Humans can smell disease
Humans can smell sickness in someone whose immune system is highly active, according to a new study from Karolinska Institutet. According to the research published in *Psychological Science*, there is anecdotal and scientific evidence suggesting that diseases can have particular smells. A person who suffers from diabetes, for example, is known to sometimes have a breath smelling of acetone. For the study, participants were injected with either a form of lipopolysaccharide (LPS) – a toxin made from bacteria and known to ramp up an immune response – or a saline solution. The volunteers wore tight T-shirts to absorb sweat containing odorant molecules connected to immune response over the course of four hours. A separate group of participants were instructed to smell the sweat samples. Overall, they rated T-shirts from the LPS group as having a more intense and unpleasant smell than the other T-shirts.

New gum created to fight US Army plaque problem
U.S military scientists have created a ‘combat gum’ that kills the bacteria that cause cavities, according to the *New York Daily News*. The gum has been produced to help remedy dental problems among Army recruits. All necessary dental work must be done before the troops deploy, which could mean they miss training time. If toothaches occur overseas, the soldiers have to be pulled and taken to the nearest dentist, wherever that may be. Scientists now have seven years on the gum, which contains an ingredient that enhances the body’s natural ability to kill the bacteria that cause plaque. Fighting tooth decay and gum disease could be as easy as chewing the gum for 20 minutes after meals.

Clearance for HIV positive healthcare workers
The Department of Health has announced a system of health clearance for healthcare workers living with HIV whose disease is adequately controlled, so that they are able to return to their chosen profession.

In August 2015, Chief Medical Officer Sally Davies announced that healthcare workers who are HIV-positive will be able to return to practice, and now the Department of Health announced a system of health clearance, setting those wheels in motion. In January 2011 the DoH said that it was reviewing its policy on the prevention of HIV-positive surgeons and dentists from carrying out exposure-prone procedures, and now the day has come for the UK to fall in line with most other Western countries, and give these healthcare workers their careers back.

As Kevin Lewis, Dental Director of Dental Protection put it: “After decades of living in fear and dealing with prejudice, dentists can finally return to their professional calling.”

From carrying out “exposure-prone procedures”, and now the day has come for the UK to fall in line with most other Western countries, and give these healthcare workers their careers back.

Decided on a case-by-case basis, HIV-infected healthcare workers may be allowed to undertake certain procedures if they are on effective combination antiretroviral therapy (cART); have an undetectable viral load; and are regularly monitored by their treating and occupational health physicians.

Those with HIV wishing to perform exposure-prone procedures will need to be registered on a confidential national register, the UKAP-OHR. An interim paper-based version is being made available to allow healthcare workers to register, whilst the web-based version is in development and will be made available in April 2014.
New BDIA marketing campaign launched

Tony Reed, BDIA Executive Director, explained: “BDIA offers rebranding of the dental profession beyond the direct ‘trade’ including banks, insurance companies, publishing companies as well as suppliers of services and technologies to the dental industry amongst its membership. The new advertising campaign is designed to convey the increasing diversity of its membership, in addition to highlighting the benefits of choosing to do business with quality-conscious BDIA member companies.

Since 1923, the Association has played a crucial role within the industry as a not-for-profit organisation, using its funds solely for the purpose of developing dentistry for the benefit of its members, the profession and the public.

Today, BDIA plays a pivotal role in driving quality standards within the dental industry; equipping its members with exclusive information and statistics to provide greater insight and opportunities for networking with collaboration to address market challenges; shaping the future of the wider dental industry through its proactive engagement with relevant bodies; organising exhibitions that deliver a key focal point for the industry and the profession to conduct business for mutual benefit, as well as providing highly regarded training for the industry ensuring a thorough understanding of the essentials of dentistry.

To find out if you are members of BDIA or if you interested in becoming a BDIA member, please visit www.bdia.org.uk or call 01494 782873.”

Dental nurse stuck off following ‘number of convictions’

Dr Judith Husband, Chair of COPDEND, each applicant was asked to state a preference in the Committee’s view, very difficult to remedy. Moreover, there is a need to declare and uphold standards within the profession. You have demonstrated repeated conduct which is capable of bringing the profession into disrepute.”

Hundreds of students without foundation training place

According to a release issued by COPDEND, each applicant was asked to state a preference in the Committee’s view, very difficult to remedy. Moreover, there is a need to declare and uphold standards within the profession. You have demonstrated repeated conduct which is capable of bringing the profession into disrepute.”

E-cigarettes banned for under-18s

The law change will be introduced in Parliament this week as an amendment to the Children and Families Bill. Ministers also plan to make it illegal for adults to buy traditional cigarettes for anyone under 18. The new rules, which could be in force by the autumn, may mean that anyone caught buying cigarettes for a child could be given a £50 fixed penalty notice or a fine of up to £2,500.

Three decades. You subsequently made a false declaration to the GDC for the purposes of obtaining registration as a dental professional. Your repeated dishonesty and criminal conduct goes to your character and is therefore, in the Committee’s view, very difficult to remedy. Moreover, there is a need to declare and uphold standards within the profession. You have demonstrated repeated conduct which is capable of bringing the profession into disrepute.”

1.3m people in the UK use e-cigarettes

The BDA continues to believe that e-cigarettes could provide a tax-free buy traditional cigarettes and while smoking cigarettes, the government has announced.

An estimated 1.5 million people in the UK use e-cigarettes, the government has announced.

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Across the course of the first stage of DFT allocations marks the beginning a difficult and anxious time for those who may have not been awarded a place. Those currently completing their studies must remain focused on giving themselves the best possible chance of securing a place by concentrating on doing three schemes and 88 per cent on one of their top 10 schemes.

Further training places are expected to become available later in the year.

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Editorial comment

Welcome to this month’s edition of Dental Tribune UK.

Now we are settled into the new year (unless you just celebrated Chinese New Year, in which case Kung Hei Fat Choi) I hope all those resolutions you made are working well for you and your practice.

This month the news is about the establishment of a workable system to allow HIV positive healthcare workers to return to work.

Providing a certain criteria is met, healthcare workers – including dental professionals – with HIV will be allowed to work with patients, even where it is considered an exposure prone procedure (in which dentistry often falls).

This is fabulous news – for too long healthcare workers have either been stigmatised or forced to lie (or worse, live in ignorance) because the rules governing their working status have been left behind by infection control procedures and advances in medicines.

Now people who have already had such a life-changing event such as an HIV diagnosis do not have to face losing their working status and livelihood too.

Let us support colleagues who need it to get back to work and caring for patients where they belong.

Fluoridated water does not increase bone cancer risk

Fluoride levels in drinking water do not lead to a greater risk of primary bone cancer, a new study has found.

Researchers at Newcastle University found that higher levels of natural or artificial fluoride in drinking water in the UK had no impact on the incidence of either osteosarcoma or Ewing’s sarcoma in people 0-49.

Dr Richard McNally of the Institute of Health & Society at Newcastle University led the study. He said: “This is the largest study that has ever been conducted examining the possible association between fluoride in drinking water and risk of osteosarcoma or Ewing sarcoma.

