DENTAL HEALTH

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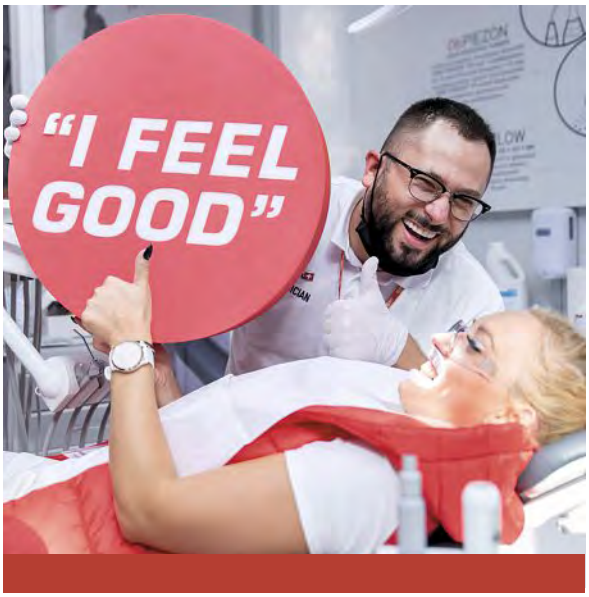

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The mission of BSDHT is to represent the interests of members and to provide a consultative body for public and private organisations on all matters relating to dental hygiene and therapy. We aim to work with other professional and regulatory groups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

BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY
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EDITORIAL

Pride in who we are

BSDHT is committed to equality and diversity and has worked hard as an organisation to increase diversity and gender balance within our profession. Our Diversity Inclusion and Belonging advisory group (DIB) has been working on several projects to ensure all members are fairly represented in our organisation. The group undertook a survey earlier this year and we plan to share the results with you through the pages of *Dental Health*. We also have active representation on the profession wide Diversity in Dentistry Action Group (DDAG) that was established last year by the Office of the Chief Dental Officer for England. Last month, our social media feed celebrated the UK's LGBT+ history month.

However, in spite of our efforts, particularly in terms of a balance of genders, race and special characteristics, we have not achieved anything like the numbers and percentages that occur in the recruitment and training of dentists.

Dentistry today is very different from the profession it was just a few decades ago when it was dominated by white middle-class males. Many UK dental schools have more female than male students and a considerable proportion of students of South Asian heritage. The reasons behind this are obviously more complex than a shift to more diverse selection and interview protocols. It has to be recognised that dentistry, along with law, medicine and pharmacy, is a particularly attractive profession with high perceived status among certain communities. Couple that with the grade-inflation for entry over the same period and dentistry has become more accessible to the children of families who have a diligent work ethic.

As we celebrate International Women's Day on 8th March 2022 I was particularly taken, personally, by the comments of Adele at the recent Brit Awards. Regarded as controversial by some she said:

"I understand why the name of this award has changed but I really love being a woman and being a female artist. I do!" while accepting the award. *"I'm really proud of us, I really, really am,"* she added.

Her comments followed on from her acceptance of the gender-neutral Artist of the Year award at the 2022 Brits on Tuesday the 8th of February 2022. The new category replaced the separate Best Female and Best Male artist categories from previous Brit Awards shows. It is apparently unclear why the Brits had moved to gender-neutrality.

It is hard as an empowered woman, often working with other equally empowered and self-assured women, not to have enormous sympathy for that point of view. Dental hygiene and therapy careers are empowering but like nursing careers in medicine they remain dominated, at least numerically, by women.

One look at our website confirms that we still have a way to go in the area of proving our commitment to a diverse and gender-balanced profession. On our Executive team pages and even our Coaching and Mentoring team pages, it is hard to see past the sea of white faces. Our Publications team and Ambassadors pages are a slightly better reflection of our ambition but we need to state our commitment more boldly if we are going to be seen to take these issues seriously. Never has it been truer to say that "If I can't see it, I can't be it".

All of us, in whatever field we work, be it practice, hospital or academia need to look at ways to encourage young people of all genders, sexualities and ethnicities to join this wonderful profession. In the meantime feel free to stand with me and be proud on the 8th March.

Heather Lewis

FROM THE PRESIDENT

Spring is in the air and after a long winter in hibernation life is slowly returning to some kind of normal and, writing this *from the President*, I realise that it's the same here at BSDHT.

March is the start of the regional group spring study days. The regional group teams have worked so hard to put together some fantastic study days so please ensure you book your place.

Since the Prime Minister announced the end of the working from home rule, last January, the administration team has been back working in the new office at Bragborough Hall.

Council and Executive Team

In January we held our first Executive and full Council meetings in the conference centre at Bragborough Hall. The two meetings were productive and we worked through the business of the day, discussing and sharing ideas and putting plans into place for the year ahead. The new cohort of BSDHT Ambassadors attended and were officially welcomed to the team. Two Council members were elected to the Executive for one year at the January Council meeting: I would like to welcome Sabina Camber (South West Peninsula Regional Group Representative) and Simone Ruzario (Elected Member to Council) to the team. We are all looking forward to working with you both this year.

Regional Group Training Day

Regional Group training days have been held over the years and always well received. I would like to acknowledge and thank all those members who attended and shared their many ideas and enthusiasm for making the regional group study day a success. My thanks also go to the Executive, Sharon and Selina – the success of this event really was the result of great team work!

OHC2022

Planning for OHC2022 in Manchester in November is underway. The feedback from Glasgow OHC has highlighted what is working well, and also what we can improve on to attract more members.

Catherine Cutler and Gamze Eroglu, the current Student Representatives on Council will be joining the BSDHT team on the monthly planning meetings with Profile Productions to ensure we are working to make the OHC attractive to all members, at every stage of their career.

If you would like to take a look at some of the photographs from OHC2021 in Glasgow, please visit the new BSDHT website

www.bsdht.org.uk go to the *Gallery* section and you will see a selection of the many photographs taken - they really do reflect the joy and excitement of being together again for the first time in two years.

What BSDHT did in 2021

A series of social media posts in January highlighted what BSDHT did throughout 2021 from the launch of the Coaching and Mentoring programme, to establishing student representation in the dental hygiene and therapy schools throughout the UK, to representation on many profession wide projects such as the fourth edition of *Delivering Better Oral Health,* the GDC *Scope of Practice Review* and our collaborative work with other professional organisations including BADT with the *Post Nominals Information Sheet*. The last post in the series asked: *What do you want from us in 2022?* Please do tell us!

ProDental Vaccination Webinar and Mandatory Vaccination in England

In January, I was invited to take part in a panel session webinar hosted by ProDental. In preparation for the event a short questionnaire was emailed to all members. With more than 25% of members responding, the data collected were insightful and helped form some of the answers to the questions put to me on the night.

On the same the day as the webinar, a joint statement from the College of General Dentistry (CG Dent) and the British Association of Dental Nurses (BADN) was published. These organisations requested a deferral of mandatory vaccination, citing a potential catastrophe for dental patients. The results of a recent survey carried out by BADN of 1000 dental nurses showed that almost 25% of dental nurses will not be double vaccinated by 1st April and the impact this could have on the dental workforce.

The Secretary of State for Health and Social Care, Sajid Javid MP, announced on the 31st January that subject to a consultation and parliamentary approval the mandate for health and social care workers in England, including all members of the dental team, to be double vaccinated by 1st April 2022 would be revoked.

BSDHT will continue to keep members up to date with changes to the current situation in England.

Consultation on Regulation Reform

The Department of Health and Social Care is requesting views on the arrangements for deciding which health and care professions should be regulated in future. Its consultation **Healthcare regulation: deciding when statutory regulation is appropriate** is now open and provides an opportunity to give perspectives on this fundamental question of patient protection. The consultation closes at the end of March and the Executive will formulate and submit a collective response.

Diversity in Dentistry Action Group (DDAG)

BSDHT has been represented on the DDAG workshops, led by Nishma Sharma from the Office of the Chief Dental Officer for England (OCDO England), since its inception in the autumn of 2020. At the most recent workshop, Simone Ruzario and Miranda Steeples gave a short presentation highlighting the work BSDHT has done to date and what we can do better as a Society to ensure that all members are equally represented, and special characteristics considered by the Society.

BDIA Dental Showcase

On Friday 25th and Saturday 26th March the first of the prominent dental shows, BDIA Dental Showcase opens its doors for the first time since October 2019. The two-day event is being held at London ExCel and BSDHT will have a stand there so please stop by stand A30 to say hello!

Diane Rochford

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CLIMBING KILIMANJARO IN KIMBERLEY'S MEMORY

Last month saw FMC founder Ken Finlayson preparing to climb Mount Kilimanjaro in memory of his wife who was one of the first Britons to die from Covid-19.

Ken is fundraising to buy a new mobile dental unit for the dental charity Dentaid that will be named after his wife Kimberley who sadly died in March 2020. He was joined on his epic climb by his colleague Tim Molony and the pair hope to raise in excess of £40,000. The money will help to buy a new vehicle that will allow Dentaid volunteers to provide free outreach dental care for homeless and vulnerable people across the UK.

Kimberley was on holiday in Bali when she tragically died of Covid-19 in an Indonesian hospital. She was a supporter of many charitable causes and Ken has been inspired to climb Africa's highest peak in her memory.

'I set a goal of raising enough money to help Dentaid to buy a new mobile dental clinic so people in the UK can access urgent dental care," said Ken. "Kimberley and I spent our lives building FMC into dentistry's major communications company. She was very committed to charity projects related to the profession and organised multiple fundraising activities. We had 30 fabulous years together."

The new unit will visit soup kitchens, night shelters and day centres with volunteers offering emergency dental treatment and oral health advice for rough sleepers and people experiencing homelessness. The vehicle will also be used to provide dental clinics for head and neck cancer patients, refugees and asylum seekers, children in care, fishing communities, ex-service personnel and victims of domestic violence.

In addition to alleviating dental pain, Dentaid volunteers also help to teach their patients about oral health, protect teeth from future damage and provide restorative dentistry to increase confidence and self-esteem.

"We are honoured that Ken has chosen Dentaid to fundraise for us and we will make sure this vehicle is a fitting tribute to Kimberley," said Dentaid CEO Andy Evans. "This mobile dental unit will have a lasting impact and help us meet the growing demand for clinics for the most vulnerable people in our communities. Having a chance to access dental care can have a very positive impact and changes people's lives."

Ken and Tim set off on their eight-day trek on February 15th and climbed 5895 metres to the summit of the Tanzanian mountain. They faced tough physical conditions and the effects of altitude. "It was a tough climb," said Ken. "But a challenge I was determined to see through for a great cause."

You can contribute to their cause at:
https://www.justgiving.com/fundraising/ken-finlayson

REGIONAL GROUP TRAINING DAY

On Saturday 29th January 2022, the BSDHT executive team welcomed regional group team members, ambassadors, elected council members, the student representative co-ordinator and student representative to Bragborough Hall Business Centre, where we now have an office.

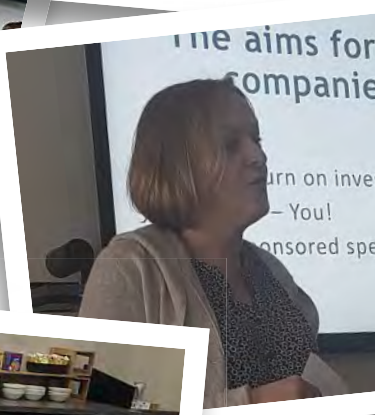
The meeting opened with a welcome by Diane Rochford, BSDHT President. The aim of the day was to support the regional group teams and identify ways to grow delegate numbers at regional group study days. The morning sessions were dedicated to presentations:

- Your role within BSDHT team - Miranda Steeples, BSDHT President Elect
- The role of the administration team with regional groups - Sharon Broom, BSDHT Director of Operations
- Social media: what to do and what not to do - Annette Matthews, BSDHT Social Media Coordinator
- Working with our partners in the trade - Fay Higgin, BSDHT Sales and Marketing Executive
- BSDHT Publications - Heather Lewis, BSDHT Publications Editor

The second session of the morning was dedicated to the specific regional group team roles.

After lunch, and a blustery tour of the grounds, the afternoon sessions focussed on working groups where the challenges the regional groups faced with the study days – online and face-to-face - were discussed. The groups were encouraged to brainstorm ideas and make recommendations for future study days. Each group was then invited to present their ideas.

A most productive and fun day was had by all. The Spring dates are available on page 49

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A MODERN TWIST ON INTEGRATED LEARNING

by **HANNAH DULAY**

As a student at the University of Liverpool, School of Dentistry, I have had the opportunity to experience an innovative method of teaching, representing a potential change that can influence the way dental professionals are trained.

Just over two years ago, Liverpool introduced the combined curriculum, or Collaborative Learning Core (CLC), between the BSc dental therapy students and the BDS dental surgery students. Students from both undergraduate programmes now train and learn together for the first three years, under the scope of practice of a dental therapist.

The idea of a combined course integrating students with different capabilities or expectations initially seemed overwhelming. Reassuringly, the reality has been a mutual building of respect between the two similar yet specific roles that contribute to a varied dental team.

Experiencing this combined curriculum, it is clear to see the emphasis placed on all students being equal, no matter which undergraduate programme the student is studying. In addition, it also avoids those students studying for a BSc feeling segregated during learning: in many dental schools there are limited places and so class numbers can remain quite small. All lectures, seminars, clinical times and outreach placements are with groups of the year that include both BDS and BSc students with no differentiation placed between us.

As many of my qualified dental hygienist and therapist peers can relate to, the quality of teamwork is closely linked to the quality of care the team provides. All members of the dental team have a role in ensuring the best possible contribution to patient care. This is especially true during the current pandemic when teamwork and close collaboration are at the forefront of making sure the dental profession deals with the challenging impacts as effectively as possible.

There are almost six times as many registered dentists as dental hygienists so it is understandable why in some cases the role of a hygienist or therapist can become overshadowed. The BSDHT recognise this: "…the dental therapist is a woefully underused professional" and makes clear their aim to raise the profile of the dental therapist as a valuable team member contributing to cost-effective dentistry and reducing the stress placed on principal dentists.

