DENTAL HEALTH

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THE JOURNAL OF THE BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY

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DENTAL HEALTH

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.

BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY
Promoting health, preventing disease, providing skills

bsdht.org.uk

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EDITOR
Heather L Lewis,
Bragborough Hall Business Centre, Welton Road,
Braunston NN11 7JG
Email: editor@bsdht.org.uk

BSDHT NATIONAL ENQUIRY LINE
Tel: 01788 575050
Email: enquiries@bsdht.org.uk

ADVERTISING SALES
Fay Higgin
Email: sales@bsdht.org.uk

CLASSIFIEDS & JOBLINE
Tel: 01788 575050
Email: enquiries@bsdht.org.uk

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Warners Midlands plc
The Maltings, Manor Lane, Bourne,
Lincolnshire PE10 9PH
Telephone: 01778 391000
Email: helpdesk@warners.co.uk
Web: www.warners.co.uk

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22 ON THE COVER
The 'no-added-sugar-tribe' Revisited

Colosseum Dental Careers

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GUEST EDITORIAL

Direct Access

May 2023 marks 10 years since the GDC allowed dental hygienists and dental therapists to work within their Scope of Practice without the need for a referral from a dentist. This monumental change was widely celebrated by our profession at the time. Finally, we had recognition of our capabilities as autonomous clinicians.

Whilst we celebrated, it was clear that Direct Access was not received as favourably by many other parts of the profession. I clearly remember how difficult it was lobbying for the support of many allied organisations during the early stages of our proposals to the GDC. Many viewed these proposals as a threat, and argued that it would fragment the profession. Furthermore, they had concerns about patient safety. Conversely, having thoroughly examined the proposals by BSDHT and BADT the GDC disagreed.

Since then, many thousands of patients have benefited from the ability to seek the care of a dental hygienist (DH) or therapist (DT) without the need of a referral from a dentist. Patients deserved to be given this choice, something that the Department of Trading Standards fully supported. We knew there were so many patient groups that would benefit from being easily able to access our skill set and the previous referral arrangement was wasting clinician and patient time and increasing the costs for both patients and dental teams.

Over the last 10 years our hard-won professional autonomy has led to: independent dental practice ownership; self-supporting domiciliary care services; increased research opportunities; and facilitated our freedom to practice within our scope within our dental teams.

However, Direct Access has not been without its challenges. It has been a relief to see confirmation in recent years that we are able (once trained, if not included in our undergraduate training) to prescribe, take, and report on radiographic images within our scope. This 'grey' area caused some confusion and uncertainty in the early days.

The use, supply, and administration of the necessary prescription only medicines for us to work fully within our scope of practice is still proving to be a hugely frustrating stumbling block. However, BSDHT and BADT are working hard to lobby the necessary changes required to lift this significant barrier in patient care.

Until very recently, the UK NHS dental services have seemingly overlooked the benefits that direct access to a DH or DT could have for the population seeking NHS dental services. Last year, NHS England began more seriously examining how they could make autonomous working for DCPs operate within current contractual arrangements. This appears to be a work in progress as the contractual reform process continues.

There were a few passionate and inspirational trailblazers lobbying for direct access in the early days and their growth and success since has been an inspiration to watch. Christina Chatfield launched the Dental Spa in 2007, taking full advantage of the change in law allowing dental professionals, other than dentists, to become practice owners. She has since then grown a 20 strong team, in a 6-surgery practice in Brighton that has survived when other businesses fell during the Covid pandemic. Christina told me recently: *"I'm so proud of the business I have built with the help of my team. All five of my dental hygienists and therapists have the choice to work autonomously, something that I really enjoyed so much that I continued to work clinically for a further 15 years."*

Christina credits her success to providing her staff with all the equipment and support they need and creating a fabulous working environment that means full scope of practice can be utilised. She tells me it's been hard work, and there have been tough times, some of which came at great personal cost, but it's been worth seeing her dream come to fruition. Christina has now taken a step back clinically and while she is still very much at the forefront of her business, she has more time to enjoy the simple but most important things, which for Christina, is the sunny Brighton early mornings and a dip in the sea!

Many business owners and independent autonomous dental hygienists and therapists now join Christina in helping our UK population with their oral care needs. When we began developing the proposals over 12 years ago, our patient's needs were at the very centre of our drive to push Direct Access. We are safe, conscientious, and caring professionals who have always put the needs of patients first and have always enjoyed the responsibilities of patient care within a wider team.

While I'm now at the twilight of my career I'm excited to see how the profession develops in the next 10 years!

Sally Simpson

BSDHT Past president 2010-2012

FROM THE PRESIDENT

by MIREANDA STEEPLES

Welcome to May's edition of *Dental Health*. For me, this month usually means beautiful blossom and horrible hay fever, so if you are a fellow sufferer, you have my sympathy!

Direct Access

The 1st May is also a very important date in our history as dental hygienists and dental therapists. In 2012, the Office of Fair Trading explored the reasons why a patient could not see a dental hygienist or dental therapist directly, without the need for a 'prescription' or treatment plan from a dentist.

Direct Access was a controversial issue at the time. There was a lot of resistance to this change, predominately from dentist organisations. Similar to decades before, there was still fear that we would dilute the profession of dentistry and that patient safety would be compromised. Consequently, there were demands for evidence of 'safety'. However, there was no evidence. There was equally no evidence showing that patients would suffer harm if this was to happen… because nobody had looked into it! This is why research, including the surveys we send out to you, is so important. Without data that answers a question, we have no evidence to back up what we say. BSDHT continues to build and grow this body of knowledge around our professions.

A hard-fought campaign ensued and reassuringly, subsequent studies have shown that when it comes to spotting suspicious oral abnormalities, detecting caries, and managing deep carious lesions, compared to a dentist, there is no difference in our competency and no risk to patients. In some cases, we are actually more proficient.[1,2,3] On 1st May 2013 Direct Access was legally granted and without the hard work and dedication of two representative organisations, BSDHT and BADT, this would not have happened.

There are still some clinicians who choose not to offer it, and that is ok. You cannot be made to do it. However, if you offer direct access, you need to inform your indemnity provider and ensure that your patients understand the limitations of what you can and cannot do. Ensure that you have a referral policy in place for anything that is out with your scope of practice. We are here for advice, whether you are offering direct access appointments in private practice or under the NHS. And so can your indemnity provider, so use them! There is no penalty for doing so, and in the last 10 years, there is no suggestion that fees or claims have gone up due to this change.

Celebrating 75 years

We have been offered an exciting opportunity to collaborate with the *International Journal of Dental Hygiene*. In celebration of 75 years since the inception of BDHA, the editor in chief, Dagmar Slot, has invited us to have our own commemorative, anniversary special edition. We have been requested to invite authors to write for this edition. See page 21 for further information.

Political…moi?

When I first told a friend about doing this role, they said to me, "Oh you're so political." At the time I didn't think I was. However, now I have realised I am, but I quite like it! I figured I have 18 months to see what change I can bring about, and if the title of BSDHT President means anything, then now is the time to find out.

I have attended a number of meetings on behalf of the BSDHT, and some have been as part of the Dental Professionals Alliance (DPA). The DPA is an umbrella organisation that includes representatives from other dental professional groups, such as dental nurses, orthodontic technicians and dental technicians, along with the BADT. We recently had a group meeting with Sandra Egan and colleagues from the DHSC dental policy team, and were invited to give a report of our particular issues. I highlighted the time it is taking for the Exemptions legislation to come through, and how this is a barrier to us offering Direct Access appointments. The other problem is our knowledge of NHS rules and regulations, which will be helped by our Refresh and Refine opportunities and will be supported by training from HEE as well. Then I addressed the elephant in the room! I pointed out that NHS pay is typically less than when offering private dental hygiene appointments; that some dentists will pay less because they believe a dental therapist is cheaper than a dentist; and that this mindset needs to change. Furthermore, there is an issue

about access to NHS pensions, which I have also discussed with the LDC confederation. The Confederation first raised this with BSDHT and there is now a growing clamour for all team members in an NHS practice to be able to access this, because they all contribute to NHS care of patients. Watch this space for any further developments as they come.

On a lighter note, I went to the BDIA dental showcase where it was so good to meet a number of members who came by the stand to say hello. I really hope to see some of you at the Dentistry Shows in Birmingham and in Glasgow. Also, fast approaching are the Refresh and Refine days in Edinburgh and Bristol, and it would be great to see you at one of those events. If they are popular, we will offer more of them around the country. Bookings will also be open soon for this year's OHC, and I would love to see this be a record breaker of a conference down here by the seaside - do support us to support you!

References

1. Brocklehurst P, Pemberton MN, Macey R, Cotton C, Walsh T, Lewis MAO. How accurately do members of the dental team detect malignant lesions? *BDJ Team*. 2016;**3(6)**:16103. https://www.nature.com/articles/bdjteam2016103
2. Richards D. Hygiene-therapists could be used to screen for dental caries and periodontal disease. *Ev-Based Dent*. 2015;**16(4)**:116-117. https://pubmed.ncbi.nlm.nih.gov/26680523/
3. Edwards D, Bailey O, Stone S, Duncan H. The management of deep caries in UK primary care: A nationwide questionnaire-based study. *Int Endo J*. 2021 Oct;**54(10)**:1804-1818. https://pubmed.ncbi.nlm.nih.gov/34089184/

Date

Part 1 – Online (date to be confirmed, but will an evening or Saturday morning)

Part 2 – In person, hands-on event. Choose one date/venue to suit, either:

a) Dentistry Scotland Show

Saturday 3rd June – Edinburgh ICC

OR

b) South West Dentistry Show

Saturday 1st July – Ashton Gate Stadium, Bristol

NB – you will have to attend both online and at one event in person to qualify for CPD.

AS PLACES ARE LIMITED IN NUMBER, PLEASE ONLY BOOK IF YOU CAN COMMIT TO ATTENDING.

Cost: £109

To register:

Bristol

https://www.eventbrite.co.uk/e/493640621387

Edinburgh

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DID YOU KNOW?

The National Institute for Health and Care Excellence (NICE) has an update on their website?

Follow the link:

https://www.nice.org.uk/guidance/qs207

DIRECT ACCESS REFLECTIONS 10 YEARS ON

It is hard to believe that it is already 10 years since that momentous day at the General Dental Council in Wimpole Street when the (some would say controversial) decision was taken to allow patients to directly access the services of dental care professionals other than dentists. For younger colleagues it might be difficult to appreciate the magnitude of the decision so I thought it might be useful to reflect on the lead-up to the decision and on what has happened since.

The decision was taken on 28th March 2013, the Thursday before Easter. Representatives from many organisations, including the BSDHT executive team, gathered in the GDC chamber to hear the conclusion of the committee:

'From 1 May 2013, dental hygienists and dental therapists will be able to carry out their full scope of practice without prescription and without the patient having to see a dentist first.'

Additionally, there were relaxations in the rules for dental nurses, orthodontic therapists and clinical dental technicians.

The Chair of the GDC, Kevin O'Brien, later said: 'Registrants treating patients direct must only do so if appropriately trained, competent and indemnified. They should also ensure that there are adequate onward referral arrangements in place and they must make clear to the patient the extent of their scope of practice and not work beyond it.' [1]

The British Dental Association had vociferously opposed the changes and released a damning statement from Dr Judith Husband, their chair of the Education, Ethics and the Dental Team Committee:

'This is a misguided decision that fails to consider best practice in essential continuity of care, patient choice and cost-effectiveness, and weakens teamworking in dentistry which is demonstrated to be in patients' best interests. Dental hygienists and therapists [...] do not undertake the full training that dentists do and on their own are not able to provide the holistic, comprehensive care that patients need and expect. Our fear is that this could lead to health problems being missed in patients who choose to access hygiene and therapy appointments directly.'[1]

Perhaps the most quoted argument at the time was the fear that an underlying condition such as mouth cancer, might be missed; such fears were not borne out by the evidence though and a comprehensive literature review, published later in 2013, as one of its conclusions stated:

"…there is evidence of ongoing training needs to strengthen the assessment and referral skills of DCPs in respect to patients with other health

Members of BSDHT and BADT at the GDC following the announcement to grant Direct Access.

IMAGE COURTESY OF DAVE MARTIN.

problems or risk factors, but little evidence that dentists are any less in need of such training."[2]

Many dentists at the time believed that it would lead to a plethora of 'hygiene shops' on the high street and this, of course, has not been the case. For many of us, the changes have not been that significant, we care for patients in much the same way whether they are referred from a dentist or not. The referrals are often fairly generic and the patients may attend without any clear understanding of why they have been referred. The discussions on periodontal disease, its manifestations and its treatment are left entirely with us; just as they are for a patient attending under direct access.

