FMC CONNECTING DENTISTRY

Dentistry CPD

THE EASY, STRESS-FREE WAY TO COMPLETE YOUR RECOMMENDED CPD

DENTIST EDITION

Dentistry CPD

DENTISTRY CPD: DENTIST EDITION 2024
This publication aims to present articles to help dental professionals fulfil their General Dental Council CPD requirements for recommended topics.

HEAD OF CPD CONTENT
Siobhan Hiscott

DESIGN
Glenn Baxter

PRODUCTION
K-Marcelyne McCalla

CONTENT DIRECTOR
Guy Hiscott

01923 851777
cpdsupport@fmc.co.uk

FMC CONNECTING DENTISTRY

Finlayson Media Communications
1 Hertford House, Farm Close,
Shenley, Herts WD7 9AB
info@fmc.co.uk

READ, SIGN UP, EARN

Welcome to *Dentistry CPD: Dentist Edition 2024*, brought to you for the first time by *Dentistry*.

In this issue, you'll find articles covering the General Dental Council's (GDC) eight recommended CPD topics, including the three specific topics identified as 'highly recommended'.

Continuing professional development (CPD) is a critical part of practice as a dental professional that forms part of the GDC's requirement for ongoing registration. This publication is designed to make it as easy as possible for all dental professionals –but particularly dentists, in light of the approaching 31 December deadline – to meet those requirements.

Taking advantage of this publication is simple – read the articles, either here or online by following the QR code on each one – complete the quiz online, and relax! Your certificates will be automatically generated and sit in your account until needed. If you're already signed up then the process is seamless: just log in like usual!

If you're not already a Dentistry CPD subscriber then you'll need to sign up – but that's simple too. Costs start at £29.99 for access to recommmended subjects – with access to all clinical content available for just £99.99.

HIGHLY RECOMMENDED TOPICS

Despite it being the 'Dentist Edition', the material in this issue is suitable for the rest of the dental team too. All dental professionals must complete the minimum number of verifiable CPD hours for their professional title, and aside from slight differences for dental technicicans, there is overlap between what some of these hours should cover.

The GDC identifies three specific topics as being 'highly recommended', which are as follows:

- **Medical emergencies:** at least 10 hours in each CPD cycle, and the GDC recommends you do at least two hours of this type of CPD activity every year
- **Disinfection and decontamination:** the GDC recommends you do at least five hours in each CPD cycle
- **Radiography and radiation protection:** if you undertake radiography, the GDC recommends you do at least five hours in each CPD cycle. If you are a dental technician, you can do CPD in materials and equipment, instead of radiography and radiation protection. The GDC recommends at least five hours in each CPD cycle.

RECOMMENDED TOPICS

Beyond this, the GDC also recommends that you keep your skills up to date by completing CPD in the following areas:

- Legal and ethical issues
- Complaints handling
- Oral cancer: early detection
- Safeguarding children and young people
- Safeguarding vulnerable adults.

All the recommended topics needed by dentists are included within this publication: we hope you find it useful.

IMPORTANT: COMPLETING YOUR CPD ONLINE

All CPD in this publication must be completed online. The questionnaires on each article are for personal reference only: paper forms and questions are no longer accepted. To complete your CPD online:

- Read the articles in this publication
- Visit the website cpd.dentistry.co.uk or scan the QR code shown here with your smartphone
- Find the article you wish to complete
- Complete the questionnaire.

Your certificates will be stored in your personal account online and can be retrieved whenever needed. If you have any problems, contact us:
CPD hotline: **01923 851777** Email: **cpdsupport@fmc.co.uk**

Myocardial infarction

John Laszlo discusses the management of myocardial infarct and the resuscitation protocols to be followed, both with and without the use of an automatic external defibrillator

A heart attack (myocardial infarction or MI) is a serious medical emergency in which the supply of blood to the heart is suddenly blocked, usually by a blood clot.

This medical emergency may follow angina. In such instances, you will be fortunate to have the time to be able to gather your wits and your dental team about you as you consider how to manage this medical emergency. In other circumstances, a myocardial infarct may arise quite unexpectedly with no symptoms and no signs whatsoever.

In some 10% to 20% of cases of myocardial infarct, the first and only sign is loss of consciousness following the overwhelming obstruction of blood supply to the left ventricle. In these cases, the swift cardiogenic hypotensive shock is life-threatening and will typically lead to death.

In other instances of myocardial infarct, only partial obstruction of blood supply to the myocardium occurs. In such cases, the coronary arteries are able to maintain at least something of the blood supply to keep the heart and the patient alive for some time and the myocardial infarct may result in distress for many hours.

Other clinical signs of myocardial infarct are pulmonary oedema from left ventricular dysfunction. In such cases, the symptoms of pulmonary oedema will present as the patient:

- Coughing up blood or bloody froth
- Shortness of breath and difficulty breathing when lying down
- Grunting, gurgling, or show wheezing sounds when breathing.

These clinical signs must not be confused with those of asthma, where there is an expiratory wheeze.

Due to the high pressure of blood flow in the coronary arteries, atherosclerotic plaques are unstable. The presence of plaques causes platelet adherence and activation, or the plaques can rupture, with fragments detaching from the artery wall. Once activated, platelets and platelet-derived inflammatory mediators result in further growth of the existing thrombus and formation of new thrombi.

This cycle continues with inflammatory processes and fatty deposits causing further platelet adhesion and activation. These may eventually completely obstruct the blood flow in a coronary artery.

Perhaps worse than the blockage of a coronary vessel is the breakaway of an occlusive thrombus to embolise in the systemic circulation, resulting in the cerebrovascular accident (CVA) or stroke.

MYOCARDIAL INFARCT: SIGNS AND SYMPTOMS

- Your patient will complain of a pain that is deep, and that is pressing in the middle of the chest
- This pain spreads to the shoulder, arm and jaw to the left mostly, or the right too
- Stomach cramps, nausea, vomiting, and extreme discomfort are also seen
- Your patient will become pale or appear grey, and will be sweating.

If you have access to nitrous oxide, and the patient is in extremis, giving nitrous oxide

