

As we face the these new variants, students can only hope to gain enough experience whilst still indulging in the character building and unforgettable university life.

Author: Umara is a second year DHT student at the University of Leeds.

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Here marks the spot

Mike Wheeler

During 1942 and the dark days of world war two the Royal Air Force (RAF) Medical Training School and Depot moved from Harrogate to Sidmouth on the South Devon Coast. It was housed in a number of buildings in the town, including 'Glenside', which was a hotel. One of its functions was to train "dental clerk orderlies" and new entry dental officers.

At that time, William Kelsey Fry, a distinguished surgeon and pioneering maxilla facial surgeon, was a civilian dental consultant to the RAF. He recommended that in order to help alleviate the large numbers of cases of acute necrotising gingivitis the RAF employ the skills of dental hygienists. He had previously witnessed their important role during many visits he had made to the US. The Air Ministry accepted this recommendation and the first training course for dental clerk orderlies commenced dental hygienist training at Glenside in 1943.

The Blue Plaque

In the mid-nineties the Sid Vale Association, a voluntary conservation charity, was developing its blue plaque scheme. Air Commodore Noel James, Principal Dental Officer Royal Air Force Support Command, had a long association with Sidmouth having lived there as a child. He had visited Glenside on many occasions when the RAF medical school hosted a weekly children's film night. He approached the Sid Vale Association and outlined the important role that Sidmouth played in the development of the dental hygienist profession in the UK.

The Sid Vale Association accepted Air Commodore James recommendation and the role Glenside made is commemorated by the blue plaque. One of 64 in the town and vale. It was unveiled by Group Captain Ian McIntyre (CO RAF Institute of Dental Health and Training) and Flight Lieutenant Carol Brennan (OC Dental Hygienist training) in 1993.

Don’t miss the deadline!

Check now to ensure you will meet the 10 hours over 2 years CPD requirement

All dental hygienists and dental therapists should check now to ensure you are on track to meet the minimum CPD requirements for maintaining GDC registration before the end of the CPD year on 31 July 2021. This includes the need to comply with the 10 hours over two-years rule and making an annual CPD statement.

The Enhanced CPD Scheme requires all dental professionals to complete a minimum of 10 hours of verifiable CPD over each consecutive two-year period, including any two-years that span more than one CPD cycle. This means in one year you could do no CPD activity, but in the following year, you would need to complete 10 hours of CPD to meet the requirements. This rule has been introduced to help ensure CPD is spread out over the full five-year cycle, and is the reason you are asked to make a CPD statement each year at annual renewal time.

You must meet these requirements to maintain your GDC registration. The only exception is those who are new onto the register, so have not yet started a CPD cycle. Please check the number of CPD hours you logged last year on your eGDC account, and the number done so far this year, to ensure you are able to meet the minimum requirements.

If there is shortfall due to COVID-19, please do all that you can to be compliant by the end of the CPD year. However, if this proves not to be possible for reasons related to COVID-19, the GDC will take your exceptional circumstances into account. You might also consider applying for a grace period if you need more time to complete your CPD, but you need to apply for this in writing before the 31 July deadline.

Further guidance on CPD requirements and the rules of the Enhanced CPD scheme are available from the GDC website, which includes tools to help record and submit CPD. For further information or advice on CPD requirements please contact the GDC.

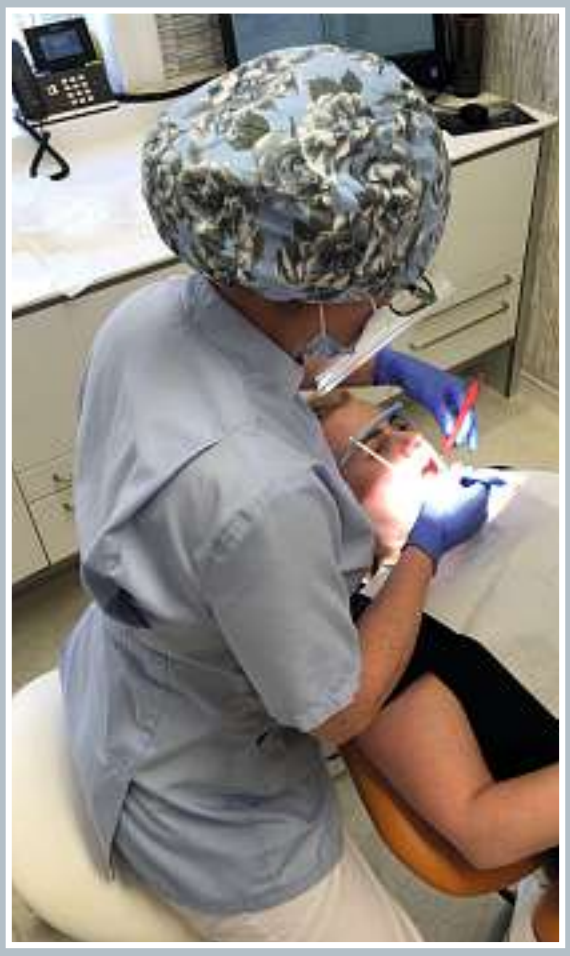
Check Your Posture

Gillian Greenwood

New standard operating procedures for dentistry, in response to the pandemic, have created additional daily pressure for the profession. Do any of the following ring true for you?

- Increase in number of hand scaling procedures to limit AGP
- Patients requiring more treatment and increased number of visits after lockdown
- You find yourself giving emotional support to patients who want to talk about their experience of the last year
- The time-consuming protocols required
- So many more layers of PPE
- More surgery cleaning

The list goes on…!



GOOD POSTURE

Figures 1-3: **Good posture and working with space between the patient and the hygienist**

Figures 4-6: **Bad posture using the legs of the stool to stabilise and leaning in on the headrest for support. They also show leaning in for a better view, hence the need for loupes or an eye test**

It's not surprising that you may find your appointments over running which in turn makes you neglect your posture whilst trying to catch up and get on with your day. My hygienist clients have noticed that when they are running late, they fall back into a default unnatural posture.

How to sit with good alignment on your saddle stool

Does resting your toes on the stool feet sound familiar? When you first sat on the stool you probably put your feet firmly down on the floor. However, in time, you discovered that you could rest your feet on the stool feet. This might seem ok at first, however you will gradually collapse your spine until your shoulders hunch. You will then probably find yourself leaning on the head rest. This in turn will make it harder to hold your instruments, let alone use them effectively.

Check your posture throughout the day

Try doing each exercise separately, then see if you can travel with your mind's eye up and down your body 'ticking all the boxes' as you perfect your position.

Standing

- Bring your weight to your right foot, then to your left foot then find the centre.
- Move your weight forward, as if you are impatient. Move your weight back, as if you were standing at the edge of a cliff. Now move your weight slightly forward, slightly back etc. to find your middle perfect position.
- Really concentrate on feeling all your toes, balls of feet and heels on the floor.
- Take a step forward still leaving the toes of your back foot in contact with the floor. You will need to use your abdominal muscles to keep

you balanced. Now move one or both of your arms slightly forward and notice how you need to use your core muscles to keep you standing in good posture.

- Try performing everyday tasks whilst in this stepping forward position. You can alternate legs after a few minutes.
- Drop your 'tail' towards the floor and gently lift your tummy up and under your 'belt'. This is a very subtle movement.

Standing or seated

- To release your neck, turn your head a centimetre to the right (or left) then back to the centre. Just do this once to one side only to release any tension building up from holding your head still for any length of time.
- You need to connect your upper arms, your triceps, to your mid back. Then lift up through your pelvic floor and tummy - transverse abdominals. You then connect all those areas together i.e. arms into back, back into abdominals and also pelvic floor. This is your 'centre'.
- Send your 'hat' to the ceiling to 'grow' as tall as possible.
- Make space at all of your joints: ankles, knees, hips, vertebral column and neck.

Seated

- Think of your thighs like 'feet' stretching forwards to help release your hip flexors.
- Send your feet down into the floor weight level under them (remembering that resting them on the stool feet is not a good idea.)
- Sit directly on your 'sit bones' the right and left ischial tuberosity.

Exercises to do at home whilst seated or standing

Neck release

- Roll your shoulders all the way up to your ears, all the way forward, downward and backward. Then reverse. Leave them in the relaxed downward position.
- Lift your shoulders up to your ears as high as possible and then let them 'drop' down.

Pelvic floor

Variation 1: Lift the pelvic floor suddenly and hold for a second, then relax.

Variation 2: Lift the pelvic floor gradually as if it's an elevator you are going up in! When you get to the top floor gradually allow the pelvic floor muscles to relax. Gradually let the elevator descend.

Consider getting a sight test

The longer you spend working the more you are using your eyes. This can lead to eye strain. To balance out all the close-up vision, consider looking far away every now and then so that your eyes get to focus on distant objects as well. If you have a window to look out of you can focus your eyes for 30 seconds on a distant tree, for example. As our eyesight deteriorates, we tend to just lean in to get closer to the patient to see. Consider instead investing in loupes or have an eye test regularly so that you can hold your correct posture.

In the March edition of *Dental Health* I explained that we need to address two types of movement to be fit; explosive movements and also the fine accurate movements which are necessary to treat patients' mouths. Our bodies need to be strengthened in order to accomplish these fine movements without hunching (using the neck) and bending over (using the back).

Have another look at my article if you'd like to be reminded about finding the arm and lower trapezius connection, multifidus, pelvic floor and transverse abdominal muscles.

My dental hygienist clients tell me that they really feel the benefit of attending my Pilates and Yoga classes. For more exercises check out my Zoom classes and ebook "Pilates and Lifestyle by Gillian Greenwood" is available from Amazon for the Kindle.

Author: Gillian is a Body Control Pilates® and Yoga teacher with over thirty years teaching experience, gaining her education in Los Angeles, New York and London. She also teaches pre/post-natal exercise, ballet for absolute beginners and stress management, presents workshops, writes articles for health magazines. Over the years her clients have included: Julian Clary, Flora Fraser, film director John Irvin, singer Marcella Detroit, the Princess of the Arab Emirates and the Princess of Thailand. She is an AFAA Associate Consultant and Examiner, (Aerobic Fitness Association of America).

Gillian teaches on Zoom and in person in London: Chelsea, Kensington and Camden.
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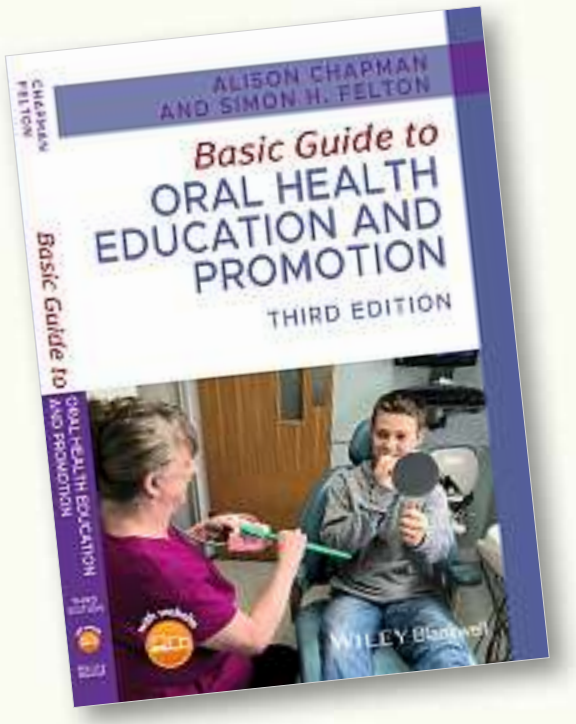
COPY DATES FOR

DENTAL HEALTH

1ST AUGUST FOR THE SEPTEMBER ISSUE

The Editor would appreciate items sent ahead of these dates when possible

Email: editor@bsdht.org.uk



BOOK REVIEW

Reviewed by:
Patricia Macpherson

Title: Basic Guide to Oral Health Education and Promotion (Third Edition)

Author: Alison Chapman RDH, FAETC and Simon H Felton BSc (Hons)

Publisher: Wiley-Blackwell (2021)

Pages: 368

ISBN 978-1-119-59162-7

Price: £39.99

I had the pleasure of reviewing the first edition of a *Basic Guide to Oral Health Education and Promotion* (2009) and I am delighted to review this third edition.

The first edition was written by two experienced dental hygienists and oral health educators: Ann Felton and Alison Chapman. It was edited by Ann's son, Simon. There was an updated edition by Alison and Simon in 2014, who have now revised and authored this third edition, dedicating it to Ann, who sadly passed away in 2007.