Direct Access has meant that patients who see NHS dentists where hygienist services are not offered have been able to seek the care, that *they* feel they need, elsewhere. For many of us in long-term general practice the patients have ties and bonds to us that are just as strong as those to dentists and with the high turnover of associates in some practices the relationship with the dental hygienist is often of longer standing. Many of us will have seen patients under direct access arrangements who come for several visits over a number of years before they decide that they like the team and environment so much that they then transfer the whole of their care across.

One of the other consequences, perhaps less obvious, has been the deterioration in our relationship as a professional body with our sister organisations and the BDA in particular. Prior to 2013 there had been considerable efforts on all sides to build relationships and to move towards what might have been called a confederation model. Members of BSDHT executive were involved in planning the BDA conference and at one point the BDA Chief Executive was made an honorary vice-president of BSDHT. The BDA chair at the time had been a long-term advocate of teamworking and had worked with us to promote co-operation on many levels. The GDC decision coincided with a marked turning point in that level of co-operation and the BDA Executive committee, under a new chair, appointed former GDC chair Alison Lockyer, known for her opposition to Direct Access, as lead on matters relating to DCPs. Happily, we are now re-establishing those collaborative relationships.

Going forwards, I for one will continue to offer optimum care to my patients, as I always have, whether they arrive with a referral from a colleague or not. For many, the issues around onward referral for conditions detected has been much more about gaining access to the referral portals put in place by trusts and commissioners than it has about the competence of the referrer.

Heather Lewis

References

1. GDC announces controversial decision on direct access. *Brit Dent J.* 2013;**214**:379.
2. Turner S, Tripathee S, MacGillivray S. Direct access to DCPs: what are the potential risks and benefits? *Brit Dent J.* 2013; **215**:577–582.

SOUTH WEST SOUTH WALES REGIONAL GROUP

On Saturday 1st April, the South West South Wales Regional Group held an implant themed, hands-on workshop style study day in Bridgend, Wales. For this meeting the committee decided to change the familiar format and location by utilising a morning session rather than a full day. We also decided to move to a venue further west to allow more flexibility for our delegates - especially those travelling from all over Wales who typically have the furthest to travel.

The setting at the wonderful Court Colman Manor hotel presented an ideal excuse for some delegates to catch up with colleagues, stay over and enjoy a night or two in one of the quirky rooms and experience the food in the amazing restaurant. Some delegates were hoping to venture into the surrounding countryside for the afternoon following the study morning but made do with the bar instead, due to the weather!

We had a respectable turnout of over forty delegates, and the conference room was full with the chatter of friends catching up. We were well supported with trade. Our thanks go to: Haleon; Oral-B; Oralieve; Orascoptic; Stoddard and TePe. All were generous with their time and expertise.

The study day commenced with Rhiannon Jones talking us through her regional rep report from Council. We were delighted to hear that she is now BSDHT President Elect but sad that she will be stepping down from our regional committee. The SWSW group is incredibly excited to watch her progress within the society!

Delegates were firstly treated to a mini lecture by Matthew Weeks from Oral-B, who made impactful use of statistics to demonstrate our potential role in patient care, which continues beyond the clinical setting.

Next, we had the brilliant Elaine Tilling from TePe who delivered a hands-on workshop exploring the concept of product to problem. She offered a wide variety of vintage, current and some unusual oral hygiene aids to each table of delegates. We were then invited to share our opinions about the efficacy and user friendliness of the aids we had been given.

After a short break where delegates were able to explore the trade and enjoy refreshments, we returned to hear Kathryn Mayo, sponsored by J&S Davis, give an excellent lecture followed by interactive hands-on practice with dental implant models. This presentation focused on implant maintenance and was a fabulous opportunity to update both theoretical and practical instrumentation skills.

Finally, Dr Aly Virani presented an engaging and informative lecture examining the team approach to caring for dental implants. This presented the available evidence supporting rationale behind implant maintenance protocols and how to implement these in practice.

The early afternoon brought the study session to a close. The majority of delegates also stayed for a buffet lunch served just as the sun began to appear through the large windows. Overall it was a fabulous opportunity to catch up and enrich our minds with all things implant maintenance!

Harriet Elsworthy

MIDLANDS REGIONAL GROUP

On Saturday 18th March, our spring study day was hosted at the East midlands Hilton hotel. This is a lovely venue situated close to the M1 with ample parking, and they never fail to look after us all day with great food and plenty of refreshments!

The committee welcomed Helen Westley our new chair, who did a fabulous job of organising and hosting everyone. So, thank you and welcome Helen!

Highlights of the day included the wonderful speakers that kindly gave up their time to spend the day with us to share their knowledge:

Frank Parsons from Lloyd and Whyte, who talked to us about retirement and financial planning. He

certainly got everyone thinking about the future!

Phil Boxell from Oral-B who discussed behaviour change and then shared the company's latest research about the use of their electric toothbrushes.

Deborah Stratford talked to us about musculo-skeletal disorders. She got us all moving after lunch with chair Pilates! We left feeling a bit looser and with the knowledge of some simple exercises that we could implement in the surgery right away to help keep us as pain free as possible!

Caroline Smith ended our programme with a lecture about her holistic approach to periodontal treatment, using lifestyle medicine, with a focus on airway health and nasal breathing. Again, we left with simple exercises that can improve health in our patients and ourselves.

We had a speaker unable to attend for personal reasons, so a big thank you to Orascoptic and Haleon who stepped in and to Caroline for extending her lecture also.

The trade showed up in full force and there was plenty of time to network and engage with each one, so a big thank you to: C-Med; CTS; DMG; ICON; Haleon; Lloyd & Whyte; Oral-B; Oralieve; Orascoptic; Stoddard and TePe.

The hotel supplied a tasty and healthy lunch, and it was so lovely to see the delegates networking and taking the time to talk and get to know each other. We couldn't hold this event if it wasn't for those that support and show up each time. So, thank you to our delegates, for supporting us with engaging energy. You turn up each time, for us, the speakers, the trade and, importantly, for each other.

The day was wrapped up with the raffle and many prizes were won and we are so happy to say we raised £100 for our chosen charity CRISIS.

We are very excited to say that our autumn event will be held on September 23rd at BSDHT HQ, Bragborough Hall. A very pretty venue in the countryside, also with ample parking and lovely food!

So please save the date and we will update with more information soon, we would love to see you there!

Feedback from a delegate that attended the day: *"Excellent presence and support from the Midlands group, who made the day informal and enjoyable. A sense of networking was expressed as important for all delegates I spoke to. Variation in topics covered by speakers worked well".*

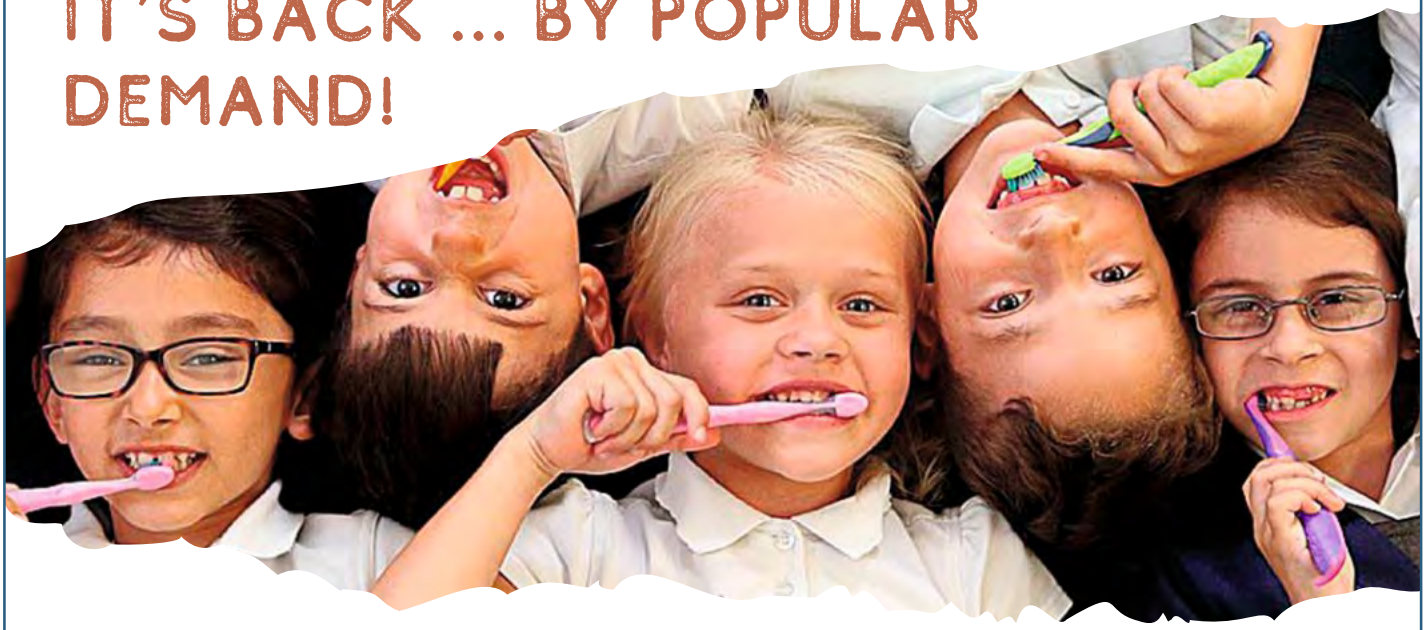
Nina Farmer

BSDHT

First Smiles Campaign

in partnership with Oral-B

IT'S BACK ... BY POPULAR DEMAND!



About BSDHT First Smiles

Whether it's their first tooth or their first visit to the dentist, a child's early experiences of oral health can impact on the rest of their lives.

Creating healthier smiles

It is a staggering thought, but in primary schools across the UK around eight or nine children in every class will have already developed tooth decay.

Our Aims

Schools, working with parents and health professionals, have an important role to play in educating young people about healthy lifestyles, including their oral care.

What we've achieved so far

First smiles is back again for 2023 and we can continue the amazing work our members have been doing. Whether it is a school or a nursery, BSDHT members have delivered fun and accessible lessons to children aged between 3 and 11 on the importance of good dental health.

How YOU can help?

Whether it's for a whole morning or afternoon, an hour or two, or just for one lesson, on Friday 16 June 2023, block out some time to teach young children about the importance of oral health.

Register for free First Smile resources HERE:
https://www.surveymonkey.co.uk/r/FIRSTSMILES2023

THE DR GERALD LEATHERMAN AWARD

The late Dr Gerald Leatherman was influential in promoting the role of the dental hygienist. As a pioneer of preventive dentistry in the UK, he dedicated his professional life to raising the profile of dental hygienists. He was actively involved with our organisation from its inception until his death in 1991.

It was during his early professional years, working in the United States, that he first experienced the *new profession* of the dental hygienist and oral hygiene clinics. Being the great visionary that he was, Dr Leatherman recognised the potential benefits of such a group of auxiliaries and began the crusade with like-minded colleagues in the UK. This action ultimately led to the recognition of the dental hygienist as an integral member of the dental team. BSDHT continues to recognise his work and support with the Dr Gerald Leatherman Award.

This award is made to any individual, not necessarily a dental hygienist, who has taken a role to further the aims of the profession of dental hygiene or the BSDHT. Each nomination should be accompanied by a resume of services to the profession of dental hygiene along with written testimonials from two sponsors who should be full members of the BSDHT. The individual must agree to be nominated. The candidate to whom the award is made should be prepared to present a paper at the OHC in November in Bournemouth.

This prestigious award will not necessarily be given each year. Nomination forms are available from BSDHT administration.

If you have anyone in mind that has shown consistent and true dedication, professionalism and determination for the greater good of the profession and the BSDHT, this is the time to celebrate their continued commitment.

- **Kay Cullen was the last recipient. Kay was awarded this posthumously in 2021.**

Nominations close at 5.00pm on Friday 15th September 2023

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.