“Karen Blakely used sophisticated software to link together data on the geographical distributions of bone cancer incidence and fluoride levels. Statistical modelling of these data showed that there was no evidence of an association.”

Andy Hall, chairman of Bone Cancer Research Trust’s (BCRT) Independent Scientific Advisory Committee, said: “Bone cancer is diagnosed in about 500 patients every year in the UK and Ireland, many of whom are children. However, at present, very little is known of the factors which trigger the disease.

“The study funded by the Bone Cancer Research Trust and reported by the team in Newcastle provides very important reassurance to patients and their relatives that fluoride is not involved in this process and shows that more research is needed to find out how this potentially devastating form of cancer can be prevented.”

Fluoridated water has no impact on incidence of bone cancer

Fluoridated water does not increase bone cancer risk

“I am convinced by GrandioSO’s similarity to natural teeth!“

Dr. H. Gräber

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Fukushima children’s teeth to be checked for radiation impact

The Fukushima Prefecture Dental Association will spearhead efforts to determine whether children’s teeth contain the radioactive isotope strontium-90 following the meltdown from the Fukushima nuclear plant in 2011, according to the Japan Times.

Similar to calcium, strontium-90 tends to be absorbed by the bones and teeth once it enters the body. It is widely believed to cause bone cancer and leukaemia, and cannot be detected by whole body radiation counters.

The teeth of children aged five to 15 will be checked if extracted during regular dental visits, and the research will start by examining the teeth for cesium or other isotopes. For the other teeth, checks for radioactive isotopes will be carried out in groups of ten, rather than on individual teeth.

The education ministry released readings for strontium detected in the Fukushima area in September 2011 that said the amount present in soil was less than a hundredth of the cesium present.

Noboru Takamura from Nagasaki University said: “Based on past radiation data, any detected amount would be extremely small. If that is proved by the research, people will feel relief. I want the researchers to take the time to explain the results to the children whose teeth will be examined.”

Leicester MP calls for sugar ban in schools

Leicester MP Keith Vaz is campaigning for sugary products to be banned in all schools in the city, according to the Leicester Mercury.

Mr Vaz said: “For too long, food and drink manufacturers have misled parents about the amount of sugar added to their products. These hidden calories are contributing to an epidemic of childhood obesity.”

He has written a letter to the Leicester’s education cabinet member, councillor Vi Dempster, urging the education authority to ban sugar from school canteries and vending machines.

Valence Primary School in Dagenham banned fruit juice, and Mr Vaz wants to follow this example.

Councillor Dempster said: “All of our menus are devised with the help of a dietician – all of our recipes meet Government guidelines.

“Over the past few years, our menus have been reviewed to reduce the amount of sugar that’s used. Given the levels of childhood obesity in the city, I absolutely support the points Keith Vaz raises about sugar.”

Lords backs ban on smoking in cars with children

The House of Lords has backed a Labour plan to ban smoking in cars carrying children, despite opposition from the government.

According to the BBC, government backbenchers will not be pressed to reverse the change in the Commons. Instead, they will have a free vote on the amendment when the bill returns from the Lords.

The amendment to the Children and Families Bill was brought forward by Lord Hunt of Kings Heath, Lord Faulkner and Baroness Hughes.

Lord Hunt said: “I was very surprised by research that has been identified by the British Lung Foundation, which shows that a single cigarette smoked in a moving car with a window half open exposes a child in the centre of a backseat to around two-thirds as much second-hand smoke as in an average smoke-filled pub of days gone by.”

This level increased to 11 times when the car was not moving with the windows closed.

Conservative peer Lord Cormack argued that any law which “brings the state into the private space of individuals should be deplored”.

However, Lord Hunt said: “There are more important principles than that. One for me is the need for child protection. Unlike most adults, children lack the freedom to decide when and how they travel, they lack the authority most adults have to ask people not to smoke in their company.”

Director of pro-smoking group Forest, Simon Clark, said: “Legislation is completely unnecessary. Most adult smokers accept that smoking in a car with children present is inconsiderate and the overwhelming majority choose not to. Education, not legislation, is the way forward.”
The World’s First Online
MSc in Restorative & Aesthetic Dentistry

Two of the UK’s most respected education and academic organisations have joined forces to provide an innovative, technology driven MSc in Restorative and Aesthetic Dentistry. Healthcare Learning Smile-on, the UK’s pre-eminent healthcare education provider and the University of Manchester, one of the top twenty-five universities in the world, have had the prescience to collaborate in providing students with the best of everything – lecturers, online technology, live sessions and support.

The programme is designed to encourage the student to take responsibility for his/her own learning. The emphasis is on a self-directed learning approach.

The majority of the learning resources on this programme will be online. The masters will combine interactive distance learning, webinars, live learning and print.

Ownership
The programme is designed to encourage the student to take responsibility for his/her own learning. The emphasis is on a self-directed learning approach.

Community
Students will be able to communicate with a diverse multi-ethnic global community of peers, with who they will also share residential get-togethers in fantastic settings around the world.

Opportunity
This innovative programme establishes the academic and clinical parameters and standards for restorative and aesthetic dentistry. Students will leave with a world recognised MSc.

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Blackpool defers decision on fluoridated milk

Blackpool councillors have deferred their plans to introduce milk containing fluoride into local primary schools, according to the Blackpool Gazette.

The council met on 27 January 2014 to make a decision on whether school children should have fluoridated milk, but decided to hold off introducing it.

Blackpool’s director of public health, Dr Arif Rajpura, said: “We have decided to defer the decision on fluoridated milk.

“A study which took place in Newcastle showed slightly higher levels of fluoride than expected in children who used the milk. Public Health England has asked that any local authority considering a decision on using fluoridated milk to await the findings of its study.

“The information was only provided to us today [27 January] and we will look at the findings and make a decision on fluoridated milk in the coming weeks when we have a chance to review it.”

If the council goes ahead with the plans, parents will be given the chance to opt out of the scheme.

Councillor Sarah Riding, cabinet member for health, said: “The issue for us is that unfortunately children’s teeth in Blackpool are some of the worst in the country.

“Introducing fluoride would not be something that happens in isolation – we would continue with all our initiatives in schools around brushing teeth.”

Paediatricians should manage dental trauma, says report

Non-dentists can play a key role in preventing and treating dental trauma, according to a new report by the American Academy of Pediatrics.

In guidelines published in Pediatrics, the academy lays out the basics of prevention, diagnosis, and treatment for injured teeth.

In children six years of age and younger, oral injuries are the second most common injury, writes Martha Ann Keels, chief of pediatric dentistry at Duke University, and her colleagues. Anyone who sees children in urgent care settings needs to be prepared to treat dental trauma because often no dentist is available and time may be of the essence.

The authors write that physicians who care for children should try to prevent injuries to their patients’ teeth by recommending safety measures. They should also tell their patients to wear mouth guards during sports.