We can only hope that a combined curriculum, fostering mutual respect and collaboration at its core, results in more dental practices placing greater trust in dental hygienists and therapists to carry out high-quality care to patients in need.

Author: Hannah is a final year student studying at Liverpool. Even though it's a bit scary to be leaving the safety of the dental school, I'm excited to finally join the working world of dental therapy!

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IN PRACTICE

The president elect, Miranda Steeples, responds to member enquiries. This month's round up sees a great variety of questions. Thank you for getting in touch and please keep them coming! Do keep these pages, they are written to be a reminder for you to use in the future as well.

Q *Where can I access medical emergency drugs for a new Direct Access practice?*

A It is advisable to consult the CQC 'Dental Mythbuster 4 – Drugs and equipment for a medical emergency' **Dental mythbuster 4: Drugs and equipment for a medical emergency | Care Quality Commission (cqc.org.uk) which states:**

Professional guidelines: NICE: Prescribing in dental practice (Medical emergencies in dental practice)

These should be available to manage common medical emergencies:

adrenaline/epinephrine injection, adrenaline 1 in 1000, (adrenaline 1 mg/mL as acid tartrate), 1 mL amps	glyceryl trinitrate spray
aspirin dispersible tablets 300 mg	midazolam oromucosal solution
glucagon injection, glucagon (as hydrochloride), 1 - unit vial (with solvent)	medical oxygen
glucose (for administration by mouth)	salbutamol aerosol inhalation, salbutamol 100 micrograms/ metered inhalation

Professional guidelines: Quality standards: Primary dental care

This is the minimum equipment recommended:

adhesive defibrillator pads	pocket mask with oxygen port
automated external defibrillator (AED)	portable suction
clear face masks for self-inflating bag (sizes 0,1,2,3,4)	protective equipment – gloves, aprons, eye protection
oropharyngeal airways sizes 0,1,2,3,4	razor
medical oxygen cylinder	Scissors
oxygen masks with reservoir	self-inflating bag with reservoir (adult and child)
oxygen tubing	if there are ampules in the medical emergency drugs kit, there must be adequate numbers of suitable needles and syringes.

The GDC states that the Human Medicines Regulations 2012 permit dental hygienists and therapists to hold emergency drugs on their premises, but not to purchase the medicines directly. A dental hygienist / dental therapist practice needs to ensure that they hold emergency drugs on site. Such dental practices without an on-site dentist can obtain an emergency kit through a prescribing dentist or doctor under a patient-group directive: **Medical emergencies (gdc-uk.org)**

The GDC offers this website for further standards that should be followed: **Quality Standards: Primary dental care equipment list | Resuscitation Council UK**

Q *I have seen a local business offering teeth whitening. There are no registered dental professionals working there, what should I do?*

A There are a few options to raising a concern:

1. Contact them directly to advise you have seen the advertisement and explain that this type of treatment must be carried out by a dental professional.
2. You can report this to the Oral Health Foundation's Tooth Whitening Information Group – **helpline@dentalhealth.org** (they might refer you to the GDC).
3. Report to the GDC **https://www.gdc-uk.org/information-standards-guidance/information-for-patients-public/tooth-whitening-and-illegal-practice**

Q *Can a dental therapist use biodentine in permanent teeth?*

A Yes, even in permanent teeth a dental therapist may use biodentine. It would be indicated as part of the management of a deep carious lesion as a lining material, and would be particularly useful when utilising a step-wise technique. It can also be used as a direct pulp cap in the event of an exposure, which hopefully would be a rare occurrence if appropriate referrals are made. If an accidental exposure did happen, you would still use it to seal over, dress the tooth and send it back to the referring dentist to review and complete any potential further treatment. This pdf is quite useful **brochureBiodentineHDUK.pdf (septodont.co.uk)**

Q *Is there a definitive list of health conditions or scenarios that might affect dental care and when it might be appropriate to treat such patients?*

A Unfortunately, there is no such document in existence, that I know of. It is a question that occurs frequently and I agree it would be useful. The trouble is that with that sort of advice comes a lot of responsibility and potential for liability, so it is considered best practice to contact the patient's own medical professional for their view. They will each have their own opinion on how things should be managed, and will know what is best for each individual patient. There is no one size fits all approach and thus, no standardised written guidance for this.

by IMAN IMTIAZ

ADMINISTERING LOCAL ANAESTHESIA FOR THE FIRST TIME

I have never experienced an injection of dental local anaesthetic (LA). It has therefore been challenging for me to relate to patients who would avoid dental treatment due to fear of the pain associated with the needle! It was really only when I began to accompany my sister to the orthodontist that I began to comprehend the degree of anxiety about receiving dental treatment due to a fear of LA.

Preparing for the LA exam

As a student who is always eager to learn new things, I was very excited to start this module. It includes the theory of local anaesthesia, the different agents involved and selection of the correct anaesthesia based on different patients. I was relieved to find out that my peers and I would be practising the administration of LA on a phantom head rather than on each other (phew)! We practised the local infiltration and the ID block LA on the phantom heads before a pass/fail assessment and I was really happy to have passed the exam first time. However, the real test of administering LA on patients was daunting!

My first buccal infiltration administration

I rarely gets nervous so it was odd for me to feel anxious before the arrival of my patient. However, I calmed my nerves by reading through my notes and preparing myself. I administered infiltrations at three different sites for this patient and was able to successfully achieve anaesthesia with great guidance from my clinical supervisor. I was delighted to receive their feedback: *'Wow! Superb first set of infills, fabulous patient reassurance'.* I was very pleased and proud of myself for my very first LA delivery. Throughout the procedure, I reminded my patient to remember to breath. However, I found I was the one holding my breath!

Before the administration I felt that I wouldn't be able to relate

to the patient and what they are feeling as I had never been in that position. However, I feel that being an empathetic person in general and having watched my sister experience dental related anxiety helped me to put myself in the patient's shoes and provide effective reassurance.

My first ID block delivery

By the time I got to deliver my first ID block I had done quite a few infiltrations, so I felt more confident. However, as the anatomical landmarks which need to be identified are different in every patient, in addition to an expectation of increased discomfort for my patient, I became quite nervous. Fortunately, I was able to ensure all the pre-checks were complete and identified all the landmarks correctly. This ensured I was able to administer and achieve good anaesthesia for my patient. I still feel administration of more ID blocks will help to increase my confidence and ensure autonomous working.

Administering LA for the first time

Preparation is key for any part of this course however I feel that preparation to administer LA is different. You prepare yourself and calm your own nerves as well as ensuring the patient is comfortable and calm. My advice to all those who are yet to provide LA is to prepare yourself thoroughly. Have a good knowledge of the theory behind the administration, make simple concise notes of the landmarks to look out for when administering LA and ask for the help of your clinical supervisors as much as possible. Simply asking them to help stabilise your hand for the first few administrations or talk about any concerns you might have prior to delivery really helps. Most importantly, remember that no one expects you to be perfect. Delivery of good safe anaesthesia, like any other part of this course, is all about practise and confidence.

Local anaesthesia is a fundamental part of pain free dental treatment and therefore management and rapport with the patient, as well as confidence in yourself, can help to reduce the patient's fear of the needle. This makes them more likely to return for future treatment.

Author: Iman is a second-year student and the BSDHT representative for Teesside University.

Correspondence: imanimtiaz.77@gmail.com

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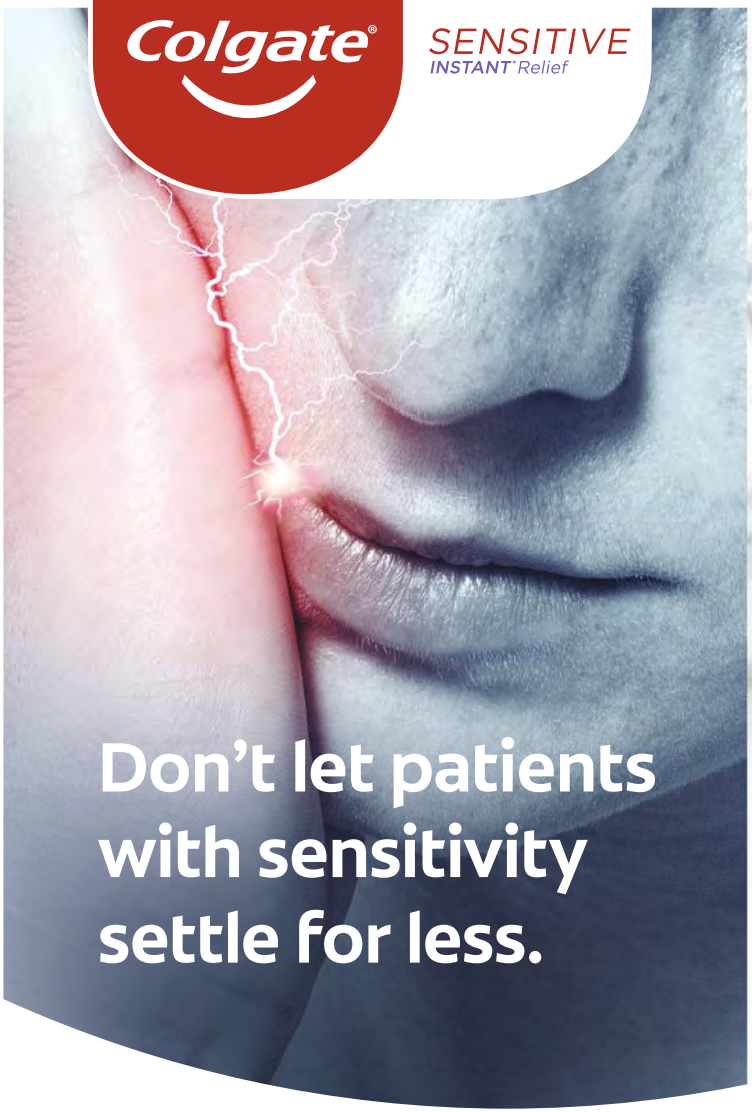

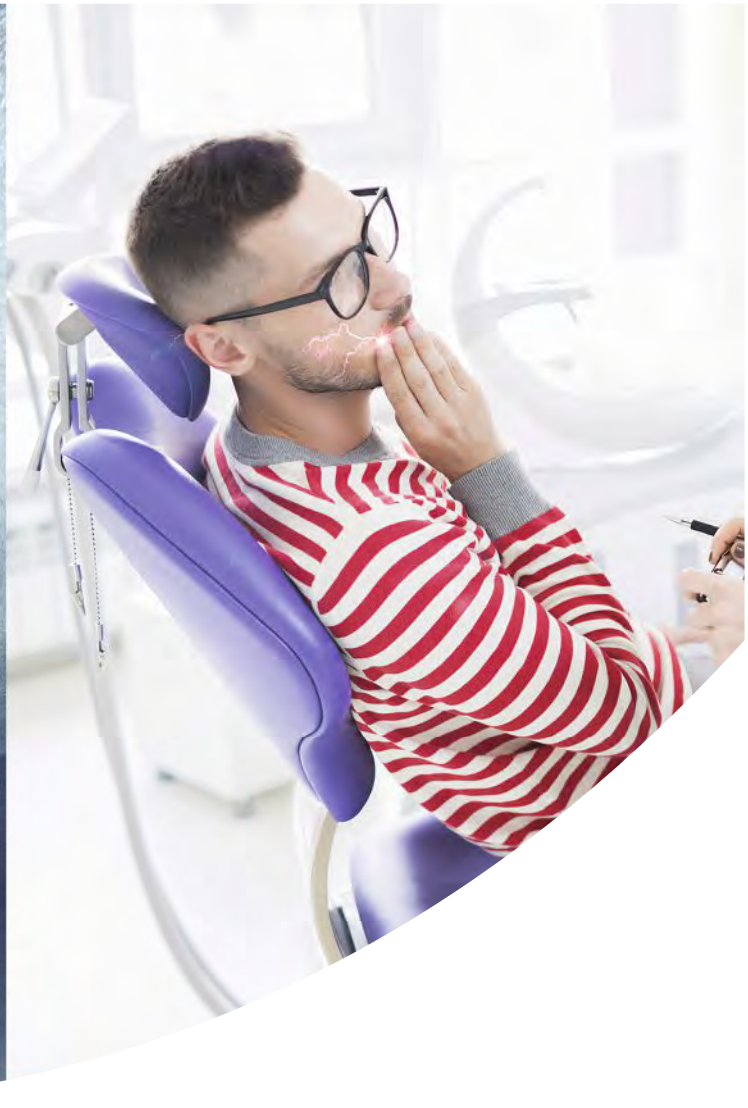

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References: 1. Nathoo S, Delgado E, Zhang YP, et al. Comparing the efficacy in providing instant relief of dentine hypersensitivity of a new toothpaste containing 8.0% arginine, calcium carbonate, and 1450 ppm fluoride relative to a benchmark desensitising 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.