This is a well laid out, beautifully illustrated, very informative and comprehensive book, which now has the benefit of a companion website: www.wiley.com/go/felton/oralhealth, where one can test one's knowledge of each chapter through multiple choice questions.

The book comprises six sections, divided into chapters that in turn look at various aspects of oral health. Each chapter has clearly defined learning outcomes and a useful reference section to enable further reading.

Section 1: *Structure and Functions of the Oral Cavity:* the oral cavity in health.

Section 2: *Diseases and Conditions of the Oral Cavity:* plaque, calculus and staining; dental plaque-induced gingivitis; periodontal disease; caries; tooth surface loss and sensitivity; xerostomia; and other diseases and disorders affecting the oral cavity.

Section 3: *Oral Disease Prevention:* nutrition, diet and exercise; sugars in the diet; fluoride; fissure sealants; smoking cessation and substance misuse; antiplaque agents.

Section 4: *Delivering Oral Health Messages:* communication; education and planning sessions; setting up a preventive dental unit; planning an oral hygiene presentation to a group; and practical oral hygiene instruction.

Section 5: *Oral Health Target Groups and Case Studies:* pregnant patients; parents and guardians of pre-11-year-olds; adolescent and orthodontic patients; older patients; at risk and people with special needs; minority cultural and ethnic populations in the UK; other health professionals; planning education case studies, exhibitions, and record of competence.

Section 6: *Oral Health and Society:* sociology; epidemiology; evidence-based prevention; UK dental services; oral health promotion; and dental research.

Although termed a 'basic guide', it is immensely readable, concise and, most importantly, contains updated evidence-based information. With the General Dental Council's requirement for continuing professional development, the dental care professional needs to keep abreast of changes within the profession and dentistry as a whole, whether it is through advances in technology, scientific research, new products or policies.

This book is a useful revision tool that will help to reinforce the information that dental care professionals give to their patients. I would recommend it as a reference book for the whole dental team who wish to educate and promote oral health: dentists; dental hygienists; dental therapists; dental nurses; and oral health educators. This book continues to be a course companion for UK dental nurses, who are studying oral health education and it would be a useful learning tool for dental hygienist/dental therapy students and other professionals such as nurses, health visitors, dieticians, midwives and teachers.

For those of us who knew Ann Felton, it is a fitting legacy that this remains a useful companion book for the next generation.

Alison and Simon deserve recognition for this worthy update in what has been a difficult year.

Enhanced Continual Professional Development: reflection and the reflective practitioner

Fiona Ellwood

ABSTRACT

The process of reflection has widely gained momentum over the years and is often 'associated with higher intellectual skills and a perceived need to raise the profile of the profession…'[1] Notably, it is widely utilised in the healthcare setting, acknowledged as a significant concept and mobilised as a component of professional development[2], connecting knowledge and experiences to bring about new learning. As a profession, dentistry is no exception.[3] When contextualising reflection in this manner, the work of Schön (2009)[4] and earlier authors such as Dewey (1933)[5] are important, as the reflective practitioner is celebrated.

KEY WORDS

Reflection, ECPD, Reflective Practitioner, General Dental Council, Registrants

Context

The General Dental Council (GDC) requires registrants to undertake Enhanced Continual Professional Development (ECPD).[6] As part of this process, there is a need to participate in reflective practice: the registrant morphs into the reflective practitioner. In this context reflection serves to allow professionals to demonstrate progression and the continual meeting of the required professional standards. Whilst serving as a reminder of the regulatory requirements, of equal importance is the need for a deeper understanding of the concept of reflection and reflective practice, giving it a greater sense of purpose and value. Reflection is deemed to be an enabler of greater self-awareness, self-identity and personal growth.[7] It must however be noted that the concept of reflection and reflective practice is not without its critics.[1]

The GDC asserts that '…reflection is an important process … to evaluate the impact of your ECPD activity on meeting your professional needs for maintenance and development'.[6] To consider this further, the GDC makes clear that, 'reflection is an individual process that brings with it different meaning and application to everyone'.[6] Nevertheless, registrants are asked to consider what has been 'learned … and how this will influence daily practice and duties as a guide to reflective practice'.[6] Registrants are however, given an element of autonomy in the way that they reflect, how frequently they reflect and whether reflective practice is an individual activity or undertaken with others. Furthermore, the GDC is not prescriptive about how the reflective activity is recorded, only that it should be recorded as having taken place, on the registrant's ECPD Activity Log. In addition, a commitment statement can be made within the registrant's Personal Development Plan (PDP) as to the frequency of intended reflective practice.

Whilst some registrants may find that a structured and routine approach to the undertaking of reflective practice works best for them, others may not. Registrants may wish to embed reflective practice into a template and, on completing their ECPD Activity Log for a specific learning event, reflect on that event in isolation. Others may decide to reflect quarterly or annually, employing a summary approach to reflective practice. Not reflecting after each learning event requires an element of self-discipline so as not to fall behind. It is, however, important to note that reflective practice if undertaken well can highlight gaps in knowledge, understanding and practice and as a result can mean that an adaptation to the registrant's personal development plan will be necessary to address shortfalls.

Defining reflection and reflective practice

Having considered the regulatory requirements of reflection and reflective practice there is a need to better understand the concepts more widely. In attempting to make clear a sound definition of reflection and reflective practice it is apparent that this is troublesome. Pierson (1998)[8] suggests that there are diverse understandings of the meaning of reflection, but nevertheless it is deemed as an appropriate vehicle for the analysis of practice and the development of critical thinking. To undertake an in-depth exploration of all the different perspectives of reflection is beyond the scope of this paper, but some examples have been shown in the following table to conceptualise some of the varied meanings of reflection.

In essence, reflection is a way to '…make sense of experience, moving on and doing better' (Bulman et al. 2012).[14]

Boyd and Fales	1983	Reflection is the process of creating and clarifying the meaning of experience … in terms of self [9]
Schön	2009	Reflection can help professionals to learn from their experience [4]
Korthagen	1985	Reflection is an inductive approach that rationalises the non-rational aspects of learning [10]
Mantzoukas and Jasper	2004	Reflection is an essential attribute for the development of autonomous, critical, and advanced practitioners [11]
Chong	2009	Reflective practice should be a continuous cycle in which experience and reflection on experiences are inter-related [12]
Donovan	2007	Reflection is a process of deliberative thinking, looking back, examining oneself and one's practice in order to improve future practice [13]
Bulman, Lathlean and Gobbi	2012	Reflection is a professional motivator to "move on and do better within practice" with the goal of learning from experiences and examining oneself [14]
Caldwell and Grobbel	2013	Reflective practice is the ability to examine one's actions and experiences with the outcome of developing their practice and enhancing clinical knowledge [15]

Models, tools and methods

There are several models of reflection which have the potential to aid the reflective process. For the purpose of this paper and the importance placed on reflection and reflective practice within dentistry, the work of Schön (2009)[4], Gibbs (1988)[16] and Johns (1995)[17] are considered to be relevant to the demands of the field.

Schön's work in reflection is perhaps most referred to and relates more to the reflective practitioner rather than the concept of reflection and how professionals think. It is widely applied across the healthcare sector and dentistry and it speaks of reflection in three stages:

1. **Stage 1: Reflection on-action** – re-living the experience, to notice what was going on and to critically analyse what was going on, then create new understanding.
2. **Stage 2: Reflection in-action** – otherwise known as an ability to 'think on one's feet', planning responses and choosing what to do moment by moment.
3. **Stage 3: Reflection for action** – combines insight with intention to apply learning in professional life.[18]

Gibbs' Reflective Cycle[16] (Fig. 2) considers reflection as a systematic cyclical process of six distinct questions, beginning with the description element. The questions are focused on: description; feelings; evaluation; analysis; conclusion; and action plan. For the novice starting out on this reflective journey the Gibbs Reflective Cycle is perhaps a clearer model to refer to and follow. Johns'[17] Model of Structured Reflection (Fig. 3) also takes on a cyclical pattern, beginning with the description element, although it is known for its 'looking in' and 'looking out' approach.

Tools

There are also a number of useful tools to support registrants in undertaking reflection and reflective practice, some of the most common are identified as: reflective journals; diaries and logbooks; lists and tables; audio/visual recordings; thought showers and drawings;[18,19] and story boards.[19] With no hard and fast rules this may well come down to preference and context.

Figures 1: **Schön Reflection-in-Action and Wain Reflection-on-Action**

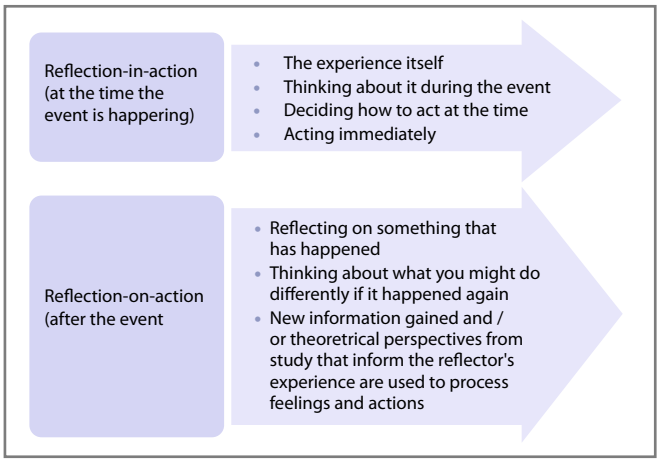


Figure 2: **Gibbs Reflective Cycle**

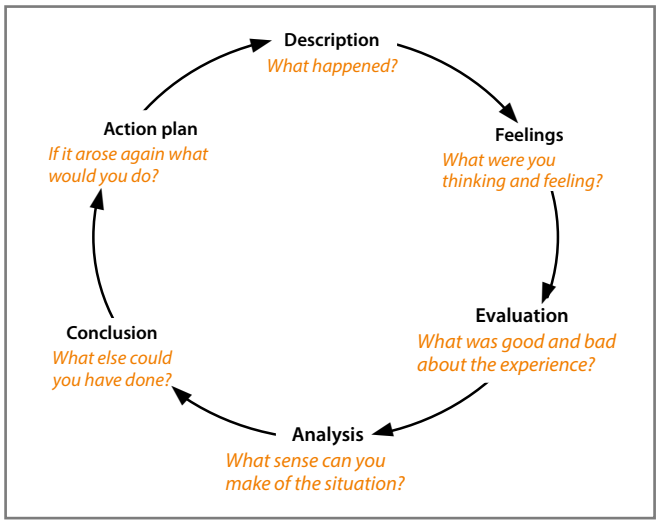
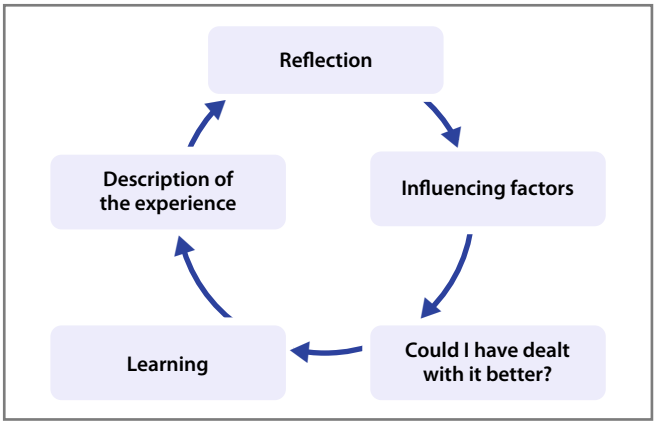


Figure 3: **Johns' Model for Structured Reflection**



Methods

What is apparent is that reflection is an active process, about lessons learned from the past, considering the present and looking to future possibilities and is it is distinctively different to description and descriptive practice. All too often description and descriptive practice is mistakenly presented as reflection.

Of course, occasionally, there is a need to help others as they begin their journey into reflection and reflective practice. Informal and formal reflection both have their places when supporting others; the use of positive questioning, listening, and facilitating will be paramount in helping them to move forward. The introduction of a reflective portfolio or journal will bring a more formal structure to the process and act as a pool of useful insights to draw upon.

Opposing views

It is perhaps at this point worth considering some of the challenges surrounding reflective practice so that the pitfalls are considered when undertaking this activity. Clouder (2000)[1] and Finlay (2008)[20] reiterate opposing views relating to reflection and reflecting practices with a strong focus on how, when, where and why reflection takes place[20] and both refer to intersubjectivity. A further concern is the ability for this to become ritualised without relevance and the striving for improvement; which has the potential to cast feelings of self-disapproval and self-rejection, whilst reinforcing prejudices and bad practice.