Council will meet on Thursday 7th September 2023

To register your interest please email enquiries@bsdht.org.uk

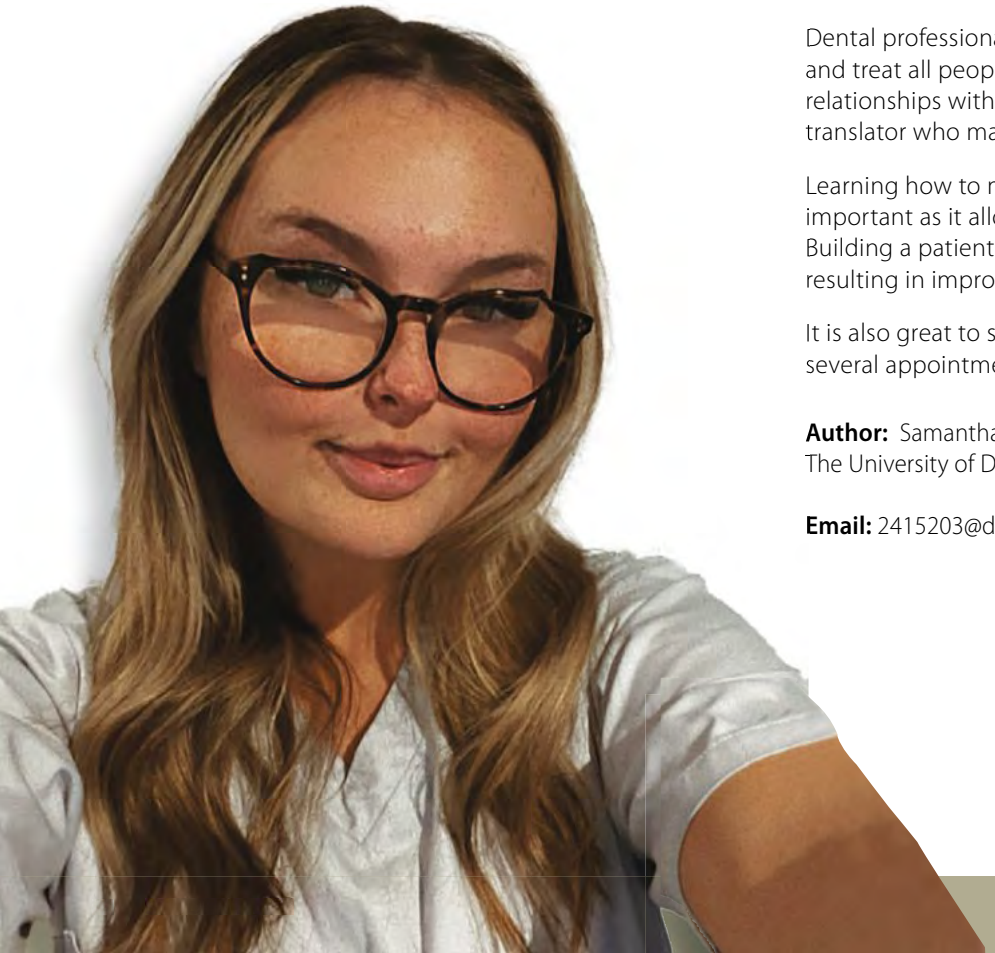
MANAGING CHALLENGING PATIENTS

by SAMANTHA FORREST

As students, and later as qualified dental therapists, we will all encounter patients with whom communication is often challenging and achieving optimum treatment outcomes is difficult. A patient may have emotional or behavioural issues that will impact their dental care.

When such a patient presents for treatment, it is important to be able to ascertain why their behaviour is proving to be a barrier to successful treatment. It may be that the patient is in pain and feeling distressed, common in the dental setting. Other reasons may include language and communication barriers. A patient feeling frustrated can result in them acting in ways they normally would not, for example by being rude and uncooperative.

Sometimes it can be difficult being a student, especially when you have such a challenging patient. In one particular situation, where I was trying to encourage a patient to stop smoking, the patient could not understand why I expected them to take my advice. In the patient's eyes I was too inexperienced, too young and not even qualified! These sorts of situations are very common to students on clinic.



However, in practice, whether or not you are a student or a fully qualified clinician, the most important thing is keeping yourself and others safe, including the patient. Although we may want to do what is best for them, sometimes we have to accept 'no' for an answer.

My top tips for managing a challenging patient:

- Give them an opportunity to explain why they do not want your help or are feeling frustrated. This demonstrates empathy and shows that you have their best interests at heart.
- Reassure and acknowledge their concerns.
- Try to find a mutual solution that allows the patient to feel in control.
- Maintain a physical distance both for safety but also so that the patient does not feel trapped.
- Pay attention to your own body language and how you are talking. Remain calm and do not make the patient feel invalid.

Dental professionals have a duty to understand, consent and treat all people. It is important to build good relationships with our patients and any carer, guardian or translator who may accompany them.

Learning how to manage a challenging patient is so important as it allows everyone to be treated equally. Building a patient's trust will ensure a good rapport resulting in improved clinical outcomes.

It is also great to see the work that you have put in over several appointments pay off!

Author: Samantha is a 2nd year oral health science student at The University of Dundee, her home city.

Email: 2415203@dundee.ac.uk

OVERCOMING CHALLENGES AND BUILDING RELATIONSHIPS

by SANDEEP SAMRA

There are only twelve of us in my year group, which has been beneficial, especially in the time of covid restrictions. We have been able to maximise our supervisors' time and frequently received one-to-one support and guidance. In the skills laboratory particularly, we really benefitted from such close supervision, honing our operative skills and safety before treating patients for the first time.

Clinical assessments were spread throughout the year enabling our progression to safe practice. We had an introduction to clinical activity with placements in the hospital setting at the end of year one. This helped build up my confidence and relieve some of my anxieties by getting over my 'firsts'.

Year 2 was intense!

A gear shift meant that the demands on us increased. We were now required to: carry out treatments; write reflective accounts; sit clinical competency assessments; complete assignments; contribute to group projects; learn new content; and practice restorative treatments in the skills labs. This ran in tandem to my own external pressures.

During second year, I experienced personal stressful life events. I began suffering from anxiety, constantly feeling tearful and on edge. Lack of sleep was an issue and I felt that there were not enough hours in the day. My own poor time management compounded my low mood and irritability. I was also contending with 'mum guilt' from not spending enough time with my children. When my childcare arrangements broke down my start and end time on clinics were impacted and this became a real stressor for me. Fortunately, the university was understanding and accommodated flexible working whilst I made other arrangements.

Although assignments were given early on, I struggled with understanding them. Compounded by fear of failure and procrastination, my stress levels continued to increase and I found myself failing some assessments, which I had to re-take.

I was aware that it takes me longer to understand some of the content than my peers and I have to read literature a few times before fully grasping its meaning. I was already aware that I was dyslexic, having been diagnosed in my first year, but I kept this to myself. I felt embarrassed and did not want to feel different.

I was overwhelmed and there were so many times I thought of just giving up. The workload seemed beyond my capabilities.

I finally disclosed that I was struggling and asked for help, very late into the course. I was then given one-to-one interventions to support me with my studies by my tutors who have been brilliant. On reflection I should have spoken out sooner and this would have relieved some of my stress. But hindsight is a wonderful thing, isn't it?

Building such good close relationships from the start of the course with my peers has helped me develop both personally and professionally and create lifelong friendships. It has been an intense journey which at times has made it so difficult to enjoy the process. It really has been a rollercoaster of emotions. However, the clinical exposure that we have had, and the wealth of knowledge and experience shared by the tutors, has been invaluable in developing me as a dental professional. I am really looking forward to finishing my final year alongside my peers and tutors as we are a brilliant team together.

My message to every student is this: 'Don't give up!' When you feel like giving up - pause, reset and restart. But don't quit!

Author: Sandeep is a final year dental therapy student at the Eastman Dental Institute..

Email: thandi.sandeep@yahoo.co.uk

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References: 1. Nathoo S, Delgado E, Zhang YP, et al. Comparing the efficacy in providing instant relief of dentine hypersensitivity of a new toothpaste containing 8.0% arginine, calcium carbonate, and 1450 ppm fluoride relative to a benchmark desensitising toothpaste containing 2% potassium ion and 1450 ppm fluoride, and to a control toothpaste with 1450 ppm fluoride: a three-day clinical study in New Jersey, USA. *J Clin Dent*. 2009;20(Spec Iss):123 -130. **2.** Docimo R, Montesani L, Maturo P, et al. Comparing the Efficacy in Reducing Dentin Hypersensitivity of a New Toothpaste Containing 8.0% Arginine, Calcium Carbonate, and 1450 ppm Fluoride to a Commercial Sensitive Toothpaste Containing 2% Potassium Ion: An Eight-Week Clinical Study in Rome, Italy. *J Clin Dent*. 2009;20(Spec Iss):17- 22.

CAN IGNORANCE EVER TRULY BE BLISS?

Have you ever been in a really difficult situation where you thought that ignorance would have been bliss? This is where I have found myself recently and I am not sure how I actually got here. I am sharing this because some members may identify, or benefit, from my recent experience. However, I am writing anonymously to protect all those involved.

Back to basics

On the 30th September 2013, the General Dental Council (GDC) published Standards for the Dental Team. A document that sets out the principles for conduct, performance and ethics that govern all dental professionals. I trained as a dental therapist after the GDC Standards was published. As students you are taught to follow the principles at all times and it is your individual responsibility to behave professionally. The Standards clearly state what you must do. If you fail to meet the Standards you will be removed from the register and unable to work as a dental professional.

Prior to becoming a student dental therapist, in April 2011, I was a dental practice manager. I clearly remember the day the Care Quality Commission (CQC) became the statutory regulator of dental services in England. Before that date, Primary Care Trusts regulated dental practices, but this was for NHS practices - private practices were simply not regulated. The thought of yearly inspections filled me with dread and the long list of boxes to tick grew by the day. For many practice owners and practice managers the dread is still real but as a dental therapist my focus is now on patient care and the practicalities of implementing and updating the practice's policies and procedures is not within my remit.

Taking a stand

I strongly believe that in dentistry the best teams work together and are great communicators, with our joint focus on patient care. I am lucky that I joined a fantastic practice. We are a very small team with just two surgeries and we all work well together. Then it all changed!

A few weeks ago, I awoke on a Friday morning and made the decision to cancel all my patients and refused to work. My colleague also decided to follow suit. It was one of the hardest decisions I have had to make, but the truth is that I am having to make quite a few hard decisions right now.

Previously, that same week, I had phoned my indemnity provider to check a couple of issues that had come to light. I needed them to confirm that as the issues did not involve patient care, it was not really a concern for me. After speaking to several advisors, I was reminded of The *GDC Standards for the Dental Team, Principle 8: Raise concerns if patients are at risk*. More specifically, 8.1: *You must always put patients' safety first* and 8.2: *You must act promptly if patients or colleagues are at risk and take measures to protect them*. The issues that had come to light were in fact reportable to the CQC who would automatically report to the GDC. I had a duty of care to follow whistleblowing procedures and raise concerns.

I expect you remember the GDC hearing in 2019, where 563 patients were told they needed HIV tests. These patients had been treated with equipment that was potentially not cleaned 'adequately'. A concern was subsequently raised to Public Health England. Alarmingly, four years later, I still see questions being raised on social media around the issue of practices not providing an adequate number of ultrasonic handpieces, which should be autoclaved after each patient. If you find yourself in this exact situation than ask yourself: "Are you putting patient safety first?"

The day I cancelled my patients, I had to ask myself: "If I work today, knowing that there is, amongst other things, an issue with the drugs and equipment for a medical emergency, am I putting patient safety first?" Even although the chances of a medical emergency at the practice were likely to be low, I could not stop worrying that something might happen. In a worst-case scenario, how would I defend my actions in continuing to treat patients with the clear knowledge that there was an issue with the emergency drugs and equipment?

I had raised a few issues two days prior about the practice's general compliance. The problem with the emergency drugs and equipment had still not been resolved and would not be resolved immediately. On my first day back in the practice following that conversation, I realised that my colleague was unaware of the situation. I was left with no choice but to inform them. As we had been unsuccessful in contacting the principal dentist, to discuss the concern with them, together we decided to cancel our lists and refused to work until it was safe to treat our patients.

The other issues with compliance are still on going and not fully resolved. I am now left with a dilemma. Should I just leave, and then the problem goes away, or should I report my concerns to the CQC as there are still breaches in compliance? After a great deal of thought, and many sleepless nights, I decided to give the principal a short deadline to make the practice compliant, which they have agreed to do.

I am currently awaiting the conclusion to this agreement. However, if the practice is not brought up to standard, I will resign and regretfully report the matter to the CQC.

Knowledge is bliss, ignorance is not an excuse!

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In 2022, I virtually joined the National Mobile & Tele-dentistry Conference (NMTC) and this year I was lucky enough to attend in person. Fortunately for me, Sonya (Geriatric Tooth Fairy) and Melissa (thetoothgirl) were happy to contribute to my costs, so I booked my ticket.

