**DENTAL TRIBUNE**

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**News in Brief**

Fake dentist kisses patient
A fake dentist from Florida has been arrested for kissing his female patient’s buttock. John Collazos had been practising dentistry without a licence, directing his services towards migrants. A woman complained to police about Collazos after attending an appointment with him for toothache. According to the patient, Collazos gave her an injection in her buttock to relieve the pain, and subsequently kissed the wound. Collazos has been charged with four counts of practising without a licence, another four for using equipment without a licence, and one count of battery.

Dallas star dies of mouth cancer
TV star Larry Hagman, best known for his role as JR Ewing in the hit series Dallas, died of tongue cancer on Friday 23rd November, having been diagnosed with the disease in October last year. Chief Executive of the British Dental Health Foundation, Dr Nigel Mirer, hopes this latest high-profile case will help to spread the message and raise awareness about mouth cancer. Dr Carter said: “Larry’s passing is a reminder of how deadly mouth cancer can be. Latest figures show more than 6,000 cases have been diagnosed in the UK. Without early detection, half of those will die.”

**In-Home HIV Test**

**News**

**Feature**

**Infection Control Tribune**

**Event Review**

In-Home HIV Test is a breakthrough product in the fight against HIV and AIDS because it empowers more people to learn their HIV status in the comfort and privacy of their own homes,” he said.

**OFT campaign gives patients ‘Right to Smile’**

Consumer and competition authority initiates drive to encourage patients to know their rights before visiting their dentist

The Office of Fair Trading has launched a new campaign to help patients understand more about their rights when visiting the dentist.

The Right to Smile campaign has come off the back of the report from the OFT earlier in the year, where it was claimed that patients do not always have the information to allow them to make informed decisions about their choice of dentist and treatments.

As part of the campaign the OFT is advising NHS patients:
- They are entitled to a wide range of treatment that is needed to get their mouth, teeth and gums as healthy and pain free as possible.
- If the dentist discusses a particular type of treatment, patients shouldn’t be required to pay for it privately. Private options may be discussed, such as cosmetic alternatives or specialist treatments such as dental implants which is up to the patient to decide if they want them.
- Even if treatment involves a number of visits, patients will only pay one charge for each complete course of NHS treatment, unless there was an emergency visit to the dentist first.
- Should NHS treatment fail within 12 months, the dentist should repair or redo most treatment free of charge, unless the patient was advised that treatment was unlikely to be a long-term solution. Advice for private patients includes:
- Ask what guarantees the dentist provides. In addition to any rights patients may have under guarantee, they will also have rights under the Supply of Goods and Services Act 1982.
- The Right to Smile campaign is supported by organisations such as the BDA, Oasis, IDH, Which?, NHS Choices, the Department of Health, the Welsh Government, the Scottish Government and Citizens Advice.

Judith Frame, OFT Head of Campaigns, said: “While the UK has one of the highest standards of oral health in the world, and satisfaction levels among patients are high, our report found that people are often confused about what they’re expected to pay, and don’t always have the information they need.

This campaign aims to help patients better understand what to expect, and more engaged when making decisions about their choice of dentist and treatments.”

Barry Cockerott, Chief Dental Officer for England, said: “Giving patients good information is key to a high quality service. We are delighted to support the Office of Fair Trading’s campaign. This material will help patients make informed choices about their dental care.”

A Which? spokesperson said: “We support the ‘Right to Smile’ campaign to help consumers understand their rights when visiting the dentist. It’s vital patients are given clear, timely and transparent information on the proposed treatment and the costs and how to complain if something goes wrong.”

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**Hand hygiene**

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**Africa**

**Erik Ahlbom recollects Ugandan trip**

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Earthquakes responsible for teeth grinding

The stress of Canterbury’s earthquakes could be damaging people’s teeth, a Christchurch dentist says.

New Zealand Dental Association (NZDA) Canterbury president Donna Batchelor said the region’s dentists had noticed a growing number of people seeking treatment for teeth grinding, with stress believed to be the cause of the problem.

Some people were seeking treatment for fractured cusps, where the pointed chewing surface of the tooth was broken off from grinding.

“There’s significantly more patients coming through with that,” Batchelor said. “You can’t stop it if it’s something that’s coming from an internal thing.”

Dentists were working more closely with counsellors and family doctors to support stressed patients, she said.

The earthquakes had also seen dental work become less of a priority for some families.

“There’s so many other things to worry about. A lot of people are possibly leaving things more until there’s an issue, she said.

For elderly people, getting across town to their dentist had become a challenge, and more dentists were now taking the time to go to them, such as visiting rest homes to check on patients with dentures.

Batchelor said the region’s dentists had been stressed since the quakes, with many losing their premises in the February 2011 quake.

Many were still working out of temporary premises or sharing space with other practitioners.

Others were worried about losing the premises they had. A Rangiora dental clinic was forced to move at short notice in March because its building was deemed to be quake-prone, she said.

World-renowned dentistry expert Professor Ray Bertolotti will speak to a group of Canterbury dentists today about alternative treatments.

Bertolotti, a clinical professor of biomaterial science at the University of California, is donating all proceeds, more than $18,000, to the Canterbury University of California, is donating all proceeds, more than $18,000, to the Canterbury

News

Check your faulty defibrillators warns MHRA

The manufacturer, HeartSine Technologies Ltd, has issued a global correction notice for samaritan® PAD 500/500P defibrillators distributed from August 2004 to December 2010. Serial numbers for devices affected by these issues are below:

- 0400000501 to 0700052917 inclusive
- 08A00055000 to 10A00070755 inclusive
- 10C00200000 to 10C00210518 inclusive

The MHRA’s Director of Medical Devices, said: “People who are responsible for these public access defibrillators that are in use at shopping centres, railway stations, dental surgeries and other public places need to check the serial numbers and, if they have an affected device, follow the advice in the manufacturer’s field safety notice.

If the defibrillator is part of this corrective action, and you are unsure of what to do, you can contact the manufacturer on +44 02 8909 9400 or the MHRA Adverse Incident Centre on 020 7084 5080 or aic@mhra.gsi.gov.uk

Teeth Whitening Salesman Jailed

A trader who was found to be selling illegal teeth whitening products over the internet was sentenced to prison at Chelmsford Crown Court.

Mr Barrington Charles Armstrong Thorpe was sentenced to eight months in prison followed by an additional eight months under license under the Consumer Protection from Unfair Trading Regulations 2008 (CP(T)Rs) for misleading consumers as to the legality of a tooth whitening product; and 10 charges for breaches of the Cosmetic Product Regulations 2008 for supplying a tooth whitening product that contained or released excessive levels of hydrogen peroxide.

Essex County Councillor Kevin Bentley, Cabinet Member for Trading Standards said, “This conviction is great news for consumers. The products that were being sold over the internet were not only illegal, but also dangerous. This conviction should act as a warning to other traders that may be trying to make money by selling these illegal goods. You will be caught and potentially get a prison sentence.”

Mr Thorpe has been involved in the sale of a tooth whitening product since at least 2005 through a company called Smile Brighter Marketing Limited. After the company was liquidated, Mr Thorpe continued to sell the product as a sole trader. He used several websites to sell this product including www.smile-brighter.co.uk; www.brighter-smile.co.uk; and www.smilebrighternow.com.

It is understood that Mr Thorpe first became involved in selling this product on return from the USA after making an acquaintance with a supplier. In 2007 Mr Thorpe was informed by Bath Trading Standards that the tooth whitener he was selling was not compliant with the regulations. Nevertheless, Mr Thorpe continued to trade. In 2009 he was contacted by Essex Trading Standards, and an investigation into his business was undertaken. Mr Thorpe accepted a caution in 2010, acknowledging that the tooth whitener was illegal. Still, Mr Thorpe failed to cease trading and Essex Trading Standards launched a prosecution.

The jury found unanimously that Mr Thorpe was guilty of misleading consumers as to the legality of the product, and also for not providing information on the website that is required by law. Mr Thorpe pleaded guilty to the breaches of the Cosmetic Products Regulations. These charges included the supply of a product containing excessive levels of Hydrogen Peroxide and for deficient labelling of the tooth whitener.

GDC suspend council member

The GDC have announced that they have suspended David Smith, a dental technician, from office as a Council Member.

This follows David Smith’s referral to the Privy Council as a result of on-going fitness to practise proceedings.

The suspension was imposed at a meeting of the Council on 15 November 2012 in accordance with the GDC’s procedures. The Privy Council has been notified of this decision and the suspension will remain until the Privy Council reaches a decision on whether or not to suspend or remove him under the General Dental Council (Constitution) Order 2009.

The GDC will not be making any further comment at this stage.
Dental association launched

Dental Fusion Organisation (DFO), a new association with the mission to support and represent dental professionals working in primary dental care, improve oral health and provide social and clinical training for members, was launched on 9th November.