Conclusion

In reiterating the position of the dental regulator and the requirements of the registrant, it is clear, that the acts of reflection and reflective practice are central to the profession. Whilst some registrants will be well versed in these skills others are likely to find them daunting. With insight into some of the models, methods and tools it is hoped that those reading this paper will look at both reflection and reflective practice through a different lens and reconsider their personal reflection and reflective practice.[20]

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Implants and peri-implantitis in patients with dementia: what evidence currently exists?

Richard Fitzgerald, Stacey Clough, Latha Davda

AIM

To summarise any available evidence regarding implants and peri-implantitis in patients with dementia.

OBJECTIVE

To complete a rapid review and informal synthesis of existing literature of any type relevant to the above aim.

LEARNING OUTCOMES

Following reading this article the reader should be able to:

1. Describe the current lack of high-quality evidence in this area;
2. List the evidence that does exist in this area;
3. Identify areas where research is needed in the future.

Aligned with GDC development outcomes: C, D

ABSTRACT

There is limited evidence regarding dental implants in patients with dementia. As the population ages, the number of dementia patients requiring implant care and maintenance will present a challenge to the current dental workforce. This narrative review aims to summarise currently available literature of any study design to inform clinical practice in this area, as well as make recommendations for much-needed future research in this area. Articles reviewed: two case reports; two case series; and one cohort study. Relevant reviews and guidance are also discussed.

Learning points include:

- awareness of severe lack of evidence in this area;
- a high rate of complications is found in case reports (but publication bias is likely), and;
- accessible maintenance plans (including both daily and professional hygiene components) and foresight in implant treatment planning are essential to maximise implant success in patients with dementia.

KEY WORDS

Dental implants, dementia, dental hygienist

Introduction

Alzheimer's Society UK describes dementia as: 'a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language.'[1] It is most commonly caused by Alzheimer's disease but can also be caused by other conditions such as cerebrovascular accidents (stroke) or Lewy-body disease. The total number of people with dementia is forecast to rise to over one million by 2025 and over two million by 2051.[2]

An estimated 130,000 dental implants are placed every year in the UK.[3] Implants can be used as a replacement for single or multiple missing teeth and are being increasingly offered as a treatment option. Excellent rates of long-term success are achievable, and two-implant supported overdentures are seen as the first-choice treatment option for edentulous mandibles, since the York consensus statement.[4] However, like teeth, implants need long term maintenance that includes meticulous oral hygiene. If they are not reviewed regularly, or maintained with personal and professional hygiene interventions, complications such as mucositis and peri-implantitis may lead to implant failure.

Extrapolating from the above, the prevalence of patients with both dementia and dental implants is likely to increase. However, the maintenance of oral health and continuing dental care of patients with dementia presents challenges. Patients with advanced dementia will need support with daily oral hygiene, may be unable to self-report oral problems, and cooperation with dental examination and treatment could be reduced. Maintaining complex prosthodontic treatments such as implants may prove challenging indeed.

This narrative review aims to informally summarise existing literature to inform current clinical practice as much as possible, to make recommendations for future research, and to highlight the role of dental therapists and dental hygienists in the care of these patients and future research in this area.

Table 1: **Literature search strategy – search words, inclusion and exclusion criteria**

Literature search strategy	
1	Dement* or alzheim* or cognitive declin* or cognitive impair* (all fields)
2	Dent* or mouth or oral* or alveol* (all fields)
3	Implant* or per implant* or per-implant* or periimplant* or perimplant* (all fields)
4	1 and 2 and 3

Inclusion criteria:

- Population: patients with any type dementia
- Intervention: dental implants
- Control: any or nil
- Outcome: any
- Study design: any

Exclusion criteria:

- Not in English language
- Not accessible by any of the 3 authors (no contact made to original authors)

- Two independent reviewers
- Reference lists of included papers were manually searched for other relevant papers
- Databases: Ovid MEDLINE(R), Cochrane library, Web of Knowledge, references lists of included papers were also searched
- No grey literature search
- No formal quality assessment (case-report/series level evidence anticipated)
- Informal thematic analysis

Methods and study design

This study was of a narrative review design selected due to existence of relatively recent high-quality systematic reviews looking at success rates of implants in patients with dementia.[5,6] These reviews found no studies regarding implants in dementia patients but did not include all study design types such as case reports or series. Case reports and series are ranked as low-level evidence for reasons including a high risk of bias and low case numbers. However, when no other higher-level evidence exists, they can provide guidance and insights with an appropriate level of caution. Summarising this evidence can also provide valuable suggestions for future research of higher study designs.

This review selected a narrative design to summarise any available literature, including case reports and series, while acknowledging the weaknesses that accompany these evidence types. Although a narrative review, a comprehensive search strategy was employed as illustrated in Table 1, to allow for as much reproducibility and transparency as possible.

Results

The search strategy highlighted 238 papers. After removing duplicates and applying inclusion/exclusion criteria as above, 10 papers were selected. These consisted of two systematic reviews that found no studies[5,6], a systematic review that included two case reports regarding dementia[7], one commentary[8], one survey of care homes[9], and five case reports/series.[10-14] (A list of excluded papers is available on request.)

Lack of evidence regarding implants in patients with dementia

Several reviews exist that demonstrate a dearth of high-quality evidence examining implants in patients with dementia[6,7,15], including a high-quality systematic review in 2018[5] which found no studies examining implant survival in dementia patients.

There is more literature examining implant survival in the geriatric patient (including or excluding dementia) but several authors comment that evidence here is similarly lacking.[15-18] A full review of implants in geriatric patients without dementia is beyond the scope of this review, but of note is that a high-quality systematic review and meta-analysis found a 10-year implant survival rate of 91.2% with a low rate of complications, although this was based on case-series-level evidence.[16]

Summary of low-level evidence regarding implants in patients with dementia

Regarding empirical studies: two case reports[10,13], two case series[11,14], and one cohort study[12] were found. Adverse outcomes and challenges with maintenance are frequently reported in these studies.[7,8,10-12,14] Treatment of implant complications (peri-implantitis, implant fracture[14] etc.) ranged from professional oral healthcare scaling, to burying the implants, to surgical removal of the implants under general anaesthetic.[7,10,14] The benefits of implants in the older population are reported as increased oral health, boosting self-esteem, and aiding nutrition.[14]

The rate of success/failure/complications of implants in patients with dementia would be of benefit to patients and clinicians alike, but no studies found by this review reported such a rate. One study did find that 17 of 725 older persons newly admitted to a nursing home in the Netherlands had implants, and that the rate of complications was high (see below).[12] Readers should bear in mind that although almost all cases reported adverse outcomes, there is a high likelihood of publication bias where successful, complication-free implants in patients with dementia are not being reported.

A maintenance plan for daily and professional healthcare was frequently highlighted as crucial to avoid complications in those individuals with dementia.[11,17-19] Foresight or consideration regarding potential advancement in dementia/frailty, in implant treatment planning was a common solution to avoiding complications.[8,11,17,19] An interesting finding, from a survey study[9] and a narrative review,[18] was that care home staff had little to no knowledge regarding implants and their upkeep.

Case reports in detail

A Dutch study examined a mixed population of older persons (725 patients: 479 with dementia, 246 without) and found that reliable probing of peri-implant tissues was not possible.[12] No

dentate patient had implants but 17 edentulous patients had implants with the aim of retaining a lower denture – however, only three were wearing their prosthesis regularly. The authors describe these 17 patients: six were non-cooperative for exam; five had unsatisfactory oral hygiene; and two had insufficient fit of prosthesis. Of five patients who did not wear their mandibular denture, two had their superstructures removed due to causing mucosal trauma.[11]

An issue highlighted by the authors is that several different brands and superstructures were used, while concurrently their previous dentists could not be identified. This creates a large potential problem if interventive treatment such as deconstructing the implant is planned.

Laidlaw (2010) reports a case of maintenance of a three-implant-retained mandibular denture in an 89-year-old woman, where the implants were placed when she was 67 years old.[10] The patient had been attending a dental hospital for quarterly hygienist visits but due to advancing dementia, could no longer attend. The use of implant-compatible hand scalers by a community dental hygienist on a domiciliary basis was implemented. Of note, is that contemporary implant design favours endosseous implants where the implant itself is not above bone level (unless bone loss has occurred, but even in this scenario, it will be difficult to clean in deep pockets with any form of scaler). The dental hygienist also provided training to the care home staff on oral implant hygiene. The author reports insufficient guidance on the maintenance of implants in this population.

Visser et al. (2011) report two cases of implant-maintenance for the dementia patient.[11] In the first, an 86-year-old female with advanced dementia is described with two lower ball-attachment implants. She did not wear her prosthesis and the care home staff were unaware that the implants were present which resulted in repeated trauma to the patient's labial mucosa. The ball attachment of the implant was replaced by cover screws which led to gingival overgrowth and burying of the implants to prevent further trauma. In the second case, an 85-year-old female with dementia had her complete, implant-retained mandibular denture mistaken for her natural dentition by care home staff. This led to no oral hygiene of the implants and subsequent peri-implantitis. The implants were removed under general anaesthetic – quite an invasive procedure in an older individual where healing will be prolonged and where general anaesthetic carries a significant risk of accelerating the advancement of her dementia.

An article exploring oral health in dementia[14] describes two relevant cases. A case of an 86-year-old man with dementia who had a four-implant-retained lower fixed bridge that had received no professional maintenance for six years, resulted in a "compacted bolus of debris" which caused facial swelling and lymphadenopathy. This bolus was removed under sedation which led to the resolution of symptoms. A second case of an 86-year-old female with dementia with an unspecified fixed maxillary reconstruction was suffering from peri-implantitis due a broken screw. No interventional treatment was possible due to her dementia. The article reports her care home happened to have a resident dental hygienist who maintained oral hygiene in the area, weekly.

Another case report from the USA[13] describes the placement of two mandibular implants to retain a mandibular complete denture in a 73-year-old with mild dementia. The implants were placed immediately following extraction of her natural dentition which had a poor prognosis. The rationale for implant placement is discussed and included consideration of advancing dementia and future maintenance, ease of insertion of removable prosthesis, and also the difficulty with uncertainty over a patient's medical prognosis.

Discussion

It is clear from both this and other reviews that there is severely limited evidence surrounding the topic of implants in patients with dementia. Yet, in juxtaposition are the reports that implant complications *do* happen for these patients and that treatment of these complications can be invasive, or even impossible if dementia is advanced. Are we, as the dental profession, forgetting about our patients' needs once they become challenging; at a time when oral health-related quality of life is more important than ever due to the importance of nutrition and self-esteem? Addressing this issue will only become more pressing as the use of implants, the proportion of the population in old-age, and the rates of dementia continue to increase.[2,3,20]

The little evidence that does exist is ranked at a low level, and although does allow for shared learning, does not establish how large the problem is in terms of how many patients with dementia have implants, and how many have complications. So, what can clinicians do to care for implants in these cohorts while awaiting further research?

Firstly, it is clear that planning for frailty/advancement in dementia and a tailored oral healthcare maintenance plan are crucial given the lack of knowledge and skills of care home staff in this area.[9] Patients and clinicians must be fully aware that implants are not "fit and forget" and that long-term maintenance is critical to success. This should include details and advice regarding daily cleaning of implants and prosthesis, regular professional hygiene visits, a plan for how to treat complications, and a description of what brand implant/superstructure was used.

Secondly, the dentition and implants should be prepared for advancement of the patient's dementia. The superstructure used to help the patient retain their denture, may lead to mucosal trauma when the patient can no longer cope with inserting their denture. However, making this decision is challenging indeed: attaching healing abutments and burying the implants too early may result in a decrease in oral function; too late and it may not be possible without general anaesthetic and associated risks of advancement of dementia.

This very problem is discussed in the International Team for Implantology (ITI) treatment guide.[19] It argues that implants can be of benefit to these patients, but that special considerations are needed for both the placement and maintenance of implants, including planning for deterioration in the patient's condition.[19] It states that custom maintenance plans are needed that involve both patient and caregivers. It also gives advice that implants should '…be put to sleep in good time' by connecting gingiva-level healing abutments before cognitive decline.[19] Given the case reports and articles explored in this review, it raises a question as to whether or not this advice is being followed.