NMTC has developed over the last three years, and has been appropriately themed: Evolved (2021); Velocity (2022; and Momentum (2023). I was absolutely thrilled to be taking part in this fast growing dental movement. I relished the opportunity to meet entrepreneurs, industry experts and brand leaders at a conference where delegates had more than 30 educational and innovative sessions to choose from.

And what a conference it was! The overwhelming vibe was one of welcoming love, interest and positivity. I was surrounded by people who spoke my language i.e. mobile, portable, tele-dentistry!

On the final day, the Denobi Award party brought the conference to a close. I was thrilled when my name was called out. The noise was incredible and I collected 'high fives' on the way up to the stage as the audience stood to cheer. I could not stop smiling!

The Denobi awards are for people like you, people who work tirelessly without praise. The NMTC's mission is to show how great WE are!

Who is coming with me next year? Email me on info@flyingsmiles.co.uk or on social media. If you are interested, have a look at my moment in the spotlight here:

https://drive.google.com/file/d/1qfrdNgRr9Gow3-2kuQqsWwIWJWZ2JlL-/view?usp=share_link

Fiona Perry

ELECTRONIC NICOTINE DELIVERY SYSTEMS DO WE KNOW ENOUGH?

by STACIE DE KLERK

It is widely accepted that smoking is a modifiable risk factor that contributes towards oral diseases and oral soft tissue destruction.[1-4] Although, over the last decade tobacco use has decreased, the use of electronic nicotine delivery systems (ENDS) continues to increase, particularly amongst adolescents and young adults.[5-7] Data collected in 2022 showed that 15.8% of 11–17-year-olds had tried vaping, compared to 11.2% in 2021. Furthermore, 7% of 11-17 year-olds in 2022 were current smokers, compared to 3.3% in 2021. The data also showed that 83.3% of this demographic are 'never smokers' or unaware of ENDS.[8] If ENDS are also proven to be modifiable risk factors for oral diseases, in a similar capacity to cigarette smoking, this is likely to further impact on the incidence of periodontal diseases and our daily clinical practice.[9]

Although there is limited information about the safety and impact of ENDS compared to the use of cigarettes, there is a wealth of data on how effective they are at helping smokers to stop smoking, which poses a known and greater risk to health.[10] As clinicians, we need to determine and weigh the benefits against the known risks when recommending and advising patients in our discussions around smoking cessation. There is obviously a need for robust research into the effects of these systems on oral diseases. Nonetheless, the evidence that is currently available shows that ENDS do affect the oral soft tissues, impacting gingival inflammation, DNA changes and potentially the formation of cancerous cells.[11-15]

Currently, the National Health Service promotes the use of ENDS as an alternative to traditional smoking and as a support in attempts to quit smoking.[16] Although consideration should be given to ENDS as an alternative to smoking, patients should be warned about the potential associated risks.[17]

The Delivering Better Oral Health document offers some information and advice on ENDS in Chapter 11: Smoking and Tobacco Use. However, there needs to be more detailed information and advice aimed at clinicians to equip us to effectively manage this growing cohort of patients.[18]

The regulations and legislation currently in place are designed to help protect the public and regulate the production of ENDS, as well as to regulate the selling and buying of ENDS.[12] However, is this enough? Should further action be taken to ensure stricter selling to the public? The safeguarding of the young people who are increasingly using ENDS must be paramount. As dental hygienists and therapists we have a major role to play.

Author: Stacie qualified as a dental hygienist in 2022 from the University of Essex. She is currently studying for a BSc in Oral Health Science at the University of Essex and practises in Colchester. Her specialist interest is in electronic nicotine delivery systems and oral health and smoking cessation.

Email: StacieDeKlerk@hotmail.com

Further resources

British Medical Association: E-cigarettes: Balancing risks and opportunities. https://www.bma.org.uk/media/2083/e-cigarettes-position-paper-v3.pdf

DBOH Chapter 11: Smoking and Tobacco Use. https://www.gov.uk/government/

publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-11-smoking-and-tobacco-use

NHS Better Health: Vaping to quit smoking. https://www.nhs.uk/better-health/quit-smoking/vaping-to-quit-smoking/

References

1. Office of National Statistics. Adult smoking habits in the UK: 2019. London: ONS; 2020 7 July 2020. Chapter 11: Smoking and tobacco use [Internet]. GOV.UK. 2021. Available from: https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-11-smoking-and-tobacco-use
2. Genco RJ, Borgnakke WS. Risk factors for periodontal disease. *Periodontol* 2000. 2013;**62(1)**:59-94.
3. Ahmed N, Arshad S, Basheer SN, Karobari MI, Marya A, Marya CM et al. Smoking is a dangerous addiction: a systematic review on an underrated risk factor for oral diseases. *Int J Environ Res Pub Health.* 2021;**18(21)**:11003.
4. Chattopadhyay A, Patton LL. Smoking as a risk factor for oral candidiasis in HIV infected adults. *J Oral Pathol Med.* 2013;**42(4)**:302-308.
5. Chaffee BW, Couch ET, Gansky SA. Trends in characteristics and multi-product use among adolescents who use electronic cigarettes, United States 2011-2015. *PLoSOne*. 2017;**12(5)**:e0177073. doi: 10.1371/journal.pone.0177073.[PMC free article]
6. Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA. Notes from the Field: use of electronic cigarettes and any tobacco product among middle and high school students - United States, 2011-2018. *MMWR Morb Mortal Wkly Rep.* 2018;**67(45)**:1276–1277. doi: 10.15585/mmwr.mm6745a5. [PMC free article]
7. Farzal Z, Perry MF, Yarbrough WG, Kimple AJ. The adolescent vaping epidemic in the United States—How it happened and where we go from here. *JAMA Otolaryng – Head Neck Surg.* 2019;**145(10)**:885-8866.
8. Action on Smoking and Health. Use of e-cigarettes (vapes) among young people in Great Britain [Internet]. 2022 Jul. Available from: https://ash.org.uk/uploads/Use-of-e-cigarettes-among-young-people-in-Great-Britain-2022.pdf?v=1661866458
9. Vohra F, Bukhari IA, Sheikh SA, Albaijan R, Naseem M. Comparison of self-rated oral symptoms and periodontal status among cigarette smokers and individuals using electronic nicotine delivery systems. *J Am College Health.* 2020;**68(7)**:788-793.
10. British Medical Association. E-cigarettes: Balancing risks and opportunities [Internet]. 2017. Available from: https://www.bma.org.uk/media/2083/e-cigarettes-position-paper-v3.pdf
11. Isik Andrikopoulos G, Farsalinos K, Poulas K. Electronic Nicotine Delivery Systems (ENDS) and their relevance in oral health. Toxics. 2019;**7(4)**:61.
12. British Medical Association. E-cigarettes: Balancing risks and opportunities [Internet]. 2017. Available from: https://www.bma.org.uk/media/2083/e-cigarettes-position-paper-v3.pdf
13. Beklen A, Uckan D. Electronic cigarette liquid substances propylene glycol and vegetable glycerin induce an inflammatory response in gingival epithelial cells. *Human Experiment Toxicol.* 2021;**40(1)**:25-34.
14. Holliday R, Chaffee BW, Jakubovics NS, Kist R, Preshaw PM. Electronic Cigarettes and Oral Health. *J Dent Res.* 2021;**100(9)**:906-913.
15. Atuegwu NC, Perez MF, Oncken C, Thacker S, Mead EL, Mortensen EM. Association between Regular Electronic Nicotine Product Use and Self-Reported Periodontal Disease Status: Population Assessment of Tobacco and Health Survey. *Int J Environ Res Pub Health.* 2019;**16(7)**:1263. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6479961/
16. NHS Choices. Using e-cigarettes to stop smoking - Quit smoking [Internet]. NHS. 2019 [cited 2022 May]. Available from: https://www.nhs.uk/live-well/quit-smoking/using-e-cigarettes-to-stop-smoking/
17. Weke A, Holliday R. Electronic cigarettes: an update on products, regulation, public health approaches and oral health [Internet]. www.cdhjournal.org. *Comm Dent Health J;* 2022 [cited 2023 April]. Available from: https://www.cdhjournal.org/issues/39-2-june-2022/1124-electronic-cigarettes-an-update-on-products-regulation-public-health-approaches-and-oral-health
18. Public Health England. Delivering better oral health: an evidence-based toolkit for prevention. https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention

THE 'NO-ADDED-SUGAR-TRIBE' REVISITED

by TIM IVES

In 2020 I invited a group of 41 international dental hygienist and dental therapist colleagues to join me in a research project that I was keen to undertake. The subject of our curiosity was added-sugar and behaviour change. My research is ongoing, and you can read about it in the *Annual Clinical Journal of Dental Health*.[1,2]

One of my initial discoveries was that, for a variety of reasons, these dental hygienists and dental therapists struggled to stop eating sugar.[1] The biggest surprise for many was to realise that they were, in fact, addicted to sugar and therefore unable to kick the habit without help and support.

In my second study, one of the participants set up a support group on Facebook. Fifteen members joined and participated. It was subsequently found that those dental hygienists and therapists who joined the support group were more likely to be successful in quitting sugar.

Following on from this, in 2021 I created a 'no-added-sugar- tribe' involving sixteen of the 41 original participants.[2] For three months, the group was asked to join weekly online video meetings to provide emotional and mental support for one another and avoid added-sugar in their diets. The results were amazing! Most participants lost weight, were more happy and far healthier both mentally and physically, so much so, they did not want the study to end.[2]

In February 2023, just over a year since they left the 'tribe', I sent the participants an online questionnaire to discover how they were currently managing their relationship with sugar. This follow-up provides a general summary of their responses and discusses the implications for successful behaviour change amongst dental teams and our patients.

Q: Looking back, what were your general thoughts on being a member of the no-added-sugar tribe for three months?

For all participants, it had been a positive experience. All had benefited from hearing and sharing one another's experiences and struggles.

"I worried it might be a bit cult-y and Slimming World-esque initially, but we were all so supportive of each other and I really enjoyed the meetings."P1b

"It was a very positive experience. I gained knowledge on all things to do with sugar and sweeteners and became much more aware of my consumption. It also gave a great sense of community and accountability." P1a

Q: How did your mental and physical health change during the three months when you were a member of the tribe?

There was confirmation of the improvements in their mental and physical health, including weight loss.

"My mental and physical health changed beyond recognition during the research. How much of that was down to the absence of sugar and how much was the support that the tribe brought, is hard to define. It was such a profound change for me that the lines are a little blurred…." P1d

Q: Has your added-sugar consumption changed since you stopped participating in the online meetings?

There was approximately a 50:50 split in participants who have remained added-sugar free for the last year and those who had let sugar creep back into their diet. Many of those who had abstained, had noticed a change in taste sensation, so much so that they now disliked the taste of sweetened foods and drinks. Of those who were still consuming added-sugar, some were at much lower levels than previously. However, others had allowed added-sugar back into their lives completely, despite having been previously convinced this would not happen!

"It took a while as the health benefits were so profound for me and I couldn't ever imagine going back but as I relaxed around it and allowed gaps to appear in my rigid no-sugar diet it soon became less of a gap and more of an open flood gate!" P1d

Q: Has your mental and physical health changed since you stopped participating in the online meetings?

Those whose diets had remained free of added-sugar noticed very little change in their mental and physical health while most of those who were now once again consuming sugar, noticed a deterioration.

"I let sugar gradually creep back into my diet so that's been a big change. Physically I gained weight and stopped exercising as much as my energy levels dropped. Mentally that has an impact. The thought of eliminating sugar again feels daunting without being part of the research group and having the momentum of a tribe all pushing forwards together." P3a

Two participants have recently had babies. Both have been consuming sugar and noticed a deterioration in their physical and mental health. This was attributed to a combination of morning sickness, feeling tired and an increase in sugar consumption.

Q: Please describe what you have learnt about your relationship with sugar.

"It's everywhere. It's addictive. It's unhealthy. it's so good. It makes me happy, but only for a while." P3b

All the dental professionals discussed the addictiveness of sugar and how quickly their consumption increased unless they were extremely vigilant. Most are convinced they are addicted to sugar.

"Quite simply I am a sugar addict. I cannot have it without craving more and more. It is my version of heroine. My version of nicotine. My version of alcohol. There's very little space between abstinence and binge." P1d

Q: Has anything changed regarding your relationship with colleagues and patients on the topic of sugar since the study ended?

Most participants had changed the way that they communicate advice regarding sugar reduction or cessation with their patients.