The association has no governing body as DFO members vote directly on every major issue through Web and postal voting. If the members approve, one of the first campaigns will be to reverse the demise of the small independent family practice. Membership is open to all dental professionals and there is also a tight integration between the association and dental suppliers.

Any company can gain direct access to Dental Fusion members by putting goods or services on their Web site free of charge. The association’s margin is recycled back to the members in the form of Reward Points.

“In addition to dental health and business success, training and assistance with compliance will be a major theme of the new association”, says Chief Executive Derek Watson. “This will be delivered mainly through a series of Webinars which enable dentists to learn at any Web-enabled PC, tablet or smartphone.”

So far fifteen lunchtime Webinars have been organised, including Management Monday, Financial Friday and a course on improving your IT skills. These are open to all, but DFO members are entitled to priority registration and verifiable CPD.

Awards

Campaign highlight patient’s rights to treatment at the dentist.

This is being complemented with videos and an information sheet, tailored to each country in the UK. To see the video, go to the OFT’s YouTube channel and take a look – probably worth it as you can bet your patients probably will!

Last week saw the ninth annual BACD conference in Manchester. It was an exceptional conference with some really world class names speaking at the event. I have to say my favourite (and I did go to more than one, I promise) was a lecture by Rafi Romano on Current Innovations in Aesthetic Orthodontics. I am hoping to get a clinical case study from him for an upcoming 2013 issue of Dental Tribune, watch this space!
Effects of tooth whitening under inspection by EU

The Council of European Dentists (CED) is currently conducting a one-year survey on possible negative side-effects of tooth whitening and bleaching products. The CED has called upon dentists in the EU to report their own and their patients’ observations.

The survey includes tooth whitening and bleaching products that are not freely available on the market to consumers, that is, those that contain between 0.1 and 6 per cent hydrogen peroxide. It runs until 51 October 2015. The initial results will be reported to the European Commission by the end of next year.

The research is being carried out in accordance with an agreement between the CED and the European Commission that was signed in March 2010 owing to the increasing availability of tooth whitening products on the EU market. The agreement was signed to ensure appropriate tooth whitening treatment through qualified dental professionals and to improve patient safety.

About one year ago, the Council of the European Union passed an amended directive on tooth whitening products, which resolved that tooth whitening or bleaching products containing more than 0.1 per cent and up to 6 per cent hydrogen peroxide will only be sold to dentists. Products with concentrations of up to 0.1 per cent continue to be freely available on the market.

The CED is a non-profit organisation, which represents over 340,000 dentists across Europe. It is aimed at the promotion of high standards of oral health care and effective patient-safety-centred professional practice in Europe.

GDC sets out new guidance for employers

The guidance contains a number of key points, including what defines a student/trainee dental nurse or dental technician:

- They are either:
  - 1. Employed and enrolled or waiting to start on a recognised programme that will lead to GDC registration; or
  - 2. Studying on a recognised programme that leads directly to GDC registration.


Polar bear enters dentist’s chair

A team of vets at a Scottish wildlife park have given a polar bear root canal treatment.

The vets were called in after the usually-playful Arktos was feeling subdued, leading staff at the park to discover a problem with his upper left canine tooth.

Arkots, who weighs 75 stones, was sedated and placed on an operating table made up of scaffolding poles and thick planks. His tooth had become damaged at the tip and rotted through, causing the polar bear to need root canal treatment.

After three hours, the treatment was successfully completed.
UPCOMING WEBINARS:

12/12/12  19:30  ‘Demystifying clinical research papers’ Stephen Hancocks

13/12/12  19:30  ‘Modern Treatment Options for Periodontal Disease’ Ian Peace

19/12/12  18:00  ‘Medical Emergencies’ Joe Omar

www.dentalwebinars.co.uk has built a solid reputation as the original and best dental webinar provider. The webinars are live and interactive to give a unique learning experience. Interact with some of the industry’s leading experts as they present the very latest innovations finding the solutions you need.

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Dental practice wins at MyFaceMyBody Awards

Businesses pledge for more fruit and veg

Parents responsible for dental fears

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The team at Perfect 12

Beverley-based NHS and private dental practice, Perfect 52, has won an award for recognition of its contribution and commitment to community and charity projects at the inaugural MyFaceMyBody Awards held at The Landmark Hotel in London on 3rd November.

Perfect 52 was presented with The Best Community and Charity Award for its work in raising awareness of oral cancer and for its mouth cancer screening initiative in practice. The practice is also working alongside the award winning UK charity, The Mouth Cancer Foundation, to develop and launch a mouth cancer accreditation scheme for dentists across the UK.

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Stephen Handisides, owner of MyFaceMyBody, said: “The competition was fierce so even making the shortlist was an accomplishment. These awards were voted for by consumers – the people actually using these products and services, so they mean so much more.

“The awards showcased the commitment of businesses to reach exemplary standards and demonstrated our popularity amongst consumers.”

Perfect 52’s Practice Manager, Nicki Rowland, said: “We are absolutely delighted to win this award. I am immensely proud of my team and our practice and everything we do for our patients. The award works beyond the call of duty to provide a top-notch dental service but also to give back to patients and the community by raising awareness of mouth cancer and screening for it in practice. We are very honoured to be working with the Mouth Cancer Foundation in introducing a national accreditation scheme for general dental practice. The scheme will help in ensuring that every dental practice has a robust system for the screening and referral of all patients over the age of 16. Earlier detection and intervention will ultimately save many lives every year.”

Coverage of The MyFaceMyBody Awards can now be viewed on YouTube at www.youtube.com/results?search_query=MYfacemybody awards.

Tooth whitening company prosecuted

The General Dental Council (GDC) has prosecuted illegal teeth whitening company Pearl Teeth Whitening Limited.

The company, trading as Pearl National, was charged under section 45 of the Dentists’ Act 1984, which states: “A body corporate commits an offence if it carries on the business of dentistry at a time when a majority of its directors are not persons who are either registered dentists or registered dental care professionals.”

A representative of Pearl National was guilty at Doncaster Magistrates’ Court on Friday 23rd November.

During sentencing, District Judge Bennett said: “It is clear from their website that Pearl National operated from a large number of locations and from the facts of the case presented to me, that they employed unqualified people to provide teeth whitening to their customers.”

He added that it occurred to him that the company “must have received a lot of money and had never filed accounts at Companies House.”

The court has fined the firm £5,500 and ordered them to pay £4,000 towards the GDC costs.

Parents responsible for dental fears

A new study conducted by scientists at the Rey Juan Carlos University of Madrid highlights the important role that parents play in the transmission of dental fear in their family.

Previous studies had already identified the association between the fear levels of parents and their children, but they never explored the different roles that the father and the mother play in this phenomenon.

América Lara Sacido, one of the authors of the study explains that “along with the presence of emotional transmission of dentist fear amongst family members, we have identified the relevant role that fathers play in transmission of this phobia in comparison to the mother.”

Published in the International Journal of Pediatric Dentistry, the study analysed 183 children between seven and 12 years and their parents in the Autonomous Community of Madrid. The results were in line with previous studies which found that fear levels amongst fathers, mothers and children are interlinked.

The authors confirmed that the higher the level of dentist fear or anxiety in one family member, the higher the level in the rest of the family. The study also reveals that fathers play a key role in the transmission of dentist fear from mothers to their children as they act as a mediating variable.

“Although the results should be interpreted with due caution, children seem to mainly pay attention to the emotional reactions of the fathers when deciding if situations at the dentist are potentially stressful,” states Lara Sacido.

Consequently, transmission of fear from the mother to the child, whether it be an increase or reduction of anxiety, could be influenced by the reactions that the father displays in the dentist.

Amongst the possible implications of these results, the authors outline the two most salient: the need to involve mothers and especially fathers in dentist fear prevention campaigns; and to make fathers to attend the dentist and display no signs of fear or anxiety.

“There is little evidence that children who experience dental anxiety at an early age will outgrow it,” notes the author.

More fruit and veg will be added to ready-meals, and supermarket fruit and veg sections will be expanded as part of a new drive to encourage everyone to get their 5-a-day. Public Health Minister Anna Soubry announced today.

The move comes as part of the latest Responsibility Deal pledge, aiming to encourage action across the food industry to help people eat more fruit and vegetables. This includes foods right across the board - fresh, frozen, canned, dried and juiced products, as well as fruit and vegetables in pre-prepared food, such as ready-meals.

Eating five portions of fruit and veg a day helps to lower the risk of serious health problems, such as heart disease and some cancers, but figures show that two thirds of people still don’t eat enough.