Research in this area is desperately needed before these clinical scenarios become more common. Dental hygienists and therapists are ideally situated to provide care for this group and were involved in the above treatment or maintenance care.[9-11,14,21] This is no surprise. As daily and professional oral hygiene becomes more complex with advancing dementia, dental hygienists' expertise is of more value than ever. Dental hygienists and therapists could become leaders in research in this area and ensure that implant patients with dementia enjoy good oral health when they need it most.

Specific relevant areas of research recommended by the authors are:

- Prevalence of implants in patients with dementia (both in and out of care homes)
- Rate of inclusion of implant maintenance in care home oral care plans
- Knowledge of implant maintenance in patients and their carers
- Effectiveness of educational programmes to increase awareness of implant maintenance for patients and carers

Conclusion

Research examining implant care in patients with dementia is pressingly needed. It is unknown what proportion of dementia patients have implants and the likely clinical outcomes for these patients and their implants. Forward planning and long-term maintenance plans are critical to reducing complications.

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Table 2: **Summary of cases in included papers.**

Title (Year)	Authors	Demographic of patients with implants and dementia
The impact of dementia on the care of dental implants: a case report (2010)[10]	Laidlaw, LA	• 89-year-old female with dementia • Three implants with superstructure to retain lower complete denture • Could cope with examination and treatment, but lacked capacity to consent
Treatment planning considerations in older adults (2014)[13]	Oong, EM An, GK	• 73-year-old female with dementia • Could cope with examination and treatment
Oral implants in dependent elderly persons: blessing or burden? (2009)[11]	Visser, A de Baat, C Hoeksema, AR Vissink, A	• Two cases • First case ◆ 86-year-old female with dementia ◆ Two implants lower arch, denture not worn ◆ Implants causing trauma to labial mucosa ◆ Lacking capacity and non-verbal • Second case ◆ 85-year-old female with dementia ◆ Four implant-supported superstructure to retain lower denture ◆ Dentures mistaken for natural teeth by caregivers, plaque and calculus causing peri-implantitis
Ageing, dementia and oral health (2015)[14]	Foltyn, P	• Two cases • First case ◆ 86-year-old female with dementia ◆ Four-implant-supported fixed 12-unit bridge ◆ Could not tolerate examination. Had examination and radiographs under sedation • Second case: ◆ 86-year-old female with dementia ◆ Perimplantitis surrounding a fractured implant screw ◆ Immobile
Oral health status and need for oral care of care-dependent indwelling elderly: from admission to death (2016)[12]	Hoeksema, AR Peters, LL Raghoebar, GM Meijer, HJA Vissink, A Visser, A	• 725 patients, of which 479 had dementia • 17 had dental implants, all edentulous ◆ Not reported how many with dementia ◆ 6/17 not co-operative ◆ 5/17 unsatisfactory oral hygiene ◆ 13/17 had two implants, 4/17 had four implants ◆ 3/17 wearing prosthesis ◆ 2/17 insufficient fit of prosthesis

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The role of dental hygienists and therapists in UK hospitals: results of a pilot study

Lucy A Baker and Shihab A Romeed

ABSTRACT

Aim
This article aims to raise awareness of the role of a dental hygienist or a dental therapist in the head and neck oncology multidisciplinary team in UK hospitals.

Methods
Utilising SurveyMonkey®, an online questionnaire was designed to gather information and qualitative data on the roles of dental hygienists and therapists in teaching and general district hospitals in the United Kingdom. It was posted on dental hygienist and therapist social media platforms on 20 April 2020 during the first national lockdown. It was active for four weeks.

Results
Twenty-one dental hygienists and therapists currently working in a hospital setting completed the online questionnaire. Of these, 12 reported full use of their scope of practice and 9 reported that their hospital colleagues did not fully understand their scope of practice and often had a misconception regarding their clinical abilities.

Conclusion
Dental hygienists and therapists working in a hospital setting are beneficial to the entire multi-disciplinary team. This group of dental clinicians contribute to patients' wellbeing and quality of life. A national study is now planned with questionnaires distributed to all UK maxillofacial units to collect current data regarding the numbers of dental hygienists and therapists employed in hospitals and to gain a fuller understanding of their roles and utilisation of their scope of practice.

KEY WORDS

Dental hygienist, dental therapist, hospital setting, multi-disciplinary team, periodontology

Introduction

The value of effective oral health care and its potential impact on a patient's quality of life (QoL) has been recognised.[1,2] Cooperation between dental clinicians and other health care professionals, to work in the best interests of patients, has been encouraged by the General Dental Council (GDC).[3]

Presently, the majority of the dental hygienists and therapists (DH and DT) work within the private primary dental care sector. The remainder are employed within community and hospital settings. In March 2020, 3665 dental therapists and 7627 dental hygienists were registered with the General Dental Council.[4] However, little data exists on the roles of DH and DT in areas other than private practice within the UK. Many countries, including the United Kingdom, have employed dental hygienists within secondary care for many years. [5]

Methods

An online SurveyMonkey® questionnaire was posted on several social media DH and DT groups on 20 April 2020. It was active for four weeks. The majority of participants replied on the 21st and 22nd April with a remaining few on the 27th. No more information was collected after the 27th April. The national lockdown, during the Covid-19 pandemic, was deemed a good opportunity to obtain a pilot data set about the roles of DH and DT in hospitals, while considering the need for anonymity and General Data Protection Regulations (GPDR). A combination of multiple-choice and open-ended questions was employed. This questionnaire was designed to gather and explore data, in a cross-sectional survey to identify: the approximate number of DH and DT currently employed in a hospital environment; their experience level; groups of patients treated; and perceived challenges within their roles.

Results

The number of DH and DT currently employed in all UK hospitals is currently unknown. Twenty-one DH and DT completed the questionnaire, of these respondents, five (24%) were registered as dental hygienists and 16 (76%) as dental therapists (Fig. 1). The respondents were located across different

regions of the UK: the majority worked in Greater London and in the North West of England, where more teaching and general hospitals are located (Fig. 2).

Contracted hours varied with eight (39%) respondents employed for five days a week, while the remaining 13 split their working hours between the hospital and the private sector in general practice (Fig. 3).

The majority (15; (73%)) of respondents had worked in the hospital setting for more than one year and in some cases for as long as 25 years (Fig. 4).

Considering the complexity of patient care, only 14 (67%) respondents reported working with full time assistance from a dental nurse. Five respondents were provided with occasional support and two received no assistance (Fig. 5).

Figure 1: **Registered role**

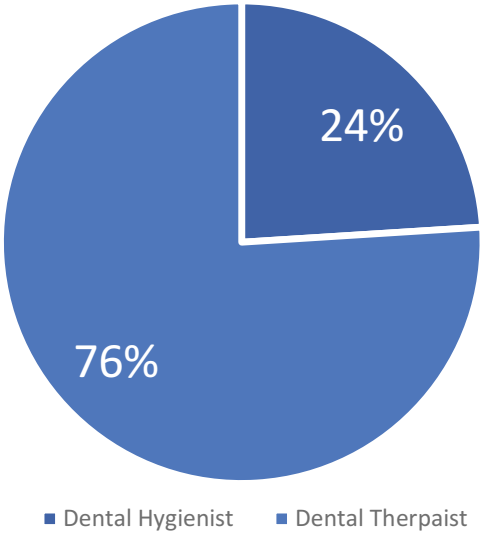


Figure 5: **Dental nurse support**

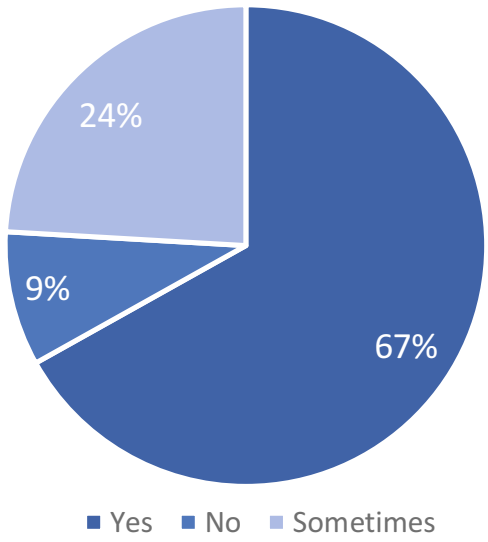


Figure 2: **Regional location**

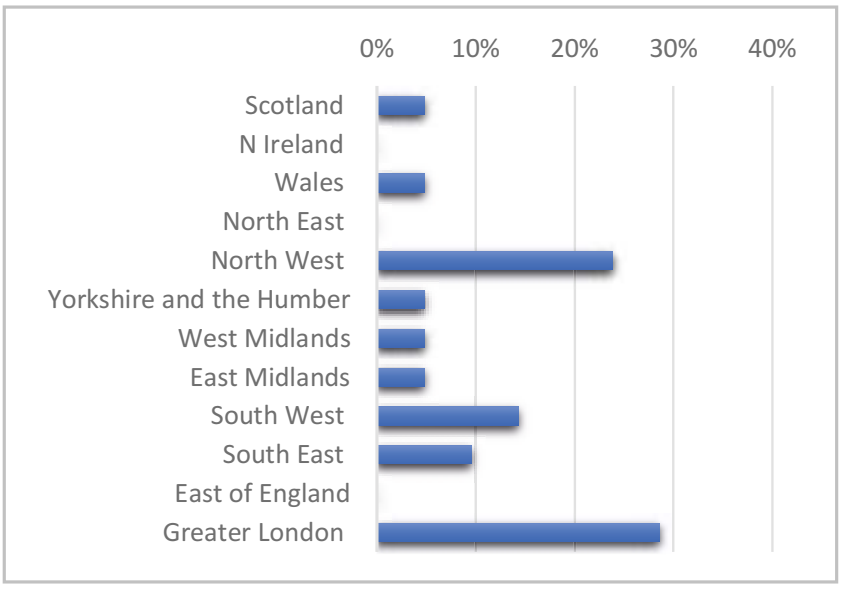


Figure 3: **Contracted days per week in hospital setting**

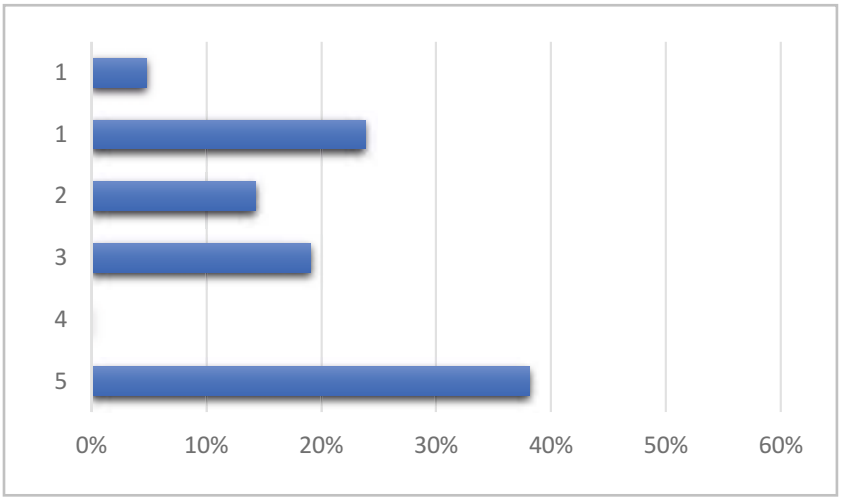
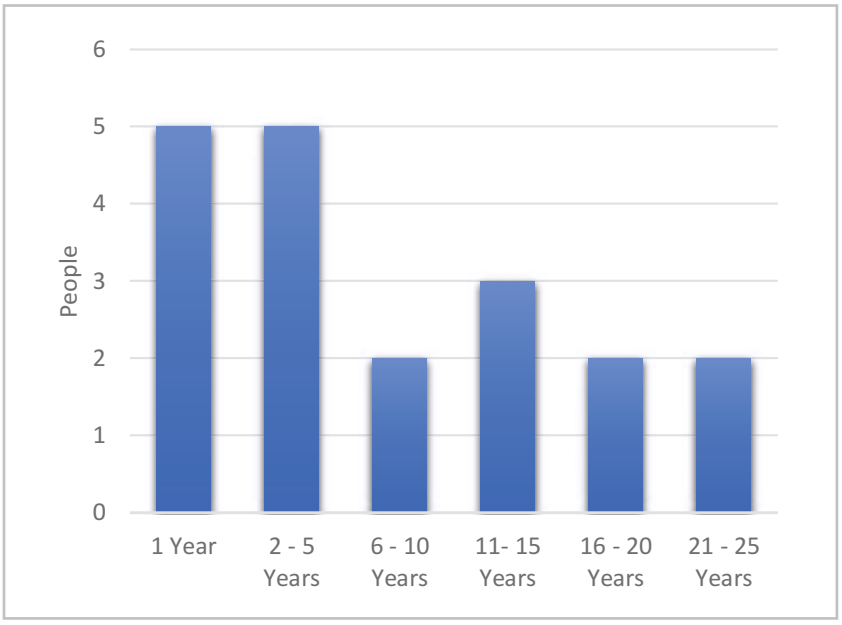


Figure 4: **Number of years working in hospital setting**



Just over half of the respondents (12; (57%)) reported using their full scope of practice. Those participants, who did not use their full scope of practice (9; (43%)) reported they are not utilised as a dental therapist (Fig. 6).