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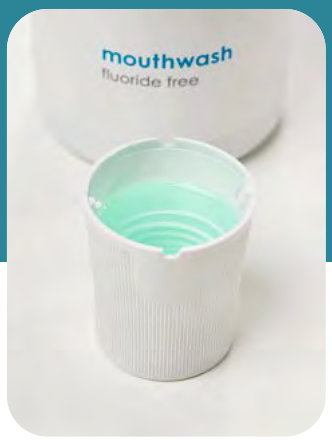

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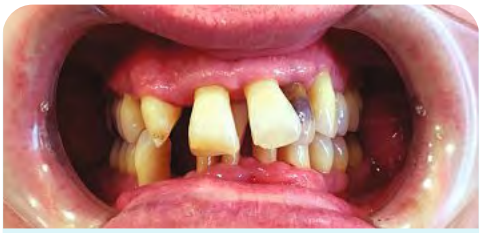

Recall at 12 months.

Case study and photographs courtesy of
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"I now approach these conversations entirely differently and am better placed to support them. I have independently sourced details of other healthcare professionals in the area around where I work so I start conversations now knowing I have the resources to refer on." P1d

Some of the participants were already making sugar cessation discussions a priority prior to taking part in the study. A few, for various reasons, have been reluctant to discuss sugar addiction and cessation.

"Since I have been eating sugar again, it has felt a little hypocritical to bring up the subject when I know it's not something I'm currently following." P1b

Q: Do you have any other comments?

"I am staggered by others resistance to give up sugar." P2b

"It is criminal that more weight is not put on it as a serious dental and health issue, but I'm not surprised." P3a

Discussion

I have previously documented the alarming statistics regarding sugar and our nation's oral and systemic health.[1,2] We are the 'frog that is being boiled alive' and the temperature is now getting very warm.[3]

The UK National Health Service (NHS) provides help and information on its website and lists the most common addictions as: gambling; drugs; alcohol; and smoking. There is also mention of: work; internet; solvent; and shopping addictions. There is no mention of sugar or processed foods![4] Most sugar is bound up in processed foods.[5]

A systematic review on food addiction concluded: "Overall, findings support food addiction as a unique construct consistent with criteria for other substance use disorder diagnoses. The evidence further suggests that certain foods, particularly processed foods with added sweeteners, demonstrate the greatest addictive potential"[6].

It is essential that the NHS aligns its advice and guidance with the current evidence base!

The participants in this study have clearly demonstrated that reducing and/or quitting added sugar is far from straight-forward and simply educating and/or advising patients on this topic will not end in success for all. At the same time, sugar cessation is almost certainly within our remit, and if successful, may have the biggest impact on a patient's and clinician's oral and systemic health.

In this study it has been demonstrated that to reduce and/or quit sugar successfully, some people need constant support. In the long-term we should investigate the possibility of creating and developing practice supported groups for patients and staff needing guidance regarding sugar addiction and cessation.

Top TIPS

In the short-term, to be more successful and start to reduce the strain on our dental services there are many small steps we could take within our dental practices.

1. Attempt the 28 day no-added-sugar challenge – see how far you can go and what you learn from the experience.
2. Become the sugar expert in your practice.
3. Discuss with your dental teams the importance of this topic. Ensure all staff are 'singing from the same hymn sheet.'
4. Consider opening a dialogue about sugar addiction with your patients and start to identify the ones who would benefit from more support.
5. Start to measure your success rate and reflect on what works and why.
6. As a team, develop a plan as to how you can be more successful and set goals. Give updates at team meetings and ensure it stays on the agenda. Be creative!

Thank you to all the participants who gave up their time to increase our knowledge, reduce disease and help our patients become healthier.

If you feel you need more help and guidance with any of the above, please get in-touch.

Author: Tim qualified as a dental hygienist 30 years ago whilst in the Royal Air Force. He is a self-confessed sugar addict. He is also co-founder of O'Hehir University (www.ohehiruniversity.org) where he teaches the new online Master's Degree in Oral Health Promotion.

Email: tim@ohehiruniversity.com

References

1. Ives T. An investigation into what dental hygienists and dental therapists would discover if they attempted to stop consuming added-sugar for 28 days. *Ann Clin J Dent Health.* 2021;**10**:11-15.
2. Ives T. An investigation into knowledge gained by a group of dental hygienists and dental therapists invited to join a 'no-added-sugar tribe'. *Ann clin J Dent Health.* 2022;**11**:50-55.
3. Canadian Medical Association Journal. The tale of the boiling frog. *CMAJ.* 2004;**171(12)**:1425. doi: 10.1503/cmaj.1041718 Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC534568/ (Accessed March 2023).
4. NHS. Addiction: what is it? Available from: https://www.nhs.uk/live-well/addiction-support/addiction-what-is-it/ (Accessed March 2023).
5. Ifland J. Processed Food Addiction: Foundations, Assessment and Recovery. New York: CRC Press, 2020.
6. Gordon EL, Ariel-Donges AH, Bauman V, Merlo LJ. What is the evidence for 'food addiction?' A systematic review. *Nutrients*: 2018;**10(4)**: 477. https://doi.org/10.3390/nu10040477

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PERIODONTITIS DIABETES INITIATIVE A REFLECTION

by VARKHA RATTU

'Integrated care pathways' and 'interprofessional collaborations' are systems often discussed in relation to guidelines and policies but, as we all know, difficult to make a reality.

The first time that I had heard about the potential for an integrated care pathway between medical and dental professionals, to aid with the management of patients with diabetes, was September 2019, at a local dental committee (LDC) meeting, Professor Iain Chapple spoke about the NHS commissioning standard: *'Dental care for People with Diabetes.'*

At that time, I had just began my dental core training year 1 in Oral and Maxillofacial Surgery (OMFS) at New Cross Hospital, Wolverhampton. My educational supervisor had asked me to consider undertaking an OMFS audit. However, I had my heart set on applying for the Periodontology MClinDent programme at Guy's Hospital (King's College London). I therefore did the unthinkable (well, the unthinkable when you're in OMFS)! I asked whether I could undertake a perio-related project for my DCT year instead.

Fast forward a year and I had successfully teamed up with the Diabetes Department at New Cross Hospital to mimic the, then, recently published commissioning standards within a secondary care setting. We introduced a periodontal review within diabetes consultations and were signposting diabetes patients to see their dental professionals for periodontal assessments.

The project was a huge success and was recognised nationally, winning the British Society of Periodontology (BSP) Audit Award. Following this, I was approached by the lovely team at TePe who asked what my plans were for this project going forward. They thought it was a great initiative and had the possibility to be expanded further.

Truthfully, I had no plans for the project going forward. I had gained a place on the MClinDent Periodontology Programme at KCL and would be heading down to London a few months later. But their interest did prompt me to stop and reflect on the journey to date. The project had turned into something much bigger than I could ever have imagined. We had successfully changed the mindsets of our medical colleagues who were now factoring in periodontitis as an important complication of diabetes. This had resulted in a wonderful and new collaboration with them. Would it really be right to stop at the peak of it all?

I started thinking…what can I do next?

I went back to the diabetes team and asked how they felt they could improve compliance with the initiative. They informed me about their lack of confidence discussing dental-related concerns with their patients and that they often wished they had dental personnel within their team to whom they could actively refer. With the latter requiring serious legislation change, I decided on doing something 'smaller' to help them when discussing periodontitis with their patients.

I designed and created a 'Periodontitis and Diabetes: Your guide to better gum health' leaflet with the support of the team at TePe. It included comprehensive information for the patient and allowed the diabetes healthcare professionals to use it as a guide for their conversations. In addition, it also included QR codes to signpost patients to the BSP and TePe websites for further information and to claim a free sample pack of interdental brushes. The offer of the brushes was extremely important to me and I was adamant this had to be included with the leaflets. We know successful behaviour change will be more likely when patients are able to see the positive outcomes an initiative can have upon their life.

So where are we now and what have we achieved?

To date:

1. We are successfully raising awareness of periodontitis amongst our diabetes patients within hospital settings and undertaking periodontal reviews as part of diabetes consultations. You can see the project in action here: https://www.youtube.com/watch?v=_4dw1VUojnE
2. We had a phenomenal response when we presented this work at the International Symposium on Dental Hygiene 2022 in Dublin.
3. The University of Birmingham has included our work within their 'Diabetes and Oral Health' short CPD course which has gained a lot of positive interest.
4. Dental professionals are delivering talks locally to medical health professionals about the importance of periodontitis and using our leaflet.

Looking back on the last three years, when I ask myself whether I thought we would be here now, the answer is absolutely not! I never ever expected something I had to do as a 'tick box' exercise during DCT to achieve the positive response it did. The significant impact it has made on patients, and our medical colleagues, was beyond anything I could have ever imagined.

This is why 'interprofessional collaborations' and 'integrated care pathways' will and should work – working together is always so much more beneficial than working individually.

Author: Varkha qualified from Queen Mary, University of London, in 2018. Following graduation, she undertook posts in general practice and hospital. She is now on the four-year periodontology postgraduate programme at Guy's Hospital, London. She was the recipient of the prestigious British Society of Periodontology Systematic Review Prize for her high-quality research where she collaborated with some of the World's leading periodontists.

Email: varkha.rattu@nhs.net

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INFORMAL LEARNING IN AN ONLINE COMMUNITY OF PRACTICE OF DENTAL HYGIENISTS

by JOHN STANFIELD

Introduction

Generally, the formal learning process takes place in an educational setting: courses are developed with educational outcomes and delivered by educationalists or experts. However, as a working professional, often an individual's learning is experiential, it happens incidentally on a daily basis.

Dental hygienists learn from a variety of informal learning situations and the General Dental Council requires its registrants to have formal documented evidence of their continuing education. To date, there have been no studies into informal learning for UK dental hygienists, there have however been studies carried out for other healthcare professionals.[1-3]

An online forum

The website www.hygienist.co.uk was set up to support dental hygienists in the United Kingdom. The site has been in operation since 2000 as an online forum for discussions around the practice of dental hygiene in the UK. This forum is essentially a Community of Practice (CoP).[4] The website has no affiliations to institutions or professional bodies and points for discussion are raised by the members. Membership of the site is restricted to members of the dental profession and some suppliers to the profession.

The use of the word informal may have different meanings depending on an individual's viewpoint and the context in which it is used. It is used here in the context of being outside of institutional control and with no formal agenda or structure. The members in this CoP discuss matters relevant to them, at that point in time, and whilst there are moderators there is no overall leadership as such. Participants develop their own concepts of value placed on contributions to discussions.

This online forum does provide informal learning, but its value and any improvement to patient care is unknown and is a subject for investigation in the author's ongoing PhD thesis.

Some background

Informal and non-formal learning

Three forms of informal learning have previously been identified: [5]

1. **Self-directed learning:** there is intention and awareness of learning something.
2. **Incidental learning:** there is no intention but there is awareness that some learning has taken place.
3. **Socialisation:** (also referred to as tacit learning) refers to the internalisation of values, attitudes, behaviours, skills etc. that occur during everyday life. Not only do we have no prior intention of acquiring them, but we are not aware that we learned something.

Community of Practice - Framework

1. **A Domain:** members share an interest in the dental hygienist profession.
2. **A Community:** members interact with each other via the forums which are not open to outsiders.
3. **A Practice:** members are practitioners in oral health and practice as dental hygienists.

Member Volunteers

A request for volunteers to share their experience of the forum, by answering some questions via email, was posted onto hygienist.co.uk by the author. The questions were designed to encourage the participants to think about the learning that took place both for them, and for others, and how this learning could be developed (Fig 1.). Ethical approval for the study was obtained from Lancaster University, participants were provided with an information sheet via email and their consent was obtained via email. Assurance of confidentiality and anonymity was given and that they could withdraw consent up to the point of data analysis commencing. Six members volunteered. To protect their anonymity, they were assigned a letter and a number to their written responses.

The dental hygienist volunteers had a range of experience between 10 years and 40 years. It would have been interesting to gather views from newly qualified members; however, this particular group was not engaged with the forum.

Findings

The volunteers emailed their responses to the author. They described their personal conceptions of the learning that took place in the forums. Each had a range of experience both as a dental hygienist and as a member of the CoP. The intention in the questions asked was to explore their thoughts on the

Figure 1: **Questions**

QUESTIONS

1. Can you think of a discussion on the forum, whether you were involved in the discussion or not, where you learnt something that added to your practice?
2. Do you ever go on the forum to learn something new or do you find that you just discover something that you learn from?
3. Do you feel that when you are involved in discussions, that others learn from your input?
4. Do you feel that the discussions that take place impact upon the care for your patients?
5. How do you value (if you do value it) having somewhere to come and discuss ideas
6. In your overall learning process, how does this sort of informal learning fit in?
7. Would you prefer the learning that happens in hygienist.co.uk to be more of a constructed learning (in that we choose a theme or a paper to discuss for a set period)?