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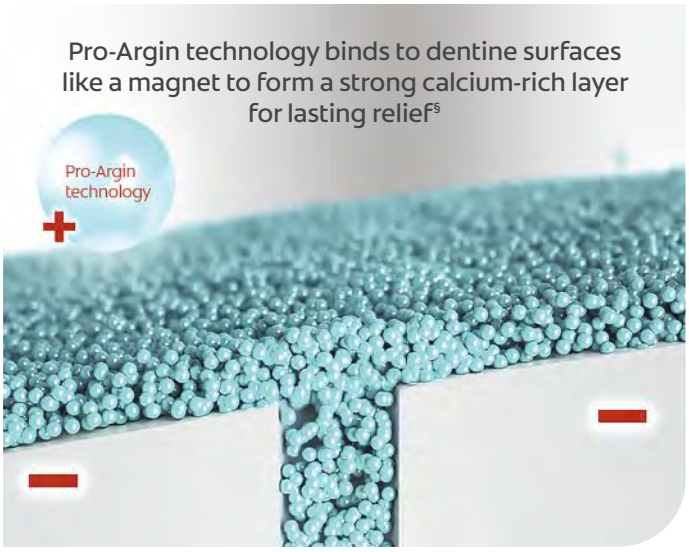

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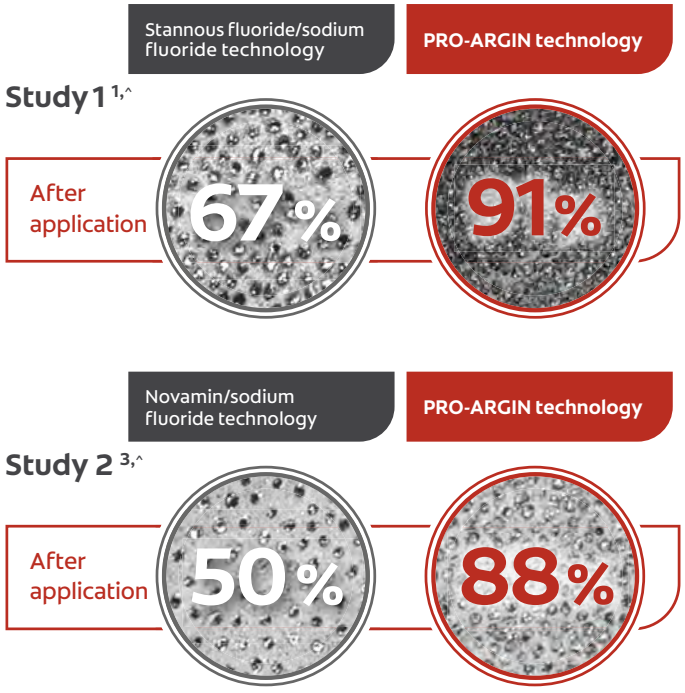

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References:
1. Hines D, et al. Poster #3406, July 2018 IADR. Colgate- Palmolive Company 2018. **2.** Nathoo S, et al. J Clin Dent. 2009;20(Spec Iss):123 –130. **3.** Hines D, et al. Poster #0742, March 2018 AADR. Colgate- Palmolive Company 2018. **4.** Docimo R, et al. J Clin Dent. 2009;20 (Spec Iss):17– 22.

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REACHING BEYOND THE PRACTICE

by TRACY DOOLE

How one dental hygienist's own levelling up agenda is helping to address inequalities in dental health.

For some, recent events have left a far-reaching legacy. With socio-economic injustices laid bare throughout the pandemic, there are few of us who will not have undergone a reassessment of the way our lives can impact on others. As a consequence, we continue to reshape our day-to-day world with these inequalities in mind.

Dental hygienist Tracy Doole has always prided herself on her empathetic and caring approach to life and her profession. Hugely passionate about oral health promotion and disease prevention, she has long been aware of the health inequalities that exist in society.

A graduate of Queens University, she has been part of the dental hygiene team at several practices across Belfast for more than 10 years and sees first-hand how oral health inequalities can have a negative impact on patients' overall wellbeing.

Oral health inequalities

'Northern Ireland has the highest oral health inequalities in the UK,' she says. 'There are many factors that contribute to this – low socio-economic status, poor access to dental services as well as a lack of oral health education in schools, care homes and other community settings. However, some Trusts have no dedicated oral health promotion staff and preventive programmes are suffering as a result.' (Oral Health Strategy for Northern Ireland)

There is also a dearth of a dental hygienist and therapist workforce. This is due to several factors, including retirement and, unfortunately, Northern Ireland is without a dental hygiene or therapy school, which, says Tracy, 'will contribute further to the lack of workforce that is expert in providing oral health education and preventive dentistry'.

Helping reduce dental disease by oral health education and prevention is something Tracy feels passionate about – 'I feel the government could ease the situation by utilising dental hygienists and therapists to deliver prevention.'

Caring Beyond the Practice

However, she is seemingly doing her level best to level up the inequalities that exist. 'I pride myself on having a holistic approach – it's part of our role – and have always tried to do my part in the community. But, during the pandemic, it was something that was heightened for me. Hundreds of thousands of patients were unable to access care, including those most in need - children, the elderly and those with learning disabilities. With many services now running at reduced capacity, I see it as my responsibility to reach out to them.'

'I have worked in the primary dental setting in both NHS and private practices. In my spare time, I offer oral health education talks to local schools and at L'Arche, a charity that creates a network of communities where people with and without learning disabilities share life together,' she explains.

Volunteering

Tracy expanded her volunteering role at arts and crafts classes for adults with learning disabilities, which led to her giving oral health education to the group as well. 'This developed over time.' She says, 'building good rapport with the clients and staff members through general discussions, it was highlighted that some of the members struggled with their oral health. The staff knew my profession and it led to me volunteering advice on a one-to-one basis and later in group sessions.'

Tracy is a long-term member of the BSDHT. Joining as a student, she has been treasurer and trade liaison officer for the Northern Ireland regional group team and is now chairperson – voluntary roles that are both demanding and gratifying but help in her bid to help those outside of her patient base and peers.

The BSDHT's First Smiles campaign is a good case in point and, she says, 'a very rewarding initiative'. Aimed at encouraging dental teams to go out into their local communities and deliver key oral health messages, it also provides members with plenty of supportive material and take-home resources, often donated by oral health companies.

Tracy even designed and adapted her own presentations that are evidence-based to suit each key stage. During lockdown she was part of a campaign by the BSDHT and Oral-B to conduct virtual oral health consultations with patients unable to access dental care.

She recalls: 'It was such an innovative way to reach out. In fact, the patients were taking in a lot of information and were not as nervous as they might have been in a clinical setting. They were

free to discuss their oral hygiene, dental concerns and dietary habits that we could then help modify. We used the Oral-B Test Drive and mouth models to demonstrate optimum toothbrushing methods and the feedback was great. It proved to be a good way to break down barriers in communication, albeit on screen. The pandemic has certainly pushed the profession onwards and more rapidly towards virtual consultations and telemedicine, which can only help to improve access.'

Inequality and discrimination

Tracy is also working hard to address other areas of inequality in access. People living with HIV often face numerous psycho-social challenges and hurdles to accessing care, especially in Northern Ireland where, she says, HIV continues to bring with it a stigma.

She explains: 'It's sad to say that discrimination still very much exists in today's society and people with HIV are failing to access good dental care. I was approached by a local charity on the back of a patient's positive experience at my practice. They had felt safe and confident to confide their medical condition to us and were impressed by further preventative advice given and the empathy shown through the holistic approach I pride myself on. The charity's clients revealed the negative experiences they had within the healthcare settings – not just dentistry. They lacked confidence in the medical and dental profession to keep confidentiality.

When I visited the charity, I was initially met with hostility, and rightly so. I was told horror stories about how people living with HIV were being treated and the stigma around it. It was awful to hear how this meant many people were afraid to seek the healthcare they needed. So, I tried to provide reassurance and confidence in our profession by building rapport and sharing existing patient testimonials.'

Self-care

But self-care is important, too. The role of a dental hygienist can be a lonely role and Tracy believes activities outside of the workplace helps to combat this. 'Working for the BSDHT has given me the opportunity to interact with many dental hygienists and therapists who I wouldn't have been able to reach in practice. It has certainly allowed me to build on professional and personal relationships.'

So, what advice does she have for colleagues looking to stretch their experiences beyond clinic?

She recalls: 'A few years after I graduated, I suffered a little with imposter syndrome and needed to find my feet in my new profession. Reaching out helped me. My advice would be… don't delay! Have faith and confidence in yourself – you're trained to a very high level and if it's something you are passionate about, go for it, we all learn by trial and error.'

'Plan and research evidence-based guidance, don't be afraid to ask for help and support from colleagues and dental companies and, most importantly, have fun. It can lead to different opportunities, be very rewarding and allow you to find another passion that could complement your career or take you on another journey.'

This article has been brought to you in partnership with Oral-B who will be making a donation to **https://www.dentalmavericks.org/** on Tracy's behalf

If you would like to share your experiences of reaching beyond practice please email: michelle@ab-communications.com

VIRTUAL CONSULTATIONS A TEMPORARY SOLUTION OR A PERMANENT FIXTURE?

by DAN NAYLOR

As we approach the second anniversary of the first lockdown, this is a good time to reflect on what has changed in dentistry. With further de-esculation we may all be wondering which procedures will go and which might stay and what we can expect as the new normal?

One aspect of the Covid-19 pandemic that has certainly changed in dentistry is the discussion around teledentistry.[1] This is the interaction of a patient and a service provider where the two individuals are separated by distances, often using information technology systems to exchange information. Other terms, synonymous with this are virtual consultations (VC) and remote consultations (RC).

During the pandemic, those of us that needed to access our GP surgeries were offered a phone call or a remote consultation. In addition, if the doctor needed an image, they often got you to send it via a link or even, in some cases, Whatsapp! The BMA surveyed doctors during the first wave and 95% of medical interactions were carried out remotely by phone with around 4% over video. This has increased since, and with improved integration of systems, such as EMIS and Accurx, there has been a rise in GP surgery uptake, supported by funding and better training for staff.

In dentistry, there was certainly some resistance to adopting virtual consultation software (VCS). The main objection was that, unlike medicine, we usually need to see the patient to be able to treat them. Other barriers included technology issues, be it hardware or integration of a virtual consultation software into the team. Concerns were raised around information governance and confidentiality, with little reassurance or firm guidance, at the time, from the protection societies. In addition, cost of integration and lack of infrastructure were also mentioned.[2]

Practices in Wales

The Welsh Government made clear that after a successful pilot on the use of VCS, it planned to support service providers to develop their practices to provide this service.[3] In Wales, dental practices were given a small encouragement grant to begin rolling out the services in the autumn of 2020 and by Christmas 2020, there had been around fifteen hundred virtual consultations completed, with 225 virtual waiting rooms created. Much has been written on this subject since then[3] but there is a lack of individual experiences available for colleagues to consider in order to, perhaps, reconsider if there is a place for VCS in their practices.

From a dental therapy and hygiene perspective, there are areas to be explored and plenty of research opportunities to be considered, especially in the ways that oral hygiene care can be delivered and monitored.

Team work

Some of the ways we made VCS work in our practice are listed below. Not all of these are carried out by dentists, and it was very much a whole team approach.

- New patient introductions and initial practice presentation
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- Medical updates

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

- Treatment planning and presentations for consent
- Interpreter support
- Online prevention and product demonstration
- Virtual chaperone
- Specialist opinion
- Care home support
- Anxious patient review
- Laboratory and colleague discussion/case reviews.

When there was very little or no face-to-face contact with patients, the VCS was used mainly to reach out to patients and provide them with access to their oral health team. Sessions were booked, mainly for kids, to run over brushing techniques and diet control. One of our dental therapists provided video content that we were able to share with patients virtually. This involved her and her young family discussing the importance of good oral hygiene where they especially concentrated on diet. As children were home from school, the demands on the family to provide more snacks and juices were far greater so we were able to reinforce good eating and drinking habits via the VCS and other social media platforms. This got some great feedback and it is something that we will certainly take forward in the future.

As we move into the reform programme, once again in Wales, the hope is that we will be able to provide support for our patients as part of our daily care, via the VCS. The use of periodontal pathways and prevention plans is one way to keep the patient accountable for their own oral health. Using the therapy and hygiene team, we will look to plan virtual reviews, saving patients unnecessary trips that they often don't prioritise and therefore fail to attend. This, if done well, will allow multiple patients to attend the virtual waiting room and the dental therapists manage their appointments more effectively, negating the need for repeated decontamination of surgeries, and saving on clinical time that can be used for other patients.

Making it work

The secret of good VCS technique is to be well prepared and practiced. Make sure the team is involved from the start with good training and support. The patient journey is very much like it would be in reality. The first point of call in the virtual waiting room is the receptionist who will review that the patient is present and has no technical difficulties. Occasionally we will need to call the patient and talk them through the login process. However, unlike systems such as Zoom and Teams, Attend Anywhere, which is the preferred system in Wales, is internet based or webRTC, requiring no third-party software to be downloaded. Access is through a web browser, on a phone, tablet or computer. It is important that patients are sent an initial email with login in details and instructions, otherwise it can be somewhat confusing. Each practice has a defined VCS waiting room address and this never changes so the same login address works each time.

Once the reception team has opened the patient file, checked that relevant documents and administration is complete, they can review the medical history and advise the patient to go back to the waiting room to wait for their dental care professional. We found the reception team helpful in keeping the patient up to date on waiting times and this can be done via a message on the system.

When ready, the dental care professional can access the call, again either in surgery during a VCS session or from home. The important thing to note is you must treat the consultation the same way as you would a face to face, so the environment must be professional. The use of dual screens can be helpful so as you can look at the patient and at the same time have their notes to hand and any special investigations you might need. Occasionally, if a patient requires a special investigation, this can be arranged and reported in advance and made ready from when you are on the call.

Once the call is completed, and before you let the patient go, it is always very helpful to have a summary of the call and an agreement on following actions. We usually follow each call with an email summary which is based on a template in our software. The patient will not leave the call completely but return to the VCS waiting room for the reception team to either reappoint, take payment or answer any further questions. The VCS receptionist can be the same person who works on the front desk, but we found that putting a team member in the back office to deal with the online administration was far more effective.

In summary

As patients flow back through the doors and regular, more traditional dentistry is reintroduced, it might be asked why complicate things further with a virtual element to care? My view, as someone who enjoys innovation, is VCS is an adjunct to care and patient management and does not replace anything we already did. As we become more environmentally conscious, and potential taxes are placed on how polluting our practices are, one great way of reducing the dental carbon footprint is to reduce journeys.[4] My hope is that the policy makers consult the profession further to get the best blend of care for patients, post pandemic, and allow us to work smarter to provide better access, care, support and monitoring in and around prevention and allow our teams to integrate better in these care pathways now and in the future.

Author: Dan Naylor is a general dental practitioner and practice owner in North Wales. Dan is heavily involved in North Wales dentistry, representing the Local Dental Committee as secretary. He has also provided courses on virtual dental consultations for Health Education and Improvement Wales and continues to be involved in the development of the reform program in Wales.