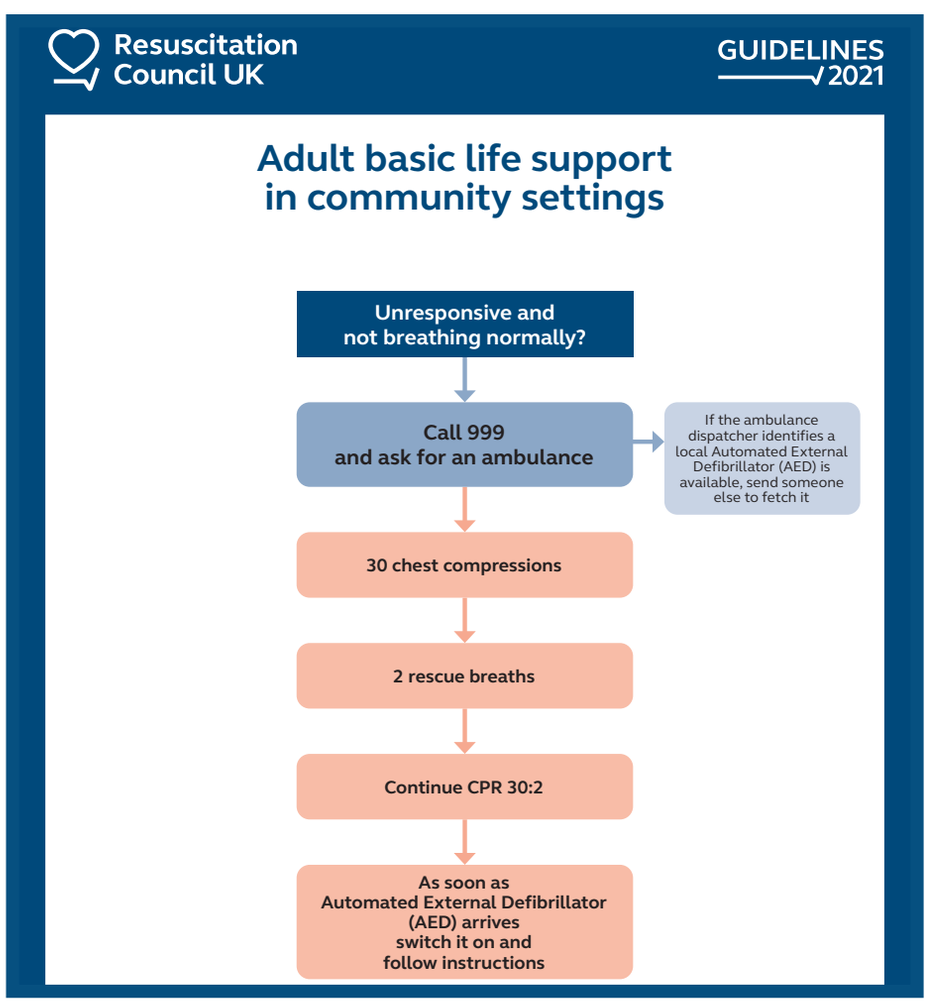
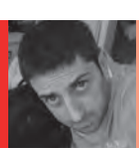


Figure 1: Adult Basic Life Support (Resuscitation Council UK)



John Laszlo

John is the author of *Cuspid: Clinically useful Safety Procedures in Dentistry* volume one and volume two.

would be a kindness, although this is not in the Resuscitation Council UK guidelines. You should be qualified and experienced in administering nitrous oxide at the appropriate concentration of up to 50% oxygen and 50% nitrous oxide for analgesia. Use the pulse oximeter and monitor their response.

If three attempts to stop pain with glyceryl trinitrate (GTN) do not work, your patient has a myocardial infarct.

THE TREATMENT OF MYOCARDIAL INFARCT

Even if you are not certain but you strongly suspect your patient is suffering from a myocardial infarct then immediately call for emergency medical assistance and follow MOVE:

- Monitor. Observe the patient and reassess their AVPU (alert, verbal, pain, unresponsive), their NEWS2 (National Early Warning Score 2), and their ABC (airway, breathing, circulation)
- Oxygen. Ensure this is delivered at 15 litres per minute
- Verify. Check that the medical emergency first responders are coming
- Ensure. In this emergency, make sure the patient is comfortable, safe and is not left alone.

COMMUNICATING WITH THE MEDICAL EMERGENCY SERVICES

The steps to communicate myocardial infarct to the medical emergency services are:

- Dial 999, 911 or 112 from any mobile
- Ask for the ambulance service
- Give your name and location.

Next, state the following:

- I have a patient with suspected heart attack
- I have given GTN, aspirin and oxygen. I am monitoring the patient. The patient has an AVPU level of…
- Send an ambulance now. This is an emergency
- Our location is…
- Please read back this data to me.

While waiting for the ambulance to arrive and your patient remains conscious, continue your treatment of the myocardial infarct:

1. Sit the patient up. This will reduce the stress from orthopnoea (if there is a left ventricle infarct and failure)
2. Reassure your patient the ambulance will arrive shortly and they will be ok
3. Give oxygen at 15 litres per minute from the bag-valve-mask. Monitor their response
4. Give GTN spray sublingually, continuing at five-minute intervals, monitor their response
5. Give aspirin 300mg, order the patient to chew this, placing it under the tongue. Monitor their response
6. If the patient is in extremis, and you are qualified and experienced, administer nitrous oxide at the concentration of 30% oxygen and 70% nitrous oxide. Monitor their response.

Be prepared to expedient the handover of your patient to the medical emergency first responders. Advise them on your use of aspirin so further thrombolytic treatment can be coordinated in the hospital.

Continue to MOVE until the medical emergency first responders arrive. Every two minutes, undertake NEWS2 and AVPU and note the data.

After you have dialled 999, the medical emergency first responders might not be able to arrive before a myocardial infarct develops into a cardiac arrest.

In the UK, 75% of requests for assistance in immediately life-threatening emergencies should be responded to within eight minutes.

Where onward transportation is required, NHS England reports that 95% of calls for assistance in life-threatening cases will receive an ambulance capable of transporting the patient safely within 19 minutes of the request for transport being made.

Therefore, for a period of 20 minutes from your diagnosing a myocardial infarct, which may lead to cardiac arrest, you must be capable and be able as a dental team to give basic life support to every one of your patients.

CARDIAC ARREST BASIC LIFE SUPPORT

If the myocardial infarct continues unabated, the patient will lose consciousness and stop breathing. The Resuscitation Council UK algorithm should be used. The flow chart details the steps you must take to ensure your patient has the best possible chance of survival (Figure 1). This is available to download from the UK Resuscitation Council website (www.resus.org.uk).

While this algorithm begins with the patient who has already collapsed, it is more likely in the dental surgery that either you or your colleagues will already be attending to the conscious patient and will witness their descent and collapse into unconsciousness.

Despite the start to this algorithm, begin your management by first checking the responsiveness of the patient (ie don't wait for them to collapse!).

Check the patient is responsive by taking hold of their shoulders and asking if they are ok. If there is a response, then you can continue with your emergency clinical monitoring as follows:

- The patient's AVPU and NEWS2 should be assessed. This is repeated and help summoned as necessary
- If the patient appears to be unconscious, lay the patient on their back, either in the dental chair or on the ground
- Gently shake the patient, if there is no response,

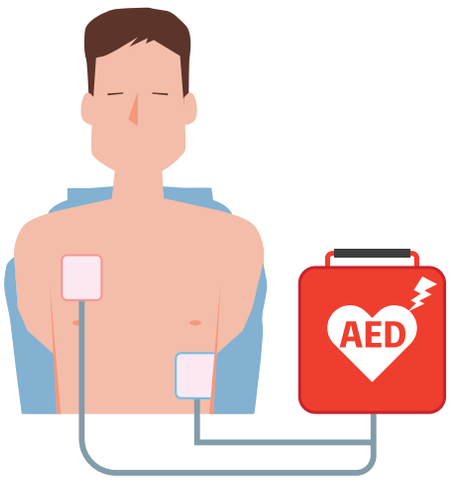


Figure 2: Automatic external defibrillator pad placement

begin the steps as listed in the algorithm, going through the routine of ABC:

- Airway. Check your patient's airway for any sign of obstruction. This can be achieved by placing one hand on the forehead, tilting the head back and lifting the chin to open the airway
- Breathing. Keep the airway open and look for any sign of normal breathing. Look for movement in the chest. Listen for sounds of breathing. Feel for exhaled air on your cheek. Do not take longer than 10 seconds to determine if the patient is breathing and if this is normal. If your patient is breathing, then turn them into the recovery position and continue to monitor AVPU and NEWS2, and MOVE the patient. If the breathing is agonal, abnormal or absent, then assume the patient is in cardiac arrest. Some 55% of those in cardiac arrest will show signs of agonal gasping, this is not normal and must not be confused with normal breathing, this is a sign of cardiac arrest and cardiopulmonary resuscitation (CPR) must begin now
- Circulation. In cardiac arrest, your patient will not have the ability to circulate or oxygenate blood themselves (now due to cardiac dysfunction or complete non-function). You must be prepared to support their circulation and do so for up to 20 minutes while you await the medical emergency first aid responders.