Sirona Dental Systems, Lakeside House, 1 Furzeground Way, Stockley Park, Heathrow, London UB11 1BD, Phone: 0845 0715040, info@sironadental.co.uk
Genghis Khan and how he can help your dental team

Dental Tribune reviews the sequel to Managing a Dental Practice the Genghis Khan Way: Developing your dental team's management skills the Genghis Khan way

In 2012, Dental Tribune reviewed Managing a Dental Practice the Genghis Khan Way by Michael Young; now he’s joined forces with his wife and published a follow up – Developing Your Dental Team’s Management Skills the Genghis Khan Way. Continuing with the Genghis Khan theme, this series of books focuses on his strategies such as intelligence gathering, successful people management and quick ability to learn and adopt new ideas, rather than Mongol invasions and massacres.

Michael is a former dentist, practice owner and teacher of clinical dentistry. Now a full-time author, he wrote the prize-winning book Managing a Dental Practice the Genghis Khan Way and the critically acclaimed How to be an Effective Expert Witness. Linda was a senior manager for a customer-oriented international company for more than 20 years, and developed, wrote and delivered a diverse range of training materials and courses. With such a wealth of expertise, these two know their stuff and this is evident throughout Developing Your Dental Team’s Management Skills.

This book is designed to be used alongside the first book but has a completely different approach – being more like a textbook with activities for the reader to work through rather than a book that sits on your bedside table.

Resource
It is a resource that can be used by anyone who wants to train, develop or mentor those people working in a dental practice. It will enable the team to develop a better understanding of how their workplace should function, and help all members build their knowledge and skills, giving them the confidence to grow as a professional. As Ann Gilbert says in the foreword, this resource recognises that training, continuing education and implementation of policy and procedure is crucial in a modern, successful dental practice.

The sections of this resource follow the order of the first book: Preparation, People, and Planning. It is set out in short, manageable sections which include learning outcomes, suggested background reading, and activities for the student to complete. This easy-to-follow set up allows the student to refer back to the text and activities when needed, making it useful in the long term.

Preparation is all about understanding what management is, with the aim of teaching the student the stages of the management process, as well as enabling them to understand their strengths and weaknesses.

Expectations
The People section is divided into three parts: the patient, the employee, and the practice manager. In this section, students will learn about patients’ expectations, the necessity of good communication, and why a customer care programme is so important – both for the patient and those working in the practice.

Students will learn about the process in recruiting an employee, the employee’s journey through the workplace, keeping employee records and what is needed for a good, solid team in the workplace. Further, this section will provide students with knowledge in practice management, including all of their duties and responsibilities.

The third, final, and biggest section of the book is all about Planning. This section covers everything from the nitty gritty legal and regulatory aspects of running a dental practice, to good presentation skills, mission statements, personal and business objectives, strategic planning, business plans, planning for disaster, policy and procedure, and managing change.

Useful
Everyone in the dental practice will find this resource useful, both at an individual and team level. It can be used to deliver training within all types of practices – from the single-handed practice to NHS practices and corporate dental bodies. A must-have for all dental practices.

‘This easy-to-follow set up allows the student to refer back to the text and activities when needed, making it useful in the long term’

Reader Offer
Dental Tribune readers can get 20% of all of Mike Young’s books, including Developing Your team’s management skills the Genghis Khan Way when you order via Radcliffe Health’s online shop. Go to www.radcliffe-health.com and use code YOUNGBC. This offer expires March 31, 2014.

Book info

Making Patients Feel Special

Glenys Bridges discusses patient plans

In this economic climate most people regularly make tough spending decisions. In some cases they must deny themselves one necessity in favour of another. Although it’s true that some top end practices seem to be relatively unaffected by the double (potentially triple) dip recession, many have seen a dramatic fall in income from elective, cosmetic procedures. Under these circumstances this article asks, “How in the UK where 50 per cent of the population were not regular dental attenders during the previous favourable economic climate, can we attract patients into best fit options to maintain their oral health during the current financial climate?”

When practices with a well-structured maintenance plan are losing patients for financial reasons it may be that by reviewing the way they offer their plans to patients needs to be revised. Plan patients will have two objectives, one objective being to spread the cost of their oral care and the other to save some money for the course of the year.

Care Standard
A well-priced plan will allow a patient with a good standard of home care to save money on two oral health checks and scale and polishes by paying a monthly direct debit to the practice plan. Although this will involve the practice in a monthly administration charge, this will be more than balanced out by the monthly income and potential sales of home care products on each visit.

Promoting maintenance plans need not be based solely on a financial basis. There is also the opportunity to build in added value for patients through customer care benefits linked to a loyalty scheme.

‘Promoting maintenance plans need not be based solely on a financial basis. There is also the opportunity to build in added value for patients through customer care benefits linked to a loyalty scheme’
basic oral well-being maintenance, plan patients can be assured that enhanced measures are in place to ensure that their customer care needs are fully recognised and understood in appreciation for their loyalty to the practice, by opting to pay a monthly direct debit.

Examples

Presenting plans to prospective new plan patients should involve examples of how much they would have saved over the previous year on their assessments, scales (and treatment if the Plan offers discounts on standard private treatment fees). This will require a one-to-one discussion with each patient. This should take place in a private, low pressure, ethical selling environment, always making it clear that it is perfectly OK if the patient chooses not to join the plan.

Once a patient is on a plan the practice needs to go the extra mile to thank them for their loyalty. Without any doubt every patient is entitled to the best possible standard of dental care. Beyond the clinical care plan, patients can be offered special discounts on home care products and first choice of priority appointments. This requires notes to be made about each patient's preferred appointment. Another service that can be offered to plan patients is regular updates on the latest developments in clinical and home care options.

Dental businesses need to be aware of the best offerings from their competitors; not other dental practices, rather the companies competing for the same disposable income those patients would spend on their dental plan. These companies will be gyms, spas and designer labels, all of who use their marketing to make people purchasing their brands feel ‘special’. As dentistry is a highly personal business making patients feel special and cared about is a must when asking them to commit to us and offer their undivided loyalty.  

Once a patient is on a plan the practice needs to go the extra mile to thank them for their loyalty. Without any doubt every patient is entitled to the best possible standard of dental care.

About the author

Glenys is an experienced management trainer and assessor with 20 year experience of working with General Dental Practitioners and their teams. In addition, she has expertise and qualifications in Counselling and Life Coaching. Her first book Dental Practice Management and Reception was published in 2006 her second book, Dental Management in Practice was published during 2012.

‘Once a patient is on a plan the practice needs to go the extra mile to thank them for their loyalty. Without any doubt every patient is entitled to the best possible standard of dental care’

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Prices from £799 + VAT
Focus on Standards: a review
Neel Kothari reviews the GDC’s new site ‘Focus on Standards’

Following on from the GDC’s updated ‘Standards’ document, a new interactive online tool named ‘Focus on Standards’ has been released to help registrants better understand the current guidance.

The web based tool is comprised of case studies, scenarios and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards and is freely available on the GDC website. The format of this tool will seem familiar to those who have ever undertaken online CPD, making it a slight shame that no verifiable CPD is available with its usage. In fact the legal disclaimer found at the beginning rather surprisingly states; ‘The case studies cannot be relied on to be clinically accurate’ and ‘Nor do the case studies intend to show the “correct” interpretation of GDC guidance, only one (or more) possible interpretation(s)...’ Confused? Me too.