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References

1. World Health Organization. Global diffusion of eHealth: Making universal health coverage achievable. Report of the third global survey on eHealth. 2016. 160 p. Available from: http://who.int/goe/publications/global_diffusion/en/
2. Patel T, Wong J. The role of real-time interactive video consultations in dental practice during the recovery and restoration phase of the COVID-19 outbreak. *Brit Dent J.* 2020;**229(3)**:196–200.
3. Johns G, Khalil S, Ogonovsky M et al. Taming the chaos: NHS professionals' perspective of using video consulting during COVID-19 in Wales. *BMJ Open Qual.* 2021;**10(4)**:e001318.
4. Duane B, Lee MB, White S et al. An estimated carbon footprint of NHS primary dental care within England. How can dentistry be more environmentally sustainable? *Brit Dent J.* 2017;**223(8)**:589–593.

PANDEMIC LESSONS SPOTLIGHT ON COMMUNICATION

by JEANIE SUVAN

The environment imposed by the COVID-19 restrictions, aimed at minimising risk of disease transmission, has prohibited family hospital visits during each surge, resulting in the development of new communication lines to meet the needs of patients, families, and medical staff. Family communication is an essential part of Critical Care Unit (CCU) patient care offering the possibility to enhance family, patient and medical team well-being. Implementation of a CCU family liaison team at UCLH amidst the COVID-19 outbreak highlighted lessons learned about the power of communication.

COVID-19, communication and daily life

The COVID-19 pandemic has attacked core aspects of human life far beyond the medical consequences of the disease itself. Its impact on human interaction, a fundamental part of human nature, has emerged as one of the most tragic outcomes of the pandemic as COVID-19 restricted or altered opportunities to connect with others in most every part of daily life. The need to communicate, or connect, lies at the heart of every person, regardless of their place on the spectrum of personality introversion or extroversion. Whether through a kind greeting, a listening ear, a brief smile, a passing gentle touch, a few words or an engaging conversation, interaction enhances physical, emotional and mental well-being for both giver and receiver.

Interaction, connectivity and communication play a key role in best practice to facilitate patient and family centred healthcare. The COVID-19 pandemic has had a rapid, fundamental and unprecedented effect on healthcare in the UK and globally. As the UK entered "Lockdown" on 23rd March 2020, hospital family visiting policies were amended in line with guidance, mandating restriction of family visits to end of life care only and limited to one or two family members. The impact of changing visiting policy was profound.[1] Effective communication about patients' health and wellbeing was severely hindered, affecting patients, families, friends and the care team.[2] It is hard to imagine the magnitude of the situation which was further compounded by the uncertainty about managing an entirely new disease without guidance on effective treatment protocols or likely outcomes.

Communication and CCU

Admittance to a Critical Care Unit (CCU) presents unique challenges to patients, families and hospital teams.[3] Different from medical wards, patients in CCU are more likely to lack elements of capacity, therefore increasing the need for family involvement in decision making with the CCU medical team. Effective communication helps to establish and maintain family trust in the care team, while also highlighting family needs to the team.[4] Evidence has shown that the communication skills of healthcare professionals is a determinant of relatives' long-term psychological wellbeing, assists family coping and decision making during end-of-life care and reduces the numbers of complaints from families.[5]

Family members are vulnerable to psychological stress and may suffer from post-traumatic stress syndrome associated with the care of a relative in CCU.[6] Therefore, CCU teams may have a greater responsibility than other medical specialties to family members as part of patient care enhancement and to minimise long-term effects on families. Under normal conditions, visiting their family member in CCU develops a sense of proximity and reassurance, allowing families to express their wishes or act as advocates for their relative.[7,8] Therefore, family communication is essential to enhance the well-being of not only patients but also family and medical staff.

COVID-19 and the CCU FLT service

The substantially increased patient numbers and inability of families to visit during the COVID-19 outbreak created an unprecedented barrier to the high priority normally given to communication with relevant parties associated with patients admitted to critical care units at University College London Hospitals (UCLH). Distress and anxiety levels raised noticeably within families resulting in disproportionately high numbers of phone calls to the unit, challenging the ability of the already overstretched staff members to keep up with the demand.

With daily cases and hospital admissions growing exponentially, and UCLH CCUs operating at more than double normal capacity, there was minimal time for traditional approaches of strategic discussions to design and trial new systems of family communication. Lead consultants recognised an urgent need to change current practice and implement new strategies to restore effective communication. Consequently, the Family Liaison Team (FLT) was established by bringing together volunteer healthcare professionals available for redeployment due to reduction in their normal clinical activities.

The main goal for the FLT service was to facilitate communication between staff members, patients and relatives, affected by the lack of family visiting. The first priority was to restore daily

telephone medical updates and respond to family enquiries. The team aimed to provide continuity and compassion for relatives, while respecting the privacy and autonomy of patients and ease the workload for those providing direct medical care ensuring proper documentation and follow-up of issues raised by families.

As the team grew, FLT services expanded to include conduct of video calls between families and their relatives. Team members would not only ensure a good technological connection during the call but also an emotional connection, or even the tactile element that virtual visits lacked. For some families it was important for a team member to hold their relative's hand, providing a feeling of connectivity. The team would feed back to the family any changes that they observed, such as breathing patterns, or flickers of movement in response to the voice or singing of their relatives. They might describe the wider environment, explain the various tubes or lines, and introduce the relatives to the bedside staff. Every call was an opportunity to explore how the family was coping.

Palliative visits were initiated by the medical team when a patient was deemed at high risk to die. The lead consultant would contact the family to inform them of the deterioration, then invite two relatives to visit. The FLT would follow-up to facilitate the meeting, help them don PPE, support them during the visit, safe doffing of PPE and debriefing afterwards. Over time it became apparent that the FLT were able to acquire an in-depth knowledge and awareness of the families and patients that was not possible for the care staff due to the barriers to communication COVID had imposed. As a result, the FLT became increasingly involved as advocates for both family and patient issues in multi-disciplinary team discussions.

Communication at the heart of FLT

For many of us on the team, it was our first exposure to a CCU. We wondered if we might be more hindrance than help due to our lack of intensive care skills. We soon realised that simple communication skills used to demonstrate empathy and compassion were the most essential and valuable traits. Team roles were not defined by job title, nor was there a hierarchical structure, but rather a sense of selflessness and the desire to help was common to all. Our role was to stay within the remit to communicate with the families, to facilitate a sense of proximity and connection rather than to provide medical advice.

After just a few days, a fellow FLT member, a neurologist by qualification, expressed that the most essential training needed was to "take off your clinical hat". It was quickly apparent that it was an advantage not to have critical care unit experience as it enhanced our ability to focus conversations on the family, to ask how they were coping, to acknowledge the difficult times they were going through while waiting for news of their relative each day. Perhaps the lack of hierarchical doctor-patient relationship that often occurs in medical conversations enhanced our opportunity for an open and relaxed chat with families.

It is normal for families to feel distressed, anxious, sad and helpless when a relative is admitted to an intensive care unit. The role of communication techniques is to calm and enhance family members' feelings of control or empowerment. To achieve empowerment, the relatives described the need to trust in oneself, to encounter charity and to encounter professionalism.[9] As dental professionals, we are accustomed to interacting with individuals under stress (although not to this magnitude) and we understand the power of communication techniques to empower patients, to enhance self-efficacy facilitating a sense of control to make healthy lifestyle choices to facilitate oral and systemic health.[10] It struck me that the very same communication techniques were applicable in helping CCU families feel empowered or in control during a time that life felt very out of control.

The use of open questions helped in starting conversations with family members. Rather than asking a closed question such as, "Are you doing ok?", I would ask them, "Tell me about how you are feeling". This would prompt them to share more than single word responses, which in turn allowed me to listen. Active listening is a simple but powerful tool to enhance the feeling of control in the person speaking. If you are a skilled listener, you will often hear what is left unsaid or partially expressed in addition to what is being said.

Affirmation or appreciation is another influential skill for empowering others.

It is human instinct to have the need to feel appreciated or valued. Families disconnected from their critically ill relative due to visitation limitations have little opportunity to feel affirmed or appreciated. It was amazing to see the effect of thanking a family member for taking the time to call or participate in a video call with their relative, or even for coming to the hospital for an end-of-life visit, something that many found very difficult. Expressing empathy of how difficult it is to see their family member so unwell and affirming their bravery in joining a video call or visiting are influential communication tools. As the saying goes, "people don't care how much you know until they know how much you care" (unknown source).

Another example was the impact of asking permission in conversations. For example, when preparing a family for their first video call with their intubated relative, often having last seen them when taken away by ambulance, simply asking permission saying, "Would it be ok with you if I explained a little about what you might expect when you see your relative on the video?" (calling the relative by name to personalise it) provided a sense of autonomy and respect, again supporting their sense of being even slightly in control. The simple tool of thanking them for listening expressed appreciation, contributing to the sense of empowerment and charity.

Subtle verbal and non-verbal communication skills were helpful in calming stressed family members who sometimes called with frustration while waiting for a medical update. It is normal that waiting by the phone for the medical update each day might result in a stressed or angry state. Talking slowly and softly would evoke a sense of calm and de-escalate their reactions. During end-of-life visits, non-verbal skills such as maintaining eye contact when speaking or nodding a head when listening conveyed genuine interest and warmth.

There were numerous conversations that stretched many team members beyond typical conversations in their usual healthcare setting, however the CCU team were always there to support us. Weekly group debrief meetings with a CCU psychologist provided team support, also allowing a time of learning from each other through sharing of experiences.

Feedback on the CCU FLT service

Response to the FLT service by families, patients and staff was overwhelmingly positive. Families appreciated a designated phone line and email address to stay in contact, to pass messages or medical queries, or to obtain information of aspects other than the medical care of their relative, such as psychological or palliative support or property services. Families commented that the service was an "Invaluable lifeline during difficult times". It was said, "To make the unbearable bearable". Some family members said they had the feeling they were almost there beside the patient. Although in many cases the patients were sedated, or unable to speak, simply being able to see them in video calls provided substantial comfort and sense of proximity. The inclusion of relatives in various global locations through video calls provided family support above and beyond that possible through traditional in person visits.

Patients, once conscious, commented the video calls made them feel connected to their family, or helped to orient them during times of confusion caused by their unwell state. The FLT support of communication between patient, family, and medical

team provided a sense of calm and security, providing reassurance when the patient felt vulnerable and unable to make calls to family members independently. Feedback from the CCU multidisciplinary team confirmed the service reduced medical team burden, enhanced their understanding of families' wishes, and facilitated end of life visits which were particularly complex in the context of COVID-19. Post surge, the FLT was very honoured to receive awards of excellence from UCLH and the Intensive Care Society.

Closing thoughts

Patient and family-centred care within intensive care units historically viewed the family, like the patient, as vulnerable and in need of support and care, however this has evolved to a paradigm that considers the family as both recipients of care to maintain their well-being but also active participants in the care of the patient to enhance patient well-being.[11] COVID-19 imposed restrictions intensified efforts to engage families in every way possible and have resulted in unique aspects of patient and family centred care.[12] However, beneath the technology and novel aspects remain the fundamentals of human communication that provide the framework for successful connections, a reminder to us all of the power of communication in every human interaction.

As I reflect on this article, it has been one of the hardest but perhaps most important to write. When invited, I promptly agreed, not anticipating the challenge it would be to put such an experience in words. Thank you to the editor for the opportunity to share about this life changing experience. I am indebted to the precious UCLH CCU families, their dear relatives who were patients, and every member of the UCLH CCUs and FLT for reminding me again of the extraordinary power of the most ordinary communication.

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References

1. Hart JL, Turnbull AE, Oppenheim IM, Courtright KR. Family-centered care during the COVID-19 era. *J Pain Symptom Manage.* 2020;**60(2):**e93-e97 doi: 10.1016/j.jpainsymman.2020.04.017.Epub 2020 Apr 22.
2. Montauk TR, Kuhl EA. COVID-related family separation and trauma in the intensive care unit. *Psychol Trauma.* 2020;**12(S1)**:S96-S97.
3. Olding M, McMillan SE, Reeves S et al. Patient and family involvement in adult critical and intensive care settings: a scoping review. *Health Expect.* 2016;**19(6)**:1183-1202.
4. Kleinpell R, Heyland DK, Lipman J et al. Patient and family engagement in the ICU: Report from the task force of the World Federation of Societies of Intensive and Critical Care Medicine. *J Crit Care.* 2018;**48**:251-256.
5. Anderson RJ, Bloch S, Armstrong M et al. Communication between healthcare professionals and relatives of patients approaching the end-of-life: A systematic review of qualitative evidence. *Palliat Med.* 2019;**33(8)**:926-941.
6. Latour JM, Coombs M. Family-centred care in the intensive care unit: More than just flexible visiting hours. *Intensive Crit Care Nurs.* 2019;**50**:1-2.
7. Al-Mutair AS, Plummer V, O'Brien A, Clerehan R. Family needs and involvement in the intensive care unit: a literature review. *J Clin Nurs.* 2013;**22(13-14)**:1805-1817.
8. Johansson I, Fridlund B, Hildingh C. What is supportive when an adult next-of-kin is in critical care? *Nurs Crit Care.* 2005;**10(6)**:289-298.
9. Sundararajan K, Sullivan TR, Chapman M. Determinants of family satisfaction in the intensive care unit. *Anaesth Intenives Care.* 2012;**40(1)**:159-165.
10. Ramseier C & Suvan JE. *Health behavior change in the dental practice.* John Wiley & Sons (2011).
11. Garrouste-Orgeas M, Philippart F, Timsit JF et al. Perceptions of a 24-hour visiting policy in the intensive care unit. *Crit Care Med.* 2008;**36(1)**:30-35.
12. Boulton AJ, Jordan H, Adams CE et al. Intensive care unit visiting and family communication during the COVID-19 pandemic: A UK survey. *J Intensive Care Soc.* 2021;17511437211007779.

Providing oral health support through teledentistry during the coronavirus pandemic

by SARAH MURRAY[1] MIRANDA STEEPLES[2]

AIM

To explore the provision of oral health support via teledentistry.

OBJECTIVE

To evaluate the provision of a teledentistry project and identify any benefits and challenges.

LEARNING OUTCOMES

- An appreciation of the merits of providing patients with oral health support via the medium of teledentistry.
- To review any lessons learnt and reflect on how the service might be improved for the application to daily clinical practice.

