A new study has revealed that old-fashioned, manual faucets work better than new hands-free faucets.

The latest electronic-eye sensors to automatically detect hands and dispense pre-set amounts of water have been installed in the USA based Johns Hopkins Hospital, however a study has shown that they were more likely to be contaminated with one of the most common and hazardous bacteria in hospitals compared to old-style fixtures with separate handles for hot and cold water.

“Newer is not necessarily better when it comes to infection control in hospitals, especially when it comes to warding off potential hazards from water-borne bacteria, such as Legionella species,” Lisa Maragakis, MD, M.P.H. senior study investigator and infectious disease specialist, was quoted. “New devices, even faucets, however well-intentioned in their make-up and purpose, have the potential for unintended consequences, which is why constant surveillance is needed,” says Maragakis, director of hospital epidemiology and infection control at Hopkins Hospital and an assistant professor at the Johns Hopkins University School of Medicine.

Although the new style high-tech faucets cut daily water consumption by well over half, Johns Hopkins researchers identified Legionella growing in 50 per cent of cultured water samples, which were collected from 20 electronic-eye faucets. In comparison, the bacteria were found in only 15 per cent of water cultures from 20 traditional, manual faucets. Reports even stated that weekly water culture results also showed half the amount of bacterial growth of any kind in the manual faucets than in the electronic models.

The precise reason as to why there is a higher percentage in bacterial growth on the hands-free taps is still unknown; however, researchers have suggested that the valves offer additional surfaces for bacteria to become trapped and grow.

The Johns Hopkins researchers presented their findings at the annual meeting of the Society for Health Care Epidemiology (SHEA) in Dallas in April.

Infection control experts behind the latest study say that the electronic devices were widely introduced in patient care and public areas of hospitals across the United States, where the idea was to prevent bacterial spread from people touching the faucet's water handles with their dirty hands.

Reports have stated that as a result of the study, which was conducted over a seven-week period from December 2008 to January 2009, Johns Hopkins facilities engineers removed all 20 newer faucets from patient care areas and replaced them with manual types. A hundred similar electronic faucets are also being replaced throughout the hospital, and hospital leadership elected to use traditional fixtures – some 1,080 of them – in all patient care areas in the new clinical buildings currently under construction at Johns Hopkins' East Baltimore campus. The new buildings are set to open in 2012.

Lead study investigator Emily Sydnor, MD, a fellow in infectious diseases at Johns Hopkins, says Legionella bacteria, commonly found in water supplied from public utilities, rarely cause illness in people with healthy immune systems, but pose a real risk of infection in hospital patients whose immune systems are weakened from cancer chemotherapy, anti-rejection drugs after organ transplant, or from diseases such as HIV/AIDS.
S ubstandard hygiene pro-
cedures used in the medi-
cal profession should nev-
er be tolerated. It not only puts
your patients in danger, it can
also put you and your team at
risk. It is necessary, therefore,
to enlist the use of the most
efficient methods of infection
prevention in your surgery. To
this end, it is essential that your
dental team are fully trained in
all methods of decontamination
and informed as to the different
types of harmful bacteria that
can lead to diseases, such as
MRSA and C.diff. Furthermore,
relevant inoculations should be
taken by all staff and recorded.

Before any decontamination
regimes can proceed, it is im-
portant to remove and replace
all disposable equipment in
the surgery after each patient.
Then, all areas and instruments
should be ‘zoned’ into ‘clean’ and
‘dirty’ sections. It is worth noting
that you should always clean
from the cleanest to the dirtiest
areas when decontaminating
any surface.

Decontamination can be
used as an umbrella term to in-
corporate cleaning, disinfection
and sterilisation procedures.
In the dental profession, this is
necessary for maintaining the
hygiene of surfaces and the re-
processing of instruments.

Cleaning
This removes foreign particles,
such as dust, from surfaces. It
is also the preliminary step in
reprocessing instruments, and
should be done as soon as pos-
sible after their use. It is vital for
the successful sterilisation of
equipment as debris can shield
microbes from the steam of the
autoclave.

Disinfection
This process aims to kill patho-
gen or render them inert. It is
most often achieved using bac-
tericidal cleaning agents that
are effective against a wide
range of microorganisms.