CARDIOPULMONARY RESUSCITATION

1. Begin chest compressions now. Kneeling to one side of your patient, place the heel of one hand in the centre of the patient's chest, your other hand is placed on top of the first hand, interlock your fingers ensuring your hands are in the centre of the chest

2. Do not apply any pressure over the upper abdomen or the lower sternum. Position yourself above the patient's chest, now press down on the sternum to a depth of 5cm or 6cm only and no more. Do so with straight arms and push from your shoulders. Following each compression, release all the pressure, allowing the patient's chest to reinflate. Repeat this 30 times at the rate of 100-120 per minute
3. The compression and relaxation strokes should be equal in timing force and depth.

Verify that your call for the medical emergency first responders has been acted on. If not, dial 999 and repeat the procedure as outlined previously on communicating with the medical emergency services. Remember, this should be done before commencing CPR.

Rescue breaths

Chest compressions must be combined with rescue breaths:

1. After the first 30 compressions, open the airway by using the head tilt and chin lift. Pinch the patient's nose closed. Maintain a chin lift to open the mouth. Place your lips around the patient's mouth, and make sure that you have a good seal, then blow steadily into the patient's mouth. Check for chest inflation
2. In one second, the chest will rise. This shows an effective rescue breath. Maintain the head tilt and chin lift, take your mouth away from the patient, their chest will fall as exhalation occurs. Take another breath and blow into the patient's mouth to give two times effective rescue breaths. Do not take more than five seconds to complete these two breaths
3. Return to giving a further 30 chest compressions. Continue with the chest compressions and rescue breaths to a ratio of 30 compressions to two breaths. Monitor your patient continually
4. Only if there are signs of consciousness, which includes coughing, opening eyes, speaking or moving purposefully, or your patient begins to breathe normally, can you stop the procedure. Otherwise, be prepared to continue chest compressions and rescue breaths for up to 20 minutes. Do not interrupt resuscitation and do not break from what you were doing until the medical emergency responders arrive
5. Be prepared for the handover of your patient to the medical emergency first aid responders.

Anticipate working together with your colleagues for up to, or possibly more than, 20 minutes, delegating responsibility for a team member to summon help and to coordinate the medical emergency first responders as they arrive in the dental practice.

If there are two dental team members, then chest compressions and breathing is a shared responsibly.

In addition to access to oxygen, the Resuscitation Council UK states that all dental practices should have immediate access to an automated external defibrillator (AED), which should be well-maintained and ready to use. The General Dental Council (GDC) endorses the Resuscitation Council's guidance that all clinical areas should have immediate access to an AED.

CARDIAC ARREST AND THE USE OF AN AED

According to the GDC, premises in which patients are seen clinically should have a defibrillator. This includes practices in which patients are seen by:

- A dentist only
- A clinical dental technician only
- A dental hygienist or dental therapist only
- A combination of members of the dental team.

There aren't specific legal requirements for training in the use of an AED in the UK; it can be used safely and effectively without training. However, it's recommended that training is undertaken on a regular basis by anyone who might need to use one. This will improve the efficiency with which it will be used, reducing the time from correctly assessing that a cardiac arrest has happened, through correctly placing the AED pads to delivering a shock to your patient.

If an AED is to be used, there has to be minimal interruption in the chest compressions and rescue

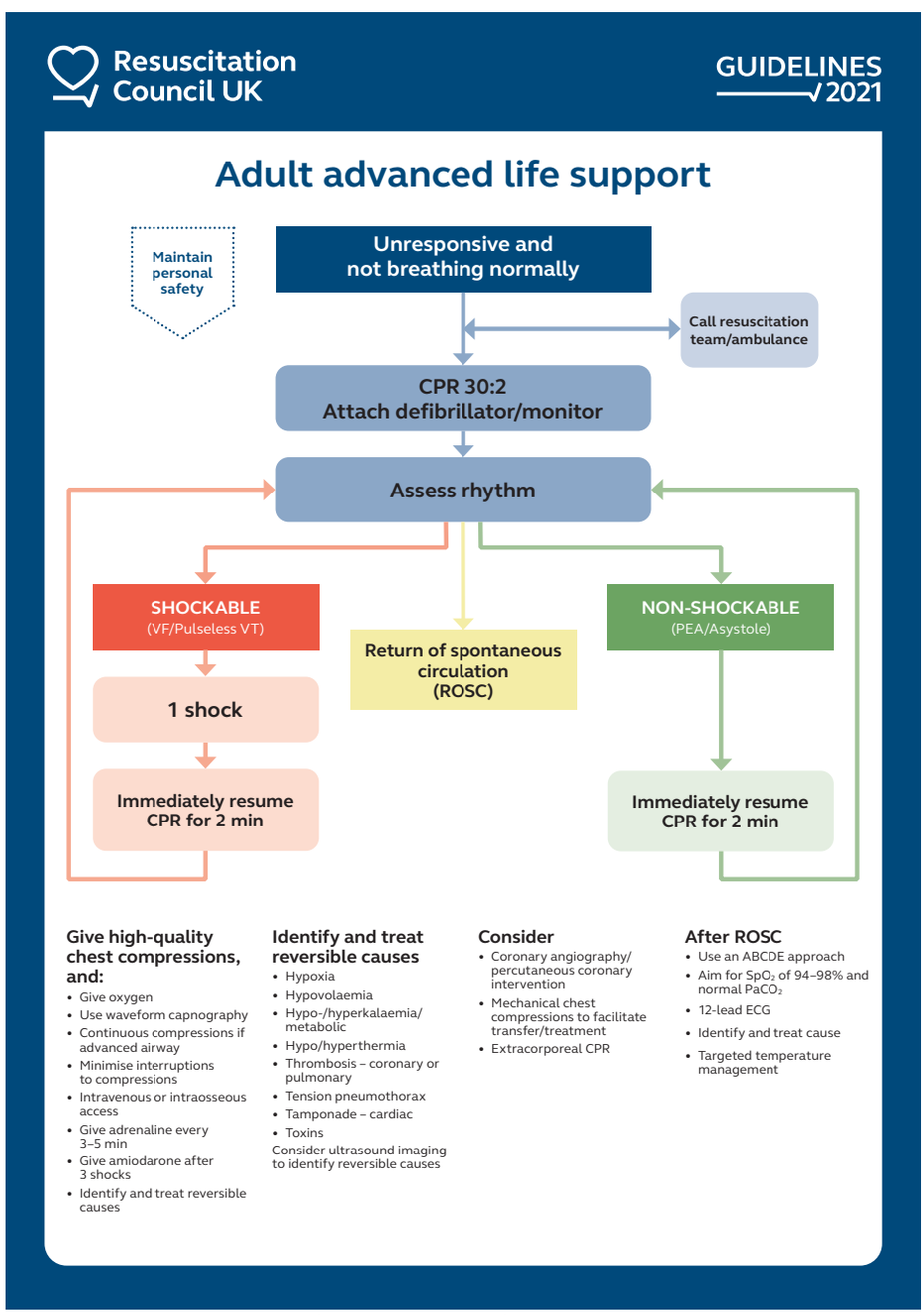


Figure 3: Adult Advanced Life Support (Resuscitation Council UK)

breaths while the AED is collected and the pads are attached to the patient.