An open-ended question was used to collect qualitative data exploring the challenges DH and DT faced in this setting: five (26%) reported other hospital staff do not fully understand their scope of practice; two reported high numbers of patients requiring periodontal treatment which, in some cases, could be treated in primary care. The inconsistency of dental nurse support was also reported.

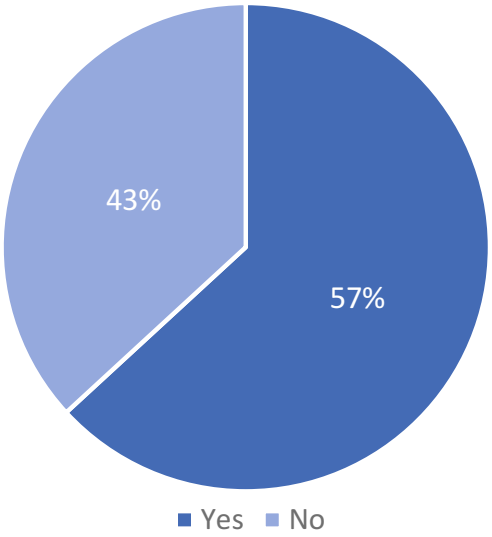
The responding DH and DT treated a variety of patient groups including a high percentage of periodontal disease and head and neck cancer patients (HANC) (Fig. 7).

Discussion

Maxillofacial surgery, orthodontics and restorative dentistry services accept patient referrals from general medical and dental practitioners and consultants or other specialties. An audit carried out at Queen Alexandra Hospital in Portsmouth looking at the external referral numbers to the restorative specialist in 2017, found that over a period of two years 673 new patients were examined with 68% treated and 32% referred back to primary care. Changes in dental epidemiology and an ageing population have caused an exponential increase in referral rates.[6]

The role of DH and DT in hospitals is predominantly based at out-patient services. A variety of diverse and complex cases are referred to DH and DT as they are considered a valuable resource for supportive care.[1,5]

Figure 6: **Number of DH and DT using full scope of practice**



The role of the dental hygienist and therapist

Multidisciplinary team (MDT)

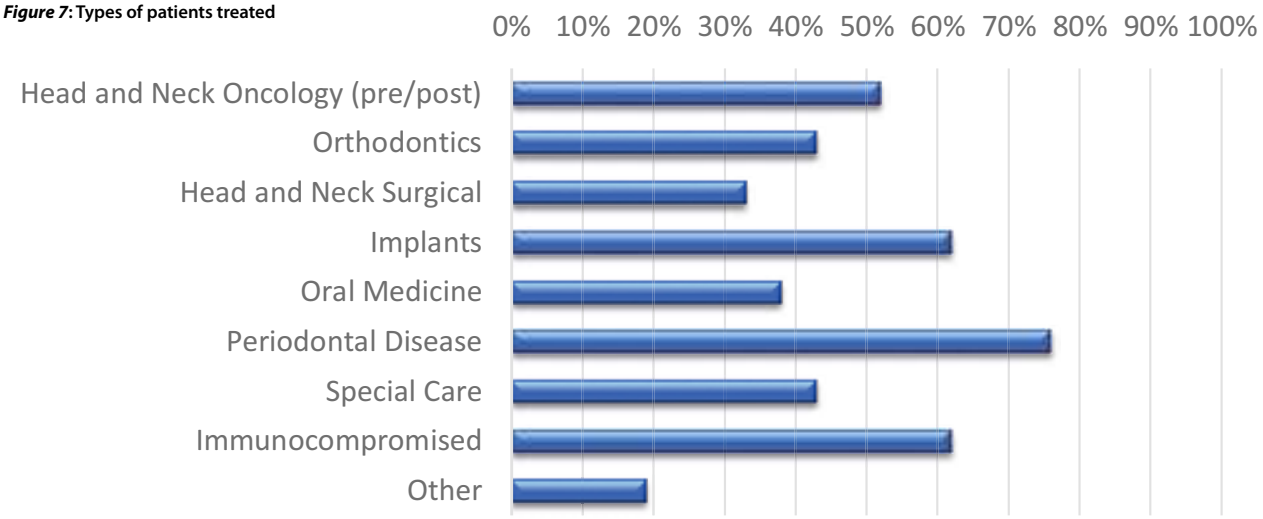
The role of the DH and DT involves effective communication with other healthcare professionals.[1,3,5] Most teaching and general hospitals provide MDT cancer services. The HANC MDT team consists of: oral and maxillofacial surgeons (OMFS); ear nose and throat surgeons (ENT); restorative consultants; clinical oncologists; radiologists; dieticians; speech and language therapists; histopathologists; clinical psychologists; and cancer nurse specialists (CNSs). Jhul (2016)[5] found the following patient groups are cared for by DH and DT: oncology; developmentally impaired; and medically compromised patients.

The complexity of treatment may vary within the hospital setting, with multi-phased treatment plans produced between clinicians, often integrating a specialist restorative input within other services.[7] Many of these patients are referred to DH and DT for:

- Oral hygiene advice and supportive care for high-risk groups
- Smoking, diet, and behavioural input especially in high-risk group patients
- The management of periodontal disease in terms of stabilisation and initial treatment

Some patient groups are at an increased risk of developing oral health disease due to either one or a combination of medical, cognitive, or physical disabilities.[2] Craniofacial abnormalities are often treated and managed within an MDT due to their inherent complexities.[8]

Figure 7: **Types of patients treated**



In the UK there are approximately 12,200 new cases of HANC a year and it is the 8th most common cancer, accounting for 3% of all new cancer cases.[9]

The restorative and oral surgery teams complete a thorough dental assessment identifying all treatment needs prior to commencing treatment, particularly radiotherapy. A treatment plan is formulated which may include dental extractions. A referral to the DH and DT is completed prior to radiotherapy.

Oral hygiene (OH) instructions are provided with reinforcement of the importance of effective OH and fluoride therapy. Any required restorative and initial periodontal stabilisation is completed. This can be achieved over a few appointments prior to treatment. This also provides an opportunity to review healing extraction sites prior to radiotherapy. Alani and Bishop (2012)[8] discuss the increased pressure on primary and secondary care services to ensure the patient is dentally fit before treatment.

Table 1: **Planned treatment sessions with DH or DT**

Prior to radiotherapy (RT) or chemotherapy (CRT)	On referral
Pre-dental extractions at least two weeks prior	1. OHI, diet, initial supra and sub gingival debridement 2. Apply Duraphat Fluoride Varnish as prescribed and check prescription for Duraphat toothpaste 5000ppm 3. Short and long-term effects of radiotherapy/chemotherapy on the oral cavity are discussed 4. Decide on the teeth which require extraction by senior colleague 5. Complete/plan any prescribed restorations
Post dental extractions if required, prior to the start of CRT	1. Review OH, supportive care 2. Second debridement if required 3. Review extraction sockets and check with senior colleague if there are any concerns 4. Complete outstanding restorations
During treatment	Supportive care and oral care advice if patients requires
After treatment 12-16 weeks post completion	1. OHI, supportive care, diet advice 2. Assess xerostomia, advise, and offer salvia substitutes 3. Discuss how patient is managing in general and liaise with dietician/CNS/oncologist if extra support needed 4. Discharge back to primary care if patient happy and OH good Letter of communication to GDPs/GMPs. If extra support required with OH, or signs of radiotherapy caries, regular monitoring is arranged 5. Post-surgical rehabilitation by the restorative team

In HANC patients, quality time is spent with the patients on a regular basis particularly during the maintenance phase. This allows for a thorough assessment at each visit, providing the opportunity to reinforce preventative care and recognise and observe any aspects of the patient's medical, dental and oral health that may require reviewing by the restorative team or other members of the MDT team.[10] Treatment may need to be staged and supported with appropriate timed sessions ensuring this process is manageable by patients.[11] The hospital is the ideal setting for this phased approach.

Osteoradionecrosis of the jaw (ORNJ)

During this maintenance period extraction sites can be regularly monitored for any early detection of bony exposure. ORNJ is not uncommon and a serious side effect of radiotherapy which may cause changes in the bone, such as reduction of blood flow which may lead to necrosis of the bone. The patients are advised to maintain the area of exposed bone with effective local OH measures using a single tufted brush to prevent colonisation of bacteria. They are then referred to the restorative/OMFS team for further management.

Surgical

Following treatment for mouth cancer, complete rehabilitation of all oral functions is preferable but challenging to accomplish in some patients. Surgical intervention may alter the anatomy of the oral cavity, resulting in deformities affecting aesthetics and oral functions. Resection of the mandible or maxilla may impair speech, mastication, and swallowing.[12]

Rehabilitation may involve removable protheses such as dentures, obturators or implant-supported prostheses, which can also impact adversely on psychological wellbeing and quality of life. The DH or DT can offer support and advice on adapting to the new appliance, whilst providing guidance on maintenance and oral hygiene. Prevention of dental disease is an important factor when implants or natural teeth are present.

A free flap can add soft tissue volume which may reduce the mobility of the tongue, impairing mastication and swallowing (Fig. 8).[12] The tongue's reduced dexterity affects the cleansing action resulting in an increased build-up of plaque biofilm and food debris, therefore adaption of OH techniques may be required.

Dysphagia

One of the side effects of radiotherapy is dysphagia. Dysphagia affects eating, hydration, and the increased risk of aspiration pneumonia. Some patients may have had a laryngectomy or tracheostomy. Careful planning and comprehensive risk assessments are required during the session to ensure the

patient's comfort and safety. Many individuals will prefer to be treated in an upright position with regular breaks to swallow and to feel more in control. This can make access more challenging for the DH or DT.[13] A high-volume aspirator is required and the appropriate equipment available in case of a medical emergency, including surgical suction and oxygen with an appropriate pocket mask.

Implants

There has been an increase in implant-based treatment in secondary care settings. Many of these cases are complex involving rehabilitation following HANC surgery, hypodontia, orofacial trauma, cleft palate, and peri-implant disease.[14] Specific referrals to restorative dentistry may present with a variety of issues and complications.[15] DH and DT have an important role in supporting the restorative consultant with such cases (Figs 9,10).

Immunocompromised

The dental team is a vital component of the wider MDT contributing towards optimal care for this cohort of patients, who are at higher risk of infections and other complications. [11,16]

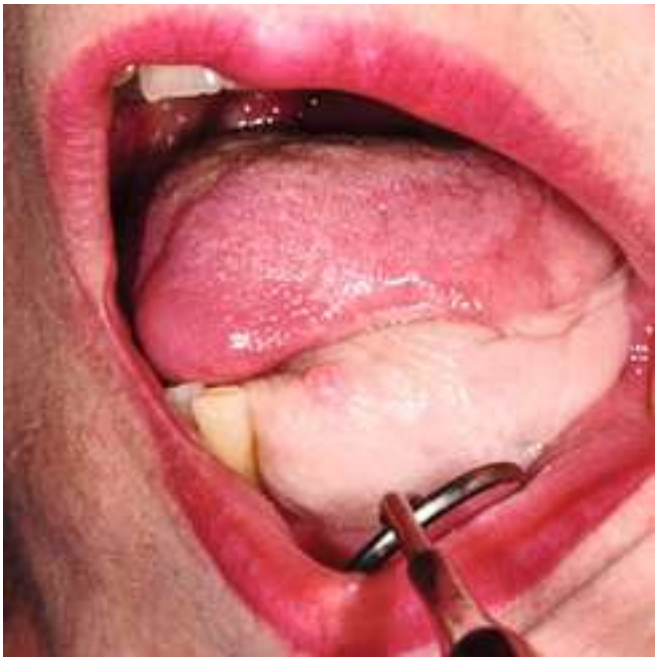


Figure 8: **Partial glossestomy or free flap**

Figure 9: **Peri-implantitis around existing implants**

Patient education is key to prevent dental caries and infection, which may result in extractions. The DH and DT support and reinforce OH whilst implementing an appropriate preventative regime. They also provide education and support to family members who help care for the patient prior to returning to primary care. With effective care the oral cavity will become more comfortable resulting in a better QoL.