Sterilisation
The ultimate stage in instru-
ment reprocessing, sterilisa-
tion destroys all forms of
microbial life, including bac-
terial spores. It is a process
crucial for those ‘critical risk’

Richard Mugrave discusses cleaning and disinfection

Infection prevention
Cleaning removes foreign particles such as dirt from surfaces with the surface. This is enough, although the minimum of one or two minutes using such a disinfectant will generally suffice. However, at least fifteen minutes. However, in the surgery, alcohol-based solution for at least十五 minutes. However, appliance is in contact with an infection product. Clarification is needed to bind blood and fix protein and therefore to prevent alcohol from being shown to be effective. However, it would be prudent to use aldehyde-free solutions.

The largest area in the surgery is the floor and, as such, it is a potential field for pathogens to thrive. Look into using a powerful disinfectant with strong particle loosening properties. It is important to remember the type of materials you are cleaning and disinfecting. Sensitive materials in the surgery, such as leather and soft PVC are vulnerable to strong alcoholic chemicals, so gentle, alcohol-free solutions would be advisable. Tougher materials, such as glass, ceramics and laminate work surfaces can be cleaned and disinfected with alcohol-based products; however, it would be prudent to use aldehyde-free solutions.

Successful cleaning and disinfection products frequently contain alcohol and yet, section 6.57 of the Department of Health’s HTM 01-05 regulations recommend caution when using alcohol-based products, especially on stainless steel, as alcohol has been shown to bind blood and fix protein and biofilm. Clarification is needed here as this only occurs if the appliance is in contact with an alcohol-based solution for at least fifteen minutes. However, using such a disinfectant will only be in contact for a maximum of one or two minutes with the surface. This is enough time for harmful bacteria and viruses to be destroyed, but nowhere near enough to fix any proteins.

For more information call 0114 2545500 or visit www.schülke.co.uk

Also view their surface decontamination website at www.comparethemikrozid.com

For infection control training visit www.s4dental.com

Cleaning is the primary step in reprocessing instruments

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The areas the DBG assesses are:

- Your premises including access, facilities, security, fire precautions, third parties and business continuity plans.
- Information governance including Freedom of Information Act, manual and computerised records, Data Protection and security.
- Training, documentation and certificates.
- Radiography including IRR99 and IR/MEIR2000 compliance.
- Cross infection and decontamination including HTM 01-05 compliance and surgery audits.
- Medical emergencies including resuscitation, drugs, equipment and protocols.
- Training, documentation and certificates.
- Waste disposal and documentation and storage.
- Practice policies and written procedures.
- Clinical audit and patient outcomes including quality measures.

About the author

Richard Musgrave brought his knowledge and experience to schülke 4 years ago. Initially working to develop both the range of infection control products as well as the acclaimed infection control training division. Richard is now responsible for the UK marketing team. He attributes the success of Schülke to the quality of its product and its dedication to providing the best possible support to the dental profession, both in the UK and beyond. This commitment is demonstrated through schülke’s association with leading companies such as Dental Protection Limited.
The increased awareness of decontamination and cross infection control procedures within dentistry and legislative demands for compliance with HTM 01-05 have made practices consider their obligations in regard to infection control more seriously. Of all the aspects of decontamination mentioned in the guidelines one area that practices may be unaware of is their need to comply with a minimum standard of water quality, both in terms of the water going into their treatment centre and certainly in regard to the output quality of that water i.e. the water that goes into the patient's mouth.

The problem of biofilm contamination of DUWLs has long been an issue in dentistry, research as early as 1963 first raised concerns and since then numerous studies have concluded that biofilm is prevalent in dental unit water lines (DUWLs). This is mainly due to the fact that in the majority of today's most commonly used treatment centres, water is delivered via small bore tubing, providing an ideal environment for the development of bacterial biofilms. The biofilm itself gives rise to problems in two key areas: one, the physical restriction of the flow in narrow lumens and two: in significant numbers of planktonic bacteria in the output water.

Biofilm
The term biofilm refers to a collection of microorganisms that adhere to a surface and are surrounded by a protective and adherent slime (known as the extracellular matrix) which is secreted by the bacteria. Biofilms are particularly prevalent in water containing low concentrations of solids and low levels of nutrients. As well as DUWLs, biofilm can be found in streams and rivers, cooling towers and piped water systems etc.