Do not stop to check your patient or discontinue CPR unless your patient shows signs of regaining consciousness (such as coughing, opening of the eyes, speaking, intentional movement and normal breathing).

AEDs will administer an appropriate shock, but only when a patient in cardiac arrest will respond. AED pads have sensors that detect residual electrical activity, if such activity is indicative that a shock can defibrillate the heart, then a shock will be delivered.

Ease of use is essential, and AEDs can be safely and reliably used by all members of the dental team.

EVENT SEQUENCE FOR AED CPR

Collect the AED and continue CPR while a member of the dental team switches the AED on. Follow the audio and visual prompts from the AED. Attach the electrode pads to the patient's bare chest, in the positions illustrated in Figure 2.

Placement of AED pads

1. One AED pad is placed to the right of the sternum (breastbone) below the clavicle (collarbone)
2. The other pad is placed in the left mid-axillary line
3. It is important that this pad is located sufficiently laterally and that it is clear of any breast tissue. AED pads are labelled left and right with a picture of their correct placement. It does not matter if their positions are reversed. If the pads are incorrectly placed, they should not be removed or repositioned. This wastes time and the pads will not stick once peeled off and reattached.

CHEST HAIR WILL PREVENT THE PADS ADHERING TO THE SKIN AND WILL INTERFERE WITH ELECTRICAL CONDUCTION, EXCESSIVE HAIR NEEDS TO BE SHAVED OFF

ACKNOWLEDGEMENT

This article has been republished from *Cuspid: Clinically useful Safety Procedures in Dentistry* with permission.

The patient's chest must be exposed to enable correct pad placement. Chest hair will prevent the pads adhering to the skin and will interfere with electrical conduction, excessive hair needs to be shaved off.

DEFIBRILLATION

Make sure nobody is in contact with the patient after the AED pads have been placed. The AED will now assess the patient's residual cardiac electrical activity.

If a shock is indicated, again, make sure nobody is in contract with the patient. Push the shock button as directed, or, with the fully automatic AED, a shock will be given, but only when necessary.

Continue in accordance with the audio and visual prompts as given.

When safe to do so, continue the chest compressions and rescue breaths.

If no shock is indicated, then resume CPR immediately using the ratio of 30 compressions to two rescue breaths. Continue to follow the AED prompts until the medical emergency responders arrive.

If the patient shows signs of regaining consciousness, such as coughing, opening the eyes, or breathing normally, then CPR can stop. There are no other reasons to cease CPR. Becoming exhausted is not a reason, as you will be working in a team and your colleagues will carry on if you cannot.

As stated, you must be prepared to carry out CPR for up to 20 minutes, possibly more, until the medical emergency first responders arrive.

CPD

ENHANCED CPD

Topic: Medical emergencies

Educational aims and objectives: To discuss the management of myocardial infarct and the resuscitation protocols to be followed, both with and without the use of an automatic external defibrillator (AED).

GDC development outcome: C
CPD hours: two

Answer the CPD questions online at **dentistry.co.uk/cpd**. Scan the QR code to access the article. Any problems, call the CPD hotline on **01923 851777** or email **cpdsupport@fmc.co.uk**.

QUESTIONS

1. In some 10% to 20% of cases, what is the first and only sign of myocardial infarct?
- ☐ a. Vomiting
- ☐ b. Shortness of breath and difficulty breathing
- ☐ c. Loss of consciousness
- ☐ d. Temporary sight loss

2. Which of the following describes some of the symptoms of pulmonary oedema?
- ☐ a. The patient coughing up blood or bloody froth
- ☐ b. Shortness of breath and difficulty breathing when lying down
- ☐ c. Grunting, gurgling, or show wheezing sounds when breathing
- ☐ d. All of the above

3. What does the acronym MOVE stand for?
- ☐ a. Monitor, oxygen, verify, ensure
- ☐ b. Move, obstruct, view, excuse
- ☐ c. Maxillary, occlusal, view, extract
- ☐ d. Modern observational vital envelope

4. While waiting for the ambulance to arrive and your patient remains conscious, how much oxygen should be given from the bag-valve-mask?
- ☐ a. 10 litres per minute
- ☐ b. 15 litres per minute
- ☐ c. 20 litres per minute
- ☐ d. 25 litres per minute

5. In the UK, 75% of requests for assistance in immediately life-threatening emergencies should be responded to within how many minutes?
- ☐ a. Six
- ☐ b. Eight
- ☐ c. 10
- ☐ d. 19

6. How many of those in cardiac arrest will show signs of agonal gasping, according to the author?
- ☐ a. 25%
- ☐ b. 35%
- ☐ c. 55%
- ☐ d. 65%

7. For cardiopulmonary resuscitation, when positioned above the patient's chest, to what depth should you press down on the sternum?
- ☐ a. 2cm or 3cm only
- ☐ b. 3cm to 4cm only
- ☐ c. 4cm or 5cm only
- ☐ d. 5cm or 6cm only

8. What does the Resuscitation Council UK state in relation to dental practices and automated external defibrillators?
- ☐ a. All practices should have immediate access to an AED
- ☐ b. The AED should be well-maintained
- ☐ c. The AED should be ready to use
- ☐ d. All of the above

Sustainable dental waste management

Pete Gibbons discusses sustainable dental waste management and explores some of the changes dental practices can make to reduce waste and your carbon footprint

HTM 07-01, which was updated in 2023, has started to come into effect with the introduction of yellow and black 'tiger' bags being introduced into dentistry. If you haven't read the new update and are not aware of the changes that will be happening, here's a quick recap…

The new document supports the NHS's drive to be a Net Zero health system, prioritising decarbonisation, and circular economy measures in alignment with:

- Defra's 'A Green Future: Our 25 Year Plan to Improve the Environment' (2018a)
- 'Our waste, our resources: a strategy for England' (2018b)
- The NHS's 'Delivering a Net Zero National Health Service' (2020a)
- 'The NHS Long Term Plan' (2019b).

The key changes within the new document focus on trying to eliminate avoidable waste, supporting a drive to prevent offensive waste being incorrectly classified and to improve the effectiveness of waste management systems. This is outlined in the following changes targets:

- 20% reduction of waste segregated to be sent to incineration, with only 4% of that being hazardous/clinical incineration
- 20% reduction of waste segregated to be sent to alternative treatment
- 60% increase of waste segregated to be classified as offensive waste.