The new pledges include:

- ALDI will increase the amount of store space dedicated to fresh produce and feature their own brand of Super 6 fresh fruit and vegetable lines in their promotional activities including TV advertising.
- Iceland will offer coupon deals on fruit and vegetables, increase their promotion to its customers using new website and social media features, as well as introduce new fruit and vegetable products.
- LIDL will rebrand its entire fruit and vegetable range making it more appealing - particularly for children - with fun characters and jokes on kids’ packs.
- Subway will launch a new campaign fronted by elite athletes Louis Smith and Anthony Ogogo, two of Subway’s Famous Fans, to promote their choice of a Low Fat Sub personalised with their favourite extra salad items.
- Co-operative Food, Morrisons, M&S, Sainsbury’s, Tesco, Waitrose, General Mills, Mars, caterers 5685, Brakes, CH & Co Catering and the British Frozen Food Federation have also signed up to the pledge.

“Getting your 5-a-day can help lower the risk of serious health problems, such as heart disease and some cancers, but we know that can be a challenge. That is why we want to work with the food industry to help everyone make healthier choices.”

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Relationship between dental health and poverty

Children beside the poverty line face challenges

O besity and dental cavities increase as children living below the poverty level age, according to research from the Case Western Reserve University and the University of Akron.

Researchers found that as body mass index (BMI) increased with age, so do the number of cavities. These findings were published in the online Journal of Pediatric Health Care article, “Childhood obesity and dental caries in homeless children.”

The study examined the physicals of 157 children, from 2-17 years old, who were living in a homeless shelter. Most were from single-parent families headed by women with one or two children.

While studies in Brazil, New Zealand, Sweden and Mexico have shown a relationship between obesity, dental health and poverty, few US studies have examined how the three factors are linked.

The findings support reports from the Centers for Disease Control and Prevention that obesity and poor oral health have doubled since 1980, raising the risk of diabetes and other health problems, as well as issues with self-esteem.

Poverty contributes to poor dental health by limiting access to nutritious food, refrigerators to preserve food and even running water in some homes, said Maguerite DiMarco, associate professor at the Frances Payne Bolton School of Nursing at Case Western Reserve University.

“Many people do not realise,” she said, “that dental caries is an infectious disease that can be transmitted from the primary caregiver and siblings to other children.”

Another problem for children of poverty is access to dental care, where families lack the financial means and transportation to make and keep an appointment. And some working poor may not qualify for Ohio’s Childhood Health Insurance Program, which subsidises health and dental care reimbursements to providers.

“There are no easy solutions,” DiMarco said, “especially with the homeless population.”

GDC makes patient information more accessible

T he General Dental Council (GDC) has launched more accessible versions of its patient information.

The ‘Smile EasyRead’ patient information leaflet explains the role of the GDC; what patients can expect at their visit to a dental professional; and what they can do if they’re unhappy with their experience.

It features larger font, pictures to support and help explain the text, shorter sentences and language that sounds natural when spoken.

The GDC established a register of Special Care Dentistry specialists in 2008. Special Care Dentistry is concerned with improving the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors.

Sukina Moseajee, the most recent registrant on the GDC’s Special Care Dentistry specialist list and a Locum Consultant in Special Care Dentistry at King’s College Hospital NHS Foundation Trust, said: “Smile EasyRead” is comprehensive and easy to understand. It will help raise awareness among vulnerable patients and their carers about the standards of care they should be receiving from the dental team.”

Alison Keens, Head of Nursing and Therapies - Adults with Learning Disabilities at Guy’s and St Thomas’ NHS Foundation Trust said: “People with learning disabilities need information to be provided in an accessible format. This excellent document will enable more people with learning disabilities to have a better understanding of and make more decisions about their own dental care.”

As well as EasyRead, Smile is available in print in Plain English, online in Welsh, Bengali, Chinese, Punjabi and Urdu, and as online audio files in English.

Dentalprofessionals can also access audio and Large Print versions of the GDC’s Standards for dental professionals, as well as accessible continuing professional development and employment advice.

GHC Chief Executive and Registrar Evlynne Gilvarry said: “We are committed to providing accessible information and services. We want all patients to be aware of what they should expect from their dental professional and how we can help if something goes wrong.”

Free copies of Smile and Smile EasyRead, and downloads translations and audio files can be downloaded from the GDC website: www.gdc-uk.org

Is your dental partnership legal?

N ASDAL are advising all dentists to think twice before going into a dental partnership with a family member.

Some smaller practices comprise a partnership between a dentist and their spouse, but if the spouse is not a General Dental Council (GDC) registrant, this may be illegal.

Nick Hancock is a Chartered Accountant and a NASDAL member who was recently asked for advice by a dentist in partnership with his wife who was the practice manager. “Regrettably, I had to inform the dentist that he should dissolve the partnership. Under The Dentists Act 1984 it states ‘… an individual who is not a registered dentist or a registered medical practitioner shall not carry on the business of dentistry…”’

Damien Charlton, a member of the NASDAL Lawyers Group says there is one exception. “When the practice holds a General Dental Services (GDS) contract, the National Health Service Act 2006 permits certain non-GDC registrants - including a GDS practice employee – to enter a GDS contract. The Dentists Act specifically states that receiving income under a GDS contract is not deemed, for the purposes of that Act, to be carrying on the business of dentistry.”

He added: “It’s essential that the partnership formed for the purposes of the GDS contract is kept separate from any private work carried out by the practice because it is only receipt of income under a GDS contract that falls within the exception to the definition of “the business of dentistry. This means (amongst other things) keeping separate sets of accounts and ensuring that the non-GDC registrant does not receive any income from the non-GDS parts of the practice.”

Dentists in an ‘illegal partnership’ are strongly advised to dissolve it. Once the partnership has dissolved, the registered dentist can continue to trade in a different format. This could be as a sole trader, a limited liability partnership or as a limited company. It is essential that you seek expert financial and legal advice to ensure that the structure you choose complies with the complex rules and regulations which govern the practice of dentistry.

BDA Scotland welcomes new director

P ut Kilpatrick has been appointed as the new Director of the British Dental Association (BDA) for Scotland. She will take up her post in January 2015 and brings to the post extensive experience in the healthcare sector including operational and strategic management, policy development, and postgraduate teaching and research.

Graduating from the University of Dundee, Pat joined the Graduate Training Scheme for NHS management before going on to senior roles within NHS Scotland including Director of Clinical Development at NHS Argyll and Clyde and Director of Planning at North Glasgow University Hospitals Trust. She led the National Task Force on the development of Primary Care Trusts in Scotland in 1997.

As Academic Director in the School of Management at the University of Stirling, she developed the first MBA postgraduate degree programme designed to develop the management skills of both doctors and dentists.

Latterly her career has been in consulting. She joined Tribal Consulting in 2006 as a Director within their national advisory team, before going on to launch her own business in 2010.

Pat said: “Dentistry in Scotland faces a complex set of challenges. I look forward to playing my part in helping the profession overcome them and advancing the cause of oral health in Scotland.”
Regulations and relative risks

The only thing worse than over regulation is bad regulation, says Neel Kothari

My biggest pet hate at the moment is the sheer number of unenforceable policies designed to induce a culture of fear and promote the practice of defensive dentistry. In my opinion the only thing worse than overregulation is bad regulation and by keeping the profession at a safe distance from the construction of such regulations, this not only renders the policies as ‘short term’, it severely erodes the profession and its ability to self regulate.

The promise of a cut in bureaucracy by the incumbent government has quickly evaporated, leaving dental practice managers trying to understand complex protocols and policies designed for small hospitals and clinics rather than a general dental practice.

For instance, let’s look at the costs and the risks associated with Legionnaires disease and the need for a risk assessment and regular water testing. If you get a ‘professional company’ (apologies for the inappropriate use of the word professional) to carry out a full risk assessment and test the water sources you could easily pay more than £500 for the privilege. Money well spent or a complete waste of time? I guess that’s a matter of opinion.

Low risk

A risk assessment of dental unit waterline contamination carried out by Caroline Pankhurst in 2005 concluded that the risk to respiratory health from bacterial contaminants in dental unit waterlines is very low and at the Second Annual All Island Symposium on the Public Dental Services the reports state that one in three homes contain Legionella, but there is a very low attack rate in an outbreak, just 2-5 per cent. Legionella flourishes in all water types in temperatures of 20-45 degrees Celsius, and likes stagnation, sediment and scale. It goes on to further state that ‘There are no proven cases of Legionnaire’s disease linked to dental treatment’. The question then becomes, is forcing dental practices to adhere to Legionella testing a cost effective way to promote public policy? And should practices really divert time and money away from front line services?

Relative risk is something that seems to be completely absent from the architects of HTM01-05, which may go some way to explain why the DH review of HTM 01-05 has been further pushed back to 2013-14 and why the BDA as our trade union has pressed for the immediate removal of the unnecessary and burdensome restriction on instrument storage times, which the DH has conceded is not evi-
The reality of modern day dentistry is that central government is far more concerned with the perception of how clean our instruments look and feel rather than the skill with which we use them. The move towards getting our instruments to be ‘sterile’ rather than ‘clean’ is not only expensive and time consuming to achieve, but does not address the fact that the relative risks of using ‘clean’ instruments is very low. After all restaurants don’t steam sterilise their knives and forks, yet we are all happy to put them in our mouths. Now I am not trying to compare a night out with dental treatments, but aren’t the relative risks to people still the same?