Table 1: **Participant Coded List**

Member	Joined	Posts	No of Years as Hygienist
L1	2008	150	40
G1	2009	270	12
R1	2013	110	38
S1	2008	3350	23
R1	2008	1900	10
E1	2009	390	25

learning they felt took place and why they interacted with others in the CoP.

The responses gathered from these volunteers revealed a clear variation about how they viewed the CoP as a vehicle for their learning and how their participation assisted others to gain from their knowledge and experience.

Conception 1: Structured learning

The volunteers were questioned about having a more constructed and formal type of learning within the CoP. Some felt it may work, or that it may work for others but maybe not for themselves. Some thought that they were alone in preferring the informality of the CoP and that maybe others preferred structure, and that perhaps they should also.

- R1 – *'I can see the reasoning…I prefer the informality where nothing is expected or asked.'*
- E1 – *'I think this may be beneficial. Some people like structure.'*
- R1 – *'Giving some direction and structured learning would give a new dimension. Online CPD tends to be quite soulless… having ongoing discussions would improve that experience.'*
- L1 – *'…in addition not as a replacement for informal questions and opinions. Reading papers and discussing with peers would be beneficial.'*

Conception 2: Learning relevant to practice

Volunteers described how discussions they had been involved in within the CoP had added to their clinical practice as they had learnt from their peers. This type of incidental learning happens when professionals get together in face-to-face meetings or online.[6] They may not have asked the initial question but would get involved in the subsequent discussion. Others would have been bystanders, not directly involved but had read the discussion thread (which may be some time later after on an online forum).

- S1 – *'I used the forum to discuss why Chlorhexidine caused certain problems. A well-informed member furnished the information.'*
- G1 – *'I have asked many questions relating to my practice and have had useful answers. I have become engaged with others questions and have learned from these.'*
- R1 – *'Shared updates… I rarely read email updates… But I do read updates shared by peers. Sometimes I follow a discussion and learn more as my colleagues interact, e.g. "flxxxie" started a discussion on IRMER which reassured me that I was operating within my competency levels. Every now and then a post unfolds from which a lot is learnt and that information can be passed to colleagues and developed to ensure the practice is moving with the times.'*

Conception 3: Shared experience and camaraderie

Volunteers described how their discussions in the CoP led to a sharing of experiences and how this also promoted a feeling of camaraderie. Some went so far as to belittle their own input, feeling that others had more to offer. Many shared feelings of isolation as a practitioner and added that the CoP offered an identity alongside others in their profession.

- R1 – *'Certainly for myself, having somewhere to chat over 'our' world is something I value tremendously. I have no problem asking a question of my colleagues (probably too old to be worried about being embarrassed for asking) if I need to find something out. The simple expedient of 'letting off steam' to an understanding and like-minded group of colleagues can also be advantageous.'*
- R1 – *'I enjoy people making me question my knowledge and see things from a different perspective. What is most important to me is knowing I'm not the only person facing struggles in clinic, reading how others deal with a situation is reassuring.'*
- L1 – *'For many of the 40 years since qualification the profession was a mainly solitary experience and it was difficult to target learning.'*

- G1 – *'I value having somewhere to come and discuss ideas. As hygienists we are quite isolated and often working in a practice as the only hygienist. I try to link to evidence where my information has come from so that people know that it is not just me giving my own opinion.'*

Conception 4: Informal and non-critical

The knowledge that you can ask questions without your peers dismissing it out of hand allows for a freer discussion of ideas. By discussing ideas, a critical reflection can take place to creatively encourage a wider range of options and justify or alter their own perceptions or assumptions. The volunteers described the informality of learning in a CoP and liked that discussions were non-critical.

- L1 – *'I feel comfortable to post questions and comments. I am not sure that my opinions are particularly helpful to other people. However, I would feel comfortable to post if I thought I could be of help.'*
- R1 – *'Having a forum with is non-judgemental and semi-anonymous where we can discuss concerns and ideas is invaluable. During my early career I needed much more support and guidance.'*
- E1 – *'It is a huge value for everyone to have places where they feel they can contribute and not be criticised. Having a safe environment for learning and developing is vital. This is particularly useful for newly qualified hygienists.'*
- R1 – *'In a forum setting, where the only link is your profession, an element of anonymity, relaxation, self-learning motivation, pride in your profession and self and the ambition to do the best for your patients, these are the elements that have the potential to make the learning experience fulfilling.'*

Discussion

The significance of informal learning is clear from the input of these six volunteers :

- **Self-directed learning:** there is intention and awareness of learning something. Some of the volunteers went onto the forum with the express intention of finding answers to their questions; they knew that someone within the CoP may well have had similar experiences because they share a common domain.
- **Incidental learning:** there is no intention but there is awareness that some learning has taken place. During the discussions taking place, individuals are learning even when not actively involved in the actual discussion.
- **Socialisation:** (also referred to as tacit learning) refers to the internalisation of values, attitudes, behaviours, skills, etc. that occur during everyday life. Not only we have no prior intention of acquiring them, but we are not aware that we learned something. The knowledge that ideas may be discussed in a non-critical environment allows the individual to put forward their ideas and join discussions. It becomes an exploration and a sharing experience without the pressures that may be present in face-to-face and formal learning situations.

Conclusion

Formal and informal are two modes of education insufficiently represented in the literature.[7]

These dental hygienists felt that they were informally learning within this CoP. They described their informal learning experience as being relevant to their sphere of practice carried out in a safe and non-critical environment. They perceived that this type of learning impacted and improved their patient care. They also placed a great value on this form of learning. Much of this is due to the fact that a dental hygienist often works in isolation from their peers and that face-to-face meetings may be difficult. Within the CoP they may dip in and out as they feel the need for connection. The final question as to the potential addition of more formal or non-formal learning within the CoP, rather than informal, is still open to debate as many can see the benefit but prefer the informal approach for themselves.

Within the dental profession, this type of informal learning is accounted for but not very well articulated within continuing professional development (CPD): there are no identifiable learning aims and outcomes and a certificate to prove that you attended (but not necessarily learnt anything). If the body of research can show that learning is taking place, then it surely follows that some form of CPD verification should also be available.

Author: John is a dental hygienist with over 40 years of experience in private practice. Currently the Chair of the Faculty of Dental Hygienists and Dental Therapists at the College of General Dentistry, he is a PhD candidate at Lancaster University researching Social Learning Networks.

Email: info@johnstanfield.co.uk

References

1. Swanwick T. Informal learning in postgraduate medical education: from cognitivism to 'culturism'. *Med Educ.* 2005;**39(8)**:859-865.
2. Bjørk IT, Tøien M, Sørensen AL. Exploring informal learning among hospital nurses. *J Work Learn.* 2013;**25(7)**:426-440.
3. Crawford K, Gordon S, Nicholas J, Prosser M. Conceptions of mathematics and how it is learned: The perspectives of students entering university. *Learn Instruct.* 1994;**4(4)**:331-345.
4. Lave J , Wenger E. Communities of Practice 1991; 2016. Available from URL: http://www.learning-theories.com/communities-of-practice-lave-and-wenger.html
5. Schugurensky D. The Forms of Informal Learning. Toronto: Ontario Institute for Studies in Education of the University of Toronto (OISE/UT); 2000.
6. Marsick VJ, Watkins KE. Informal and incidental learning. New Direct *Adult Cont Educ.* 2001;**89**:25-34.
7. Latchem CR. Informal learning and non-formal education for development. *J Learn Develop.* 2014; **1(1)**:1-11.

Dementia friendly dentistry

by CHARLOTTE JEAVONS

AIM

To highlight how dental hygienists and dental therapists as clinicians and practice owners can deliver dementia friendly dentistry

LEARNING OBJECTIVES

- To detail the scale of people living with dementia in the UK and how this population has increased over time.
- To explain how the built environment can be adapted for people living with dementia.
- To highlight possible tools to aid communication with people living with dementia.
- To outline specific clinical considerations for dental hygienists and therapists when treating someone living with dementia.

LEARNING OUTCOMES

Readers should be able to evaluate their own attitudes towards this topic and engage in further training to improve knowledge and confidence to communicate with this cohort of patients.

GDC development outcomes: A, C

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ABSTRACT

This paper aims to set out four key areas for consideration when treating a patient with dementia: dental environment; communication; clinical issues; and specialist care. The purpose is to shed some light on the growing number of people living with dementia and to explore ways that dental professionals can adapt current practices to meet their complex needs.

KEY WORDS

dementia, Alzheimer's, communication, dental practice environment, clinical considerations, specialist care

Introduction

Dementia is one of the most common neurological disorders in older people. The number of people living with dementia (PLwD) was approximately 1 million in 2021 and, as the population ages, estimates expect this to reach 2 million by 2051.[1] Almost 40% of those people aged over 65, that are thought to have dementia, have received a formal diagnosis and more people are living longer after diagnosis.[2,3] As such, most dental professionals will treat a number of people with dementia, whether formally identified or not.

Dementia comes in a variety of forms including: Alzheimer's disease; Vascular dementia; Mixed dementia (a term used when people have both Alzheimer's and vascular dementia); Dementia with Lewy bodies; Fronto-temporal dementia; and Parkinson's dementia, among others.[4] Of these, Alzheimer's is by far the most common but, regardless of the type of dementia, patients living with the condition often have many symptoms and behavioural characteristics. For example, symptoms may include: memory loss; difficulty concentrating; being confused about time and place; mood changes; struggling to follow conversations; or an inability to find the correct word. Changes in behaviour may manifest as: rudeness; aggression; becoming withdrawn; overly affectionate or sexual; repetition of small acts like hand rubbing or foot tapping; or repetition of particular phrases or words.[5]

Dementia is a progressive condition where neuro-degeneration occurs to an extent that is beyond normal

aging.[6] There is a substantial burden of oral disease and orofacial pain in PLwD and this is greatest in those with the most advanced dementia who are unable to self-report.[3] Research into the impact of oral-diseases routinely include markers for health-related quality of life (HR-QoL). Unfortunately, for older people, only a few include PLwD.[3] However, dental professionals can plan a key role in helping PLwD to maintain their quality of life as much as possible for as long as possible.[7]

In order to do this, it is important to establish an oral care routine that involves dental professionals soon after a diagnosis, if this is not already in place. This will help to establish familiarity and continuity for the patient while they are still able to adapt to new environments, people and situations. Adopting dementia friendly practices will make it possible for PLwD to access compassionate and individualised care, helping them to feel a sense of belonging and a valued part of community and civic life.[8] Below are four key areas that if considered from the perspective of a patient with dementia, can be easily incorporated into routine care to improve the dental experience and quality of care for PLwD.

Dental environment

The dental practice environment can make a significant difference to a PLwD's experience. Advertising the practice as being 'dementia friendly' can take some of the fear out of registering as a new patient for PLwD and their carers. It can be helpful to offer familiarisation visits prior to dental appointments, to help alleviate anxiety. Being flexible with appointment times and offering longer appointments can help accommodate PLwD and carer needs, particularly as the disease progresses and life becomes more complex.

The experience of being in a dental environment is felt at a sensory level for a PLwD and as cognitive function deteriorates, the ability to integrate sensory experiences and understand context declines.[4] The environment of a dental practice will need to be carefully managed so that it is not overstimulating to the point of frightening PLwD. Signage with yellow font on a bold black background that has a matt finish, not gloss, is thought to be most effective.[8] Spatial awareness, understanding and perception of once familiar objects can become distorted for a PLwD and this can lead to a refusal to enter a practice or surgery. To an observer this may appear as difficult or problem behaviour but to a PLwD this is perfectly rational and based on their understanding of what they can see. Traditional seating in the waiting room in a contrasting colour to the floor will help visibility and a feeling of familiarity.[8] Shiny or gloss finish surfaces can create problems for PLwD who may identify these as slippery or as water.[8] Very dark floors can be seen as holes or pits to be avoided. If possible, maintain the same flooring throughout, any changes can be seen as level differences or obstacles to some PLwD.[8] The same applies to shadows from poor lighting i.e. these can appear as areas to be avoided. Equally, use contrasting colours in lavatories. All white sanitary wear can be confusing and different elements e.g. sinks and toilets can be indistinguishable, as can modern taps and fittings.[8] A simple remedy is to use a contrasting coloured toilet seat and clear signage. Some PLwD react differently to noise and music, so to limit any potential issues keep background noise to a minimum, play gentle low volume music or turn it off, if needed. This will help PLwD to keep calm and avoid anxiety for them and any carers.