HAZARDOUS AND NON-HAZARDOUS

All healthcare waste produced in practices can be categorised as either non-hazardous waste or hazardous waste.

Pete Gibbons

Pete Gibbons is decontamination consultant and owner.

Non-hazardous waste is any rubbish or recycling that causes no harm to humans or environmental health. These are also waste items produced from the treatment of non-infectious patients and not contaminated with infectious body fluid. This waste stream is disposed of in any of the following national colour coded bags: yellow and black 'tiger', black, clear.

Hazardous waste is waste that is considered hazardous under environmental legislation and could be harmful to human health or the environment. This waste could come from the treatment of infectious patients or those suspected of having an infection, or it could be waste contaminated with body fluids of known infectious patients. This waste stream is disposed of in the following national colour coded bags/containers: orange, yellow, red, purple, blue.

To coincide with this implementation, Defra has been in consultation to discuss the possible banning of all wipes in the UK that contain plastic. This will have a huge impact on dentistry as profession as we dispose of an enormous amount of wipes every year.

Implementing the new HTM 07-01 strategy will ultimately see a reduction in the quantity of hazardous waste (orange bags) by 20% and an increase in the quantity of offensive waste (tiger bags) by 60%. This will also mean that in treatment and decontamination areas, another bin for the newly adopted tiger bags will be introduced. These areas will now provide space for black, orange, tiger and sharps bins where space allows.

I am finding that many practices are now seeking to become more sustainable in an effort to reduce their individual carbon footprint and also to reduce the additional cost burden seeking alternative products can have. Let's explore some of the possible ways that practices could do this.

HOW CAN PRACTICES REDUCE THEIR CARBON FOOTPRINT WITH WASTE?

Saliva ejectors and aspirator tips

Rather than using single use saliva ejectors and aspirator tips, we could look at using reusable ones that are available in the market.

Unlike items such as metal three-in-one tips, these items can be cleaned internally as cleaning brushes usually come with them. They can also be sterilised through vacuum autoclaves.

Pouching alternatives

As an industry, dentistry disposes of a huge amount of sterilisation pouches used for storing dental instruments. Not all instruments need to be pouched, particularly those that are going to be used in the day's procedures.

There are also solutions in the market that offer full storage safety without using pouching or wraps, such as Melag Melastore. These systems are typically metal boxes that have a sterile filter to keep the instruments sterile for any period of time. These are designed with safety in mind and help to dramatically reduce unnecessary waste.

Hypochlorous acid generating units

Hypochlorous acid is a mild form of acid that is naturally produced in the human immune system to kill invading germs. Units are available that produce this, and the resulting solution can then be used in many areas through the practice, ie surface cleaning/disinfection, dental unit waterlines disinfection etc.

Because it contains no alcohol, chemicals or irritants, it is classified as non-hazardous thus making it more sustainable.

Plastic cups

Why not look at using paper or metal alternatives to the traditional plastic cups?

Paper cups have been available for many years, but I have seen many practices reverting to metal cups that are cleaned and disinfected after each use.

These are just a couple of ways practices could start to reduce the amount of unnecessary waste by using reusable or environmentally friendly alternatives. I would say that, before changing to a reusable product, always consider if the item can be fully cleaned and sterilised. If the answer to any of these is no, changing over should be avoided.

Heavy duty gloves

Under the UK guidance documents, the use of heavy duty gloves when carrying out decontamination work is imperative to ensure staff safety, particularly from sharps injuries. The guidance also states that these are to be changed on a weekly basis, resulting in a large amount ending up within healthcare waste.

At best, if a practice has one pair of gloves per week, we are looking at 52 pairs being thrown away per year. A large percentage of practices will, however, have at least two pairs in current circulation at any one time resulting in even more pairs being thrown away.

There are solutions on the market that can help to reduce this. These gloves can be sterilised up to five times at 134°C, which would be done at the end of each week, ready for the following week.

By sterilising them once per week, each pair of gloves could last up to six weeks which will result in a dramatic reduction in the amount being thrown away each year.

Biodegradable wet wipes

Biodegradable wipes, which are usually made of materials such as bamboo, cotton and wood pulp, can decompose within a matter of weeks. Once these are disposed of correctly, biodegradable wipes get broken down naturally by microorganisms and returned to the ecosystem.

There are many manufacturers that already supply biodegradable wipes, so there are definitely options available should you want to make the change without compromising patient and staff safety.

Chlorine generating tablets

Chlorine generating tablets are a low-cost, effective way at cleaning and disinfecting all surfaces throughout the practice. If your practice is using a variety of different detergents/disinfectants for floors etc, not only can this be quite expensive, but it also generates a lot waste in the form of plastic containers.

Why not substitute everything for chlorine tablets instead?

Chlorine tablets have a multitude of uses throughout the clinic. They can be used to clean/disinfect the floors, dental unit waterlines (DUWLs), water bottles, distiller kettle jugs, and for disinfecting after blood spillages along with many more.

These are usually supplied in small tubs of 100-200 tablets and contain 1,000ppm of chlorine per tablet. When needed, they are simply used in the ratio of one tablet per one litre of water.

Reusable mops

Under the UK guidance, each practice should have a good selection of mops to use in each area that has hard flooring in line with the

national colour coding:

- Blue – general/communal areas
- Green – kitchen areas
- Yellow – surgeries and local decontamination units (LDUs)
- Red – toilets.

I see a lot of practices slowly moving over to using alternative methods such as disposable mop heads or disposable mop wipes. Using these methods can generate a lot of waste along with becoming quite expensive over time.

Instead, using a traditional reusable mop and disinfecting after use with chlorine will not only provide a clean head for the next use, but it will also be more sustainable.

These are only suggestions and may not be suitable for all practices to try to implement, but hopefully they will help you if you do want to explore the options of becoming more sustainable without minimising patient or staff safety.

Compliance policies

I visit a lot of practices around the country, carrying out practice audits. A common thing that I see is banks of folders containing all of the various policies that are required in order to keep consistency.

These policies are constantly being reviewed and changed, as procedures or equipment change, resulting in further documents being printed off. These are also usually printed off so that everyone can read them and also have access to them.

Instead of continually printing your policies and storing in folders, why not just keep them on the computer in individual folders? These can then easily be updated, read and accessed from the computer. Policies that require staff members acknowledgement can be done by printing off an acknowledgement sheet for them to sign and date.

This will dramatically reduce the amount of paper used and thrown away along with reducing the number of physical folders required. Any inspector would then be able to access the folders via your practice PC.

Spray and microfibre cloths

As previously discussed, the Department for Environment, Food & Rural Affairs (DEFRA) has been in consultation regarding the possible banning of all wet wipes containing plastic in the UK. If this happens, practices will need to look for alternatives that would either be wipes without plastic or a biodegradable product. Practices could also consider using spray cleaner/disinfectants and microfibre cloths.

Microfibre technology is proven to be great at debris removal and also capturing debris so that it isn't redeposited back onto surfaces.