The beefed up 2015 ‘Standards’ document more closely resembles computer software terms and conditions, with its heavy use of ‘should’s and ‘must’s rather than a straightforward ethical code of practice. In fairness to the GDC, this is simply a reflection of the world we live in, so it’s no real surprise that the GDC felt the terms set out in the standards document, which in many cases can be rather confusing, and in this respect it does exactly what it says on the tin.

Unfortunately, where it falls down is in the issue it chooses to cover. The new standards document clearly goes much further than the former and in doing so has created many issues that remain vague to the profession. For instance, standard 3.2.5 (obtaining consent) states: ‘You must check and document that patients have understood the information you have given them.’

But how is this actually possible? Unfortunately without clarification of terms such as these the GDC has allowed itself a very wide berth to pass judgement on its members whilst at the same time is arguably not doing enough to clarify ‘good practice’ on more opaque issues such as this.

Going further, standard 6.2.2 states: ‘You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting.’

However the FAQ’s part of section six states that nurses do not need another team member when providing oral health education, but is less clear cut when the same situation is applied to hygienists stating: ‘It is not acceptable for dental professionals to be working alone on the premises when they are treating patients. Ideally, we would want all members of the dental team to have another member of the dental team with them in the same room, when they are treating patients.

However, if in their professional judgement, they decide that having another member of the dental team on the premises who is able to offer them support if needed, complies with the requirement to ‘work with’ an appropriately trained team member and does not put patients at risk, and they therefore choose to work under this arrangement, they must be able to justify their decision.’

I suspect that the same can be inferred for dentists, but once again the GDC have not clearly nailed its colours to a mast on this rather controversial issue, after all let’s not forget that many health care providers (such as General Medical Practitioners) vary very rarely work with nurses and arguably treat some of the most vulnerable members of society. Leaving such ambiguities up to the interpretation of its registrants in my opinion allows far too much scope for the GDC to say ‘you’ve got it wrong’ whilst at the same time offering its members no actual guidance on what good practice is. This seems fundamentally unfair.

That being said, the issues that are covered here are generally handled very well and despite my concerns over what has been omitted from this online tool, in general it does a good job in helping its members better understand the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards, and FAQs that help to set out the GDC’s position when faced with potential breaches of professional standards.

http://www.gdc-uk.org/Dental-professionals/Standards/cases/Pages/default.aspx
Endodontic Report - Jamie Nelson

This is the winning entry to the 2015 Young Dentist Endodontic Award
This Case: CY – “It ain’t over till the fat lady sings”

...
Amoxicillin TDS five days (due to systemic involvement of the lymph nodes)

Stabilisation phase: Treat the periapical issues, avoiding root canal dehiscence (RSD) on the LR6, incase of a peri-endo origin, in which cell damage caused by the RSD can limit the regeneration potential for the endodontic treatment 16, OHI, diet advice, fluoride application, Smoking cessation and a fluoride toothpaste prescription (5000gpm).

Restorative phase: Restore various lesions in LR6 and LL7. Complete root treatment on LR6, due to degree of tooth tissue remaining if a conservative access can be cut, restore with GIC and composite.

Maintenance Phase: Review RCT and peri at 5, 6 and 12 months

Recall phase: Caries risk - High, Perio Risk - High, Oral cancer risk - Medium, 5-monthly CE

Treatment Completed

First visit: - LR6 extirpation

A minimally invasive access was cut into the LR6 – by preserving as much tooth tissue as possible it greatly improves the chances of a long term successful endodontic treatment. Ideally all four sides of the tooth need to remain intact, this allows for better isolation and a stronger external tooth structure. Four canals were located and cleaned to the EWL at an ISO size 20 hand file with copious amounts of two per cent sodium hypochlorite; then dressed with Idermix and restored with GIC.

A good access is key to locating canals quickly and by spending slightly longer making it as neat as possible it can really help. (photos of the access can be seen in figures 4 and 5)

Second visit: - The patient reported she was out of pain after the extirpation was completed, which meant we could proceed to stabilise all other active disease. A supra and sub gingival scale was completed on all teeth except LR6 (incase of peri-endo lesion 10), smoking cessation given, amalgam restorations placed on LL6 occlusally and fluoride applied to all teeth.

Third visit: RCT stage 1 LR6

The temporary restoration was removed and all four canals re-located using hand files, once re-located the access to each canal was improved using Gates Glidden burs, a size 2 to 1/3 estimated working length (EWL), size 4 to 5mm short of that and finally a size 6 count sunk into each canal by no more than half the depth of the bur around 3mm, (by doing this it also makes creating Nayyar cores much easier as once the bulk of the GP has been removed the size 6 Gates Glidden bur can be counter sunk once again providing a space for the nayyar core to be placed.

Each canal was then prepared to 2/5’s EWL using protaper rotary instruments sizes S1, S2, F1 and F2 17.

Handfiles were then placed into each canal measured to the EWL and a diagnostic radiograph was taken. When taking a diagnostic radiograph on multi-rooted teeth, I use a mesial swing on the tube head in order to ensure each file is in a separate canal. This can be seen in the diagnostic radiograph figure 6. Once the diagnostic radiograph has been taken the tooth is dressed with non-setting calcium hydroxide and again sealed with GIC.

The radiograph then confirmed the working lengths for each canal as:

- MB - 18mm (OA)
- ML - 18mm (OA)
- DB - 21mm
- DL - 21mm

(0A) indicates open apex

Fourth visit: RCT stage 2 LR6

The obturation stage for this tooth brings its own challenges as there is no guarantee that a seal can be achieved with an open apex present, which is why conventionally MTA is used to close the open area and allow for an effective seal and this is what I would have done had MTA been available. Instead, I adopted a technique that had never been formally taught to me and prepared the mesial canals past the radiographic apex in order to ensure effective cleaning at the open apex. Once all of the canals had been prepared to their EWLs to size F2 protaper 18 with thorough irrigation of two per cent sodium hypochlorite (the irrigant used is warmed to increase effectiveness 19 and after placement a handfile is used to ensure the irrigant reaches the apex) the total time the irrigant spends in the canals accumulatively was 10 minutes, this combined with the time of the procedure is in excess of 60 minutes. 20

Obturation – a single point obturation technique was used, using an eight per cent ISO 25 F2 Protaper point, using again a technique never taught to me. I placed the GP point beyond the apex until an

So a treatment plan was drawn up and the patient happy for treatment to begin

**Treatment plan**

**Acute Phase:** extirpate the LR6, course of antibiotics: 500mg

**Plaque Score**

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<th>25/08/2012</th>
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**BPE**

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**Caries Risk**

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**Perio Risk**

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apical twist back/tug back could be achieved (resistance to rotational or vertical displacement of the point once in place). Once that was achieved the point was marked at the coronal end, this leaves the point long, essentially overshooting beyond the apex, but giving an apical seal. This “overshoot” is then removed by once again measuring the GP and simply snipping off the excess from the apical end (figure 7). The shortened GP has essentially a custom thickness at the apex now and fits snugly into the canal, hopefully, achieving an apical seal.