Aligned with GDC development outcome: *C*

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ABSTRACT

Background

The use of teledentistry to provide oral health advice to the public during the coronavirus pandemic is a relatively new development. The provision of primary prevention to the public is well suited to this format and has the potential to support patients who are concerned for their homecare routines in the absence of their regular dental practice team.

Aim

To provide members of the public with free oral health advice, during the early phase of the coronavirus pandemic, from members of the British Society of Dental Hygiene and Therapy who are registrants of the General Dental Council.

Method

The advice provided by the clinicians was recorded on a spreadsheet. Following their appointment with the dental clinician, patients completed a questionnaire that included a series of open and closed questions about their experiences. A thematic, mixed methods approach was utilised for both aspects.

Results

The data were reviewed quantitively and a number of themes emerged for both aspects of the data set. There was a 40% response rate from the patients (n=30). None of the patients had a problem that was outside of the scope of a practising dental hygienist or dental therapist. The most common complaint related to periodontal problems. The advice provided was seen as positive by all patients. Not all advice provided was in line with the Public Health England evidence-based document *Delivering Better Oral Health*.

Conclusions

There are opportunities to develop the use of teledentistry to access the wider population, including marginalised groups, for initial appointments and preventive support. Reduced surgery time and an initial positive appointment are seen as benefits of this methodology of communication. Ensuring that advice is underpinned with an appropriate evidence base, such as *Developing Better Oral Health*, needs further consideration alongside the clinician's expertise.

KEY WORDS

Teledentistry, dental hygienists, dental therapists, primary prevention, oral health

Introduction

Due to the coronavirus pandemic in March 2020, dental services in the UK were suspended and urgent care hubs set up to support individuals experiencing dental pain.[1] Patients were unable to access face-to-face support for maintenance of their oral health, and dental hygienists (DH) and dental therapists (DT), alongside other dental team members, were unable to work clinically in general practice. It was unknown for how long routine, non-urgent dental services would be suspended and there was concern for patients regarding maintenance of their homecare routines, particularly as periodontal diseases have

significant effects on overall health and have been linked with poorer outcomes for patients with Covid-19.[2]

A period of three months elapsed before resumption of general dental services, in June 2020. Additional infection control and prevention (IPC) practices[3], including 'fallow time' post aerosol generating procedure (AGP) treatments, were put in place.[4] More than a year later, dental services in the UK are not back to pre-Covid 'normal' and the additional Infection prevention control measures are still required and will be for the foreseeable future.

Despite its inception in 1997[5], teledentistry had not been routinely used as a tool to support dental patients until the pandemic began in the UK. However, its use has grown throughout this time with an increase in remote consultations. It has complemented the 'existing compromised dental system during the current pandemic.'[6] The provision of oral health advice to the public is well suited to this format, with many benefits, offering real time consultations away from the dental surgery, involving both the patient and clinician.

Teledentistry falls under the umbrella 'telehealth', which is a broad concept within the wider delivery of general healthcare. Dental Protection[7] defines this as 'the remote provision of dental care, advice or treatment through the medium of technology, rather than through direct personal contact with any patient(s) involved'.

This paper describes a one-off collaborative initiative between the British Society of Dental Hygiene and Therapy (BSDHT) and Oral-B/P&G, who provided sponsorship funding for the programme. The aim was to provide members of the public with oral health advice at no cost to them, during the early phase of the coronavirus pandemic. For the purpose of this paper, the word 'patient' has been used to describe those who accessed this service.

Methods

The virtual clinics were undertaken over four mornings during National Smile Month[8] at weekly intervals (18th May - 18th June 2020). BSDHT Executive invited six members to participate in this project, chosen for their confidence and experience as DH and DTs. Each of the six were able to claim for their time (based on approved BSDHT renumeration) and this was funded by Oral-B/P&G. In-house training was provided at the outset, which included input from the Oral-B Senior Professional & Scientific Relations Manager, who is also an experienced DH.

The members were provided with specific email addresses to utilise on the Zoom platform for the online sessions. Zoom was chosen because BSDHT use this platform frequently and the members were confident in its use. Members of the public were informed of this initiative through social media outlets, the Oral Health Foundation, and via some of the dental practices at which the BSDHT members worked. Members of the public were invited to schedule an appointment via the BSDHT office, which ensured consent was obtained from the outset.

Methodology

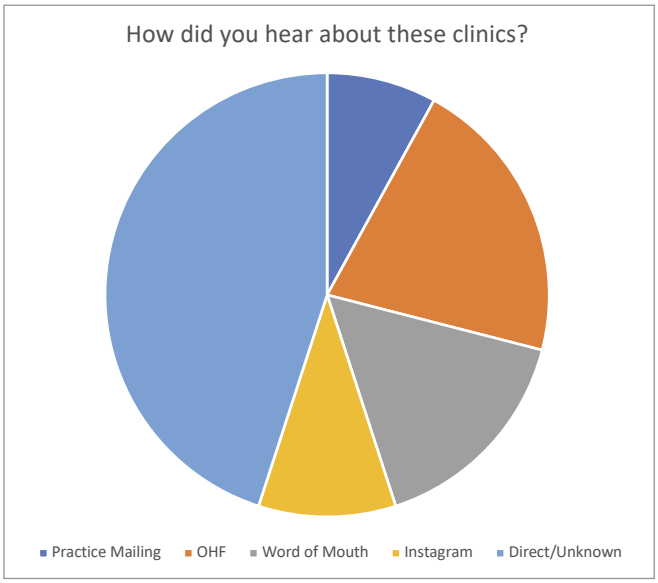
A total of 30 patients utilised the virtual clinics, however of these, 8 failed to attend their allotted appointment. The six dental advisors were randomly assigned patients from those who requested an appointment and each worked at approximately three sessions. At the conclusion of the project, the patients were sent a follow-up questionnaire; 12 out of 30 completed this, resulting in a 40% response rate. Questions were both open and closed, and can be found in Figure 1. A thematic, mixed methods approach was used in analysing the data.

Results taken from the actual appointments

Outcomes of this project can be addressed quantitatively by examining the demographic of the individuals that utilised the service, how they came to hear about the project, and the types of problems with which they presented.

It is evident that patients heard about this project via a variety of different channels: almost half (45%) did not state how they heard about the service; roughly a fifth (21%), heard via the Oral Health Foundation; while a third (34%), learnt about the service from either a practice mailing, word of mouth or Instagram (Figure 2).

Figure 2



Of the sample of the individuals surveyed, 3 were men and 9 were women, and of these, 10 regularly saw a dentist and 6 a DH. Of the patients surveyed, 2 presented with no complains. Of those accessing the service, the most common complaint related to periodontal problems that included bleeding, halitosis and tooth mobility. No patients had a problem that was outside of the scope of a practising DH or DT. All the individuals who engaged with the service received practical advice including toothbrushing and interdental cleaning, depending on their initial complaint. Where appropriate, patients were recommended to contact their dental team.

Analysis of feedback questionnaire

The feedback received was positive and included comments such as: "highly recommend": *"good service"*: *"keep it after Covid 19"*: *"thoroughly recommend"*.

From the comments, three themes were identified: 'Reduced stress'; 'Immediate benefit felt by the recipient;' and 'Increased future self-efficacy for patient'.

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Reduced stress

Each of the following comments were received more than once:

"Less stressful"

"No sitting in waiting room"

"Not rushed"

"Didn't feel judged"

"Didn't make me feel told off or lectured".

However, the keywords of *"relaxed"* and *"feel/put/so at ease",* were each mentioned three times, thus, could be deemed a prevalent benefit. This is possibly because the patients were in the comfort of their own home and not in a clinical setting, which can be stressful for some. Additionally, the clinicians recruited were all experienced and so would be naturally adept at putting the patients at ease.

More beneficial to patient

"Explained symptoms clearly to clinician"

"Not often you get to sit down and ask a dental professional"

"Glad I had chance to speak and hear what Claire had to say"

"Practices always busy".

These patient comments imply that the patients were grateful to have time to engage verbally with their clinician. This is possibly because when physically in the surgery, the emphasis is on operative work and possibly less time is spent on verbal communication. The keyword, *"helpful"* was mentioned four times, suggesting that patients really do feel a benefit in having these conversations.

Increased self-efficacy

This was perhaps the most variably evidenced theme. Patients responded positively to the advice they were given and demonstrated willingness and motivation to better take care of their oral health. Keywords and phrases included: *"realised what I could do better; "useful for my future routine"; "took in so much more information than usual"; "thank you for information"; "re-evaluate my cleaning technique"; "do correctly to help teeth and gums"; "took in more information"; "great specific advice"; "stuff I could do better to keep mouth healthy"; "informative" and "very informative".*

These themes suggest that patients would see value in, and benefit from, future remote consultations and that appointments for oral hygiene support, would be well received by patients.

These clinics were held during a time when patients could not access care at their usual dental practice, and clinicians in dental and general healthcare had to adapt to using technology to support their patients. This feedback suggests that having something like this available in future would be well received. However, there are questions to be asked as to how to fund this and to address the failed attendance rate of 21%.

The clinicians that provided feedback were overwhelmingly positive about this initiative and only reported benefits: to themselves as clinicians, the patients and to the professions as a whole. Three themes are suggested and evidenced:

Clinician's benefit

"Boosted my confidence on personal and professional level'

"Fulfilling!"

"Felt like going to work"

All are suggestive of a positive effect on mood and of developing skills.

Patients benefit

"Patients have absorbed information given during appointment": "had notepads and willingness to learn": "with patients being away from surgery they have been more receptive to information": "in this scenario they are more open and able to explain what they mean or feel": "a chance to be truly honest": "new education-focused time".

All of these comments suggest a correlation with what the patients had reported; they felt more at ease and more receptive to receiving information in this situation, and more comfortable discussing their oral health and what they could do for themselves away from a conventional clinical setting.

Jo Downs, BSDHT and Council member elected to the Executive shared one of her lasting experiences from this project: *"One of the patients booked in to see me was someone with whom I had been to school, although we lost contact many years ago. Maria was a huge dental phobic and this online meeting assisted her in gaining the confidence to book in at a local practice where I work. It was a great first step towards her receiving dental treatment and getting her confidence back. She is over the moon with the outcome".*

Profession benefit

"Eye opener as to how we can reach the dental public to educate them in oral health": "patient surprised by what dental hygienists and dental therapists could do": "innovative concept connecting clinicians and public for preventive advice": "digital appointments the way forwards": "should be available long term".

Such feedback indicates an increase in awareness of not only the presence of DHs and DTs but what we can offer the general public, our patients, with regards to healthcare.

This is a technology with which our clinicians and patients were comfortable. There was the suggestion from both parties that this should be continued and offered more in the future, both within a patient care setting and to an even broader audience of one of the patient's workplaces.

Discussion

This project highlights the benefits of teledentistry in the provision of oral health advice, particularly in a pandemic, but has shown the benefits of individuals receiving home care advice within their own environments. Anecdotal evidence demonstrates how one individual who accessed this service gained in confidence to seek dental treatment after many years of non-attendance.

None of the individuals accessing this service presented with a problem that was outside of the scope of practice a DH or DT might reasonably expect to see in their workplace. Advice

that was given heavily featured products from the Oral-B range, which given their sponsorship, was to be expected, although not a requirement of the company.

However, some advice given was not always in line with what is suggested in the Public Health evidence-based document Delivering Better Oral Health.[9] This included the use of Peroxyl or Chlorhexidine mouthwash: Chlorhexidine mouthwash with interdental brushes if the gingivae are bleeding (5); rinsing with Chlorhexidine (4); dipping the interdental brush into Peroxyl before use (5); the use of Chlorhexidine with a single tufted brush and interdental brushes (4); interdental brushes dipped into Peroxyl (5); use of Duraphat toothpaste (Figure 3).

It was not noted whether allergies had been checked when advising Chlorhexidine usage, nor whether the individual was questioned about contraindications to using aspirin or hydrogen peroxide when recommending Peroxyl. Duraphat toothpaste can only currently be prescribed by a general dental practitioner and therefore this needs consideration whether it is appropriate to recommend a product that members of the public may not easily access themselves. It also needs to be justified and on one occasion it was recommended without evidence of justification.

Conclusions

There are opportunities to develop this project further and access individuals who may not attend dental practices for specific reasons. Such groups of patients may include those who are marginalised, such as care home residents or hospitalised patients. Consideration would need to be given regarding logistics, such as appointment management and whether there are costs for the time offered from the dental professional. It can be seen how this could become a mainstay of the provision of dental treatment with the initial appointment of history taking and home care support providing reduced surgery time, and create an initial positive appointment.

Ensuring evidence-based practice, in conjunction with clinical expertise, is the mainstay of appropriate delivery of health advice and interventions; this should be in line with the patient's values and decisions, and those delivering the interventions are encouraged to utilise Delivering Better Oral Health.[9]

Often there is a gap between what research shows and what it does not. This is clear in many Cochrane systematic reviews where it is regularly stated that there is insufficient evidence to warrant an intervention. Although there may be a place for anecdotal provision of advice, this is not considered best practice and should be discouraged. All clinicians have products or techniques that work for them as individuals, and knowing our patients well, we can justify their use and this is probably low-risk. When working remotely, offering advice to complete strangers, clinicians should ensure that advice provided is robustly evidenced-based to mitigate against any harm and discuss any allergies prior to recommending mouthwashes to ensure reduced harm.

Therefore, a greater attention to evidence-based approaches is warranted should these clinics be offered in the future. This would ensure that there would be standardised information offered and follow UK evidence-based guidelines.

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Conflicts of Interest: The authors have no conflicts to declare.