Biofilms form when a few individual bacteria in the free floating (planktonic) state in water adhere to a solid surface such as the wall of a pipe or tube. The initial attraction to the surface is weak, but subsequent bacteria continue to adhere directly to those already attached and behaviour of the aggregated organisms changes and starts to produce an extra-cellular matrix. This in turn increases adhesion and enables more planktonic bacteria to adhere easily to the film, and so the process continues, increasing levels of biofilm and causing water quality levels to fall below those required by the guidelines.

Significance of biofilms in the dental practice
Biofilm is difficult to identify, remove or control because the susceptibility of biofilms to external agents such as detergents and disinfectants is quite small when compared with that of individual planktonic organisms and each biofilm bacterium requires only small amounts of nutrients in order to survive and flourish. Furthermore, the design of today's most commonly used treatment centres makes the dental unit water line the ideal substrate for biofilm growth.

DUWLs provide an ideal environment for the growth of bacterial biofilms for the following reasons:

- They are non-toxic; the materials used for tubing are selected for their non toxic properties and flexibility to suit the mechanical operation of dental units. Low toxicity to humans also means...
low toxicity to bacteria.

- Water has a low flow rate: the small bore tubes used in dental units provide water at a typical flow rate of 50ml/min. The behaviour of water flowing through a tube means that the linear flow rate decreases from the centre of the tube to its wall. Low linearflow rates favour bacterial adhesion.

- Water flows intermittently: water only flows through the tube when instruments are in use, causing minimal disruption of the growing biofilm.

- Regular replacement of super-natant liquid: when instruments are used or the system is flushed, fresh liquid is brought into contact with the film, bringing with it nutrients and new recruits to join the film. The liquid moving downstream towards the distal end of the system carries bacteria released by the maturing film. The liquid moving downstream provides and the flushing of water can be used to reduce contamination and include the emptying and storage of water bottles at the end of each working day, the use of disinfectants “periodically” as a prevention measure, although no definition of “periodically” is provided and the flushing of water lines; “for two minutes at the beginning and end of the working day and after breaks. They should also be flushed for 20-30 seconds between patients.” Despite this recommendation however, the guidance acknowledges that flushing has little effect on biofilm build-up.

- The surgery provides an ideal temperature range: dental surgeries are normally maintained at “room temperature” for the comfort of patients and staff. This is good news for the film-forming bacteria as they can thrive in this temperature range.

Why is biofilm bad for the practice?

The presence of biofilm is bad news for the dental practice on a number of practical levels not least because the quality of output water is covered by HTM 01-05 guidance and the presence of biofilm makes compliance with this standard very difficult. The existence of biofilm can lead to a reduction in water flow and even tube blockage leading to unit downtime and repair costs. In addition, biofilm can potentially accommodate large numbers of bacteria without any noticeable change in colour or smell and these symptoms are not an accurate indication of whether water lines are contamination free.

Biofilms form when a few individual bacteria in the free floating (planktonic) state in water adhere to a solid surface such as the wall of a pipe or tube

The guidelines do clearly state the acceptable maximum level of microbiological contamination in section 6.79 "Where monitoring is carried out the microbiological contamination expressed as TVC (total viable count), the number of viable bacteria per litre of water [cfu/ml] should be expected to lie in the range 100 to 200 cfu/ml." This is similar to the quality that would be expected for mains supplies or bottled water.

The guidelines then go on to indicate a range of measures that can be used to reduce contamination and include the emptying and storage of water bottles at the end of each working day, the use of disinfectants "periodically" as a prevention measure, although no definition of "periodically" is provided and the flushing of water lines; "for two minutes at the beginning and end of the working day and after breaks. They should also be flushed for 20-30 seconds between patients.” Despite this recommendation however, the guidance acknowledges that flushing has little effect on biofilm build-up.

How clean is your water?

For many years the problem of biofilm in DUWLs has been studied and data collected that clearly demonstrates the presence of biofilm reduces water quality, making it unlikely to meet the minimum standards required by HTM01-05. In a study by Walker et al 2003, 85 per cent of samples taken from DUWLs had contamination levels above the current standard for EU drinking water. So in order to establish the quality of output water a practice needs to be aware of the quality of its input water and then regularly monitor levels of contamination.