The canals were then lined with Tubliseal and the GP cemented into each canal. GIC was used to line the GP as this provides a dynamic bond with the tooth, reducing the risk of GP contamination 

The restoration can be seen in figure 8.

Once the restoration was complete, the post operative radiograph was taken (figure 9).

The radiograph shows that the GP is to length, has a good taper, good density and doesn’t show any voids.

Review stage:

The patient attended her three-six-and-nine month review appointments and has demonstrated a huge improvement as summarised by Table 1.

Also during the nine month review, the nine month post op endodontic radiograph was taken (figure 10). The radiograph showed an almost complete resolution of the pathology and has demonstrated a successful endodontic treatment.

The Results

Taking into account all of the above, the Table 1 shows a clinical breakdown of the LR6 comparing the pre and post treatment results, as well as both pre-operative and 9 month post operative radiographs.

This case demonstrates that no matter how bleak the outlook there’s always a possibility for success. I myself treat difficult cases with an attitude summed up very nicely by Henry Ford “Obstacles are those frightful things you see when you take your eyes off your goal”. 

References:

3) Clifford J. Ruddle. The ProTaper Technique Shaping the Future of Endodontics

About the author

The son of a dentist and a former Kings College student, Jamie works part time in two practices. He trained at The Bromley Road Dental Surgery in Colchester and at the end of his training year, all the dentists in the practice decided to give up a proportion of their units of dental activity to keep him in the practice. It was here that he carried out the case which made him one of the winners of the award. He also works at a private practice in Basildon where his colleagues assign most endodontic cases to him.
Young Dentist Endodontic Award

Non surgical endodontic treatment of the maxillary right central incisor with incomplete root formation by Rupal Shah. This is the second place entry for the 2013 Young Dentist Endodontic Award

This report discusses the successful management of an anxious 10-year-old patient, who required root canal treatment of her immature upper right central incisor, following a previous history of trauma. She was initially referred to the paediatric department at Birmingham Dental Hospital by her general dental practitioner. Following assessment and diagnosis, she underwent root canal therapy of her upper right central incisor, which was deemed to be non-vital and had an open apex.

Patient details
10 year old female, school pupil

History
presenting complaint: The patient’s chief complaint was her ‘fractured front teeth’ which she did not like the appearance of.

History of presenting complaint: revealed that she had suffered trauma in November 2011, when she had fallen in the school playground and knocked her front teeth on metal railings. Both upper central incisors had fractured, but there was no obvious displacement at the time of injury.

No loss of consciousness or head injuries had been noted, but there was a laceration to the upper lip. She initially attended Heartlands Hospital, from which she was referred to Birmingham Children’s Hospital for a chest x-ray, as the tooth fragments had not been accounted for. The chest x-ray reported no abnormalities.

The patient then saw her GDP one day after the injury, and had adhesive compos-ite restorations placed on the URI and ULI. However, these were subsequently lost after six weeks, and were not replaced.

Medical History
The patient suffers from asthma, for which she uses Ventolin and Becotide inhalers, as and when required. She has not had any previous hospitalisations due to her asthma.

Dental History
There is no history of any other previous trauma. Co-operation appeared to be reduced as the patient had not had any previous extensive dental treatment, and was therefore quite nervous.

Examination
Extra - oral
Scarring was noted in the mid-line of the patient’s upper lip; she had sustained a laceration to the area at the time of injury.

Intra – oral
Soft tissues
Oral hygiene was fair, but some gingival inflammation was present.

Hard tissues
Teeth present were: 6U1221 12CD8 6U1221 12CD8

Unrestored enamel-dentine fractures were evident on the URI and ULI, with the ULI fracture being fairly extensive. Caries was noted on the LLD.

Occlusion
Occlusal analysis revealed a class 1 incisor relationship with class 2 right molars, and class 1 left molars.

Special investigations
All maxillary incisors responded positively to ethyl chloride. The UR2, ULI and ULI2 responded positively to Electric Pulp Tester whilst the URI tested negative. None of the maxillary incisors were tender to percussion and no labial sinus or tenderness, discoloration or mobility was noted.

Radiographic examination
Periapical radiographs
Long cone periapical radiographs URI and ULI (Fig 1.1) revealed open apices on all maxillary incisors, and PDL widening around the apex of the URI. It also showed the unrestored enamel-dentine fractures on both maxillary central incisors.

Upper Standard Occlusal Radiograph
This radiograph confirmed PDL widening around the URI, with associated periapical pathology. It also shows the open apices of all four upper incisors, as well as the presence of maxillary canines.

Soft Tissue X-ray
The soft tissue radiograph of the upper lip revealed no abnormalities, and no evidence of any tooth fragments in the lip (Fig 1.5).

Diagnoses
1. Enamel-dentine crown fractures URI and ULI
2. Likely non-vital URI; chronic apical periodontitis secondary to trauma
3. Caries LLD
4. Anxious patient

Treatment options
1. Test cavity URI, and proceed to non-surgical root canal therapy with MTA apical plug if non-vital +/- RA sedation (Birmingham Dental Hospital)
2. The patient was quite nervous, so the use of RA sedation was discussed; a RA sedation information sheet was given to the patient
3. Extraction of the URI with or without prosthetic replacement (GDP).

Treatment plan
1. Immediate: cover exposed dentine URI and ULI with GIC (Birmingham Dental Hospital)
2. OH1, dietary analysis and advice, xeriating radiographs (GDP)
3. Scale and polish, restore caries LLI, fissure seal 1st permanent molars (GDP)
4. Test cavity URI and proceed to root canal treatment if non-vital +/- RA sedation. Dress with non-setting calcium hydroxide until stable (Birmingham Dental Hospital)
5. Adhesive composite restorations URI and ULI +/- RA sedation (Birmingham Dental Hospital)
6. Review (Birmingham Dental Hospital)

Treatment protocol
Appropriate verbal and written consent was obtained prior to commencing treatment. As a test cavity was carried out on the URI, no local anaesthetic was required. Isolation was achieved with dry dam, wedges and Oroscale caulking material. The tooth, as expected, was found to be non-vital, and ex-irrigated and dressed with non-setting calcium hydroxide as an intracanal medicament. A temporary dressing of a cotton wool pledget and GIC was placed in the access cavity. This initial management was carried out under RA sedation.

At two subsequent visits, the GIC fillings on the URI and ULI were removed and replaced with adhesive composite restora-

tions, and the URI root canal was further prepared. The root canal length was determined radiographically (Fig. 1.4), and the working length was measured as 21mm.

Chemo-mechanical cleaning of the canal was carried out using K-flex hand files, interdental brushes, and 2.5 per cent sodium hypochlorite irrigation. The final apical size of the canal was 86, due to the immature apex and lack of apical barrier. An apical stepback technique was used to prepare the wide canal. The canal was then again dressed with non-setting calcium hydroxide, a cotton wool pledget and GIC in the access cavity. After this visit, the patient felt less anxious, and opted to have future treatment without RA sedation.

At the next visit, the patient mentioned the tooth had been symptomatic. Therefore, it was decided to re-access and re-irrigate with 2.5 per cent sodium hypochlorite solution. The tooth was again temporarily dressed with calcium hydroxide, a cotton wool pledget and GIC.