Outcomes

My understanding is that the CQC is monitoring things on an ‘outcomes’ basis. So let’s look at things on an outcomes basis. Since the introduction of the nGDS, CQC and IHTM01-05, dental practices have seen a massive reduction in morale, a hike in practice expenses, a reduction in profits and a ridiculous amount of time wasted formulating policies and protocols that neither stand little chance of actually being enforced nor have any solid evidence that they actually improve outcomes. When will central government realise that you simply cannot legislate dentists to do the right thing when it is debatable whether there is anything wrong with what we are currently doing.

As I have already mentioned, in my opinion the ever increasing burden of legislation forcing us to do general dental practices is really designed for small hospitals and not for family practices. Whether or not they are actually enforceable is debatable; if you go into any busy A&E on a Saturday night I bet you will see a number of ‘breaches of cross infection compliance’ ranging from nurses taking bloods without gloves and smoking outside whilst wearing hospital tunics. Let’s not forget that they are treating people who are seriously sick and not simply carrying out dentistry in relatively healthy patients.

The relative risks to patients are clearly much higher compared to a general dental practice, yet nevertheless I have to spend my lunch breaks debating whether I should have a sign saying ‘dirty’ in my surgery, which until I absolutely have to I will not be doing. Furthermore, why am I told that I need a sign showing me how to wash my hands every time above my sink? This is the first thing that we learnt at dental school and simply just adds to the clutter of useless posters that do little to improve standards for patient care. Why not get dental nurses to hold open a textbook every time we prepare a cavity or a crown for a tooth?

Apologies for the rant. I will try to cheer up in time for my next article.
You can not get used to Africa
You either like it, or you don’t, but you can’t get used to it, says Erik Ahlbom

Werner and his wife Natalie, both from Belgium, are running one of the countless NGO's (Non Government Organisations) that keeps Uganda ticking over and that together with other kinds of foreign aid makes up more than 40 per cent of the gross national product.

In spite of Werner and Natalie’s best efforts, Uganda is still struggling with poverty. Half the population, that is 15 million people, don't have food security. That same group of people have little or no access to health care and dental care. There is one dentist for every 158,000 people in Uganda, compared to one for 3,000 or so, in the UK. Infected teeth can fester for years, which not only makes the sufferer miserable, but also according to the WHO, accounts for a loss of working and school days comparable to Malaria or HIV, thus perpetuating poverty. Unlike the headline grabber, the dental nurse and myself, a dentist, from the Port Erin Dental Surgery in the Isle of Man, have signed up for this DENTAID mission.

I am writing this on a rickety bus, travelling to the Kanungu district in south western Uganda, near the Rwandan border. I’m trying to keep the pen steady to the paper, while the red dust that much of Africa seems to be made up from slowly penetrates every nook and cranny in the vehicle. We are carrying on the bus a portable dental hospital that can be set up in anything with a roof on it and shortly thereafter have signed up for this DENTAID mission.

Kanungu
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Fig 2. The portable dental hospital. This can be set up in anything that has a roof on it!

Between the villages, the roadside is strewn with small farm houses, surrounded by a small patch of land where Matooke, a kind of banana that is cooked and is a bit like a potato, beans or cassava is growing. The people in them are surviving on subsistence farming, meaning that they can only just survive, as long as all goes well. There are no margins, no backup, so when a parasite strikes and destroys the crop in an area, there is nothing to help and the result is a local famine that never reaches our media. No headlines, no UN planes dumping food, no Band Aid. Just hunger.

Not enough
Still, when everything is going well, it is not enough. Most children get enough calories in the day, but not enough protein, leading to stunted growth in children and difficulties in following classes in school, if they have one to attend. When there is some protein, say eggs or beans in a household, the parents are sometimes faced with the choice of feeding their children with it or to sell it to get cash for things like shoes or school fees. We sometimes see the effect of this in our clinics as well. Children are sometimes exhausted, unable to stand up properly after simple extractions. A sugary drink helps this very quickly, strongly indicating that food was the problem in the first place.

It would be easy to dismiss Uganda as failed and hopelessly corrupt. As always, the truth is far more complex than that. The Ugandan government, unlike many of its counterparts, is in full control of their territory. And efforts are being made, although a European, parachuted into Uganda, might not recognise them as such. One example of this is Kampiringisa, a facility for children, one hour outside Kampala. It is called a ”Social Rehabilitation Centre”, but looks very much like a prison. Children are being picked up by the police for various offences, or swept up into Kampala when it needs tidying up.

Conditions are grim. The children are fed once a day, like a prison. Children are sent out to fend for themselves. Hygiene is virtually non existent. Still, it is arguable that it is safer for a child in there than on the streets of Kampala. There is food every day, they do get de-wormed and Dentaid manages a visit every month.

This is also where Werner and Natalie spend their efforts, salvaging a number of children from a life in a prison. It is not easy. As long as there is food, the children usually show up. Some are actually very happy. Others are fed up with the constant abuse and beatings and they are sent out on their own to fend for themselves. The health of these children is not good, and it is unarguable that they need help. The question is how to help them. Help from WHO, UNICEF and the Red Cross doesn’t reach far enough.

Fig 1. Inmates at Kampiringisa, a ‘Social Rehabilitation Centre’

‘There is one dentist for every 158,000 people in Uganda, compared to one for 3,000 or so, in the UK’

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My dental career started in 1983, when I qualified as a dentist from Gothenburg University, Sweden. I then spent the next 18 years in remote parts of northern Sweden, working where few other dentists wanted to work. In 2000 I emigrated to the UK and then went on to the Isle of Man in 2006. Last year I finally found another job that very few dentists want, and went to volunteer in Uganda.

We are on the way to Kinkiizi, near the borders of Rwanda and Congo. Although the Ugandans in our team say that this is a safe area since a few years back and that the Ugandan military now have full control of the territory, I have seen enough BBC news over the past twenty years to feel a twinge of apprehension anyway.

Seeing patients

Once there, we will set up our portable dental hospital, cleverly designed by the DENTAID engineers in the UK, an operation that grows more efficient by the day. We will start seeing patients inside one hour of switching off the bus engine and keep going all day. Then we will do it again and again.

Then we’ll go home, try and get the red dust out of our clothes and try to understand what we have seen and done. I’ll go through my pictures and relive the joy and the heartache that I’ve experienced and I’ll feel a twinge of guilt over my easy life.

So, did I get used to Africa? Of course not. No one does. But I will return.

Kampiringisa is a very well disguised blessing for some children.

Other efforts are being made as well. There are Ugandan dentists working with DENTAID, trying to build up a structure of dental care, free from corruption. Ambrose Matsika, Apollo Mukiza, Gilbert Rwamwitani and Sam Kisiira are unsung heroes of their country. They are skilled, dedicated and work for little return for themselves. DENTAID’s work would be very difficult without them.

It is an honour and a privilege to work shoulder to shoulder with such men.
If Traditional Marketing Is Dead - Is Social Media Next?

Rita Zamora looks at how not to lose your following

Social Media, told delegates that social media is not an option, it's a requirement. Dr. Timimi has been quoted as saying, “This is not marketing; this is the right thing to do.”

Revisit your mindset
When the leaders in healthcare social media say that social media is not a marketing tool, what does this mean for your practice and your social media strategy? It may mean that we all need to revisit our mindset. It's time to see social media more like communication tools and communities rather than marketing tools. Social media communities are two-way communication channels, not just one-way channels to push out marketing messages. Right?

If you have treated your Facebook and Twitter communities more like marketing and sales tools, the good news is you can change your strategies if needed. Learn to be thoughtful about how often and what you post or tweet. Note I have always recommended, and still do, conservative amounts of light and positive content - show your human side and a bit of personality - yet that should never mean abandoning your core values.

Lastly, a reminder to all of us that we have a choice on how many annoying images, rants, or disturbing or useless material we view on social networks (and how much social media we see, read, and fill our minds with).

Be mindful about what you choose to post and view on Facebook and Twitter. I choose to protect my psyche, enhance my intelligence, and grow relationships with people I respect and enjoy—in real life and on Facebook. You and your practice can either contribute to the beneficial rich content being shared on social networks (and help social media thrive) or you can contribute to the noise at risk of being shut off. Which will you choose? Are you aware of more of what you both consume and post on social media?

Social Media

Is social media marketing dead?

Year’s ago author and social media guru Gary Vaynerchuk said, “Once the marketers infiltrate Facebook, they will ruin it.” Many of us held hope that Facebook, unlike other media, would be different. Turns out it’s not. Just like radio, television and email, our beloved Facebook is getting ruined with the bombardment of unwanted messaging. What’s worse it’s messaging that we as consumers choose to receive.