The Welsh HTM 01-05 has specifically mentioned their use: 'The Department of Health in England has sponsored research on the use of both microfiber cloth and steam-cleaning technology in clinical and support-service areas. This work suggests that, provided deep cleaning is performed as an initial exercise, the subsequent use of microfibre-based techniques, essentially involving dry or wet wiping with microfibre cloth, can be helpful in achieving satisfactory removal of infectious agents from surfaces. The special fibre is capable of entangling and thus removing a wide range of pathogenic particles from surfaces to which they are otherwise adherent.

'However, as infective material is efficiently transferred to the microfibre, its reprocessing or disposal must take account of the infection risk. Reprocessing takes the form of washing through a conventional laundry process. This should take place at the end of each session or when obviously contaminated. The life of the cloth is likely to allow for repeated use on many occasions. The materials are available at relatively modest cost from infection control companies.'

Microfibre cloths can be reused many times before needing to be thrown away thus reducing the amount of waste. The use of these would need to be covered by a robust policy which outlines the exact procedure in order to ensure the risks are minimised and consistency is achieved.

Suction units

Many manufacturers of suction pumps are providing units that incorporate methods such as centrifugal technology, which can reduce the amount of electricity used by up to 75%. These pumps are also being manufactured using recycled materials.

If you are in the market for a new suction unit then you can discuss possible sustainable options with them.

Autoclaves

Autoclaves use a lot of electricity to not only heat up the water producing steam but also to help keep the chamber temperature warm helping with cycle times. When the unit is not used and left on this can create a lot of heat generation, and in small decontamination rooms this can become quite unbearable – especially in the summer.

Many modern autoclaves come with the addition of an 'energy save mode', which puts the autoclave into a hibernation state when not being used thus saving on energy consumption. Some autoclaves also recover the heat generated which is then used at reducing the energy used for future cycles.

If you want to know more about these features then always speak to your manufacturer.

STEAM MOPS

Under the current UK guidance and code of practice, maintaining cleanliness throughout the practice is paramount in aiding effective infection prevention and control. Part of the process of maintaining high IPC standards involves the effective cleaning and disinfection of all surfaces including floors.

UK guidance requires that all dental practices should have a selection of different mops utilising the national colour coding of:

- Red – for washrooms
- Blue – for offices
- Green – for kitchens
- Yellow – for clinical and decontamination areas.

Utilising this method has its pros and cons in dentistry. The pros are that they are relatively in-expensive to set up and the colour coding is easily distinguishable for anyone using them.

However, the cons include the fact they take up a lot of space in a dedicated cupboard, different chemicals are used which may not be environmentally friendly, and the heads will need to be changed periodically.

Why choose steam mops?

Another way practices could clean floors throughout the practice is to utilise steam mopes for cleaning and disinfection.

But why is steam so effective at cleaning and disinfecting surfaces? According to Polti: 'High-temperature steam effortlessly removes and dissolves all kinds of dirt and grime, eliminating mites, germs and bacteria. What's more, it reduces water usage and the impact on the environment, ensuring flawless cleaning with long-lasting results.'

A single steam cleaner using different colour-coded microfibre mop heads, which are available using the national colour coding, would require less space for storage. This would also eliminate the use of any harmful chemicals.

Once the mop has been used, the microfibre heads would simply be washed at the hottest temperature possible and then reused. This method would need to be backed up with a robust policy and adhered to by any staff members or outside contractors.

RECYCLE

HTM 07-01, along with identifying the various healthcare waste streams, is also promoting dental practices to recycle more using the five Rs methodology (refuse, reduce, reuse, repurpose, recycle).

The majority of dental products are delivered in packaging that can be recycled. If we incorporate a rigid recycling programme, like that we carry out in our own homes, this will help to reduce the amount of unnecessary waste that is generated.

GO DIGITAL

If you haven't gone digital already, then maybe now is the time. Since the turn of the new decade, we have been entering into what is called the fourth industrial revolution. This revolution is described as 'technological developments in cyber-physical systems such as high-capacity connectivity, new human-machine interaction modes such as touch interfaces and virtual reality systems, and improvements in transferring digital instructions to the physical world including robotics and 3D printing'.

Going digital has, along with many other things, a significantly positive impact on the environment, particularly when we look at X-rays and no longer using harmful chemicals for the developing process.

COMPOSTABLE PPE

As an industry, dentistry disposes of a huge amount of PPE including gloves and masks. Currently, many of these will be disposed of in clinical waste.

A more sustainable option could be to utilise compostable or biodegradable options that would be suitably disposed of with the newly adopted 'offensive waste'.

According to Unigloves: 'While latex gloves are made from a natural rubber compound and are naturally biodegradable, the same can't be said for most nitrile gloves. Traditionally, nitrile gloves have not been biodegradable, as they're made from a synthetic compound that takes many years to decompose'

As well as PPE, more and more manufacturers are developing environmentally friendly options of other commonly used items.

These are all only suggestions and may not be suitable for all practices to try to implement, but hopefully they will help you if you want to become more sustainable without minimising patient or staff safety.

FURTHER INFORMATION

For help and assistance with sustainable alternatives, email info@deconpete.co.uk or visit www.deconpete.co.uk.

CPD

ENHANCED CPD

Topic: Disinfection and decontamination

Educational aims and objectives: To discuss sustainable dental waste management and propose some of the changes dental practices can make to reduce waste and your carbon footprint.

GDC development outcome: C
CPD hours: one

Answer the CPD questions online at **dentistry.co.uk/cpd**. Scan the QR code to access the article. Any problems, call the CPD hotline on **01923 851777** or email **cpdsupport@fmc.co.uk**.

QUESTIONS

1. Implementing the new HTM 07-01 strategy will ultimately see a reduction in the quantity of hazardous waste (orange bags) by how much?

- ☐ a. 20%
- ☐ b. 40%
- ☐ c. 60%
- ☐ d. 80%

2. Under the UK guidance documents, how frequently should heavy duty gloves be changed?

- ☐ a. On an hourly basis
- ☐ b. On a daily basis
- ☐ c. On a weekly basis
- ☐ d. On a monthly basis

3. What material are biodegradable wipes usually made of?

- ☐ a. Bamboo
- ☐ b. Cotton
- ☐ c. Wood pulp
- ☐ d. All of the above

4. How much chlorine per tablet do chlorine tablets contain?

- ☐ a. 500ppm
- ☐ b. 1,000ppm
- ☐ c. 1,500ppm
- ☐ d. 2,000ppm

Complying with ionising radiation regulations

Ian Lloyd explores the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17) and the Ionising Radiation Regulations 2017 (IRR17)

Ever since the regulations relating to IR(ME)R and IRR were updated in 2017 there has been some confusion about what is required, and recent further amendments have compounded this.

In this article, I want to explore what the regulations and the amendments require, what dental practices should do, and what to avoid.

What is IR(ME)R 2017?

The Ionising Radiation (Medical Exposure) Regulations 2017 are the regulations that provide safeguards for individuals exposed to ionising radiation in a medical environment. The exposure could be for diagnostic, treatment, or research purposes or it could be from medical equipment for imaging purposes.

What is IRR17?

The Ionising Radiation Regulations (IRR17) is a body of regulations concerned with protecting healthcare workers from exposure to ionising radiation as a result of work activities.