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References

1. Winchester N. (2020). Covid 19 and Dental Services'. Available at Covid-19 and dental services - House of Lords Library (parliament.uk) (Accessed 10 August 2021.)
2. Marouf N, Wenji C, .Said, K N et al. Association between periodontitis and severity of COVID-19 infection: A case–control study. *J Clin Periodontol.* 2021; **48(4)**:483-491.
3. Office of Chief Dental Officer England (2021) 'Standard operating procedure Transition to recovery'. Available at Document template (england.nhs.uk) (Accessed 10 August 2021.)
4. Scottish Dental Clinical Effectiveness Programme (2021). Mitigation of Aerosol Generating Procedures in Dentistry A Rapid Review. Available at Mitigation of Aerosol Generating Procedures in Dentistry - A Rapid Review (sdcep.org.uk) (Accessed 10 August 2021.)
5. Friction J, Chen H. Using teledentistry to improve access to dental care for the underserved. *Dent Clin North Am.* 2009; **53(3)**:537–548.
6. Ghai S. Teledentistry during COVID-19 pandemic. *Diabet Metab Synd Clin Res Rev.* 2020; **14(5)**:933-935.
7. Dental Protection (2015). Teledentistry Guidance. Available at Teledentistry guidance (dentalprotection.org) (Accessed 10 August 2021.)
8. Oral Health Foundation (2020). National Smile Month downloads. Available at National Smile Month downloads | Oral Health Foundation (dentalhealth.org) (Accessed 10 August 2021.)
9. Public Health England (2014) 'Delivering Better Oral Health'. Available at Delivering better oral health: an evidence-based toolkit for prevention - GOV.UK (www.gov.uk) (Accessed 10 August 2021.)

Figure 1: Questions to patients

1. Personal details (Name and date of birth)
2. Medical history
3. Have they any current concerns regarding their oral health (e.g. gum disease, sensitivity, bleeding)?
4. What has the patient tried so far?
5. Have they sought advise elsewhere?
6. What products are they using and what is their usual regime?
7. When did they last see a dentist/dental hygienist/ dental therapist regularly (date of last appointment)?
8. Was the patient happy with the advice given?

Feedback questions to patients

1. Did they find the virtual appointment useful and convenient?
2. Would they put the recommendations into practice?
3. Would they use the service again?

Figure 3: **Clinician's records of patient interaction**

Clinician identifier	Date of appointment with clinician	Gender	Have they sought advice elsewhere?	What are their immediate concerns?	What has the patient tried so far?	Action/advice provided by clinician	Was the patient happy with the advice provided?
6	13-05-20	F	Regular attender, last dental hygienist visit Nov 2019	Bleeding gums, especially around two anterior crowns	Oral-B electric toothbrush, floss	Change head regularly. Electric toothbrush instruction given. Use interdental brushes regularly, larger the better. Consider superfloss. Do not stop if sees bleeding. Oral-B Pro Gum toothpaste advised. Toothbrush instruction around crown margins. Regular dental hygienist appointments.	Yes
6	13-05-20	M	Regular attender, Nov 19, never seen DH.	Occasional bleeding, recession, crowding, stain, sensitivity.	Oral-B electric toothbrush, Colgate Toothpaste, mouthwash, occasional tape	Change head regularly, Electric toothbrush instruction given around gum line, no rinse, Use interdental brushes regularly. Smoking cessation advice provided. Oral-B toothpaste. Discussed tooth whitening. Discussed ortho. Pay attention to bleeding areas. Care with recession and toothbrushing technique.	Yes
6	13-05-20	M	Reg attender, Nov 19, never seen DH.	Occasional bleeding, recession, crowding, stain, sensitivity.	Oral-B electric toothbrush, Colgate Toothpaste, mouthwash, occasional tape	Change head regularly, Electric toothbrush instruction given around gum line, no rinse, Use interdental brushes regularly. Smoking cessation advice provided. Oral-B toothpaste. Discussed tooth whitening. Discussed ortho. Pay attention to bleeding areas. Care with recession and toothbrushing technique.	Yes
1	20-5-20	M	Reg DH appts, GDP x 2 a year	Bleeding on ld cleaning round a lower molar with large filling in it.	Electric toothbrush Oral-B, blue Wisdom brushes, already noticed less bleeding since using wisdoms.	Electric toothbrush instruction given; Fluoride toothpaste and Fluoride mouthwash at separate time to brushing. To use interdental brushes before toothbrushing.	Yes
5	20-5-20	F	Sees DH every 3/12	Bleeding ULQ, plaque lower incisors.	Pink/blue TePes, Airfloss, electric toothbrush, Oral-B, Chlorhexidine for short time	Pt worried that perio will deteriorate with not seeing dental hygienist. Reassured that their home care should be seen as treatment. Peroxyl/Chlorhexidine with TePes if bleeding. Oral-B toothpaste recommended, pink and blue TePes. Change Oral-B head regularly.	Yes
4	27-5-20	F	Sees GDP regularly	Patients implant crown has cracked. Sensitive gum	Nothing	Use implant floss, demonstrated, single tufted brush and Chlorhexidine. Discussed different Oral-B heads.	Yes
3	27-5-20	F	Regular attender to dental hygienist and GDP	Wants to keep plaque levels down.	No problems noted	Advised to use pink TePes before toothbrushing daily. Oral-B electric toothbrush 2/day. Fluoride toothpaste and spit no rinse. Reduce frequency of sparkling water/diluted juice. Change sugar to sweetener in tea. Wait 40 min after eating/drinking before brushing. Alcohol free mouthwash and use at separate time to brushing.	Yes
5	3-6-20	M	Told by GDP needs to see dental hygienist as has periodontal disease	Family history of periodontal disease, former smoker, lower and upper anterior teeth mobile. Worried will lose teeth	Not stated	Advised to see dental hygienist as soon as possible. Red, blue and yellow TePes, until sized properly, dipped into Peroxyl, Oral-B electric toothbrush, change head every 3 months. Oral-B Toothpaste. No rinse. 10 mins 2/day to deep clean gums.	Yes
2	3-6-20	F	Nervous, just started to visit dentist	Treatment for perio. Has 1 quadrant untreated. Worried lockdown will affect this negatively.	Started to see GDP	Electric toothbrush with interdental head, use of interdental brushes, and flossettes. Smoking cessation advice given. Explained links between smoking and systemic health	Yes
1	3-6-20	F	Sees dental hygienist every 3 months	Tea stain, 4 cups/day. Pt has abrasive wear from heavy toothbrushing, notices sensitivity on toothbrushing.	Oral-B electric toothbrush. Patient uses Pro-Expert Toothbrush margins, not too hard. Daily flossettes.	Recommended oral-B flosspicks. Reinforced fluoride mouthwash at separate time to brushing.. Advised to reduce frequency of green tea. Possibly use straw to reduce stain. Pt will book appointment with dental hygienist when able to.	Yes
4	10-6-20	F	GDP prescribed antibiotics	Bad taste lower right area around crown	Had 2 weeks of antibiotics	Using Chlorhexidine with interdental aids. Electric toothbrush 2/day, not manual brushing. Red interdental brushes. Single toothbrush round crown with Chlorhexidine mouthwash, dip into Chlorhexidine and use. Advised get oral-B electric toothbrush and to use the toothpaste. Contact GDP if continues.	Yes
5	17-6-20	F	Nervous. Last dental visit 1 year ago. Exam booked June 20.	Upper anterior teeth mobile, bleeding when flossing and interdental cleaning, only occasional use.	Phillips electric toothbrush, Colgate W mouthwash through day and after toothbrushing.	Oral-B electric toothbrush advised and how to use. Oral-B toothpaste. Red TePes dipped in Peroxyl. Change head regularly. Advised needs to see dental hygienist for diagnosis.	Yes
3	17-6-20	F	Attends regularly	Wants to keep mouth/implants healthy		Advised red/blue TePes before toothbrushing. Oral-B electric toothbrush with Duraphat toothpaste. Spit no rinse. Implant toothbrush. Mouthwash to use at different time, avoid staining causing drinks.	Yes

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A retrospective audit of paediatric non-attendance rates and implementation of a 'was not brought' (WNB) protocol to safeguard children

by MALAAIKA AL-KOKY

ABSTRACT

Aim
To identify the number of paediatric patients in one dental practice, over a period of three months, that were not brought to their dental appointments and subsequently implement a new safeguarding protocol.

Methods
A retrospective audit of the clinical records of 50 paediatric patients were analysed between 30 October 2019 and 30 January 2020: an 85% standard set attendance was made. Information was generated on both the number of paediatric patients that WNB and those that were brought to appointments over a three-month period, utilising KodakR4. Data collected included: child demographics; number of WNB appointments in a three-month-period and since registered at the practice; number of siblings enrolled and whether they also WNB on the same day. Current practice management protocols for children that WNB were investigated.

Results
Over a period of three months, 96 (16%) children WNB. From the 50 patient clinical notes analysed: 8 (16%) had recently attended; 35 (70%) WNB once; and 7 (14%) WNB twice, consecutively. No child WNB three or more consecutive times. Of those children, 30 (60%) had up to three siblings that WNB on the same day while 27 (54%) had a previous non-attendance history.

Conclusion
Non-attendance by a patient affects the running of dental clinics, limiting both emergency and routine treatment for other patients. It also has financial implications and raises safeguarding concerns. Alterations to current practice included updating the WNB protocol and implementing new letter templates to ensure all parents were aware of the significance of their child's missed appointments, including a safeguarding referral. All implementations were based upon guidance from the British Dental Association (BDA).

KEY WORDS

Was not brought (WNB), neglect, safeguarding, paediatrics, non-attendance

Background

Non-attendance rates in dental practices are an increasing issue with the highest proportion involving children. Anyone under 18 is defined as a child or young person.[1] Guidance from the BDA advises that clinicians record a child's non-attendance as 'was not brought' (WNB) as opposed to 'did not attend' (DNA).[2] Children are dependent on parents and have limited input into whether they attend or not.

Non-attendance contributes towards multiple issues. These include the increased workload on reception staff to contact and follow up parents. From a business perspective, there is an impact on the revenue to the dental practice. From a psychological perspective, any dental disease in a child is likely to impair their growth, development, appearance, self-esteem, speech and school performance.[3] When children are not brought for routine examination, they are unable to be screened for caries, tooth wear, signs of periodontitis and mouth cancer.[4] Dental caries is known to have an accelerated progression in primary teeth due to the reduced enamel thickness. Children at high caries risk are six times more likely to present with carious lesions at the age of four than children that are caries free.[5] Children that only attend when in severe pain, or with an infection may, potentially, experience lifelong anxiety having endured traumatic treatments such as caries removal and/or extractions under general anaestheisa.[3]

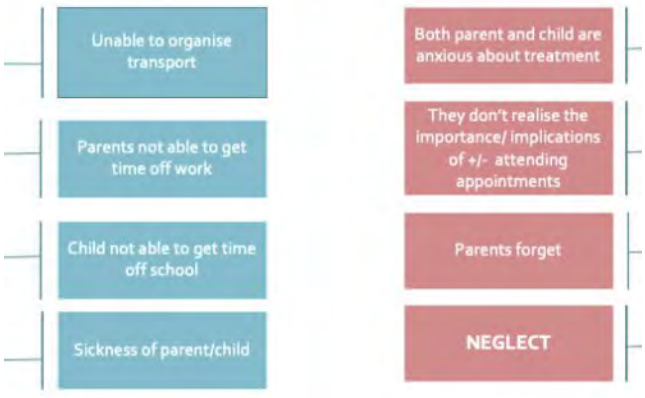
Safeguarding underpins a core General Dental Council (GDC) Principle, where all registrants are expected to raise concerns regarding 'possible neglect of children' and keep up to date with continuing personal development.[6] The

British Society of Paediatric Dentistry (BSPD) defines dental neglect as the 'persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of a child's oral or general health or development'.[7] The National Institute of Clinical Excellence (NICE), advises clinicians that if a child is not being brought to appointments, particularly if there are consecutive fails, to consider it is a sign of neglect, regardless of whether or not it is wilful, as it can have serious consequences to a child's oral health.[8]

Figure 1 explores the multiple reasons children are not brought to their appointment with factors that are within and out with the dental practice's control.[9] Factors that are within control include: both parents and child are anxious about treatment; parents are unaware of the implications of attending appointments; parents may forget about the appointment. Ultimately, these should not be the reasons that prevent the child being brought for dental treatment.

Many practices do not actively act on repeated non-attendance, nor do they have safeguarding policies in place. WNB has successfully been implemented in many practices and secondary care units across the UK aiming to tackle neglect.[10] This audit was instigated by a safeguarding incident that occurred chairside in one dental practice.

Figure 1: **Reasons as to why children may not attend their dental appointments. Reasons that are beyond the practice control are shown on the left (in blue). Reasons that can be controlled by the practice through provisions in place are shown on the right (in pink).[9]**



Methodology

Current practice policy

Information regarding one dental practice's current policy was obtained with the permission of the practice manager. Current management arrangements were explored regarding follow up for any child that WNB to their appointment. Generic template letters sent to parents were obtained from the practice administrator.

Investigation revealed that the current practice management policy involved sending a reminder letter to the parents prior to the planned appointment. A further text message prompt was sent the day before the planned appointment. Subsequently, if the child was not brought to the designated appointment a generic letter would then be sent to the parent. It did not include any reference to neglect.

All members of staff in the practice were unaware of the connection between WNB and safeguarding concerns. There was no written policy in place regarding what should be done if a child was repeatedly not brought to a dental appointment.

Data collection

Data for those children aged from 0 months to 17 years 11 months not brought for appointments were collated for all six dentists in the practice between 30 October 2019 and 30 January 2020. Patients aged 18 years and above were intentionally excluded as not classified in law as children. Approval for this audit was granted by both the practice principal and practice manager. A pilot was undertaken on a sample of ten patients. Information collated included: the child's age; the number of consecutive WNB up to four times or more; the number of siblings actively enrolled in the practice; and whether they had or had not attended also. Cancellations were excluded. Ethics approval was not required for this audit. The standard set for attendance should ideally be 100% attendance however, 85% attendance was set to make it more achievable. There is no gold standard for attendance in the current literature.

KodakR4 was utilised to obtain relevant information. Queries were created to obtain patients that had attended in the last three months, with a filter for their date of birth. Data for children born after 30 October 2002 were included, and for all children that WNB and recorded on a secure excel spreadsheet.

Results

Children that WNB

The total number of children born after 30th October 2002 that attended over the three-month period of the audit was 521. The total number of individuals that WNB in the three-month period was 96. This equated to an 84% attendance rate (1% from the standard set).

Fifty records were randomly selected from the 96 that WNB to analyse: 8 (16%) children had recently attended; 35 (70%) WNB once, with no recent attendance; and 7 (14%) WNB on two consecutive occasions. There were no children that WNB three or more times consecutively (Figure 2). Of the children that WNB: 23 (46%) had no previous history of non-attendance; 27 (54%) had at least one previous WNB history; 9 (18%) had a history of four or previous episodes of WNB with a maximum number of nine previous missed appointments (Figure 3).