At the following appointment, the patient was asymptomatic. The canal was re-irrigated with sodium hypochlorite and dried with paper points. A master cone periapical radiograph was taken (Fig 1.5) to confirm the length, and a 4mm apical plug of mineral trioxide aggregate was placed using the Micro Apical Placement System (Fig 1.6). The remaining canal space was obturated with thermoplasticised GP (Ohitura) and sealer using warm vertical compaction. A Vitrebond lining was placed over the GP, and the access cavity was restored with composite resin to create an effective coronal seal (Fig 1.7).
The patient recently attended for a six-month review, which reported no symptoms associated with the UR1. With regards to the UL1, there was a query whether there was some periodontal ligament widening, however the sensibility tests were inconclusive and the tooth was asymptomatic. It was therefore decided to continue to monitor the UL1 for now, and review the patient again in a further six months.

Discussion
The patient’s traumatic incident had resulted in pulpal necrosis of the UR1 and consequently an incomplete formation of the root. Effective cleaning of the canal walls was achieved with large K-flex handfiles, interdental brushes and sodium hypochlorite irrigation. The MTA technique allowed for successful obturation of the maxillary central incisor with an open apex.

I successfully completed this treatment in an anxious 10-year old girl, who had not had any previous extensive dental treatment. I overcame this by using different behaviour management techniques including tell-show-do, and ensuring that all appointments were not of too long a duration. This meant compliance was not lost. In fact, the patient initially began treatment under RA sedation due to her anxiety, but at subsequent visits, decided she no longer wanted it, and appeared to cope well without it.

Finally, I decided to submit this case, because I feel that I obtained an excellent final outcome, both clinically and radiographically. The tooth was symptom free at the six-month review appointment at Birmingham Dental Hospital. The 4mm MTA apical plug was to the correct length, and radiographically, there were no voids in the thermoplastic GP. The access cavity was sealed with a vitreous lining, followed by adhesive composite restoration, ensuring a good coronal seal.

The endodontic prognosis for this tooth is good, however the patient is fully aware of the long term consequences of trauma, and the subsequent need for regular dental monitoring and sensibility testing of the traumatised upper incisor teeth.

References

About the author
Rupal Shah was on duty at Birmingham Dental Hospital’s paediatric department in April 2013. A foundation dentist (in her second year of training) she had to treat a 10-year-old patient who was returning to the hospital for endodontic treatment on her UR1.
Case report by Lydia Harris
This is the third place entry for the 2015 Young Dentist Endodontic Award

This patient attended in pain from the UL5 and a diagnosis was made of symptomatic Apical Periodontitis. I was aware that the presence of an apical radiolucency, curved roots and a heavily restored crown meant that the tooth had a guarded prognosis, but as the patient was keen to keep the tooth we began root canal treatment. I placed rubber dam, accessed the tooth, located the canals, patency filed and irrigated.

At university I had trained by using the step-back technique with K files, and ProTaper hand files. I had started using rotary instruments in my DF1 placement and I attempted to use the rotary files to my corrected working length, but struggled to do so due to the canal curvature. I had struggled to get to grips with using rotary instruments in more curved canals and I therefore returned to using the step-back technique and K-files.

Upon obturation, I noted that something was awry as the Thermafil would not seat to length. I was aware that the GP was unable to negotiate the canal curvature and a radiograph showed that the gutta percha (GP) was not at length, and some had entered the 2nd canal.

Fig 1 - Pre-operative Radiograph taken 15/04/2013
Fig 2 - Working length Radiograph taken 29/04/2013
Fig 3 - Mid-obturation Radiograph taken 20/05/2013
Fig 4 - Post-op Radiograph taken 20/05/2013

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In order to achieve a satisfactory result, I needed to remove GP using DMZ-IV and Pro-Taper re-treatment files. This was my first experience of removing GP and I was careful to ensure complete removal of the GP, before re-preparing the canals chemomechanically. As I had evidently failed to sufficiently prepare the canals for the GP the first time round, I spent some time enlarging the orifice using hand files and using EDTA to ensure that I could use the ProTaper files to length prior to obturation. I then obturated using Thermafil, and have subsequently restored the tooth using a porcelain onlay.

An S-shaped curvature or double curvature can make a canal very challenging to negotiate. I learned that using hand files initially can help prepare the canal sufficiently prior to using rotary files. I now know to approach curved canals like these with more caution, and to take time preparing the canals ensuring adequate mechanical preparation. I had never used re-treatment files before and I learnt to use a pecking motion and ensure visualisation of GP on the files. I now feel more confident in doing this and therefore more able to attempt re-root treatment in the future.

I chose a porcelain onlay to restore the tooth as it provided excellent aesthetics, cuspal coverage and also helped to preserve more of the buccal and lingual tooth present, which would have been destroyed had I chosen to perform a crown preparation. The tooth was in the patient’s smile line and she was very pleased with the aesthetic result. Overall, I was pleased with the end result of this root canal treatment and hope that the patient is able to retain this tooth for many years as a result.

I feel that this case helped me to develop my endodontic skills overall as it involved improving upon a myriad of skills. Firstly, my assessment of a case; I had not previously spent a long time analysing the curvature of the roots and the effect this would have on my method of root filling the tooth. Since this case I have become acutely aware of the need to tailor your technique to the type of roots present, including ensuring adequate access, the need for anticurvature filing, and the advantages and disadvantages of using rotary instrumentation in these cases. Secondly, it made me realise the importance of establishing the aetiology of any problems encountered. I realised that as my GP had not seated to length that I had evidently not prepared the canals adequately and by establishing this aetiology I could therefore improve the outcome by rectifying this problem. I have also realised that acknowledging your own limitations and competency is key in endodontics; I was aware that the initial treatment I provided was poor, but that rectifying it may be difficult. I therefore ensured I informed the patient that I would try my best to improve on the root treatment, but that should it be beyond my competency we would have to consider alternative pathways.

This case helped me improve upon my endodontic planning and also, the techniques involved in S-shaped root canals. It has encouraged me to realise that if an ideal result is not achieved initially, things can be improved upon and should not just be accepted.

Textbook of Endodontology, Gunnar Bergenholtz, Preben Horsted-Bindslev, Claus Reit Second Edition
Harty’s Endodontics in Clinical Practice, Bun San Chong, Ninth Edition

About the author
At the time of this case, Lydia was working in a Bristol dental practice as a foundation dentist, in her second year of vocational training.
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Finders Keepers
Solving staffing issues by Kate Russell, the HR Headmistress

We all know that maintaining high standards is essential for business success. This success largely comes from being able to attract and retain employable talent. We also know that it’s increasingly hard to source and keep great workers. In my experience the major headache for busy dental practices is staffing issues.

Many practices don’t give staff retention the priority it deserves. You can pay a heavy price if it is ignored. Some of the main impacts of poor staff retention include:

- the costs of recruiting permanent or temporary replacements
- the loss of practice and/or technical knowledge and skills
- additional pressure on the practice manager who is responsible for recruiting to the vacant post and inducting and training the new recruit
- service disruption, lower levels of customer service and loss of new business; and
- a climate of uncertainty and low morale among remaining staff, particularly if several employees within the same section or team leave within a short timescale.