IRR17 is administered by the Health & Safety Executive (HSE) as part of the Health & Safety at Work Act 1974. Broadly speaking: IR(ME)R 2017 is in place to protect patients and IRR17 to protect team members.

AMENDMENTS

IR(ME)R 2017 was updated with some minor amendments in 2018, and further minor changes came into force on 1 October 2024.

Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018

These regulations amend the Ionising Radiation (Medical Exposure) Regulations 2017 ('the 2017 regulations'). There were some minor amendments to regulation two.

Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024

The amendments to these regulations came into force on 1 October 2024 and are outlined below:

- Some definitions in the 2017 regulations were amended, including expanding the meaning of 'equipment' to include any software that directly assists the operator in carrying out a clinical evaluation
- There is a new requirement for cooperation between employers. Added at 6A, this applies where two or more employers carry out (or engage others to carry out on their behalf) exposures on the same individual. The regulation requires the employers concerned to cooperate with each other with the aim of ensuring each employer has information on the exposure or the potential exposure to the extent necessary to help keep exposures to ionising radiation as low as practicably achievable. There is an additional emphasis on optimisation of every exposure to ensure that each dose of ionising radiation is as low as reasonably practicable and consistent with the intended diagnostic or therapeutic purpose.

AMENDMENTS TO THE TRAINING REQUIREMENTS

The training requirements for practitioners and operators have been updated, as set out in table two of schedule three (Adequate Training) of the 2017 regulations.

General

- The fundamentals of radiological anatomy
- Factors affecting radiation dose
- Dosimetry
- Fundamentals of clinical evaluation
- Identification of the individual being exposed
- Equipment specification.

Diagnostic radiology

- Principles of radiological techniques
- Production of X-rays.

Specialist techniques

- Computed tomography.

Practical aspects of diagnostic radiology

- Patient positioning
- Equipment selection and use Protocol selection
- Optimisation of image quality and radiation dose
- Dose assessment and recording
- Image acquisition, artefacts, processing, display and storage.

Licence fees

The licence fees charged to employers have changed. This is not relevant to dental practices as radioactive substances are not administered.

There have also been other technical and minor amendments that do not need to be expanded on.

While not part of the 2024 amendments, I'd like to provide some useful information.

THE REGULATORS

While IR(ME)R 2017 and IRR17 do not emanate from the regulators listed below, these regulators expect the regulations to be complied with as part of their regulatory processes in much the same way that the General Dental Council (GDC) requires all registrants to keep up to date with regulatory changes.

The regulators below have a mandate to ensure dental practices, in common with all other providers of health and social care services where relevant, comply with the regulations.

- The Care Quality Commission (CQC) enforces IR(ME)R in England
- Healthcare Inspectorate Wales (HIW) monitors compliance with IR(ME)R on behalf of the Welsh Ministers
- Healthcare Improvement Scotland (HIS)

Ian Lloyd

Ian is a practice adviser and trainer at Dentistry Compliance.

enforces IR(ME)R for the Scottish Government
- The Regulation and Quality Improvement Authority (RQIA) enforces the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland).

NOTIFYING SIGNIFICANT ACCIDENTAL AND UNINTENDED EXPOSURES UNDER IR(ME)R

The Ionising Radiation (Medical Exposure) Regulations 2017 and the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018 are designed to protect people while undergoing examinations and treatment that involve ionising radiation.

Any significant accidental exposure or unintended exposure must be reported as a significant incident as outlined below.

SIGNIFICANT ACCIDENTAL OR UNINTENDED EXPOSURES (SAUE)

Objectives

To ensure that:
- Any unintended or accidental exposures are appropriately investigated
- The referrer, the IRMER practitioner, and the patient or the patient's representative are informed of the occurrence of any clinically significant unintended or accidental exposure, and the outcome of the analysis of this exposure.

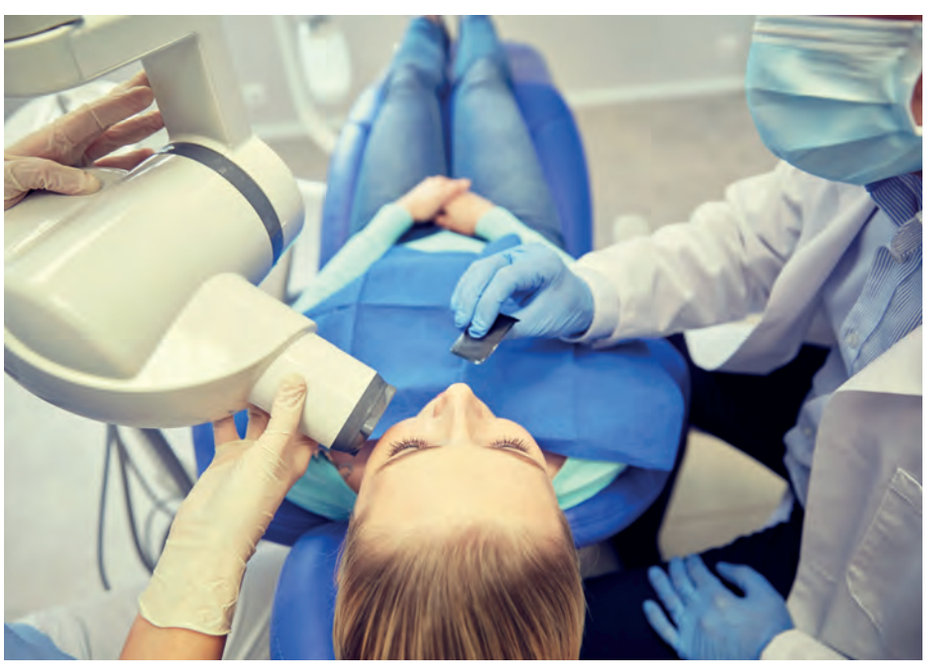
Process for informing
- If the operator suspects the patient may have received a significant accidental or unintended exposure, it should be reported to the practice radiation protection supervisor (RPS), as soon as possible
- The operator should make a note of all display or control settings, and save all images including rejects
- If the incident was due to an equipment malfunction, the equipment should be removed from service pending an investigation
- Advice should be sought promptly from the radiation protection adviser (RPA) or the medical physics expert (MPE) who will advise whether instances of equipment failure should be reported to the manufacturer and/or the MHRA
- The RPS should discuss the exposure with the appointed medical physics expert (MPE) to determine an estimate of the patient dose. If the MPE advises that the exposure is significant, the RPA will, on the advice of the MPE:
  - Notify the relevant regulator within two weeks of the incident occurring
  - Arrange for a detailed investigation of the circumstances of the event and if necessary, produce a more detailed assessment of the dose received
  - Notify the CQC/HIW/RQIA/HIS of the outcome of the investigation and any corrective measures adopted, within twelve weeks of the incident occurring.

In addition, if the MPE advises that the exposure is clinically significant, the RPS should (in addition to notifying the relevant enforcing authority) ensure that the referrer and IRMER practitioner are informed of the exposure and estimated dose as soon as possible. The referrer or IRMER practitioner should then discuss the exposure with the patient, or the patient's representative.

Recording

The investigation into the exposure should be documented together with the outcomes of the analysis, including the estimated patient dose. This should be done in consultation with the MPE.