In relation to the number of siblings enrolled at the practice: 15 (30%) had no siblings enrolled at the practice; 20 (40%) had one sibling; 12 (24%) had two siblings; and 3 (6%) had three siblings. No child that WNB in the three-month period had four or more siblings (Figure 4). Where the appointment was made jointly for a family of siblings, in the majority of instances, 32 (90%) children and their siblings WNB to their appointment.

Discussion

The practice offered the option of organising children's appointments with siblings in blocks, along with parents. More than half, (n=35;70%) of paediatric patients that WNB in the three-month period also had up to three siblings enrolled.

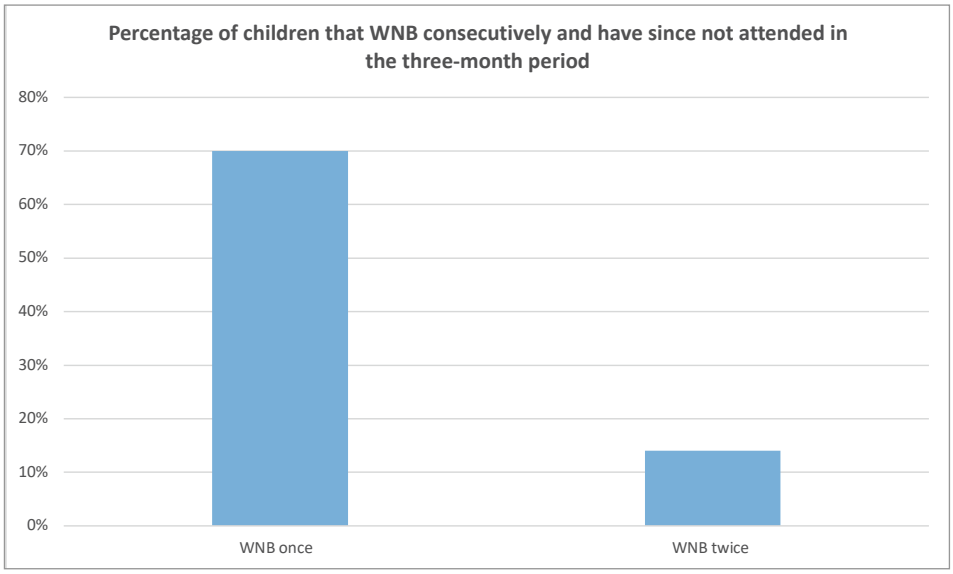


Figure 2: From the sample of 50 that WNB in the three-month period, 16% had recently attended. 70% of paediatric patients WNB once with no recent attendance history, whilst 14% WNB twice consecutively. There were no children that WNB three or more times consecutively.

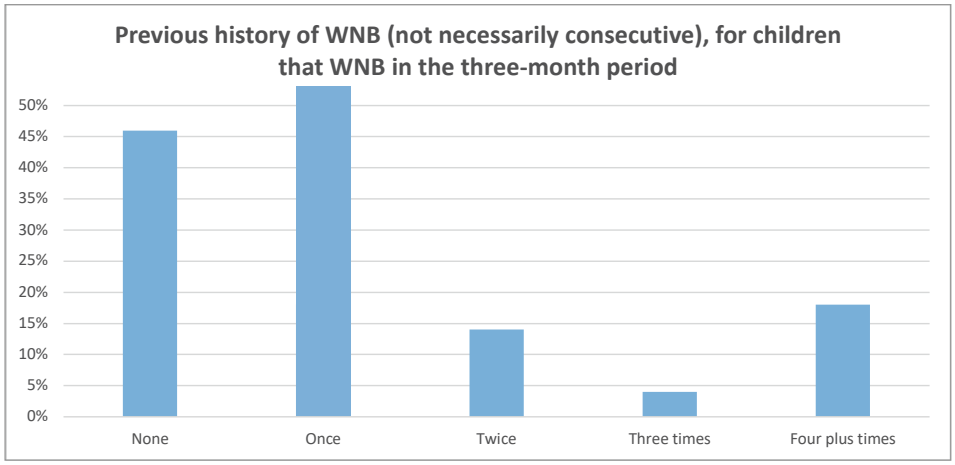


Figure 3: Highlights the previous history of WNB for the 50 children that WNB in the three-month period: 46% had no previous history of WNB; 54% of paediatric patients had at least one previous WNB history; 18% had a history of four or more previous WNB. The greatest number of previous WNB was nine appointments.

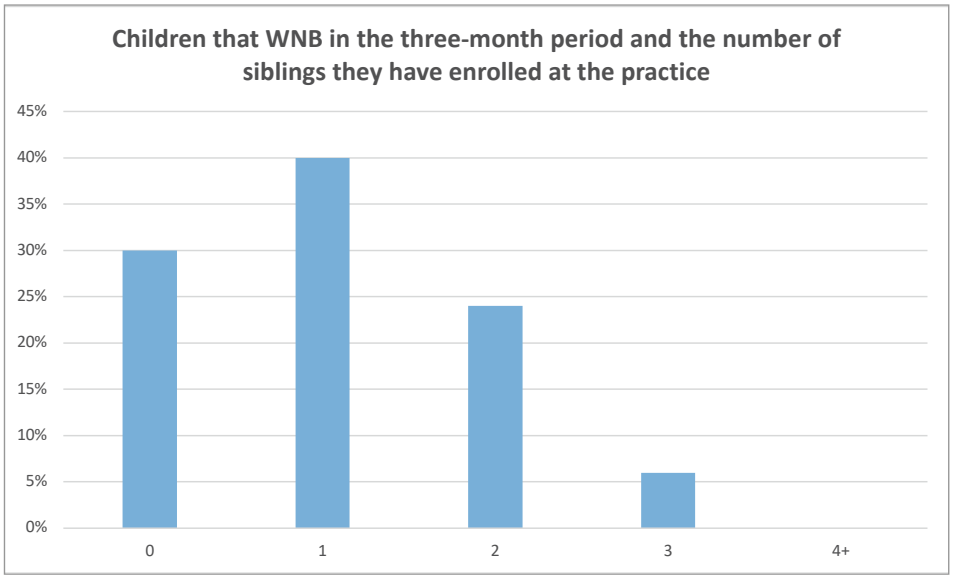


Figure 4: 30% of children that WNB had no siblings enrolled at the practice: 40% had one sibling; 24% had two siblings; and 6% had three siblings enrolled in the practice. No child from the children that WNB in the three-month period had four or more siblings.

From these patients, 32 (90%) of their siblings also WNB to their appointments.

Cumulatively, this equates to lost clinical time of up to 30 minutes for three routine child examinations. If parents had also booked their own examination, potentially this could be as much as 50 minutes of wasted clinical time. This no doubt denies access for other patients due to undertake treatments or attend for emergency treatment.

Implementing a new protocol

Following the audit, a practice meeting involving all members of the staff was conducted and further safeguarding training was provided. The rationale of the link between children that WNB to appointments and safeguarding was explained and a new protocol was formulated.

There are many reasons for children not being brought to their

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appointments as outlined in Figure 1. An additional reason (specific to this audit) for children not being brought, was that the audit was undertaken during the Christmas period and many parents were likely to have been pre-occupied. Ultimately, the primary focus of this audit was to address children that WNB as a potential safeguarding concern. Figure 5 demonstrates the changes implemented in the practice as a result of the audit.

From the children that WNB, 44 (88%) had no follow up appointments organised. More than half (n=30;60%) of those that WNB had a history of previous non-attendance, with some patients having missed up to nine appointments. Some of this group of children had not been brought for their routine dental examination and others were not brought for treatment required.

According to NICE guidance, the dental team should be alert to potential safeguarding concerns, especially if there is a history of multiple WNB. For the 9 (18%) children in this group that WNB twice, consecutively, no follow up could mean they experience up to a year or more of not visiting the dental practice. The COVID-19 pandemic lockdown was enforced shortly after the audit was conducted, compounding the delay in routine visits for to up to two years, should the child not attend

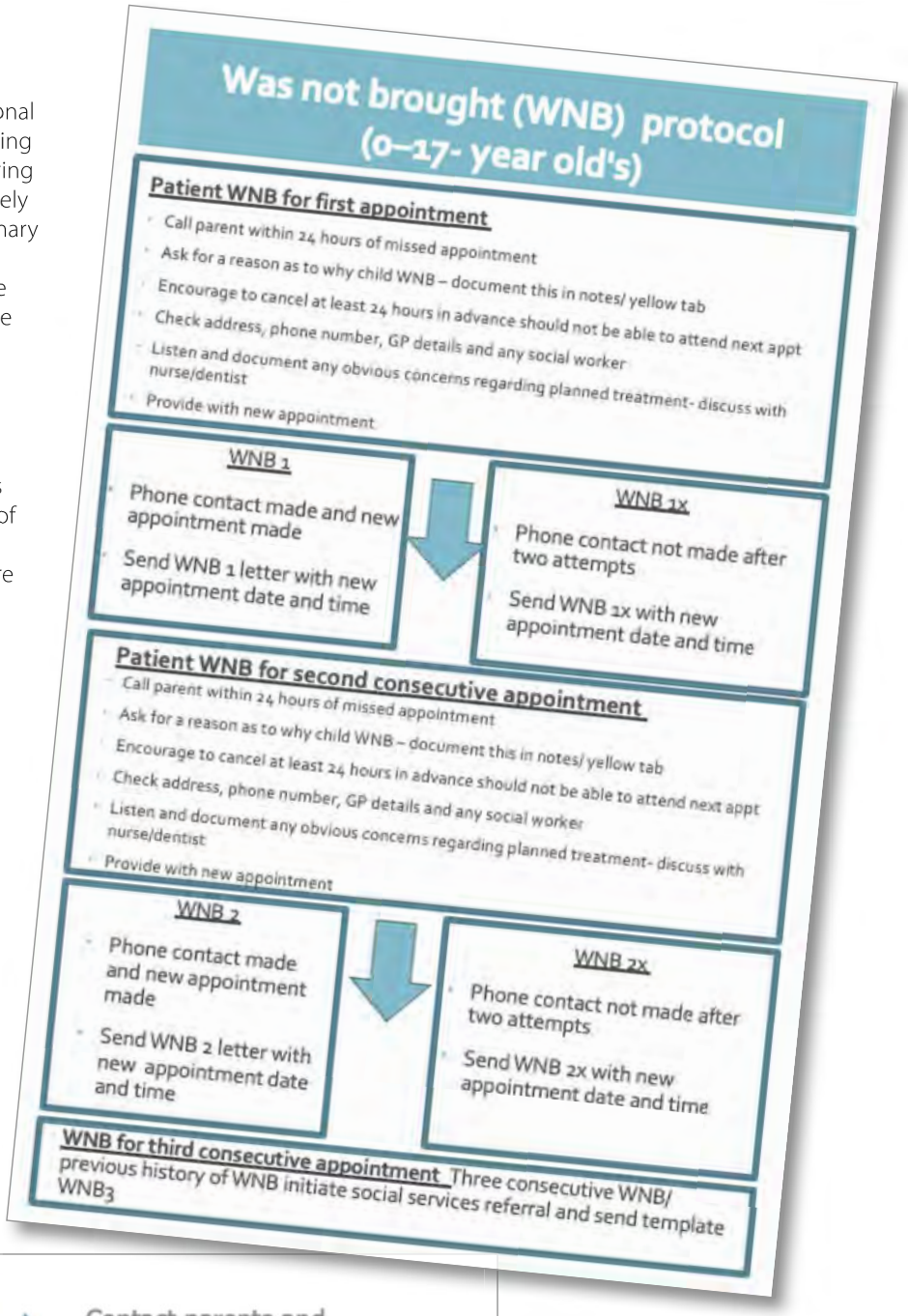

Figure 5: Flowchart that prompts staff on reception to follow this protocol when a child is not brought to their appointment. Adapted from the British Dental Association version[2].

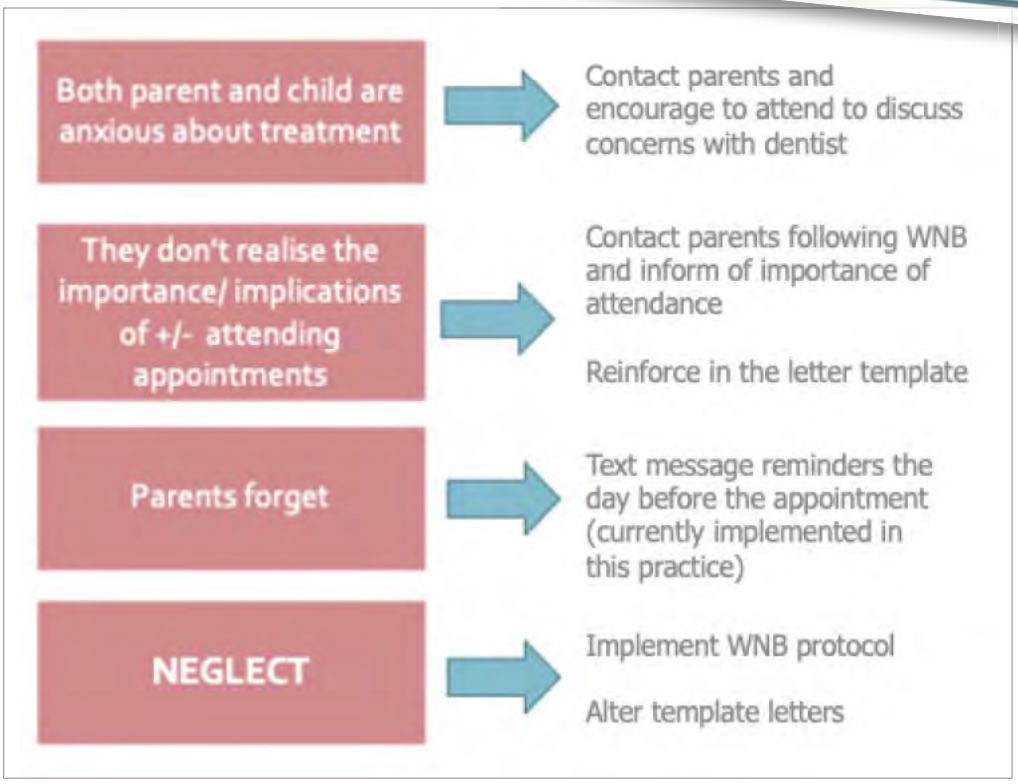

Figure 6: Tackling the factors for non-attendance that are within the practice control. The left column indicates the reason for non-attendance and the right indicates what implementations have been undertaken because of this audit.

as an emergency.[10] It is our responsibility as health care professionals to ensure successful implementation of follow up appointments for children to ensure they are not lost in the system and safeguarding alerts must be undertaken.