Reasons for staff turnover vary from practice to practice and you will have to investigate the reasons and create a plan to address any common causes of dissatisfaction. There is no “one-size-fits-all” solution to reducing turnover, but there are a range of strategies that you can use to boost staff retention.

Start by selecting people who are right for the role and the practice. Commit to recruiting the best possible person for each position and don’t compromise. Be prepared to pay for the right talent. It is far less costly in the long run to pay more for the right employee than it is to keep getting it wrong. Involve existing staff in the recruitment process.

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that job requirements can be matched to the skills and experience of candidates. Don’t just take on a pair of hands because you’re desperate. It’s tempting but believe me, you’ll regret it. Make sure you collect relevant data and only progress the best candidates. Your choice of selection tools should be based on job-related criteria. Use testing in conjunction with a competence-based interview.

When you are interviewing encourage candidates to talk about themselves and their work experiences. Use open-ended questions to do this, for example: “What did you like best about your former role?” Ask questions and/or test all the essential areas. Probe for more information if you’re not satisfied or not clear about the data you’re getting.

Once you have appointed your employees, take positive steps to encourage the right people to stay.

Involve them by creating a vision for your practice and let your staff know what it is, what it means for them and what they need to do to support it.

Surveys consistently show that what employees want most, even more than money, is appreciation and recognition. Look for opportunities to give regular positive feedback. Offer balanced and objective praise where appropriate and make suggestions for areas that need improvement. Provide clear and measurable standards of performance and give examples of what success looks like. Help employees achieve optimum performance and give objective feedback if they don’t meet all your standards. Where you do have to give criticism make sure it’s done in private.

I have already referred to this but if you want to achieve high standards of performance you will need to appoint above-average performers. It means you must pay above-average wages. Consider introducing performance-related bonuses. If you reward the type of behaviour you want to receive, you will receive more of that behaviour. It creates a win-win for you. Employees enjoy a share of increased profits, and the practice achieves higher levels of productivity and profitability.

Create a great employee workplace. As well as good pay, make sure there is up-to-date technology which is straightforward to use and works well and ongoing development opportunities. Good staff enjoy working with other good staff so ask yourself the following question: “Would I want to work here? If I were looking for a job, would this be an attractive opportunity?”

Communicate effectively. Have periodic staff meetings (once a month) to structure higher level practice feedback, plan forthcoming activities and provide information. Keep the meeting short (45 minutes), create the agenda and distribute several days before the meeting, to give participants time to prepare. Stick to the agenda and don’t allow yourself to be sidetracked.

Assembling the right team takes time and effort. So be rigorous about the recruitment process and when you have to achieve the right appointments make sure you take steps to keep them happy and wanting to stay with you.

Don’t just take on a pair of hands because you’re desperate. It’s tempting but believe me, you’ll regret it’
Dental payment plans:
A road to preventive care, by Kay Thomson

From 2000 to 2012, the number of adult patients who struggled to find an NHS dentist dropped from 55 per cent to 28 per cent. Although these statistics are a welcome development, they still leave a significant percentage of the population without ready access to subsidised dental care.

In a survey that involved more than 11,000 British people, 44 per cent of respondents don’t visit their dentist as frequently as they should because they can’t afford it. And 54 per cent of adults in the UK are worried about having the budget for their dental care needs in the future.

This trend of foregoing dental care due to financial strain can see some people skip going to the dentist altogether. As recently as two years ago, five million people in the UK hadn’t been to see their dentist in ten years, and it’s safe to assume that a considerable percentage of these absent patients have financial concerns to blame for their non-attendance.

Most people probably view dental visits as an unnecessary expenditure, as long as they are asymptomatic. But dental professionals know that this can’t be further from the truth. Prevention is of course the most expensive package to patients in good oral health, making them pay upfront for treatments that they may not need.

As we’ve seen happen with dental insurance, for example, payment schemes that turn out to be less than straightforward and leave the consumer out of pocket can fast earn a bad reputation. And unless they are offered in the most scrupulous manner possible, payment plans can quickly suffer a similar fate among consumers.

In a 2010 survey of 499 private dental patients with payment plans, 29 per cent of respondents felt that they were required by their dentists to sign up as a condition of attending the practice. To further investigate how dental payment plans are offered to consumers, the Office of Fair Trading (OFT) conducted their own survey into the matter the following year.

Twenty per cent of OFT respondents said that they felt somewhat pressured into joining a payment plan scheme, with four per cent feeling that their dentists have placed them under ‘a lot of pressure’.

The 2012 OFT Final Report states that “because dentists often have a high degree of influence over patients’ decisions, care must be taken by dentists to ensure that they are not at risk of unduly influencing patient decisions regarding whether or not to join a dental payment plan.”

While it is a reality that practices need to turn a profit, dental professionals must always keep in mind that the patient will rarely distinguish between professional advice and a sales pitch while they’re lying in the dental chair. The feeling that they have been sold to unnecessarily may come after the patient leaves the clinic, which can then sour the dentist-patient relationship.

In order to avoid this, dentists must make sure that patients aren’t given the impression that they have no other choice but to accept the payment plan on offer. If and when a practice decides to make such a product available to their patients, steps must be taken to ensure that these are presented in light of all the other payment options the patient may have, and that these plans truly give them their money’s worth.

An example of a solid payment model is the Gencare Payment Plan, the scheme that Genix Healthcare will be launching soon. Designed to be as affordable as possible for patients, the Gencare Payment Plan will offer basic check-ups, X-rays and prophylaxis at proposed payments of around £10 a month, putting its costs well below that of other offers that include similar treatments. With basic payment plans such as these, patients shell out the least amount of money for quality care, and there’s little danger of giving them the impression that they are being sold to needlessly.

If used the way they are intended to, payment plans may get more people visiting their dentist regularly. This in turn can elevate the state of the nation’s oral health and advance the dental profession towards the preventive practice that it aims to become.

For additional information please call 0845 858 4122, or email advice@genixhealthcare.com or visit www.genixhealthcare.com

About the author
Kay Thomson has extensive and successful experiences across a range of different market sectors. For the past eight years she has worked in practice, where she has worked as a Clinical Manager and Implant Treatment Coordinator among other roles. At the heart of Kay’s philosophy, she believes in exceptional customer service and good quality dentistry. This passion for excellence led her to join Genix Healthcare – a company she feels shares the same values and are always prepared to go the extra mile for the customer.

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A road to preventive care, by Kay Thomson

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With Nobel Biocare’s new online store, ordering products is quicker and easier than ever before. With your dedicated customer support team available during regular office hours, the online store provides a valuable extra option for even greater flexibility, so you can spend less time ordering more, and more time working on the things that really matter.