Hostage
Since the beginning of media, consumers have been held hostage to marketing and advertising. Before the invention of the DVR and subscription radio, we were forced to listen to paid adverts in order to enjoy the benefit of viewing or listening to what we really wanted to hear and see. For this reason, it’s easy to forget we have choices on what we opt to read and see on platforms such as Facebook and Twitter.

So, what does this mean for your practice? Note that fans that dislike the topics or frequency of your posts can easily un-like or hide you. While the ads in Facebook sidebars - and occasionally in newsfeeds - exist regardless, your followers still have total control over the majority of what they read and see on Facebook. This is why it’s so important for your Facebook community manager to be conscientious about what and how often they post.

An unfortunate trend occurring on Facebook is the alarming number of busineses that are resorting to messaging that completely abandons their branding and core values. An example of this in dentistry is a high end aesthetic practice in one of the most exclusive areas of the world posting juvenile photos and a never-ending amount of nonsense “fun facts”. Now more than ever, it’s crucial to watch your content mix.

Rather we should look to industry leaders like the Mayo Clinic, one of the top hospitals in the US and regarded as pioneers in healthcare social media. The Mayo Clinic has never lost sight of their core values and they continue to succeed on Facebook. With over 125,000 fans, they have avoided the trap of over-posting and never have they resorted to posting things incongruent with their brand and values. In return Mayo Clinic enjoys a lively, high quality social community.

In fact this year at the World Health Care Congress, Dr. Farris Timimi, cardiologist and Medical Director of the Mayo Clinic Center for Health Care Social media, told delegates that social media is not an option, it's a requirement. Dr. Timimi has been quoted as saying, “This is not marketing; this is the right thing to do.”

Revisit your mindset
When the leaders in healthcare social media say that social media is not a marketing tool, what does this mean for your practice and your social media strategy? It may mean that we all need to revisit our mindset. It's time to see social media more like communication tools and communities rather than marketing tools. Social media communities are two-way communication channels, not just one-way channels to push out marketing messages. Right?

If you have treated your Facebook and Twitter communities more like marketing and sales tools, the good news is you can change your strategies if needed. Learn to be thoughtful about how often and what you post or tweet. Note I have always recommended, and still do, conservative amounts of light and positive content - show your human side and a bit of personality - yet that should never mean abandoning your core values.

Lastly, a reminder to all of us that we have a choice on how many annoying images, rants, or disturbing or useless material we view on Facebook. Likewise we have a choice to decide who we want to follow on Twitter. If all you are seeing in your social media newsfeeds is rubbish and ridiculous content, then it’s time for you to reevaluate who you are following. Remember: what we read, see, listen to, and most importantly, the people we interact with in social media is our choice. These media chan-nels can be extremely beneficical and loaded with rich, valuable content—or they can be rubbish. It is completely our choice what we wish to see, read, and fill our minds with.

Be mindful about what you choose to post and view on Facebook and Twitter. I choose to protect my psyche, enhance my intelligence, and grow relationships with people I respect and enjoy—in real life and on Facebook. You and your practice can either contribute to the beneficial rich content being shared on social networks (and help social media thrive) or you can contribute to the noise at risk of being shut off. Which will you choose? Are you aware of more of what you both consume and post on social media?

About the author

Rita Zamora is an international social media marketing consultant and speaker. She and her team co-manage dozens of dental practices’ social media programs. Her clients are located across the United States and internationally. She has been published in many professional publications. Rita is also Honorary Vice President to the British Dental Practice Managers Association. Learn more at www.DentalRelationshipMarketing.com or email rita@ritazamora.com.
ADA updates infection control guide

The American Dental Association has launched its newly revised ADA Practical Guide to Effective Infection Control DVD and workbook.

Research presented at ID-Week 2012 shows that a specific spectrum of ultraviolet light killed certain drug-resistant bacteria on the door handles, bedside tables and other surfaces of hospital rooms, suggesting a possible future weapon in the battle to reduce hospital-associated infections.

Researchers at Duke University Medical Center and the University of North Carolina Hospital System used short-wave ultraviolet radiation (UV-C) to nearly eliminate Acinetobacter, Clostridium difficile or vancomycin-resistant enterococci (VRE) in more than 50 patient rooms at the two medical facilities.

“We’re learning more and more about how much the hospital environment contributes to the spread of these organisms,” said lead researcher Deverick J Anderson, MD, an assistant professor of medicine at Duke and co-director of the Duke Infection Control Outreach Network.

In their study, the Duke and University of North Carolina researchers questioned whether UV-C could be utilised to eliminate three of the most problematic germs and improve the cleanliness of patient rooms.

The study focused on general-medical and intensive-care units of the two medical centres and identified patients with infections from the targeted bacteria.

After the patients were discharged, the researchers obtained multiple cultures from each of five specific locations in the hospital rooms and bathrooms - “high-touch” areas that included bed rails, remote controls and toilets. A special machine with eight UV bulbs mounted on a central column was then positioned strategically in each room and turned on for as long as 45 minutes to eradicate both vegetative bacteria and bacterial spores. Fifteen more cultures were taken from the same locations in every room, and the pre- and post-treatment bacteria counts were compared.

The numbers of bacterial CFUs, or colony-forming units, fell precipitously. Fifty-two CFUs of Acinetobacter were seen before irradiation, but only 1 CFU after - down 98.1 percent. As for VRE, the proportion decrease was nearly the same - 719 CFUs before and 15 after, a 97.9 percent drop.

“We would never propose that UV light be the only form of room cleaning, but in an era of increasing antibiotic resistance, it could become an important addition to hospitals,” Anderson said.

Ultraviolet Light Effective in Hospital Infection Control
Centralisation of dental instrument decontamination?

Andrew Smith gives his take on the suitability of central sterilisation centres for the decontamination of dental instruments

With the rush to improve instrument decontamination facilities in general dental practice a frequently overlooked option is centralisation by a Sterile Service Department. Consider, by the time a practice has spent time determining throughput capacity calculations for the new washer disinfector and vacuum steriliser, optimising layout, ensuring appropriate water and electricity supply and factored in the loss of space within the practice premises, it might not seem such a bad idea to let someone else take the strain! In addition there are all the daily, weekly, quarterly and annual tests of the equipment, continual staff training and the ever-increasing pile of record keeping... will you and your practice have the capacity and the willpower to cope?

So, is there another way? In Scotland a third way is in active use in a number of directly managed clinical dental units. Of course these operate under different conditions and patient numbers to many general dental practices but if Tesco and Amazon can deliver to your doorstep why not dental instruments?

A series of papers in the British Dental Journal in the late 1980s discussed the difficulties in the organisation of microbiological (and infection prevention) principles. These workers highlighted the nature of dental treatment (aerosol generation), the National Health Service legacy, surgery and equipment design. The second paper from this group highlighted centralising decontamination into a separate room serviced by hatches from the different surgeries. Perhaps the time has now come to consider an extension of this idea whereby the central in centralisation is now the central sterile supply department located locally?

A published report investigating this option is interesting since the practitioners approached with an option
of participating in the project ‘did not feel that the capital and revenue costs were manageable due to lack of staff & time’. The costing involved are quoted in figures from that era and the comments make interesting reading since the initial costing of setting up the centralisation was ‘offset by greater reduced waiting times and loss of maintenance costs’. There has been no further work published on this topic since, although this was an option investigated in proposals put forward by an early Glennie report. However, at that time it was considered that the Central Sterile Supply service could not cope with the demand of reprocessing all instruments from general dental practice.

With the passing of time and implications of the capital and revenue costs for upgrading local decontamination units it should be noted that there are some working examples of centralisation of dental instrument reprocessing. These have been operational in a number of directly managed dental centres that have had their local decontamination removed and are being serviced by an off-site sterile supply department. In one particular example of an eight-chair dental facility, the instrument turnaround time is 24 hours and the unit has a dedicated storeroom for sterilised instruments and a dedicated room for dirty returns. Feedback from the dental service indicated that no major issues were identified with turnaround times, processing loss or damage to instruments, although the stocks of instruments purchased to accommodate the increased turnaround time were over-estimated by a factor of 3.1. The set-up demanded adoption of a more standardised tray set-up with unusual or rarely used items available as supplemental singly packed instruments.

Of course centralisation of a directly managed unit does not compare with a general dental practice but perhaps the adoption of a different business model whereby a dental practice specifies a tray content (including handpieces) and rents these from the sterile service department. This of course presupposes that a sterile service department in the locality has the capacity and facilities to cope with dental trays and handpieces. However, imagine a practice where instrument decontamination is now the responsibility of a Sterile Service manager and the practice can get on with what it does best and treat patients.

References

‘Imagine a practice where instrument decontamination is now the responsibility of a Sterile Service manager and the practice can get on with what it does best and treat patients’
A major three-year trial led by researchers at UCL, in partnership with the Health Protection Agency, has shown that giving one-to-one feedback to healthcare workers makes them twice as likely to clean their hands. The Feedback Intervention Trial (FIT) is the first such trial to be done in a large number of hospitals anywhere in the world. Carried out across 60 wards in 16 hospitals that were already implementing the English and Welsh Cleanyourhands campaign, the study showed that an intervention that coupled feedback to personalised action planning improved hand-hygiene compliance by up to 18 per cent on Intensive Therapy Units (ITUs) and 15 per cent on Acute Care of the Elderly (ACE) wards. It was also found that soap use increased by 50 per cent.