Communication

It is crucial to develop a positive relationship and encourage openness about a dementia diagnosis and the particular needs of individual patients. Forging a relationship with the PLwD's carer (formal or informal, such as a family member) is crucial, if they have one. A third of people diagnosed with dementia live alone in the community.[8] Some PLwD prefer important questions or information to be directed at their carer and as the disease progress this may become necessary. It is useful to make a note of the carer's details and their relationship to the PLwD when a person first attends the practice or discloses a dementia diagnosis. However, it is important to remember the PLwD is the patient, it can be useful to ask them directly, how you can best help them and what they need to feel calm and comfortable visiting the practice.

Some PLwD, or carers, will benefit from using the Alzheimer's Society 'This is me' document, which enables them to consider likes and dislikes in advance.[9] This can also list any medication the patient is currently taking and is sometimes called a 'patient passport'.[4] When talking to a PLwD, enable choice where possible but only ask them to make one decision at a time e.g. 'Do you prefer to attend in the morning or afternoon?'[4] Try to refer to things and people by name e.g. 'Have you seen your Doctor, Dr Smith?' Allow time for the PLwD to respond, especially if you are using words that are unfamiliar to them. As the disease progresses a PLwD's verbal ability can diminish significantly and, as this happens, they can become more sensitive to body language.[4]

Accompanying PLwD to and from the waiting area can also help to develop a personal relationship and lessen feelings of being overwhelmed. It is also helpful to maintain continuity of care by ensuring the PLwD sees the same clinician and nurse each time, if possible. Using communication methods that most suit the individual will also help to maintain their sense of independence, which is something PLwD often report is important, especially in the early days of the diagnosis. For example, print treatment plans and offer a range of recall reminders i.e. letters, calls and text messages.[8]

Clinical considerations

A person's oral health is dependant not only on the treatment and care received in a dental surgery but also on how the individual self-manages their mouth. A PLwD's oral health and oral history at the time of diagnosis provides dental professionals with an indication of the importance the individual previously placed on oral care. This is a consideration when treating someone with dementia and making decisions with them about their treatment options. An additional layer of complexity comes from the fluctuating ability and motivation many PLwD will experience. Researchers have found a link between poor oral hygiene

and worsening of cognitive functions.[10] This is particularly pertinent when considering oral hygiene advice, which should be kept simple and realistic. Interdental cleaning may not be possible for many people.

There are three broad actions to assess the oral health of a PLwD. These include: the patient's perception of need; intra-oral examination; and observation or assessment of the PLwD's behaviour.[11] The last of these may require the assistance of a carer, who often has very detailed and intimate knowledge of usual behaviour and who will be able to report any subtle change to this if communication by the PLwD is limited. If the PLwD is unable to interpret or vocalise pain or discomfort, changes in behaviour that can be indicative of oral pain include:

- Refusal to eat (particularly hard or cold foods)
- Constant pulling at their face
- Increased drooling
- Leaving previously worn dentures out of their mouth
- Increased restlessness
- Moaning or shouting
- Disturbed sleep
- Refusal to co-operate with normal daily activities, such as grooming, washing and toothbrushing
- Self-injurious behaviour
- Aggressive behaviour towards carers[12]

There is no medication that can cure dementia, but a small selection of drugs has been developed that can temporarily alleviate Alzheimer's symptoms, and in some cases slow progression.[4] These are acetylcholinesterase inhibitors (generic names include Donepezil, Rivastigmine, and Galantamine) and N-methyl-D-aspartate receptor antagonists (generic name Memantine).[4] PLwD also take medication to help with conditions associated with their dementia and these can have implications for oral health. For example, it is not uncommon for PLwD to be prescribed antidepressants, which can lead to xerostomia.[4] A minority of PLwD in more advanced stages are prescribed antipsychotic medication, which can lead to repeated involuntary tongue or jaw movements. This can make treatment itself difficult and wearing dentures problematic.[4] Equally, medication of this type can lead to bruxism. Other side effects include: drowsiness; shaking and unsteadiness; increased risk of infection; falls; blood clots or stroke. In addition, some medication is prescribed as a syrup containing lactose to help PLwD whose disease has progressed to include dysphagia. Fluoride varnish may be a useful tool for dental professionals to help limit the risk of dental caries if a sugar-free alternative cannot be prescribed.

PLwD who wear a denture should be encouraged to continue to do so. This helps to maintain self-esteem, as well as eating and speaking. As the disease progresses, they may need help putting them in and carers may need to be taught how to do this. If dentures are left out for any length of time, a PLwD can 'forget' how to wear them and never regain the habit. Denture loss is common for PLwD,

especially when they are in an unfamiliar environment.[4] Replacing lost dentures can be a difficult and an unsatisfactory process for all concerned. Depending on the severity of the dementia replacing only the upper denture may provide a compromise, but this will need to be assessed on an individual basis considering what the PLwD can tolerate.[4] Often, when the PLwD is in the advanced stages of the disease they simply stop wearing their denture(s) altogether.

People living with dementia should be given the opportunity to make an informed choice about their treatment and care. Some PLwD, or their carers, may have difficulties completing medical history and consent forms. Having these available in dementia friendly formats will help. However, dental care professionals will need to consider the person's capacity to consent to treatment. Capacity can and does fluctuate and so any consent decisions will need to be revisited at each appointment. It is important that dental care professionals are familiar with the Mental Capacity Act[13] with regard to consent and act accordingly. When caring for people with dementia, dental care professionals also need to feel comfortable not delivering care to those who decline it, or for whom treatments could harm their overall wellbeing.[7] This can be a difficult decision but, on occasion, it is a necessary one. In these instances, the treatment may be possible at a later visit, or it might be more useful to refer the PLwD to specialist care services.

Specialist care

There may come a time when a PLwD can no longer access dental care from their usual practice and at this point more specialised care will be needed. This can either be in the form of domiciliary care, which some practices deliver or, more likely, they will require a referral to a community dental service or hospital. Domiciliary care can be less stressful for the PLwD and their carer, but this will limit the type of treatments that can be carried out.[14,15] Often recall and routine treatments, such as dental hygiene appointments, can be easily carried out at a patient's home, including in nursing and residential care homes. More complex treatments are preferrable in a specialist clinical environment where sedation or general anaesthetic is available if needed.[14]

In summary

Stark oral health inequalities could be exacerbated if population trends in age and dementia prevalence continue to increase in a health system that is often seen as inaccessible to PLwD.[10] Changing demographics mean that dental care professionals, including dental hygienists and therapists are likely to need regular professional development on evolving practices to support the growing number of people PLwD, and their carers.[7] However, simple, considered, and empathetic working practices place dental professionals in a strong position to help PLwD navigate dental care helping to maintain their independence and oral health for as long as possible.

Author: Dr. Charlotte Jeavons is Head of School of Human Sciences, University of Greenwich.

Email: C.Jeavons@gre.ac.uk

References

1. Alzheimer's Society. (2014) Dementia UK Update. Available at: Dementia UK report | Alzheimer's Society (alzheimers.org.uk) (Accessed April 2023).
2. NHS. Primary Care Dementia data. February 2023. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-dementia-data/february-2023 (Accessed April 2023).
3. Geddis-Regan, A. Dental Care for people living with dementia: current challenges and planning for the future. The UK perspective. *Comm Dent Health*. 2023;**40**:1-6.
4. Batchelor, P. Dementia-Friendly Dentistry. Good Practice Guidelines. Faculty of General Dental Practice London: UK (2017).
5. NHS. Symptoms of Dementia. Available at: https://www.nhs.uk/conditions/dementia/symptoms/ (Accessed April 2023).
6. Camicioli, R. Diagnosis and Differential Diagnosis of Dementia. In: *Dementia*. Ed Quinn, J. New York: Wiley and Sons (2014).
7. Ingelhart MR, Albino J, Feine JS, Okunseri C. Sociodemographic changes and oral health inequalities: dental workforce considerations. JDR Clin Translat Res. 2022; **7(1 suppl)**: 5S-15S.
8. Tredwin C, Sherriff I, Nelder A, Puckey C. Dental Dementia Friendly Guide. November 2021. Available at: https://arc-swp.nihr.ac.uk/news/dementia-friendly-dentistry-guide/ (Accessed April 2023).
9. Alzheimer's Society. (2022). This is me. Available at: https://www.alzheimers.org.uk/sites/default/files/2020-03/this_is_me_1553.pdf (Accessed April 2023).
10. Fereshtehnejad SM, Garcia-Ptacek S, Religa D, Holmer J, Buhlin K, Eriksdotter M, Sandborgh-Englund, G. Dental care utilization in patients with different types of dementia: A longitudinal nationwide study of 58,037 individuals. *Alzheim Dement*. 2018;**14(1)**:10-19.
11. Griffiths J, Boyle S. Oral Assessment In Holistic Oral Care: a Guide for Health Professionals. London: Stephen Hancocks Ltd. (2005).
12. Department of Health (2006). Guidelines for the Development Of Local Standards of Oral Health Care for People with Dementia. *Gerodontol.* 2006;**23**:3-32. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1741-2358.2006.00140.x (Accessed April 2023).
13. Office of the Public Guardian. Mental Capacity Act: making decisions. 2014. Available at: https://www.gov.uk/government/collections/mental-capacity-act-making-decisions (Accessed April 2023).
14. National Health Service. Dental Treatment for People with Special Needs. Available at: https://www.nhs.uk/nhs-services/dentists/dental-treatment-for-people-with-special-needs/ (Accessed April 2023).
15. The Alzhiemer's Society. Finding an NHS Dentist. Available at: https://www.alzheimers.org.uk/get-support/daily-living/finding-nhs-dentist#content-start (Accessed April 2023).

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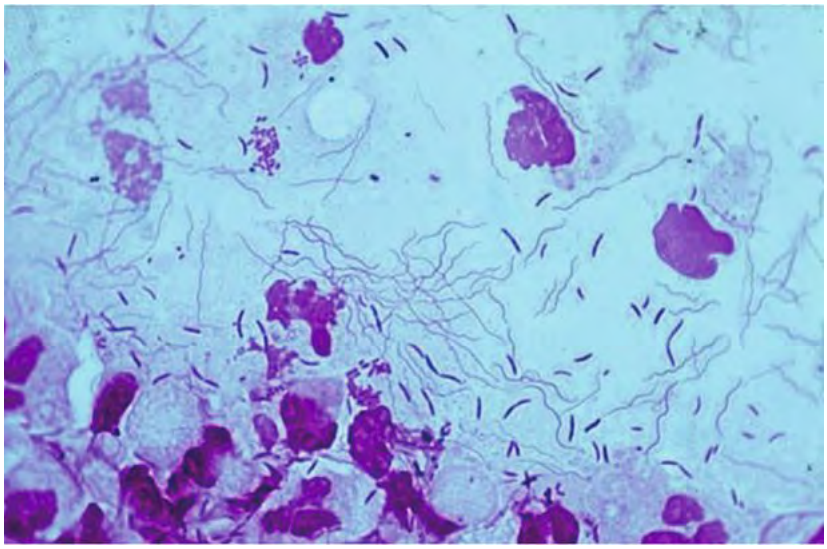
CLINICAL QUIZ

A 24-year-old female, who smokes, has rapidly developed painful ulceration between her lower incisors. She has a marked halitosis. A Gram stain of a smear taken from the ulcers reveals numerous spirochaetes and fusobacteria.



Q1. What type of bacteria are spirochaetes?

Q2. What is the diagnosis?

Q3. What antimicrobial agent should be prescribed?

SEND YOUR ANSWERS TO THE EDITOR BY 28TH MAY

Email: editor@bsdht.org.uk **Postal:** The Editor, Dental Health, BSDHT, Bragborough Hall Business Centre, Welton Road, Braunston NN11 7JG.

ANSWERS TO CLINICAL QUIZ MARCH 2023

The winner is: **Nichola Smith**

Q1. What visible clinical feature suggests a malignancy?

A1. Rolled margin of the ulcer.

Q2. What other clinical finding on examination would support malignancy?