To magnify safety and increase ease of use, Septodont has the solution.

As the world leader in pain control, Septodont understands the increasing need for safe, simple product solutions for your local anaesthetic procedures. This commitment has made Ultra Safety Plus the standard for needle stick protection.

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For over two years now, a man -
tamination.

Effective solution
For over two years now, a manufac-
turing company based in Derby has been studying bio-
films in DUWLs and the as-
associated water quality in these sys-
tems. Extensive laboratory
evidence has been collected and
has clearly shown the challenge of
managing DUWLs within the
DH guidelines. The presence of
biofilm in a DUWL system will
add bacteria to the TVC of the
input water, so to have any
change of compliance, the input
water TVC must be well below
the 200 cfu/ml limit.

The development by Den-
tisan of Bioclear as a solution to
the problem of biofilm was a
direct response to the research
findings. The challenge was to
develop a material that meets
all the needs of the dental prac-
tice in terms of ease of use, re-
liability and safety and yet is
effective in controlling and pre-
venting biofilm and at the same
time not harmful to the dental
equipment itself.

Practical development work
was undertaken at Nottingham
University School of Biosciences
using an initial grant provided by
Medilink, and in lab trials Den-
tisan was able to clearly demon-
strate that Bioclear has proven
efficacy against the bacteria that
make up biofilm, inhibiting re-
growth of the film and enabling a
system to maintain water quality
of < 200 cfu/ml, in line with HTM
01-05 section 6.79, subject to in-
put water quality.

Bifilm was grown in a flow cell
using bacteria obtained from
a dental unit water line sam-
ple and allowed to develop for
10 weeks, the images show that
the Pseudomonas aeruginosa
biofilm was effectively removed
by the product flowing through
the cell.

Bioclear
Bioclear is a pH neutral, odour-
less, non-tainting, ready-to-
use solution that requires no
mixing. Supplied in one-dose
bottles (one bottle is one week's
treatment per chair), Bioclear is
simply poured into the chair's
water bottle, drawn through so
that it fills the water lines and left
for a minimum of 12 hours. Once
the treatment is complete the
lines should be flushed through
with fresh water until the water
runs clear.

Award Winning
The work undertaken in the de-
velopment of Bioclear has been
recognised by a number of bod-
ies and 2010 and 2011 have been
awarded winning years for Den-
tisan. Starting with the Lord Staf-
ford Awards, which celebrate inno-
ciations between businesses and
Universities, Dentisan secured the ‘Innovation
Achieved’ title, quickly followed
by becoming Regional Winners
and National Finalists in the
HSBC Business Thinking 2010
Awards in which Dentisan were
commended for their ability to
identify and meet market needs
and for the significant inroads
they have made in healthcare
and dentistry, by establishing
their own brand premium infec-
tion control solutions.

2011 has continued in the
same manner when last month
Dentisan’s parent company
Quadralene was awarded the top
prize for Outstanding Achieve-
mant at the Medilink UK awards
2011 – an annual event that
celebrates the latest technologies,
outstanding business achieve-
ments and international success
across the UK Life Sciences sec-
tor.

The Solution
Dentisan believe that the de-
velopment of Bioclear can make
a huge contribution to the preven-
tion and control of biofilm and
make DUWL decontamination
a problem of the past.

To combat the problem of
biofilm in your practice requires
you first to establish the current qual-
ity of both input and output wa-
ter. Although there are differing
ways to carry out this procedure,
in order to simplify the process,
Dentisan in association with
Henry Schein Minerva are pro-
viding a water quality test, free
of charge. This simple test uses
the 5M™ Clean-Trace™ Solution,
takes a matter of minutes and is
carried out by Henry Schein Min-
erva’s field sales consultants in
your practice.

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The simplest of methods

Richard Musgrave discusses how to prevent infection through safe hand hygiene

The hands are a dental practitioner’s most important tool and as such need to adhere to the same stringent methods of cleaning as all other equipment used in the surgery. Both patients and staff can be put at serious risk of infection from pathogenic invaders as a result of lethal bacteria being spread around the practice environment by touch. This makes good hygiene protocols a must to prevent infection transmission within a clinical environment.