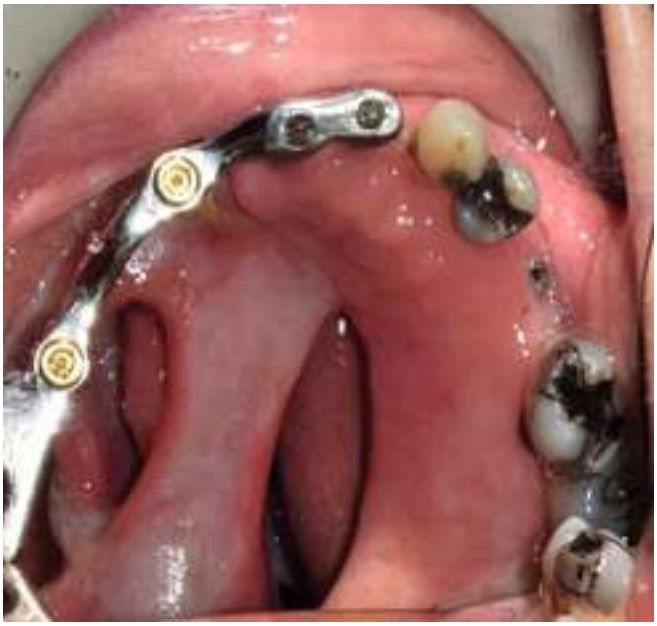


Figure 10: **CAD/CAM bar supported by zygomatic and conventional implants**

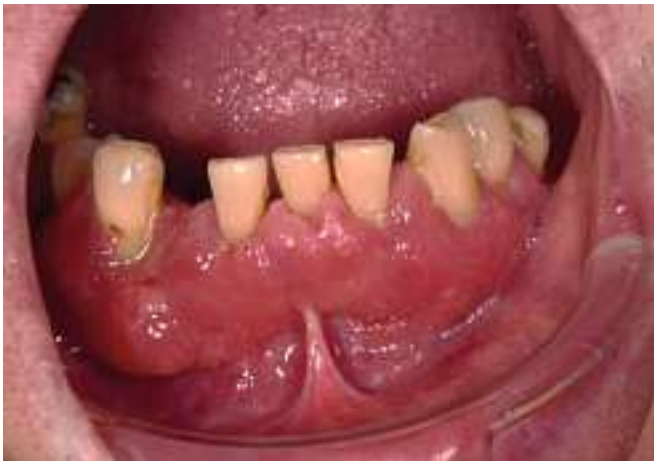


Figure 11: **Gingival hyperplasia**

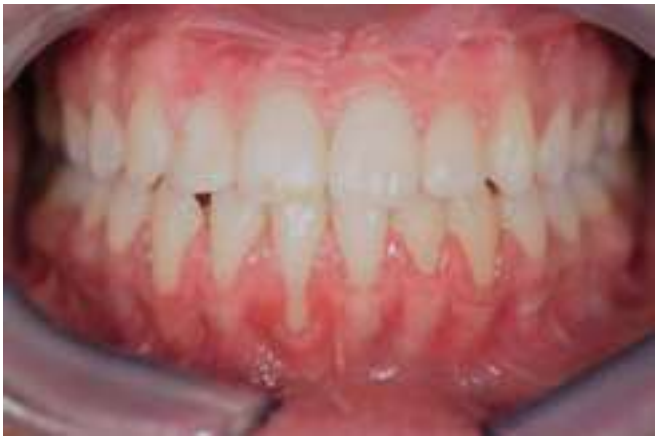


Figure 12: **Gingival recession pre graft**

Figure 13: **Desquamative gingivitis around fixed implant bridge**

Periodontal disease

DH and DT reported 76% of patients were referred to secondary care for treatment of periodontal disease (Fig. 11). Guidelines produced by The British Society of Periodontology provide a framework for appropriate referral of patients who require periodontal treatment in a secondary care setting.[17] Complexity level 3 cases should mostly be referred.

The role of DH and DT is to provide supportive care alongside consultants-led treatments. Cases such as desquamative gingivitis, pemphigoid, gingival hyperplasia, and gingival grafting require a team approach to their management (Figs. 11-13).

Discussion

As the relationship between oral and systemic diseases is becoming widely recognised, the evidence supporting the importance of DH and DT skills within the healthcare team has been highlighted and supported by various studies.[1,5] The hospital setting provides an invaluable opportunity for oral health promotion and education whilst supporting other specialities and in-patient nursing teams.

Hospitalisation can be associated with a deterioration in oral health.[18,19] Pre-existing conditions can deteriorate and new conditions can present, having a negative impact on an individual's QoL and well-being.[20] Hospital-acquired infections are linked to poor oral hygiene. Research demonstrates hospital acquired pneumonia (HAP) is accountable for almost 15% of all hospital acquired infections and is the second most common hospital acquired infection - resulting in longer hospitalisation, increase costs and mortality rates.[2]

As a result, in 2016 Health Education England introduced Mouth Care Matters (MCM),[2] an education and training initiative to improve the oral health for in-patients' services. MCM encourages hospitals to have dedicated mouth care champions or leads. A recent departmental audit at Queen Alexandra Hospital demonstrated inconsistencies across wards and departments with oral hygiene risk assessment and delivery of oral health care.[21]

This is an opportunity for the DH and DT to become integral members of the hospital-based healthcare team assisting with the development of MCM oral health care protocols, providing guidance and education to health care professionals, thus reducing the nurses' workload,[22] whilst also contributing to the well-being and QoL for all admitted patients.

The dental team is an important part of healthcare delivery in hospitals. Hospitals, in general, have started to recognise and to acknowledge the advantages of this interprofessional relationship.[22] To achieve this complex relationship between medical and dental teams, interprofessional education (IPE) is vital to develop an understanding of each other's role within a healthcare team.[23] O'Brien (2019)[24] discusses some of the barriers to intra- and inter-professional collaboration and encourages greater interaction at the earliest opportunity between healthcare and dental trainees to develop these professional relationships.

It is believed that attitudes and stereotypes between professions can change when different professionals learn alongside each other.[25] Curran et al. (2005)[26] explored a study of interdisciplinary teams, concluding that regular exposure to other professional roles provide a greater understanding of how other professions can enhance teamwork.

As a result, more emphasis should be placed on inter professional education combining clinical time and sharing learning experiences during training and placements. Sharing lecture times is often common but there is limited interaction.[23]

The current Covid-19 pandemic has encouraged health care professionals to present, learn and meet through local and national online platforms. This crisis has highlighted the importance of communication and collaboration between teams to maintain the expected levels of patient care.

Conclusions

Limited data exists on the roles of DH and DT in areas other than private practice in the UK. A follow up study to recruit more respondents is now required to collect accurate data on the numbers of DH and DT employed in a hospital setting, and explore their roles, challenges and integration as part of the MDT. A national study is now planned with questionnaires distributed to all UK maxillofacial units.

Evidence supports the contribution of the DH and DT towards patient well-being in hospital settings. Royal College of Surgeons oncology guidelines further support the role of the DH and DT as part of the wider MDT.[27]

The skills of DH and DT in a hospital setting is a perfect resource for other health care professionals. They can assist in improving delivery of care and promote integration into in-patient care further supporting in-patients and care providers. However, hospital managers are often unaware of the full scope of practice of DH and DT and questions understanding from other healthcare professionals regarding the role of the DH and DT.[1]

A career in secondary care provides the opportunity to experience work within a wider MDT, incorporating aspects of both medicine and dentistry. Although sometimes challenging, it is always extremely rewarding.[16] For those DH

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and DT who have aspiration and are dedicated to a vocation in secondary care, their contribution towards the well-being of complex patients is invaluable.

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Genetic testing for dental disease risk

Pamela Woolford

ABSTRACT

The Human Genome Project successfully mapped all 25,000 genes that comprise humans and sparked an avalanche in our understanding and knowledge of the powerful relationship between our genes and the environment. This relationship is now becoming more mainstream and personalised medicine is now emerging as a new strategy in prevention, diagnosis and treatment of disease. By knowing an individual's unique genetic makeup, lifestyle and nutritional interventions can be targeted specifically to that individual's needs (Fig.1).

Genes are made up of DNA (deoxyribonucleic acid) from which proteins are made. We have two copies of each gene inherited from our parents.

Human DNA consists of over three billion nucleotide base pairs, of which more than 99% are identical in each one of us. The remaining 1% consists of small variations known as single nucleotide polymorphisms (SNPs). These have a variation in a single nucleotide that occurs at a specific position on the DNA. One lone SNP does not usually cause disease, but can give a susceptibility to a disease, especially under environmental exposures.

Genetic testing

Genetic testing looks for these SNPs which can have a strong influence on the functioning of the gene in which it is found. This can alter biological pathways within the cell in which that gene functions and affect metabolic processes that are important for health.

Having the knowledge of this gene variant means that certain dietary and lifestyle interventions can compensate for the effect this gene variant would have (Fig.2).

To analyse an individual's DNA a buccal swab is taken and sent off to a laboratory offering these tests. The test result is presented in a report which gives a list of all the genes that have been requested to be analysed. This report describes the impact the SNP variant would have on certain metabolic and biochemical pathways.

Some gene variants are advantageous while others may

Figure 1: Personalised medicine which is customised for the individual patient will allow for more precise, predictive and preventive health care