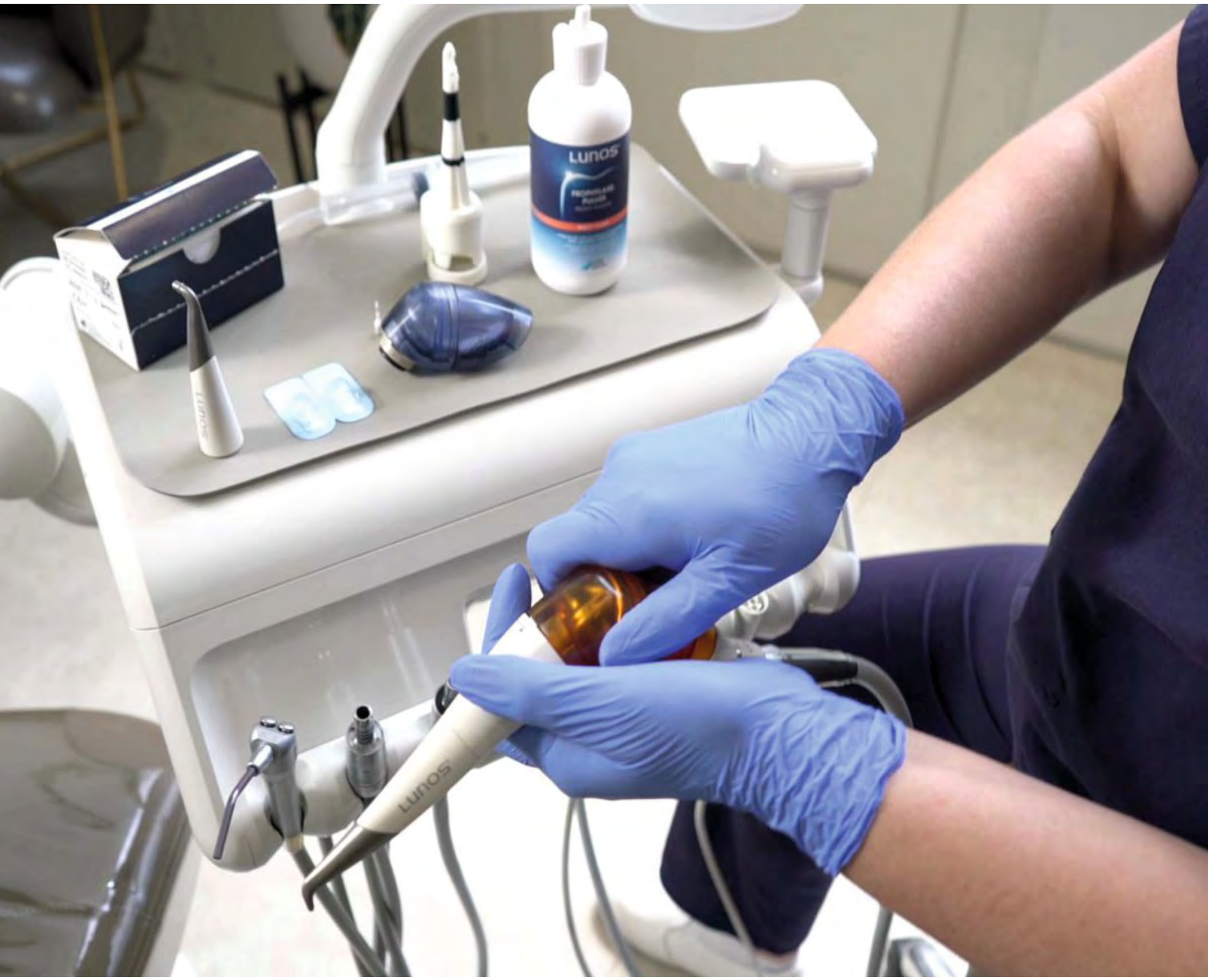
A2. Firm to palpation (indurated).

Q3. Name two types of skin malignancy that could be present.

A3. Squamous cell carcinoma and basal cell carcinoma.

Q4. Which of the two has the better prognosis?

A4. Basal cell carcinoma.



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Contact: **rimmi0402@aol.com**

UTTOXETER, Staffordshire

Dental Hygienist/Therapist required at Uttoxeter Dental Practice. We would like someone to start as soon as possible due to our current hygienist having to go on sick leave.

- Required for a Tuesday and Wednesday
- Chairside support provided.
- Piezo scaler, ultrasonic, NSK airflow and OPG available.
- The practice offers advanced treatment of Periodontal disease including surgical treatment and Emdogain.
- Salary: £35.00 per hour
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To help our overworked Principal by working within your scope of practice and competence to include:

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- De-con assistance provided.
- Salary: £40.00-£41.00 per hour

CV to: **anitha.diwakar@nhs.net**

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- Free parking
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- Training (MIST techniques, Microscopy, etc.)

Email CV to: **bordondental@gmail.com**

DIARY DATES

AUTUMN 2023 BSDHT REGIONAL GROUP STUDY DAYS

Contact: enquiries@bsdht.org.uk

Regional Group	Date	Details	Contact (Group Secretary)	Contact Details
Eastern	Sat, 14th Oct 2023	TBC	Nancy Gieson	easternsecretary@bsdht.org.uk
London	TBC	TBC	Simona Kilioke	londonsecretary@bsdht.org.uk
Midlands	Sat, 23th Sept 2023	Bragborough Hall Braunston, Daventry, NN11 7JG	Joanna Ericson	midlandssecretary@bsdht.org.uk
North East	TBC	TBC	Julie Rosse	northeastsecretary@bsdht.org.uk
North West	TBC	TBC	Karen McBarrons	northwestsecretary@bsdht.org.uk
Northern Ireland	TBC	TBC	Gill Lemon	northernirelandsecretary@bsdht.org.uk
Scottish	Tues, 26th Sept 2023	Online	Ana Malove	scottishsecretary@bsdht.org.uk
South East	TBC	TBC	Sam Davidson (Acting)	southeastsecretary@bsdht.org.uk
Southern	TBC	TBC	Ellie-May Ayling	southernsecretary@bsdht.org.uk
South West & South Wales	TBC	TBC	Alison Trinh	swswsecretary@bsdht.org.uk
South West Peninsula	Sat, 8th Oct 2023	TBC	Lauren Binns	southwestsecretary@bsdht.org.uk
Thames Valley	Sat, 16th September 2023	Small group HANDS On - details TBC - W&H Offices, St Albans NO Trade	Vacant	thamesvalleysecretary@bsdht.org.uk

BSDHT ADMIN

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BSDHT representative Health Education England Advisory Group (HEEAG): **Diane Hunter**

Student representative to council:
Sandeep Samra - studentrep1@bsdht.org.uk
Laura Bosah - studentrep2@bsdht.org.uk

Student Representative Coordinator:
Claire Bennett - studentrep@bsdht.org.uk

Coaching and Mentoring Representative:
Emma Slade-Jones - MC1@bsdht.org.uk

REGIONAL GROUP REPRESENTATIVES ON COUNCIL

Eastern: **Andrea Hammond** easternregionalrep@bsdht.org.uk

London: **Sakina Sayed** londonregionalrep@bsdht.org.uk

Midlands: **Nina Lord** midlandsregionalrep@bsdht.org.uk

North East: **Gill Cliffe** northeastregionalrep@bsdht.org.uk

North West: **Victoria Griffiths** northwestregionalrep@bsdht.org.uk

Northern Ireland: **Ruth Morrison** northernirelandregionalrep@bsdht.org.uk

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South East: **Jodie Kendall** southeastregionalrep@bsdht.org.uk

Southern: **Emma Leng** southernregionalrep@bsdht.org.uk

South West and South Wales: **Rhiannon Jones** swswregionalrep@bsdht.org.uk

South West Peninsula: **Sabina Camber** southwestregionalrep@bsdht.org.uk

Thames Valley: **Fiona Stovold (acting)** thamesvalleyregionalrep@bsdht.org.uk

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Chair: **Gulab Singh** easternchair@bsdht.org.uk

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Treasurer: **Pelagia Kaplanidou** easterntreasurer@bsdht.org.uk

Trade Liaison: **Anna Charters** Email: easterntlo@bsdht.org.uk

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Trade Liaison: **(Mary) Annastasia Kellett-Wright** londontlo@bsdht.org.uk

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Student representative: **Saffa-Noor Sabri** scottishstudentrep@bsdht.org.uk

SOUTH EAST

Chair: **Louisa Clarke (Acting)** southeastchair@bsdht.org.uk

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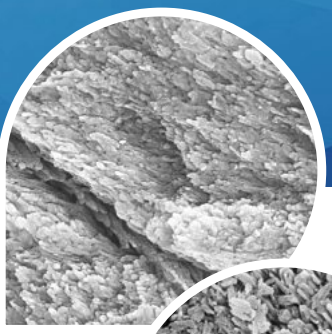
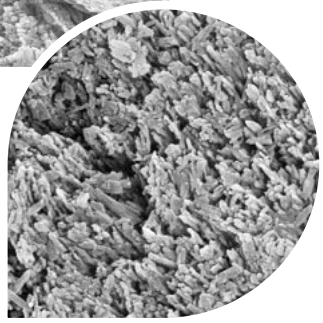
Enamel Remineralisation based on

SCIENTIFIC EVIDENCE



Untreated



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7
YEARS OF RESEARCH

3
INTERNATIONAL PATENTS

24
CLINICAL STUDIES AND CASES

Scan for Information Samples and **Treatment Protocol**

A study conducted at the University of Milan, Oral Microbiology and Biomaterials Laboratory:*

The IRCCS Galeazzi Orthopaedic Institute found that Curasept Biosmalto (Caries, Abrasion and Erosion line) was **the only system to have shown a biomimetic type of action - due to its unique ability to promote the remineralisation of a tooth surface** with newly formed hydroxyapatite crystals.

The formation of S-HAp microcrystals was seen in a regular, compact appearance with the same structure and orientation as the existing natural enamel prisms.

This proven greater biomimicry is probably linked to the **benefits of Magnesium and Strontium; which were not contained in the other tested formulas.**

* Study on 'Biomimetic Mousses and Toothpastes for Enamel Remineralisation'. Authors: Ionescu Ac., Izzo D., Pulcini MG., Dian A., Brambilla E. University of Milan, Oral Microbiology and Biomaterials Laboratory. IRCCS Galeazzi Orthopaedic Institute, Dental Clinic. Academic Board, Naples. Journal of Osseointegration 2019.

Step One

Curasept Biosmalto Impact Action Mousse (150ml):
In-Surgery Application

Step Two

Curasept Biosmalto Impact Action Mousse (50ml):
At-Home Application over 30 - 90 Days (Depending on Indication and Treatment Protocol)

Step Three

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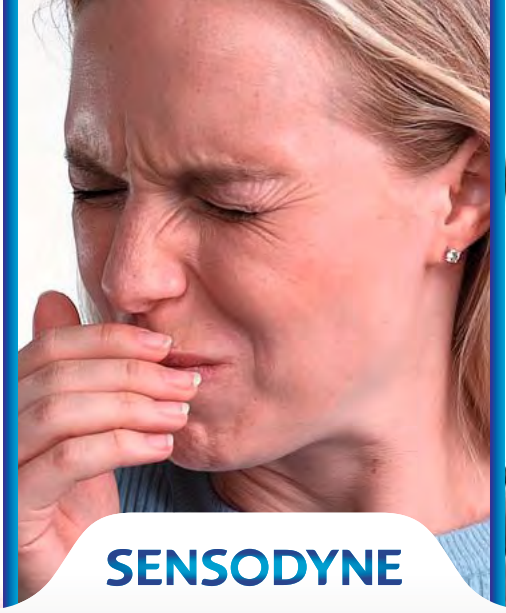

SENSODYNE

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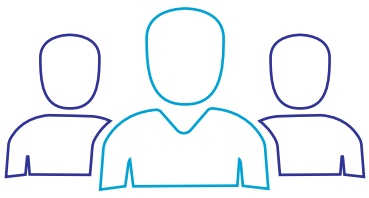

A SIMPLE CONVERSATION

As a dental health professional, **you have the opportunity to talk to your patients** and help them recognise the problem.[3]

A SIMPLE SOLUTION

Scan the QR code to go to our Psychology of Sensitivity page. Here you will learn more about the ways patients deal with sensitivity, and find a free questionnaire you can use to help them understand their condition.

References:

1. Addy M. Int Dent J 2002; 52:367–375.
2. Gibson B, *et al.* The everyday impact of dentine sensitivity: personal and functional aspects. In: Robinson PG, editors. Dentine hypersensitivity: Developing a person-centred approach to oral health. London: Elsevier Inc, 2015, Chapter 6.
3. Communicating with Patients. Pocket Dentistry. Available at: https://pocketdentistry.com/communicating-with-patients/

SENSODYNE HALEON