For instance, it is essential that before any surgery begins, any cuts or lesions on the clinician’s hands must be securely covered with a waterproof dressing before touching a patient’s mouth, as blood or saliva born viruses can enter or leave the body via open wounds.

The simplest method to ensure the removal of germs is the thorough washing of hands, and if you use the correct hand washing procedure with just hot water and soap, you should be able to destroy the majority of bacteria.

All jewellery should be removed before washing as pathogens also collect on them. The best washing procedure for your hands using soap and water should involve:

- Rotational rubbing of thumbs clasped in opposite palms
- Rotational rubbing of finger-tips in palms

This should take around 30 seconds and is more effective with a liquid wash solution. You should then rinse your hands thoroughly under running water. It is essential that this procedure is performed meticulously not only after visiting the toilet and before handling food or drink but also upon entering the surgery, before putting on gloves, after removing gloves, before leaving the surgery and after clearing a working area or handling any instruments.

Washing is made more effective when combined with the use of gloves and disinfecting alcohol rubs. The latter is very effective in reducing the spread of lethal bacteria such as MRSA on the hands of dental staff.
However, there may be some side effects in the regular use of skin-cleansing products, as it can be detrimental to the condition of the skin. Indeed, weaker skin is more prone to skin complaints and cracking and this can deter some practitioners from being quite so strict in their hygiene.

In addition, occupational skin disease such as eczema, are on the increase in medical circles and can be exacerbated through excessive washing with perfumed soaps.

Therefore, it is important that professionals do not leave themselves open to long term suffering. To this end, a delicate balance is required to ensure that hands not only remain hygienic, but also that the professional does not suffer any ill effects.

To help this, use soap-free hand washes and find a rub that can minimise dryness and irritation. In addition, at the end of each clinical session after washing and drying your hands, enlist the use of a water-based moisturising cream or lotion to maintain healthy skin on hands and arms.

Allergies are also a severe issue for many people, and these can be linked to perfumes, colours and materials, such as latex. Those with such allergies can struggle to deal with them in a clinical environment, as the materials that trigger them are so crucial to the infection control procedures used in many surgeries.

For example, the natural rubber latex (NRL) is the material used in the manufacture of medical gloves and yet the number of people with allergic reactions to it is on the increase, especially among those in the medical field.

These reactions are due to the naturally occurring proteins within the material or many other additives used within poorer quality gloves and can result in a red itchy scaly rash, which may spread to other areas.

Direct contact is not the only thing that can trigger these reactions either. Inhaling latex powder from powdered gloves can also lead to these severe issues and in the worse cases, anaphylactic shock.

When wearing gloves is a necessity for your work in the dental industry, such allergies present a real obstacle in maintaining hygiene regimes. However, this problem is recognised by many supplies of gloves and as such, latex-free surgical gloves are now available. These can be worn without discomfort whilst still upholding rigorous infection control policies.

With the heightened awareness of infections and viruses in the healthcare environment, complying with the new HTM 01-05 requirements regarding hand hygiene should be essential to every practitioner.

The best products should be used in the washing, disinfecting and moisturising of their hands. However, practitioners need not put themselves at risk in order to have the most effective solutions.

With this in mind, suppliers, have produced hand disinfectants, along with soap free hand washes and protective emulsion with the aim of getting the perfect balance between infection control and your comfort.

All staff members should be advised to use hand-cleansing products, such as these, to give themselves and their patients the best protection possible from detrimental pathogens.

Therefore, it is important that professionals do not leave themselves open to long term suffering. To this end, a delicate balance is required to ensure that hands not only remain hygienic, but also that the professional does not suffer any ill effects.

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How we did it

*Dental Tribune* talks to practice manager Janet Edwards on infection control

With all the changes to dentistry with HTM 01-05 and CQC, one practice has adopted the guidelines to suit them and work with their practice and not against it.

The changes that have been made at Hoghton Street Dental Practice has generated masses of attention; practice manager Janet Edwards has been invited to speak at this year's BDA conference and Schülke UK used Hoghton Street Dental Practice for the re-filming of their training packages in infection control.

Janet talked to *Dental Tribune* about their experience and how they achieved and managed to comply in the best way that they could...