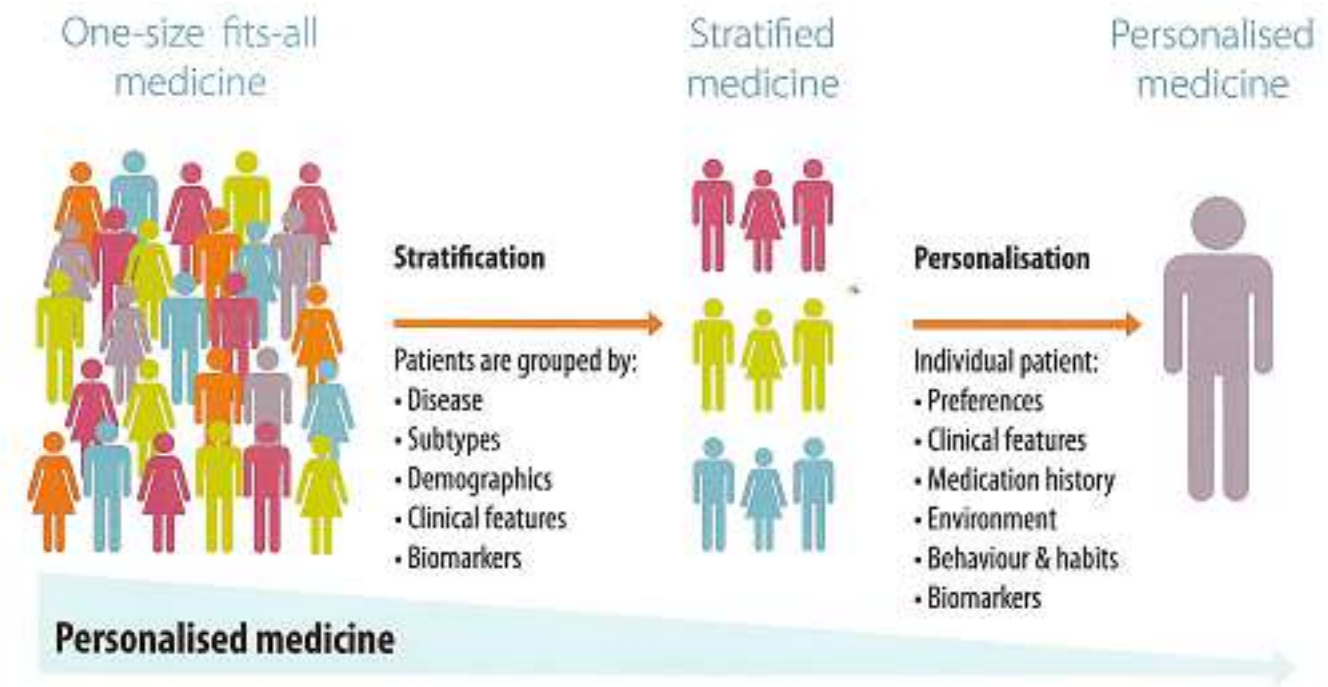
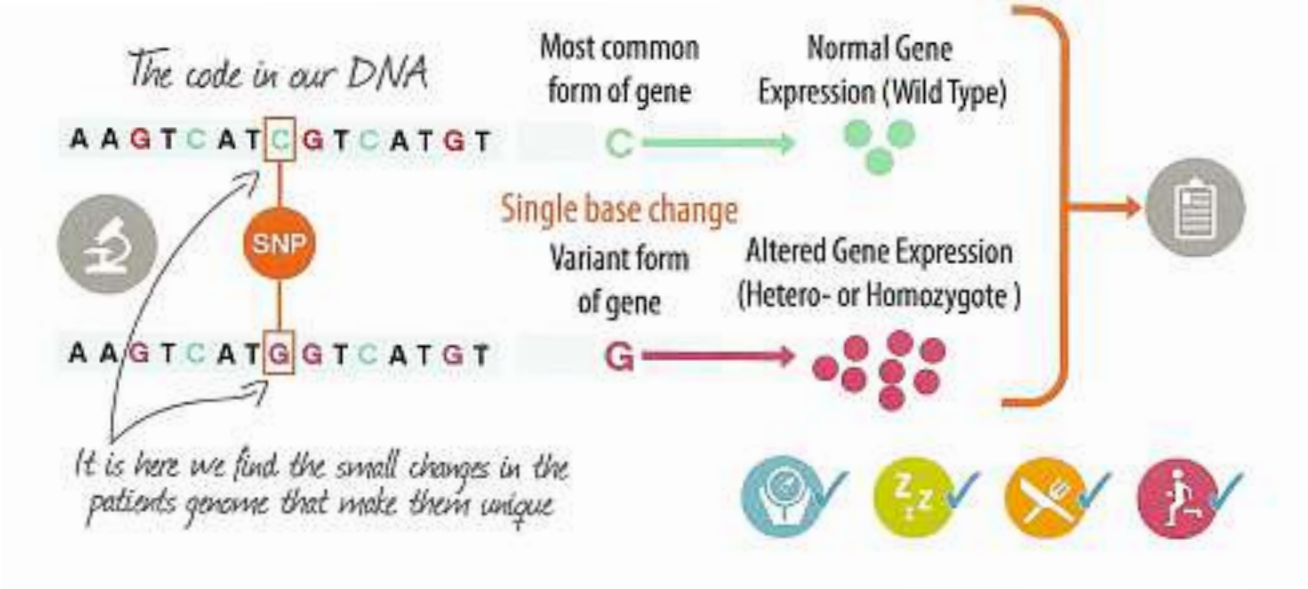


Figure 2: Diagram to show the base change from a G to a C resulting in altered gene expression (heterozygote for 1 base change and homozygote if 2)



contribute an increased health risk. The level of impact is indicated in the test report by an impact scale (Fig.3).

Genetic testing for susceptibility to dental diseases

Apart from dental health, periodontal disease has also been linked to an increase risk for other chronic inflammatory diseases, such as: coronary heart disease[1]; type 2 diabetes[2]; obesity[3]; and Alzheimer's disease.[4]

Three biological areas are examined (Fig.4):

- Innate immunity
- Inflammation and acquired immunity
- Sweet tooth

Innate immunity

This comprises the physical defensive barriers such as: the skin; the general immune response - immune cells and proteins; and also includes defensive mechanisms such as saliva. The innate immune system is activated by the presence of antigens and their chemical properties which is dependent upon pattern recognition receptors (PRR) which detect pathogen associated molecular patterns (PAMPs) which are structures on pathogens such as bacteria, virus, bacteria and protozoa.

In this example, the genotype results panel reveals that this patient does have an altered innate response when exposed to endotoxins and pathogenic bacteria, contributing a moderate increased risk for developing periodontal disease and type 2 diabetes (Fig.4).

Genes implicated in innate immunity

The **DEFB** gene variation codes for the beta-definsin 1 protein. This is an antimicrobial peptide implicated in the resistance of epithelial surfaces to microbial colonisation.

The **TLR4** gene variation is important in the inflammatory process and contributes to susceptibility for periodontitis. TLR4 cytokine expression is significantly increased in both macrophages and gingival fibroblasts located in inflamed gingiva.

Figure 3: Level of gene impact

LEVEL OF GENE IMPACT

The impact scale is assigned based on:

- Current peer-reviewed research
- Frequency of the variant in the population
- Contribution of the variant to an altered pheonotype

NO IMPACT	LOW IMPACT	MODERATE IMPACT	HIGH IMPACT	BENEFICIAL
No effect on the biological area in question	There is a mild effect to the biological area in question with a small change in responsiveness to environmental influences	Attention should be paid, and some dietary and lifestyle changes are recommended	Significant impact indicating intensive dietary and lifestyle action should be taken	The variant is advantageous to health
○	●	●●	●●●	✔

○ No Impact ● Low Impact ●● Moderate Impact ●●● Hight Impact ✔ Beneficial Impact

BIOLOGICAL AREA	GENE NAME	GENE VARIATION	RESULT	GENE IMPACT
Innate immunity	CD14	-260T>C	**TT**	○
	DEFB	3'UTR c*5G>A	**AA**	●●●
		-44 C>G	**GG**	○
	TLR4	896 A>G	**GG**	●●
		1196 C>T	**TT**	●●
Inflammation and acquired immunity	IL1A	-889 A>G	**CC**	○
		4845 G>T	**GG**	○
	IL1B	3954 C>T	**CC**	○
		-511 T>C	**AA**	○
	IL1RN	2018 T>C	**TT**	●●
	IL6	-174 C>G	**GG**	○
	IL17A	-197 G>A	**GA**	●●
	MMP3	Lys45Glu (A>G)		
	TNFA	G>A	**GG**	○
Sweet tooth	SLC2A2	Thr110Ile (T>C)	**TT**	●●●
	TAS1R2	Ile191Val (G>A)	**AA**	●●●

Figure 4: presents the results of a genetic test carried out on a patient to assess the risk of periodontal disease and susceptibility to caries.

Inflammation and acquired immunity

Acquired immunity, also called the adaptive immunity, develops over a lifetime as you are exposed to infections, disease or vaccinations. Inflammation and the inflammatory response are important factors to consider with acquired immunity. Cytokines are produced and are associated with chronic
low-grade inflammation which contributes to an exaggerated response in infections.

In this example, the genotype results panel reveals that two genes are affected in this patient giving a moderate increased risk for chronic low grade inflammation and related inflammatory disorders. This is due to increased expression of pro inflammatory cytokines and an altered response to endotoxin and bacterial exposure (Fig.4).

The **IL1RN** gene variation leads to a more active inflammatory response as an important leverage point in the inflammatory cascade and is also a regulator of the extracellular matrix where increased expression leads to osteoclastic degradation.

The **IL17A** gene variation encodes for a proinflammatory cytokine Interleukin -17A and is a strong contributing factor in the pathogenesis of various autoimmune and inflammatory diseases. Increased levels have been found in the saliva of patients with periodontal disease.

Sweet tooth

Genetics contributes to the individual variability in sugar consumption, where sweet taste receptors and glucose sensors contribute to an individual's sweet craving behaviour and sugar intake. Thus, a risk for caries.

In this example, the genotype results panel reveals that this patient has a risk of having a sweet tooth.

The **SLC2A2** gene variation codes for the GLUT protein which acts as a glucose sensor and is implicated in post prandial satiety. If this is reduced, as in this genotype, it is associated with consumption of higher amounts of sugar than usual.

The **TAS1R** gene variation encodes the taste receptors which are strongly involved in sensing sweet taste in foods. This genotype is associated with altered receptor function leading to higher sugar intake and seeking out sweet tasting foods.

Clinical implications of using this test

In the first instance, this patient was given oral hygiene advice and encouraged to strive for excellence. By implementing this test, the results were used to target improvements in lifestyle and nutrition and dietary supplements were recommended to the patient to help negate the genetic risk that was revealed.

The patient understood the risk to their oral health and also to their systemic health of which they had been unaware previously.

With the use of these genetic results this patient could clearly see and understand their genetic risk for periodontal disease and dental caries. This became a very strong behavioural change motivator; with this information this patient became more focused on their oral hygiene routine and was more motivated to adopt a healthier dietary intake.

Author: Pam qualified from Guys in 1982. She has been a tutor at The Eastman Dental Hospital and past Chairperson of the BSDHT Southern regional group. She is passionate about health and life - long learning. In 1998 Pam obtained a First Class Honours degree in Biology and Health from the Open University and in 2004 an MSc with Merit in Nutritional Medicine from Surrey University. She works in practice two days per week as well as running her own business in nutrition and clinical pilates. She uses this genetic test on her dental patients to identify their susceptibility and ultimately improve compliance and motivation.

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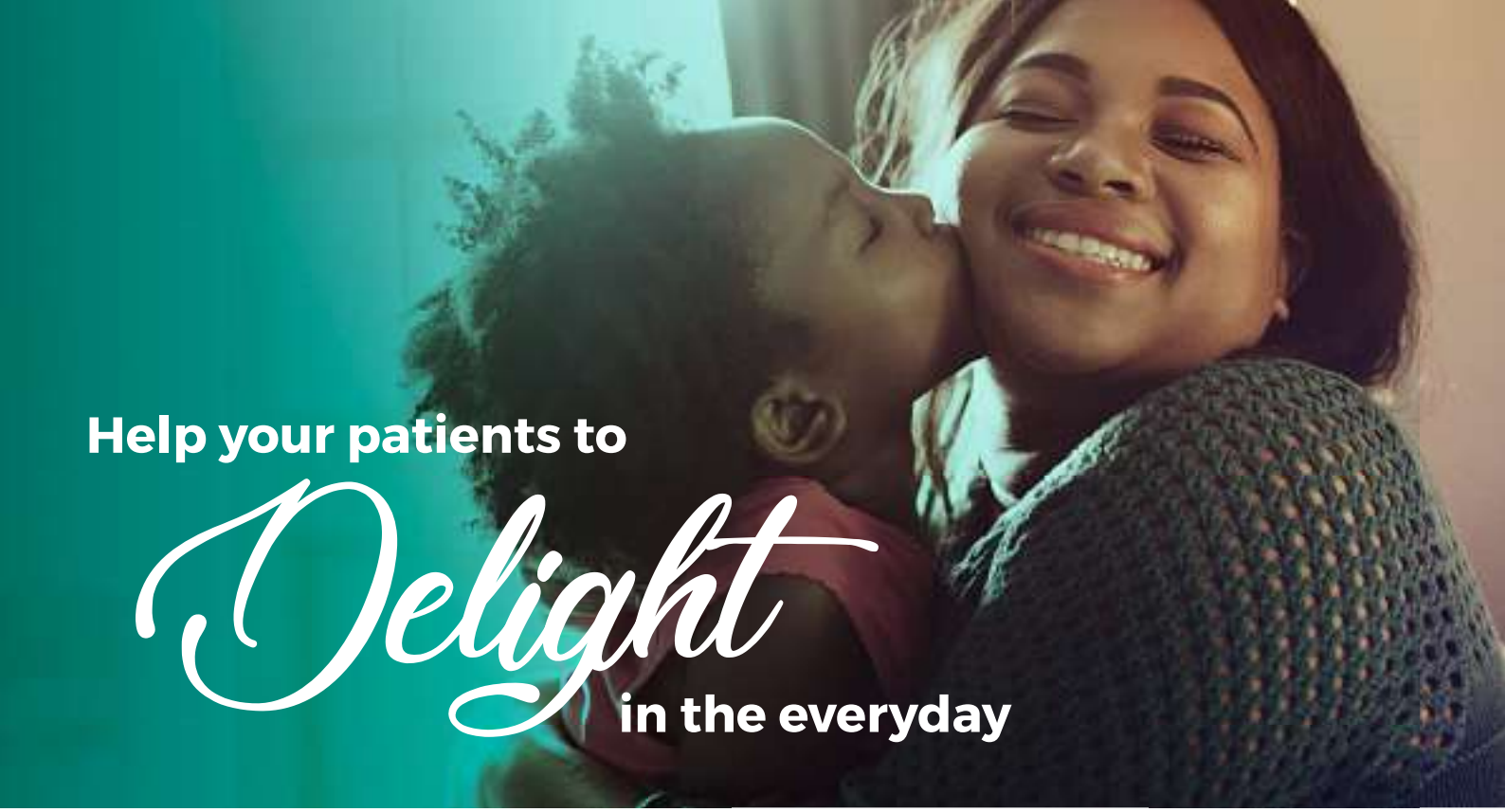