The protocol for what should take place should the child not be brought to their appointment is outlined in Figure 6. The BDA WNB flowchart was subsequently successfully adopted and tailored to the practice.

- Staff on reception are now prompted to contact the parent within 24 hours of the first appointment to which the child WNB.
- Reception staff must request the reason why the child (and any siblings, if applicable) WNB. The reason for the child not being brought is to be documented on the yellow tab on Kodak4, to alert all users of the software. (If no software system is in place, it should be documented in the child's records).
- Parents will now be reminded 24 hours prior to the planned appointment. Reception staff are trained to briefly explain the implications of not attending such as the effect it has on the child's health. Further to this, enrolled patients in the practice, other than those that have not been brought to their appointment are now refrained from booking emergency/ treatment/ examination appointments.
- The child's general medical practitioner (GMP) details must be current should a later safeguarding referral be required following subsequent WNB.
- Staff are to listen and document any concerns regarding planned treatment. Parents are encouraged to attend and discuss further with the clinician. Alternatively, they can be offered a call back from the clinician or dental nurse to explore concerns. Consider a referral to community services should this be justified (only to be offered by clinician).
- Parents are now issued with a new appointment and time following WNB1. This must take place to ensure there is follow up for the patient.

Should the child not be brought to their subsequent appointment, staff will follow each step of the protocol. A second letter is to be sent following WNB2. WNB2 will be sent, should telephone contact be made. If contact is not made, WNB2x is sent. Should the child not be brought for the third time, then this will initiate a social services referral for dental neglect. The involvement of the GMP is crucial, and hence WNB3 is sent to the GMP.

Follow up

A follow up audit was undertaken to investigate the effect of the COVID-19 lockdown on attendance rates at the practice.

The attendance rate of 84% is close to the standard set on cycle one, with 1% difference. To improve the attendance rate,

following the implementations, this should be achieved.

The follow up audit was impacted due to the COVID-19 pandemic and subsequent lockdown affecting dentistry. Once, the implementation has been undertaken for a minimum of six months to one year, it is important to re-audit the WNB rates. The pandemic has contributed towards an extra layer of complexity to children's attendance patterns. As a result of COVID-19, individuals have been required to self-isolate, schools have closed, and dental practices were operating on an emergency only basis for many months.[11]

Conclusion

Non-attendance by patients affects the running of dental clinics and blocks diary space preventing emergency or routine patients from being seen. Furthermore, there are financial implications for the practice and safeguarding concerns regarding the child who is not brought for their appointment.

Following this audit, alterations in the practice included informing staff of the link between missed appointments and dental neglect through introducing the WNB protocol. Parents are now advised of the consequences of missed appointments on their child's oral and general health, through the WNB letter templates. Three new letter templates have been successfully implemented, including a safeguarding referral to the child's GMP.

In following the protocol created, the practice staff ensure that all those children who WNB had a follow up appointment organised. This ensures they are not lost in the system and aims to prevent delayed presentation of pain, swelling and infection. It is important all health care professionals in primary and secondary care consider implementing a similar protocol to safeguard children.

Conflicts of interest: There is no conflict of interest to declare.

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References

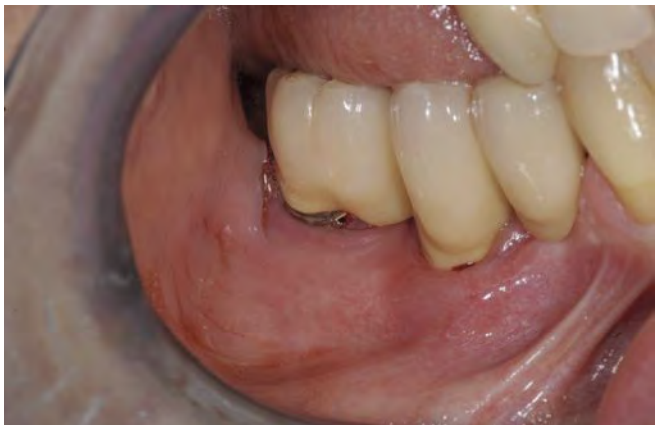
1. Child Abuse (non-sexual) - prosecution guidance | The Crown Prosecution Service (cps.gov.uk) [Accessed 2nd December 2021].
2. Implementing 'Was Not Brought' in your practice. *A tool for safeguarding children who miss appointments*. Bda.org. 2021 Available from: https://bda.org/advice/Documents/Was%20Not%20Brought%20implementation%20guide%20AW.pdf [Accessed 26th September 2021].
3. Collado V, Pichot H, Delfosse C et al. Impact of early childhood caries and its treatment under general anesthesia on orofacial function and quality of life : A prospective comparative study. *Med Oral Patol Oral Cir Bucal*. 2017;**22(3)**:e333-e341.
4. Dental checks: intervals between oral health reviews. Nice.org.uk. 2021 Available from: https://www.nice.org.uk/guidance/cg19/resources/dental-checks-intervals-between-oral-health-reviews-pdf-975274023877 [Accessed 13th September 2021].
5. The incidence of dental caries in the primary molar teeth of young children receiving National Health Service funded dental care in practices in the North West of England. Available from: https://www.nature.com/articles/sj.bdj.2008.582 [Accessed 13th September 2021].
6. Recommended CPD topics. General Dental Council. 2021 Available from: https://www.gdc-uk.org/education-cpd/cpd/recommended-cpd-topics [Accessed 20th June 2021].
7. Harris JC, Balmer RC, Sidebotham PD. British Society of Paediatric Dentistry: a policy document on dental neglect in children. *Int J Paediat Dent*. 2018;**28(5)**:e14-e21.
8. Guidance | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE [Internet]. Nice.org.uk. 2021. Available from: https://www.nice.org.uk/guidance/CG89/chapter/1-Guidance#neglect-failure-of-provision-and-failure-of-supervision [Accessed 10th August 2021].
9. Safeguarding children: a new tool to help all dental teams. Bda.org. 2021. Available from: https://bda.org/news-centre/blog/Pages/Safeguarding-children-a-new-tool-to-help-all-dental-teams.aspx [Accessed 10th July 2021].
10. Conlon C, McDonnell T, Barrett M. et al. The impact of the COVID-19 pandemic on child health and the provision of care in paediatric emergency departments: a qualitative study of frontline emergency care staff. *BMC Health Serv Res*. 2021; **21(1)**:1-11.

CLINICAL QUIZ

A 57 year old female patient attended complaining of pain and tenderness from the lower right side. This discomfort was intermittent and occurred approximately once a month. On examination she had two dental implants placed in the lower right side and a bridge had been constructed to replace the LR654. The dental implant was sound both clinically and radiographically. The occlusion was not a problem as there were no opposing teeth.

Q1. What would the possible diagnosis be?

Q2. What clinical intervention(s) might be indicated?



This quiz was kindly supplied by Elaine Tilling. Clinical photograph curtesy of Dr Amit Patel.

SEND YOUR ANSWERS TO THE EDITOR BY 31ST MARCH

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The winner is: **Rita Matukaitiene**

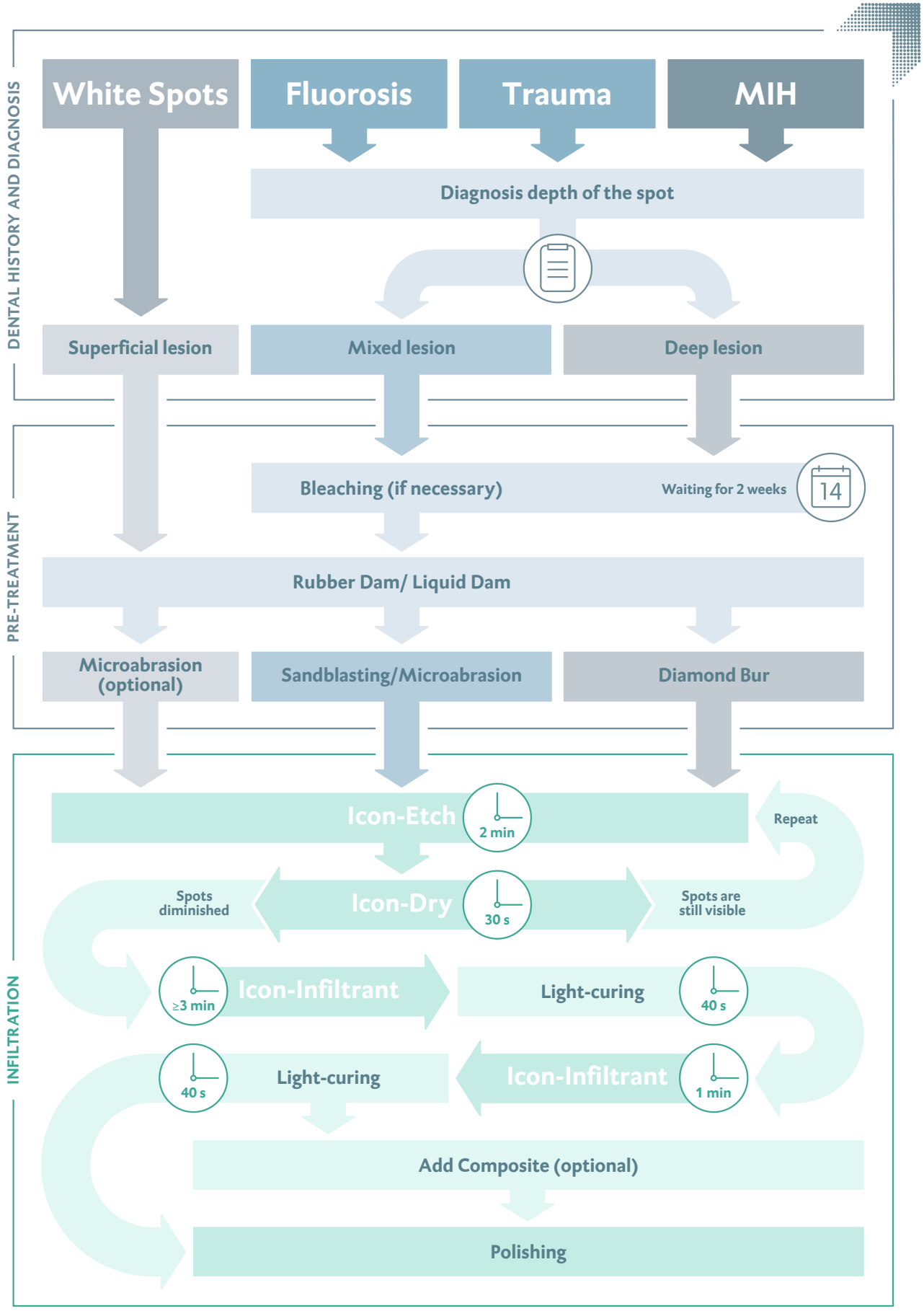
Q1. What could have caused the discolouration and mottling of the teeth?
A1. Antibiotics as a child and/or a complicated birth.

Q2. What is the condition that often causes mottling or discolouration on the molars and anterior teeth?
A2. Molar incisor hypomineralisation (MIH).

Q3. What would be the most appropriate tooth whitening treatment for this patient to ensure a predictable result?
A3. Home whitening with 10% (and / or 5%) Carbamide peroxide, for 4-6 weeks.

Q4. For which types of enamel defects or discolouration could ICON be used?
A4. white spots, fluorosis, trauma and MIH.

ICON guide to treating enamel defects and discolouration



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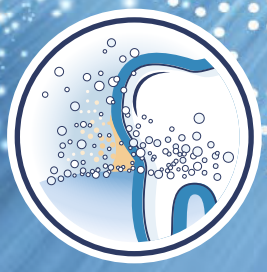

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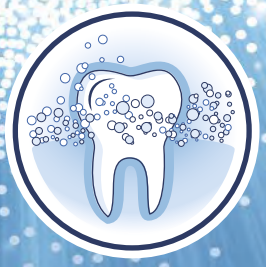

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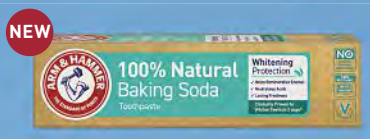
dissolves fast to clean between teeth and below the gumline

pH BALANCE
alkalinity of baking soda promotes a neutral pH to prevent caries [5]

WHITENING PROTECTION



Ⓥ VEGAN FRIENDLY
Contains Sodium Fluoride (1450 ppm F)

GUM PROTECTION

Ⓥ VEGAN FRIENDLY
Contains Sodium Fluoride (1450 ppm F)

TOTAL CARE

Ⓥ VEGAN FRIENDLY
Contains Sodium Fluoride (1450 ppm F)

SENSITIVITY RELIEF CE

Ⓥ VEGAN FRIENDLY
Contains Sodium Fluoride (1100 ppm F)

www.armandhammer.co.uk armandhammeruk armandhammeruk_official

Find out more about our full range of Baking Soda toothpastes and its oral healthcare benefits at www.armandhammer.co.uk. For enquires please email us at: ukenquiries@churchdwight.com. Available at main retailers throughout the UK (in-store and online).

1. Putt MS, et al. J Clin Dent 2008;19(4):111-9. 2. Thong S, et al. J Clin Dent 2011;22:171-8. 3. Sabharwal A, Scannapieco FA. JADA 2017;148(11 suppl):15-9.
4. Data on file: Toothpaste RDA values. 5. Abou Neel EA, et al. Int J Nanomedicine 2016;11:4743–63.