"In the beginning we went in to it blind with just the BDA guidance on infection control. To enable us to create a sterilisation room we took over another part of the building that our practice was in. We relied a lot on our equipment supplier, Eschmann, and Martin Loftus, Business Development Manager at Eschmann, was a great help. Martin helped us with the design, setting up the flow-through and the completion of the room. Initially we had looked at dividing the room in to two rooms but due to practicalities, it was decided that it was best to leave it as it was. In the room itself we’ve got four underbench washers and four autoclaves and at my other branch site I’ve got three underbench washers and four autoclaves. We basically complied with best standards."

However, complying with best standards wasn’t the only thing that Janet’s practice did. After the draft of HTM 01-05 came out in 2008, and Martin Fulford, BDS MPhil DGDP FIRMS, had audited for the practice, advising on training issues and even magnifying lights, Janet started making adjustments to their practice, advising on training and issues and even magnifying lights. Janet started making adjustments to their practice, advising on training and issues and even magnifying lights. Janet talked to *Dental Tribune* about their experience and how they achieved and managed to comply in the best way that they could...

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Special
Flu Season
Special
Protect against
Airbourne Viruses,
Bacteria & Fungi
The unit emits a constant stream of
hydroxyl radicals that fight airbourne
organisms. Proven against bacteria
and viruses in trials.

Special
Price
£279
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- Natural effective disinfection
- Continuously attacks airborne
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Two Requirements....
One Solution
Cleans and Disinfects
- Detergent integrated in the wipe
- Removes Bio-Film
- Effective in less than one minute
- Chosen by world rated University
  Hospital Leuven

Perspiration Free Gloves
with Odaban!
Guaranteed to keep skin dry, supple
and hydrated. Does not contain
allergenic substances.
Formulated for all who wear gloves for
an extended period.

- Keeps skin dry & hydrated
- Free from allergic substances
- Economical and easy to apply
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I nurse examines instruments for any particles

‘I do realise that there is a lot of resistance
out there but it’s for the patient’s best inter-
ests; it helps regulate the industry’

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Dental Tribune United Kingdom Edition - April 18-24, 2011

CREATING A FLUID-FREE ENVIRONMENT

Janet’s practice also has a heat
machine for the bagging
and storage of instruments, and
how the washer disinfec-
tors and the autoclaves need to
have printers or data capture
loggers. Janet described how
they’ve not only got printers on
the autoclaves but how they’ve
also got data capture on the
washer disinfectors: “The data
is downloaded on a monthly
basis and saved on two differ-
cent computers so we’ve got it
backed up.”

The traceability side of
things is something extra that
the practice offers, but ulti-
ately it’s a backup for the
practice.

Rotation system
Janet’s practice also has a heat
seal machine for the bagging
and storage of instruments, and
looking into finer details they
have a tray rotation system to
ensure that no trays are forgot-
ten about. Janet also explained
that if a practice has just been
using autoclaves in the past
they would be used to a 12-15
minute cycle; however, with a
washer disinfector the cycle
time can be up to an hour.

are the sorts of things that peo-
ple need to be aware of!”

“I do realise that there is a lot
of resistance out there but it’s
for the patient’s best interests;
it helps regulate the industry
in that area and if I was a pa-
tient then I would want to know
that my practice is as clean as
possible and that I’m not at any
risk of infection.

“If a patient asks us about
our infection control we show
them our sterilisation rooms
and we show them how our
instruments are being proc-
esed. Not many patients do
ask to be honest – they just
assume, but one thing we
strums that we had in the practice and
the instruments being bagged
in the heat machine and break-
ing the seal in front of them, we
had comments from patients
saying “that’s new isn’t it?”. When
they do notice we ex-
plain to them that once the in-
struments have been sterilised
this is how they’re stored so
they don’t get dirty before they
enter the patients’ mouth.”

“In the end I think it’s im-
portant that you do as much as
you possibly can with the
premises and circumstances
that you’ve got; at the end of the
day it’s one of those things that
we can’t avoid.”

Janet will be speaking on
Thursday 19th May 2011 at the
British Dental Conference and
Exhibition at the Manchester
Central Convention Complex
(MCCC), Manchester, (Thurs-
day 19, Friday 20 and Saturday
21 May 2011).