“This is a landmark trial, as until now there has been no randomised controlled trial evidence showing which interventions improve hand hygiene compliance in modern hospitals,” said principal investigator Dr Sheldon Stone (UCL Medical School at the Royal Free Hospital). “It is also the first trial to use behavioural sciences to change health care workers hand hygiene behaviour.”

“The study suggests that the NHS should explore using the FIT intervention and learn how best to implement it, as used properly it can be a really powerful tool. The intervention, which couples feedback to personalised action planning, could be included in infection control teams’ audit and appraisal systems in order to reduce the burden of healthcare associated infection on hospital wards.”

The intervention process involved a four-week audit cycle, with healthcare workers observed for 20 minutes. Immediate feedback was given after the period of observation, and the person was then helped to form a personal action plan for better hand hygiene. The effect was stronger on ITUs than ACEs, where it was easier to implement. The more frequently wards carried out the intervention, the stronger its effect.

In addition to observing and measuring hand-hygiene compliance, the amount of soap and alcohol hand-rub used each month was also collected as another measure of hand-hygiene compliance for each ward. This also gave a better picture of the total weekly usage, as such data was not subject to any observational bias.

“Although audit and feedback is often suggested as a way of improving hand hygiene, this study puts its use on a firmer footing than previous non-randomised studies, providing the strongest evidence yet that this is an effective way to improve hand hygiene when coupled with a repeating cycle of personalised goal-setting and action planning,” said Dr Stone.
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The antimicrobial stewardship programme

Why is it important in dentistry? asks Andrew Smith and Noha Seoudi

The antimicrobial stewardship is a cornerstone in any infection prevention and control programme. Its self-funded nature is attributable to its great benefit to the patient and the community. It is well appreciated that the judicious use of antimicrobial therapy decreases the side effect of the medication, including the potentially lethal anaphylactic reaction, and prevents the development of highly resistant strains and their dissemination in healthcare and community settings. In the period between 2008 and 2010, the antibiotic stewardship programme initiated by the Scottish Antimicrobial Prescribing Group (SAPG) was successful in significantly reducing the incidence of Clostridium difficile infection in Scotland through optimising antimicrobial prescription along with implementing good infection prevention measures in hospitals and primary care (Nathwani et al., 2011).

The importance of the programme became fundamental in an era of widely spread highly resistant non-fermentative bacteria acquired infections such as methicillin resistant Staphylococcus aureus (MRSA), vancomycin resistant Staphylococcus aureus (VRSA), vancomycin resistant Enterococcus (VRE), Pseudomonas aeruginosa, Acinetobacter spp., extended spectrum beta lactamase producing Enterobacteriaceae and Serratia marcescens. With the increasing risk of encountering these multiple resistant microorganisms in the dental practice, we believe that the dental team members have a duty of care toward their patients and the community to avoid establishment and dissemination of such infections (O’Leary et al., 2011). Therefore, they should be trained on the appropriate use of antimicrobial agent for the prophylactic and therapeutic purposes.

There is a consensus between the guidelines of the American Heart Association (AHA, 2007) and the National Institute for Clinical Excellence (NICE, 2008) that the benefit of endocarditis prophylaxis for dental treatments is unproven. Therefore, NICE recommended no antibiotic cover for any patients receiving dental treatment. However, the AHA recommended antimicrobial cover only to those patients who are classified as “at risk” of infective endocarditis. In-剔除括号内文字-

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a 78.6 per cent reduction in antibiotic prophylaxis prescription (Thornhill et al., 2011).

Palmer and colleagues (2000) observed many inappropriate doses and frequencies of antimicrobial prescription, falling outside the guidance of the Dental Practitioners Formulary (DPF), when they evaluated the antibiotic prescription pattern by general dental practitioners from ten different health authorities in England (Palmer et al., 2000). As a general rule, the majority of dento-alveolar abscesses respond well to incision and drainage without the need for antimicrobial treatment apart from cases with evidence of spread of infection or systemic involvement such as lymphadenopathy and/or raised body temperature. The prophylactic antimicrobial therapy before wisdom teeth extraction and implant surgery is not currently recommended, provided that good surgical and aseptic techniques are maintained (Martin 2010).

Indeed, the Health Protection Agency in collaboration with the British Infection Associations are currently in the process of developing antimicrobial guidelines for the empirical treatment of dental infections directed towards the general medical practitioner and derived from the Scottish Dental Clinical Effectiveness Programme (SDCEP Guidelines, 2011).

We believe that, implementing prescription audits and feedback is one of the most successful strategies for the antimicrobial stewardship programme which can be easily implemented in the dental practice. Also the Department of Health approach “start smart and focus” can be adopted in the dental practice. This concept advise to “start smart” by avoiding any antimicrobial prescription in the absence of clinical evidence of bacterial infection, use the available guidelines to initiate a prompt effective antimicrobial treatment if justified, document any antimicrobial usage, obtain culture before the initiation of antimicrobial therapy, prescribe single dose only of antimicrobials for surgery prophylaxis if justified. The following step is to “focus” which means to review the diagnosis and the continuing need for antimicrobial treatment after 48 hours of prescription, make clear plan of actions “antimicrobial prescribing decision”, and document the decision (ARHAI, 2011).

References:
Superbugs ride air currents around hospital wards

Hospital superbugs can float on air currents and contaminate surfaces far from infected patients’ beds, according to University of Leeds researchers. The results of the study, which was funded by the Engineering and Physical Sciences Research Council (EPSRC), may explain why, despite strict cleaning regimes and hygiene controls, some hospitals still struggle to prevent bacteria moving from patient to patient.

It is already recognised that hospital superbugs, such as MRSA and C-difficile, can be spread through contact. Patients, visitors or even hospital staff can inadvertently touch surfaces contaminated with bacteria and then pass the infection on to others, resulting in a great stress in hospitals on keeping hands and surfaces clean.

But the University of Leeds research showed that coughing, sneezing or shaking the bed-clothes can send superbugs into flight, allowing them to contaminate recently-cleaned surfaces.

PhD student Marco-Felipe King used a biological aerosol chamber, one of a handful in the world, to replicate conditions in one- and two-bedded hospital rooms. He released tiny aerosol droplets containing Staphylococcus aureus, a bacteria related to MRSA, from a heated mannequin simulating the heat emitted by a human body. He placed open Petri dishes where other patients’ beds, bedside tables, chairs and washbasins might be and then checked where the bacteria landed and grew.

The results confirmed that contamination can spread to surfaces across a ward. “The level of contamination immediately around the patient’s bed was high but you would expect that. Hospitals keep beds clean and disinfect the tables and surfaces next to beds,” said Dr Cath Noakes, from the University’s School of Civil Engineering, who supervised the work. “However, we also captured significant quantities of bacteria right across the room, up to 3.5 metres away and especially along the route of the airflows in the room.”

“We now need to find out whether this airborne dispersion is an important route of spreading infection,” added co-supervisor Dr Andy Sleigh.

The researchers are hoping that computer modelling will help them determine the risk. The findings have been compared to airflow simulations of the mock-up hospital rooms and the research team have shown that they are able to accurately predict how airborne particles can be deposited on surfaces.

The international design and engineering firm Arup, which designs hospitals, part sponsored the study. Phil Nedim, director and global healthcare business leader at Arup, said: “We are looking at healthcare facilities of the future and it is important that we look at key issues such as infection control. Being involved in microbiological studies that inform airflow modelling in potentially infectious environments allows us to get a clear understanding of the risks in these particular environments.”

The paper “Bioaerosol Deposition in Single and Two-Bed Hospital Rooms: A Numerical and Experimental Study” is published in the journal Building and Environment.
The line-up is invariably impressive and this year again provided great education, reasons why we should reflect and consider myself very lucky against perhaps more conventional missions to Oral Maxillo-facial surgery. Professor Trevor Burke gave a presentation titled “Fool’s rush in...”; the main thrust of his discussion was regarding the evidence base that we should use to offer the very best use of materials when treating patients. The professor offered some insight into the evolution of composite materials yet examined the weak evidence base that is sometimes used to support the use of various materials as well as the longevity of restorations. He cleverly used several blank slides during his presentation to demonstrate the lack of evidence for certain materials; this man so engaging and as the talk progressed he used numerous versions of the song “fools rush in” to highlight aspects of his presentation.

A tough act to follow but Dr Lloyd Searson of Kings College certainly rose to the occasion with his presentation “...where angels fear to tread” where he discussed how poor planning of implants, their placement and combined with an examination of the levels of training that some feel adequate to place implants against perhaps more conventional accepted standards.