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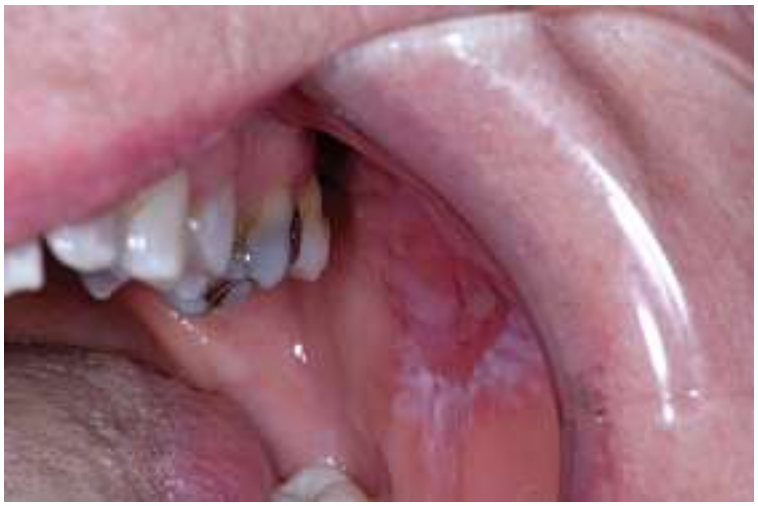
CLINICAL QUIZ

A patient mentions that they have been experiencing some discomfort in their left cheek. Your soft tissue examination reveals an erythematous area with white striations in the left buccal mucosa. This is in direct contact with the upper first molar.

Q1. What is the likely diagnosis?

Q2. How could this diagnosis be confirmed?

Q3. What treatment is required to alleviate the symptoms?



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The winner is: **Emily Parker, Student Dental Hygienist**

A patient presents with a complaint of generalised gingival discomfort. Medically she is fit and well. She informs you that she has been using an herbal toothpowder for about a year.

Q1. Q1. What clinical term is used to describe the appearance of the attached gingivae?
A1. Desquamative gingivitis.

Q2. What component of the tooth powder may be responsible for the gingival inflammation?
A2. Usually one of the flavouring agents, in particular: mint; clove; cardamom; cinnamon; or chile.

Q3. How could the relationship between the toothpowder and the gingival changes be confirmed?
A3. Advise the patient to stop using the tooth powder. The tissue should return to normal within 6-8 weeks. .

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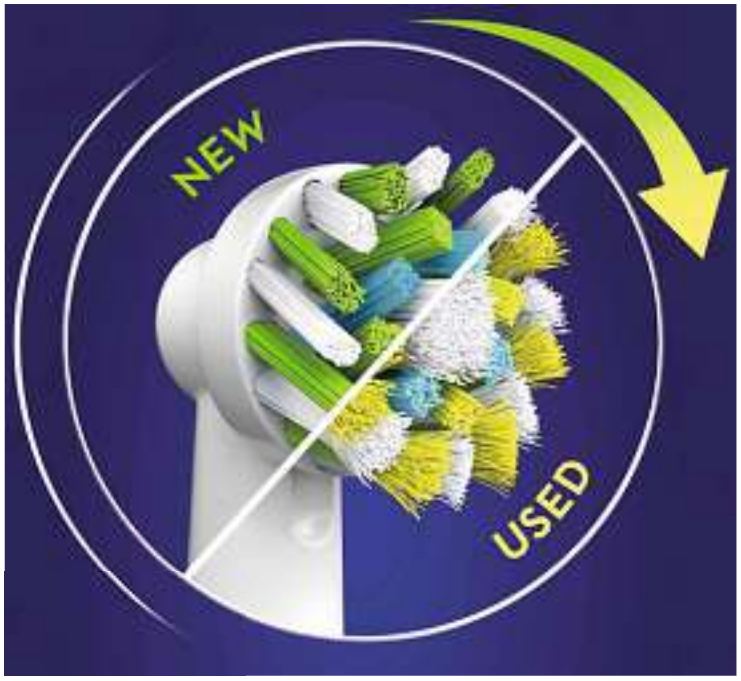

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Reference

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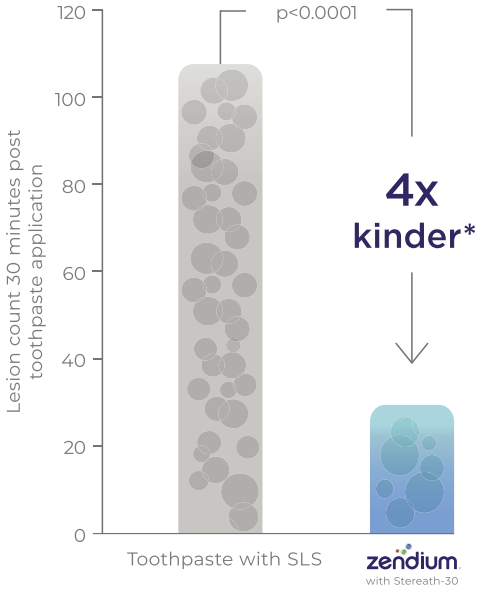

Recommend Zendium 0% SLS kinder toothpaste to patients with vulnerable mouths. Including:

- **Aphthous ulcers sufferers**
- **Dry mouth sufferers**
- **Pregnant women**

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Zendium contains 1450ppm sodium fluoride.
*Green A et al. JDent 80 (2019) S33-S39, UK 2016, n=30. Zendium (containing Stereth-30) compared to a standard fluoride toothpaste containing SLS.

DIARY DATES

AUTUMN 2021 BSDHT REGIONAL GROUP STUDY DAYS

Contact: enquiries@bsdht.org.uk

DUE TO THE CORONA VIRUS PANDEMIC THESE MIGHT BE SUBJECT TO CHANGE, PLEASE CHECK THE WEBSITE

Regional Group	Date	Details	Contact (Group Secretary)	Contact Details
Eastern	Sat, 16th Oct 2021	Bar Hill Hotel, Cambridge	Leanne De Piano	easternsecretary@bsdht.org.uk
London	N/A		Simona Dzimanaviciute	londonsecretary@bsdht.org.uk
Midlands	Sat, 9th Oct 2021	Woodland Grange, Leamington Spa	Joanna Ericson	midlandssecretary@bsdht.org.uk
North East	Sat, 11th Sept 2021	Holiday Inn, Garforth, Leeds	Jill Rushforth	northeastsecretary@bsdht.org.uk
North West	Sat, 16th October 2021	Mandec, Manchester	Karen McBarrons	northwestsecretary@bsdht.org.uk
Northern Ireland	Sat, 16th October 2021	Agape Centre, Lisburn Road, Belfast *TBC	Joanne Cregan	northernirelandsecretary@bsdht.org.uk
Scottish	Sat, 2nd Oct 2021	AGM only – online	Ellie Stiles	scottishsecretary@bsdht.org.uk
South East	Sat, 18th Sept 2021	Holiday Inn Gatwick, Povey Cross Road, RH6 0BA	Louisa Clarke	southeastsecretary@bsdht.org.uk
Southern	Sat, 9th Oct 2021	Salisbury District Hospital	John Murray	southernsecretary@bsdht.org.uk
South West & South Wales	Sat, 25th Sept 2021	Online event	Rachel White	swswsecretary@bsdht.org.uk
South West Peninsula	Sat, 2nd Oct 2021	Online event	Jade Campbell	southwestsecretary@bsdht.org.uk
Thames Valley	N/A	N/A	Rachel Hyde	thamesvalleysecretary@bsdht.org.uk

RECRUITMENT

HAMPSHIRE

Winchester: Dental Hygienist required.

A rare opportunity to join our team (2-3 days per week with potential to increase) in an established specialist referral private periodontal practice in Winchester.

Send CVs to: **nh@periosouth.co.uk** or call **01962-767900**.

EAST SUSSEX

Heathfield: Part time Hygienist needed, +/- 2-4 days/week, to work in a busy mixed practice. £45h/hour. Nursing and decon assistance available some days. 40-50% of gross private income for whitening and restorative work. Starting date end of August or sooner.

Email: **david.mahani@gmail.com** Mobile: **07803 527614**.

WEST YORKSHIRE

Huddersfield: Caring, cheerful Hygienist wanted to join friendly team at Lindley Dental Huddersfield.

Private practice, full book, great staff and nice facilities.

Please e-mail: **sharon@lindleydental.co.uk**

BEDFORDSHIRE

Bedford: Experienced Dental Therapist/Dental Hygienist required to join our established private specialist referral practice, working alongside our periodontal and restorative colleagues.

Initially 2 to 3 days, with full nursing and administrative support in a Covid secure practice alternating patients between two surgeries. Salary commensurate with experience.

Please visit our website: **www.latchfordandlatchford.co.uk** for details of our practice or contact us via Email: **latchford@latchfordandlatchford.co.uk** or call **01234 348899**.

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1. Barnett ML. The rationale for the daily use of an antimicrobial mouthrinse. JADA 2006; 137: 16S-21S
2. Araujo MWB et al. Meta-analysis of the effect of an essential oil-containing mouthrinse on gingivitis and plaque. JADA 2015; 146(8): 610-622
UK/LI/20-15605

INFLAMMATION SHOULD NOT BE IGNORED

Longitudinal studies have highlighted the significant role of gingival inflammation in the progression of periodontal disease.[1] The 2019 Periodontal Classification Guidelines highlighted the importance of actively managing gingivitis and preventing its progression to periodontitis.

This guidance went a step further to provide a distinction between patients with intact and reduced periodontium. Whilst patients may return to gingival health following treatment for periodontitis, the reduced periodontium means they will always be at lifelong increased risk of recurrent progression vs non sufferers.[1]

Formalised guidance for treatment of Stages I-III periodontitis

The European Federation of Periodontology (EFP) has developed an S3 level clinical practice guideline for the treatment of Stage I-III periodontitis to formalise the link between classification of periodontitis and approaches to treatment and prevention.[2]
The guidance outlines a stepwise approach which, depending on disease stage, should be used incrementally.

But how can these insights be reflected in daily practice for patients with periodontitis?

GSK has been working with Dr Domniki Chatzopoulou, Specialist Periodontist, QMU to help provide a practical insight into the implementation of the new guidance in practice.

STEP 01 for all periodontitis patients, irrespective of disease stage

STEP 02 should be used for all periodontitis patients, only in teeth with a loss of periodontal support and/or periodontal pocket formation

STEP 03 to be considered if the endpoints of step 1 and 2 have not been achieved (presence of pockets >4mm with BOP or presence of deep periodontal pockets >6mm)

STEP 04 supportive periodontal care. To be used if endpoints of step 1 and 2 have been achieved

> **"The key steps are the following: Step one, which is motivation and risk factor assessment. The second step is cause-related periodontal therapy. The third step is treatment of non-responding sites. And the fourth step is supportive periodontal care"**

Domniki Chatzopoulou

Taking the first step for patients with periodontitis

Step 1 of the treatment guidelines applies to all patients with periodontal disease and focusses on behaviour change and motivation of the patient to improve levels of plaque control and modify their current risk factors. This includes:

- **Interventions to improve the effectiveness of oral hygiene:** motivation, OH advice including brushing and interdental cleaning.
- **Adjunctive therapies for gingival inflammation** Adjunctive antiseptics may be considered, specifically chlorhexidine mouth rinses for a limited period of time, in periodontitis therapy, as adjuncts to mechanical debridement, in specific cases.
- **Risk factor control** (Smoking cessation, improved metabolic control of diabetes etc.)
- **Professional mechanical plaque removal (PMPR)** which includes the professional interventions aimed at removing supragingival plaque and calculus, as well as possible plaque-retentive factors that impair oral hygiene practices.

Find out more about managing patients with periodontitis and the new treatment guidelines from Dr Chatzopoulou at
www.gskhealthpartner.com

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Above and beyond for gums

References: 1. Chapple I et al. J Periodontol 2018; 89(Suppl 1): S74-S84. **2.** Sanz M et al. J Clin Periodontol 2020; 47: 4-60.
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