For more information contact Nobel Biocare on 0208 756 3100 or visit www.nobelbiocare.com To register for the Nobel Biocare Online Store go to: store.nobelbiocare.co.uk
Help your patients to feel valued by referring their orthodontic treatment to the London Smile Clinic. The team is headed up by Specialist Orthodontist Dr Preet Bhogal and supported by state-of-the-art facilities and equipment. Referral dentists are consulted at every stage of the referred treatment and receive ‘before’ and ‘after’ photographs as standard. “I am over the moon with the results! I can totally relax in front of others and can laugh as much as I like without covering my mouth with my hands.” – patient. Referring ensures patients’ care and wellbeing for specific treatment outside of your skill set. It’s an excellent way to build trust and loyalty to your patients. Patients will return to you with a spring in their step and greater interest in maintaining their beautiful new smiles.

For more information, please contact 020 7235 2559 or visit www.londonsmile.co.uk or refer.

**Compliance for digital imaging equipment**

Dentists need to ensure their digital equipment is regularly maintained, to fulfil their legal obligations. A comprehensive Service and Support Plan from The Dental Imaging Company enables practices to comply with the Department of Health Health & Safety regulations. Any employer who has control of equipment used in connection with medical exposure to ionising radiation has a legal responsibility for ensuring that equipment is properly maintained. The Health and Safety Executive Guidance Note HSG187 advises that “Equipment used in connection with medical exposure should be under some form of maintenance/service contract.”

The Dental Imaging Company’s Service and Support Plan includes a free annual service, and support for the software and hardware. Sara Elsinton describes how having the package in place has enabled the Dentist/Reflex practice in Hambledon to be ready for routine inspections. “We are on top of things and already prepared. This enables us to dedicate more time to our primary role – providing a better service to our patients.”

For more information, contact Carssen Dental on 0800 169 9653 or visit www.carssendental.co.uk

**EndoCare – because every tooth counts**

At EndoCare we understand the real value of a tooth. That’s why we have dedicated ourselves to Endodontics – the branch of dental pain and infection and save patients’ natural tooth. Our team of talented and highly experienced Endodontists are all experts in their field and heavily connected to delivering high quality treatments and outstanding levels of patient care. We welcome contact from all referring practices and we are ready and willing to assist in any matter relating to Endodontic: treatment. We particularly excel at treating nervous or anxious patients and other challenging issues such as hot spots, microsurgeries and re-treatments. Not only are we team of Endodontists all highly trained but they are also equipped with the latest technology to ensure your patients receive the very best standard of care. This includes cutting-edge digital imaging systems, NITI instruments, and The Wond to make comfortable examinations.

To find our more about we can offer valuable referral services for your practice, contact EndoCare today. For further information please call EndoCare on 020 7234 0099 or visit www.endocare.co.uk

**The Easy Way with Taxco UK**

With years of experience, the team of experts at Taxco are renowned for creating some of the most contemporary medical and dental cabinetry in the industry. Combining an Italian flair for design with effective ergonomics and top quality materials, your dental practices could be completely transformed. Illustrated is a recent project by Taxco UK. Jesmonite cabinetry from Taxco can be altered to suit any shape or size practice. Individual pieces can then be personalised further by a choice between the entire RAL color selections, with over 200 options to choose from.

Once the full design of your project has been agreed, Taxco UK will deliver your new cabinetry ready for easy self assembly. All furniture comes with compliance with health and safety guidelines and its design could significantly improve productivity among staff, making everyone happy.

Everything you need to know about Taxco cabinetry is on the new website, along with electronics and a video gallery to illustrate the whole simple process from start to finish. Do it the easy way – refurbish your practice with Taxco UK.

To see how Taxco UK can transform your practice, please visit the brand new website www.taxco-uk.com

**Get your fill of facial aesthetics from The Dental Directory**

At The Dental Directory on stand D80 at The Dentistry Show 2014 and discover a wide range of Facial Aesthetic and Slim Refinement treatments your practice can offer. Whether you are looking at starting up, you can visit their stand for help and advice. Taxco UK is supplying with a Full Pharmacy Service. Details on all these and more can be obtained from The Dental Directory’s dedicated Facial Aesthetics Sales Team at The Dentistry Show. Whether you already offer Facial Aesthetic treatments or are looking at starting up, you can take this stand for help and advice.

For your Facial Aesthetic and all other products for your Practice, you can rely on The Dental Directory. The Independently Verified Best Priced Dealer!

For more information, contact The Dental Directory on 0800 355 156, or visit www.dentaldirectory.co.uk

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To find our more about we can offer valuable referral services for your practice, contact EndoCare today. For further information please call EndoCare on 020 7234 0099 or visit www.endocare.co.uk

**Clinpro™ White Varnish**

Clinpro™ White Varnish is convenient to use for both you and your patient, with enhanced flow characteristics for reaching hard to reach areas, a unit dosage system to reduce wastage and a virtually invisible sheen upon application. For invisible protection for your patients, turn to Clinpro White Varnish.

For more information, call 01647 478145 or email philipa.goodman@3m.com

**Futurebond U**

Futurebond U is a dual-curing universal adhesive. Futurebond U is the market’s only true dual-curing universal adhesive offering usage in a disposable applicator. Besides the incredibly easy handling, the new Futurabond U offers practitioners an outstanding range of options for application, as much with regard to indication as to selection of the stitching technique (self-etch, selective-etch or total-etch) or the curing mode. This universal adhesive is fully selective-etch or total-etch) or the curing mode. This universal adhesive is fully

For more information, call Ray Goodman on 01771 707 000 email mgj@goodmanandco.co.uk or John Grant on 0131 834 0707 email jmg@goodmanandco.co.uk

**Combining capability with simplicity – the CS 8100 from Carestream Dental**

The CS 8100 features the very latest in digital imaging technology and offers you simplicity – the CS 8100 from Carestream Dental. The CS 8100 is the market’s only true dual-curing universal adhesive designed to offer the best possible fit with all light-curing, dual-curing and self-curing methylacrylate-based composites and is suitable for both direct and indirect restorations. Applied in a single layer, Futurabond U creates a strong bond to enamel and dentine, thus ensuring a durable, gap-free bond between the dental hard tissue and the restorative material. At the same time it offers firm adhesion to different restorative materials. At the same time it offers firm adhesion to different restorative materials. At the same time it offers firm adhesion to different restorative materials.

Special offer: buy one pack of 200 Singoldive and get a free Pack of 20 Singoldive for free, all with a payback guarantee. This offer is available until 31st March 2014.

For more information, contact Carestream Dental on 0800 169 9653 or visit www.carestreamdental.co.uk

**Snappy Glass Ionomer Restorative**

Snappy Glass Ionomer Restorative from 3MTM ESPETM ClinproTM White Varnish is the only varnish in the UK market with a unique formula - Tri-Calcioum Phosphate (TCP).

TCP carries the same mineral components that can be found in tooth enamel, which are necessary for maintaining oral health. In addition, TCP offers the benefit of being strong teeth. The patented formula is viscosity adjusted for the tooth surface for up to 24 hours after application, and is proven to relieve hypersensitivity.

Chlpno™ White Varnish is convenient to use for both you and your patient, with enhanced flow characteristics for reaching hard to reach areas, a unit dosage system to reduce wastage and a virtually invisible sheen upon application. For invisible protection for your patients, turn to Chlpno White Varnish.

For more information, call 01445 502 504 or visit www.mage.co.uk

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For more information, please contact your VOCO dental consultant or contact your dental dealer.

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