“When good enough” was just not good enough was presented by Dr Jason Leitch who is the Clinical Director of the Quality Unit in the Health and Social Care Directorate NHS Scotland. I have met this enigmatic gentleman on a few occasions and it is always a pleasure to hear him talk. He realised that the inequalities of healthcare standards in his native Scotland were outrageous-twisted as parts of Glasgow would have a very low life expectancy compared to other more affluent areas where there may be as much as a 15 years difference. But it was not as simple as that; he highlighted how that by applying set standards regardless of location that the patient journey is improved as well as the outcomes. This is however compounded by the lack of available funding due to these constrained times we are experiencing. Informative, clever and witty and he was quite kind to his predominately English audience.

The Premier Awards preceded lunch and were awarded as follows:

1st prize: Junaid Nayar and Mervyn Hustin (Dublin) for producing an audit checklist for panoramic radiography to reduce unnecessary exposures

2nd prize: Keri Fisher (Dental Nurse Warwick University) for work on extending the role of the Dental Nurse in orthodontic practice; auditing and assessing quality of impressions and clinical photographs.

1st prize: Alison Lowe (dental hygienist Cardiff) for a literature review of the workplace prevalence of musculo-skeletal disorders amongst dental hygienists. (Alison is a second time winner of this award so a special congratulations to her)

For postgraduate:

2nd prize: Douglas Lovelock for his rewrite of Chapter 12 of Master Dentistry Volume 3.

1st prize: Maha Meher for her work on an audit of record keeping regarding acute admissions to Oral Maxillo-facial department.

Congratulations to all winners, runners up and those who submitted work.

After a hearty lunch Dr Gerald Hickson MD presented a lecture titled “Treat me nice, treat me good (treat me like you really should)” which focussed on what patients can and should expect from those delivering healthcare. From Tennessee, USA, this delightful man entertained and informed on what leads to many cases of litigation in the USA. Communication is a vital tool in any healthcare workers job yet it seems that many of those who have numerous law suits against them lack effective communication skills; by implementing peer based assistance for his colleagues, he has helped reduce litigation brought against those who work for the organisation he is involved with and how the patient journey is also improved.

To finish the day we were treated to some new core CDP by Professor Mark McGurk who examined “Medical Risks in a complex world”. The first part concentrated on looking at and identifying lesions in and around the oral cavity and he also demonstrated that our inability to receive and full social and medical history from our patients is letting us and patients down. The simple act of ticking boxes has taken us away from really “drilling down” with our patients to examine those risk factors that we should really be paying attention to especially when our patients have a history of smoking and chronic illness and have very complex medical histories. He also highlighted the very new risks presented to us by new medical therapies that we as practitioners may not be paying enough attention too.

A thoroughly entertaining day which any team could have attended; you should perhaps consider it next year and I hope I get invited again.

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What’s the worst that can happen?
Michael Sultan discusses treatment planning

When I was young, my mother – bless ‘er – always used to say to me, “Michael, you should always ask a girl to dance – after all, what’s the worst that can happen? She can only say no!” Oh how wrong she was… Children can be very cruel sometimes, and as a shy young man growing up into the world I learnt, as I suspect many of us have over the years, that my mother was wrong, and her philosophy of always asking a girl to dance would on occasion lead to my complete and utter humiliation.

Advice
But now, many years later, in my work as a dentist I do still find myself thinking about my mother’s advice, and that age-old phrase, “what’s the worst that can happen?” Though obviously used in a completely different context, I do find it an interesting phrase, and one that particularly applies to the process of treatment planning.

As dentists, sometimes we are involved in doing a treatment that if it fails could have a worse outcome than the second option that may be less desirable for the patient, but safer. Unfortunately, we can’t always avoid it. It may be the case for example that the patient can’t afford to pay for a replacement, or health and age factors mean they are unsuitable for alternative procedures. In some cases it may even be something as simple as the patient is adamant they don’t want to lose their tooth.

In endodontics I can think of numerous instances where a patient’s call for a “heroic” procedure can sometimes lead to the result being far worse than the initial complaint. If it works, then great – amazing – you’ve saved a tooth that most dentists would have signed to extraction. If it fails, however, then even extraction may have been a better option long term.

A good example of just this type of risky procedure might be apical surgery on a tooth with both an uncertain prognosis and a failing endodontic procedure. The surgery may involve removing a lot of buccal bone that may make an implant harder to do later should there be no healing.

Herodontics
Though the above may be a fairly straightforward example of “herodontics” there are other, less clear-cut cases as well. Sometimes we will be called to attempt herodontics to try and prolong the life of
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extensive and expensive treatment, such as resecting roots and teeth from larger bridges to keep the restoration going for longer in an elderly patient. Often we know that it’s a compromise – it’s fairly obvious what we’re waiting for! With an aging population and life expectancy ever-increasing, compromises that we may have once made in a 65 year old we may now have to make in an 85 year old instead.

With patients on average living a lot longer than in the past, I do find myself increasingly dealing with patients in their 70s who ask me if it’s worthwhile spending money on a complex and risky endodontic procedure when it may be cheaper and easier just to have the tooth out instead. This poses something of a dilemma. If the patient were in their 50s say, you could outline with some degree of certainty the advantages and disadvantages of having a fully restored natural tooth for the next 20 years, as compared with a large gap. To have this discussion with a 70-year-old however, it may be a case that they will have a gap for a few more years, or they may yet live another 50 or more! The oldest patient I’ve treated for root canal therapy is 100 and she certainly didn’t want her tooth out!

When heroic procedures work, they can be fantastic; they can give a great feeling of satisfaction to the clinician and of course the patient benefits by retaining their tooth. But these things must be taken in careful consideration. Heroic procedures “beyond the normal call of duty” don’t always work, and if they fail, then sometimes the outcome will be worse than the initial complaint. For this reason we should always carefully weight up the risks, consider all the possible implications, and ask ourselves, very seriously, “what’s the worst that can happen?”

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About the author
Dr Michael Sultan BDS BDSc (FGDP) FICD is a Specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies in Endodontics and was an in-house Endodontist in various practices before setting up in Harley St, London in 2000. He completed his BDSc in Endodontics in 1993 and worked as an in-house Endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1995 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPE, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008 he became clinical director of EndoCare, a group of specialist practices. For further information please call EndoCare on 020 7224 0999. Or visit www.endocare.co.uk

‘The oldest patient I’ve treated for root canal therapy is 100 and she certainly didn’t want her tooth out!’
Complete the Jigsaw pt 2

Michael McCallion of FT&A Medical Recruitment offers practices and principals some useful advice to find that right member of staff...

Y
ou've bought the practice of your dreams. You have invested a considerable amount of time, effort and money into fitting it out to your exact specification. You almost have the team of your dreams to go with, but not quite. There is that one key position that still needs to be filled. Whether it be associate, hygienist, practice manager or nurse, it can be difficult to find that perfect person to be that final piece. What advice can we give to make the process run more smoothly?

- Sit down and plan exactly what and who you want. I wouldn't be telling tales too much if I told you that a large number of principals come to us who haven't really thought the role through or who the ideal applicant would be. Be honest and open about this – it will save a lot of time and trouble in the long run.

Pay peanuts, get monkeys
- Salary. If you pay peanuts, you will get monkeys. Have a realistic expectation of what the role is worth. You cannot expect staff to buy into your practice vision and go the extra mile if you do not reward them accordingly.

Specification
- Prepare a full job specification. Leading on from the last point, you need to consider:
  - Duties and responsibilities of the role
  - Pay and Conditions
  - Temporary, Permanent or Locum?
  - Start Date
  - Staff Benefits
  - Contract and Terms
  - Probationary period
- What form will the interview process and procedure take? The days of an informal chat in the saloon bar of the Dog & Duck have gone! Do not be afraid to go to multiple interviews. If you are still not sure then don't feel that you have to make a decision. Take a step back and ask yourself why you are unsure?

Nursing and reception staff
- They are the ‘face of dentistry’, many of your patients will have more interaction with them than they do with you. Consider carefully.
- Flexibility. For instance, if it is proving a struggle to fill a full-time role, what about a job share or a locum?
- Consider the costs of getting it wrong. As well as having to start the whole process again, there could be costs to your practice’s reputation and patients do not relish the idea of seeing someone different every time – just ask Boots & Co.

Dentalcare.
- Are you an expert in recruitment? Think very carefully about managing the process yourself. It is no longer just a case of putting an ad in the BDI, seeing the responses flood in, and employing the candidate you struck up a rapport with in a brief meeting. Employment law has changed a lot over the years and there is now so much more to consider. Also, what hourly rate do you need to make to ensure that the practice can run at a profit? If you aren't doing dentistry, you aren't earning money.
- An agency can take away the headache of the process. When choosing an agency make sure that:
  - Their fees are open and transparent
  - They are experienced with a high profile in dentistry
  - They are experts within the sector
  - Their approach to candidate selection is rigorous
  - They are members of the Recruitment and Employment Confederation
  - Having chosen your agency, ensure that you talk to them.

Give them candidate feedback, changing of terms information – whatever it takes to make the process run more smoothly. You are likely to have more than one recruitment requirement over the years – build a relationship with the agency for the long-term.

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About the author

Michael McCallion is the Business Development Manager of FT&A Medical Recruitment. Michael has huge experience in healthcare recruitment having worked in the sector for over 7 years, initially helping provide the right medical and dental staff to the MoD and the NHS. He then worked as Business Development Manager for an agency that supplied the private as well as the public sector.

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Practice Management 25
last month, we looked at the types of unincorporated business structures that a dentist can opt for when setting up a new practice. This month, we will focus on corporate business structures.

One of the hot topics at the moment is incorporation. Traditionally, dental practices have operated as sole practitioners, principals or partnerships; however, the tax benefits available through incorporation are tempting increasing numbers of dentists to give their business a legal personality of its own.

Specialist dental accountants have estimated that a typical dental practice a practitioner could save considerable sums annually by incorporating. The savings are achieved by reducing or eliminating the amount of tax paid at 40 per cent and reducing the national insurance liability. There may be some additional administrative costs associated with operating as a company but these are likely to be minimal compared to the level of savings that may be achievable. We certainly recommend that specialist dental accountant advice is obtained from a member of National Association of Specialist Dental Accountants and Lawyers (‘NASDAL’) about the financial implications of incorporation in relation to your own practice before making any decisions.

Quite apart from the potential savings, there are other benefits that can arise on incorporation, particularly with regard to the limitation of liability and the ability of companies to transfer their business by means of share transfers. As a sole practitioner or partner, while the majority of the practice’s liabilities are likely to be covered by insurance, if things do go wrong, a dentist could suffer huge personal losses.

Where there is a company structure, the company is a legal person in its own right and bears the liability itself. Shareholders are only liable for the fixed amount expected to be paid for their shares when they become shareholders (in most cases this amount will have been paid on subscription) if the company goes under. Note, however, for new companies with minimal capital, banks and land-
the practice, incorporation of an NHS practice is not without obstacles. The following should be borne in mind.

- **PCT consent** – Whilst PDS practices will be familiar with obtaining PCT consent for any contractor changes, GDS contractors have the freedom of utilising a partnership mechanism to buy and sell the practice. Generally, incorporation would provide some flexibility over the sale of the practice (through sale of shares) but some PCT’s may request the insertion of ‘change of control’ provisions in the NHS contract, or seek to reduce the contract value, which may hinder or prevent the future sale of the practice and thus the subsequent realisation of goodwill.

- **PDS contractors** should also note that unlike GDS, the NHS Act 2006 limits the type of shareholder who may hold shares in the company. These limitations effectively require all of the shareholders to be individuals eligible to hold a PDS Agreement in their own right. However, it is worth noting that the class of individuals who can hold a PDS Agreement is broader than with GDS and includes employees of NHS practices.

Understanding incorporation and its suitability for your business are important initial considerations and we recommend that you obtain specialist legal and accounting advice before making any decisions.

Next month: Financing the Practice and Choosing the Right Location and Premises.

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**About the author**

Andrew Lockhart-Mirams is the Senior Partner of Lockharts Solicitors and leads the Commercial Team primarily specialising in business advice and structures in dentistry and commercial aspects of dentistry.

Puja Patel is a member of the Commercial Team at Lockharts and works primarily in advising dentists, dental care professionals and dental corporate bodies on the commercial aspects of dentistry.
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End of an era draws near for historic dental practices

Growing legislative pressure will soon see an end to period houses being used as dental practices, predicts Roger Gullidge of Roger Gullidge Design.

The demands of legislation including HTM 01-05 and the Disability Discrimination Act are incompatible with the challenges of seeking Listed Building Consent, Conservation Area Consent and Planning Permission, he says.

“If you apply for Listed Building Consent to divide up rooms in a classic Georgian or Victorian Terrace to fit in a Local Lcommodation Unit, you are not likely to succeed says Roger. The whole process becomes unavailing and you will essentially be compelled to move. The ability to extend and modify newer buildings, and the reduced complexity involved in connecting them to modern communications, networks makes them far more practical locations for dental practices. The wider availability of parking spaces and improved disabled access can also make them more appealing to patients.

Roger Gullidge Design is a specialist design and project management consultancy specialising in the dental sector. Call 01728 794442 for more details or visit www.rogergullidge.com

Spry Toothgel with xylitol – the perfect way to keep childhood caries at bay

We all know it’s important parents introduce their children to good oral hygiene habits from an early age. To help give children the best start possible, recommend Spry Toothgel with xylitol for the perfect way to keep dental caries at bay.

Xylitol is a naturally occurring sweetener that is proven to be a powerful tool in the fight against tooth decay. Thanks to its unique chemical composition, xylitol is unfavourable to the metabolism of plaque bacteria, reducing their ability to proliferate and adhere. This makes xylitol an excellent tool in the fight against dental caries.

Available in a handy 60ml tube, Spry Toothgel is a great way to introduce children to xylitol and hygiene comes in a child-friendly flavoured format with a great taste, making teeth cleaning even more fun.

Based on all natural ingredients, Spry Toothgel is completely safe for infants – it’s even safe to swallow immediately. So very young children can be used to gently massage into gums and teeth or can be used in conjunction with Spry Baby Banana Brush as the ideal introduction to regular brushing.

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Also featured in the new Waterpik® Complete Care package is the innovative Waterpik® Water Flosser. Utilising a unique combination of water pressure and aeration, the Waterpik® Water Flosser creates a deep cleaning action between teeth and below the gumline, removing harmful bacteria that traditional flossing can’t reach. Indeed the product is so effective, the Waterpik® Water Flosser has been scientifically proven to remove 99.9% of plaque biofilm after only a 3-second treatment. For comprehensive comfort in a streamlined, single unit, Waterpik® Complete Care offers easy and more effective brushing and flossing, all in one device.

For more information please speak to your wholesaler or visit www.waterpik.co.uk Waterpik® products are widely available in Boots stores, Argos and selected Lloyds Pharmacies.

End of an era draws near for historic dental practices

Growing legislative pressure will soon see an end to period houses being used as dental practices, predicts Roger Gullidge of Roger Gullidge Design.

The demands of legislation including HTM 01-05 and the Disability Discrimination Act are incompatible with the challenges of seeking Listed Building Consent, Conservation Area Consent and Planning Permission, he says. ‘If you apply for Listed Building Consent to divide up rooms in a classic Georgian or Victorian Terrace to fit in a Local Lcommodation Unit, you are not likely to succeed says Roger. The whole process becomes unavailing and you will essentially be compelled to move. The ability to extend and modify newer buildings, and the reduced complexity involved in connecting them to modern communications, networks makes them far more practical locations for dental practices. The wider availability of parking spaces and improved disabled access can also make them more appealing to patients.

Roger Gullidge Design is a specialist design and project management consultancy specialising in the dental sector. Call 01728 794442 for more details or visit www.rogergullidge.com

Spry Toothgel with xylitol – the perfect way to keep childhood caries at bay

We all know it’s important parents introduce their children to good oral hygiene habits from an early age. To help give children the best start possible, recommend Spry Toothgel with xylitol for the perfect way to keep dental caries at bay.

Xylitol is a naturally occurring sweetener that is proven to be a powerful tool in the fight against tooth decay. Thanks to its unique chemical composition, xylitol is unfavourable to the metabolism of plaque bacteria, reducing their ability to proliferate and adhere. This makes xylitol an excellent tool in the fight against dental caries.

Available in a handy 60ml tube, Spry Toothgel is a great way to introduce children to xylitol and hygiene comes in a child-friendly flavoured format with a great taste, making teeth cleaning even more fun.

Based on all natural ingredients, Spry Toothgel is completely safe for infants – it’s even safe to swallow immediately. So very young children can be used to gently massage into gums and teeth or can be used in conjunction with Spry Baby Banana Brush as the ideal introduction to regular brushing.

For further information contact Anyone 4 Tea Ltd on 01484 625131, or visit www.anyone4tea.co.uk

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Introducing the first in a new expert range from LISTERINE® – a twice-daily mouthwash built on potassium oxalate crystal technology that blocks dentine tubules deeply for lasting protection from sensitivity.2,3

In just six rinses Advanced Defence Sensitive blocks 92% of dentine tubules; twice as many as the leading recommended pastes.1,4

It can be used alone for lasting protection,3 or in combination with the most recommended paste from the leading sensitivity brand, to significantly increase the number of tubules the paste blocks in vitro.4,5

* Based on % hydraulic conductance reduction

References:
1. Dentine Tubule Occlusion, DOF 1 – 2012.

Do not recommend this product if patients have a history of kidney disease, hyperoxaluria, kidney stones or malabsorption syndrome, or take high doses of vitamin C (1000mg or more per day).