The report should be retained in the radiation protection file/patient notes for at least five years. If the exposure is clinically significant, copies must be provided to the referrer, IRMER practitioner, and the patient or the patient's representative, and a copy retained for at least 30 years.



CPD

ENHANCED CPD

Topic: Radiography and radiation protection

Educational aims and objectives: To explore the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17) and the Ionising Radiation Regulations 2017 (IRR17).

GDC development outcome: C
CPD hours: one

Answer the CPD questions online at **dentistry.co.uk/cpd**. Scan the QR code to access the article. Any problems, call the CPD hotline on **01923 851777** or email **cpdsupport@fmc.co.uk**.

QUESTIONS

1. What does IRR17 stand for?
- ☐ a. Ionising Radiation Regulations 2017
- ☐ b. Intraoral Remote Receptor 17
- ☐ c. Interactive Radiography Regulations 2017
- ☐ d. Incorporating Radiography and Radiation v17

2. When was IR(ME)R 2017 last updated with minor amendments?
- ☐ a. 2017
- ☐ b. 2018
- ☐ c. 2020
- ☐ d. 2024

3. Which regulator enforces Ionising Radiation (Medical Exposure) Regulations in Northern Ireland?
- ☐ a. CQC
- ☐ b. RQIA
- ☐ c. HIW
- ☐ d. HIS

4. When it comes to clinically significant accidental or unintended exposures, how long should the report be retained for in the radiation protection file/patient notes?
- ☐ a. At least six months
- ☐ b. At least one year
- ☐ c. At least three years
- ☐ d. At least 30 years

Integrity in dental healthcare

Sobiah Sattar explores integrity in dentistry – the challenges, practices, and maintaining ethics under pressure

Integrity is a cornerstone of healthcare and an essential value for all healthcare professionals – including those in dentistry. Defined as the quality of being honest and having strong moral principles, integrity ensures that patient care is provided in a transparent, ethical and patient-centred manner.

Dental professionals, entrusted with the health and wellbeing of their patients, must consistently uphold integrity to foster trust and support the highest standards of care. However, despite its importance, the complexities of real-world practice – such as financial pressures, patient demands, and regulatory challenges – can sometimes lead professionals to deviate from this principle.

In this article, we will explore the concept of integrity in dentistry, the challenges that compromise it, and the practices dental professionals can adopt to promote it in their daily work. Moreover, we will examine how professionals can uphold integrity during the high-pressure situation of a GDC investigation and mitigate the ethical risks associated with such an experience.

DEFINING INTEGRITY IN HEALTHCARE: A DENTAL PERSPECTIVE

Integrity, within the context of healthcare, involves a commitment to doing what is right, even when it is not the easiest or most profitable choice. For dental professionals, this includes prioritising patient care, being transparent about treatment options, adhering to clinical guidelines, and providing ethical treatment regardless of personal gain.

The General Dental Council (GDC) highlights the importance of integrity in its *Standards for Dental Care*. It emphasises that dental professionals must maintain patient trust, be open and honest, and place the patient's interests at the forefront of all decisions.

Upholding these principles requires dental professionals to make decisions that are free from personal or financial bias, ensuring that patients receive the best possible care based on their clinical needs.

However, in practice, dental professionals often face challenges that test their commitment to integrity. Financial considerations, time constraints and administrative demands are just a few of the pressures that can cause ethical dilemmas. These real-world challenges make it imperative for dental professionals to establish workflows and behaviours that promote integrity and prevent accidental ethical lapses.

PRESSURES IN DENTISTRY

While integrity is crucial to maintaining ethical standards in dentistry, the pressures that dental professionals face daily can make it difficult to consistently uphold this value. Several key factors contribute to these challenges.

One of the most significant pressures is financial incentives. Dental practices, especially those in private care settings, run as businesses, which can sometimes create a conflict of interest between profit and patient care. Dentists may feel pressure to upsell treatments or recommend costly procedures that patients may not need. This can lead to

Dr Sobiah Sattar

Sobiah qualified as a dentist in 2006 from the University of Glasgow. She is the co-owner of two dental practices in Scotland, taking over primarily clinical governance duties. She is currently a vocational trainer and has previously mentored several overseas students in obtaining their performer list number. She is also a fitness to practise panellist for the GDC.

DEFINED AS THE QUALITY OF BEING HONEST AND HAVING STRONG MORAL PRINCIPLES, INTEGRITY ENSURES THAT PATIENT CARE IS PROVIDED IN A TRANSPARENT, ETHICAL AND PATIENT-CENTRED MANNER

over-treatment or a focus on profit rather than patient wellbeing. Additionally, financial pressures can influence decisions about which patients receive priority, with those who pay higher fees potentially receiving 'better' treatment than patients who rely on public healthcare systems.

Time constraints further complicate a dental professional's ability to act with integrity. According to a study published in the *Journal of Dental Research* in 2020, 68% of dentists reported that time constraints in practice frequently led to reduced patient interaction, increasing the risk of compromised care quality.

The need to see a high volume of patients in a limited amount of time can result in rushed appointments, reduced quality of care, and insufficient patient communication. Dentists who feel pressured to meet quotas or maximise productivity may inadvertently compromise patient-centred care in favour of efficiency, leading to suboptimal outcomes.

Moreover, dental professionals must contend with administrative and regulatory burdens. A 2020 survey by the British Dental Association revealed that 64% of dentists reported feeling overwhelmed by regulatory requirements, with 45% admitting that they occasionally struggled to keep up with infection control and documentation protocols, which further increases the risk of ethical lapses.

64% OF DENTISTS FEEL OVERWHELMED BY REGULATORY REQUIREMENTS

Keeping up with detailed record-keeping, infection control protocols, and other regulatory requirements can be overwhelming. In some cases, these pressures may tempt professionals to cut corners, particularly when time and resources are stretched thin. This can lead to lapses in transparency or accountability, which are fundamental aspects of integrity.

Finally, patient demands can also present ethical challenges. Some patients may request unnecessary treatments, particularly when it comes to cosmetic dentistry, which places the dental professional in a difficult position.

Balancing a patient's wishes with the need to provide ethical, evidence-based care can be tricky, especially when refusal could be interpreted as poor service or when a patient's expectations do not align with what is clinically appropriate.

PROMOTING INTEGRITY: BEHAVIOURS, WORKFLOWS, AND BEST PRACTICES

To navigate these challenges and maintain ethical standards, dental professionals can adopt several strategies to promote integrity in their daily work. These practices not only safeguard the professional from ethical lapses but also reassure patients and the broader dental community that their actions are in line with the highest standards of care.

One of the most effective ways to demonstrate integrity is through transparent communication. This involves being clear and honest with patients about their treatment options, costs, and the risks and benefits associated with each procedure.

A 2021 study by the Oral Health Foundation found that 87% of patients rated trust as the most important factor when choosing a dentist with 70% of those surveyed being more likely to recommend a dentist who took the time to explain treatment options clearly. By offering detailed explanations and respecting the patient's right to make informed decisions, dental professionals can foster a trusting relationship. Encouraging second opinions when appropriate and discussing alternatives openly shows that the professional prioritises patient care over financial considerations.

Another key practice is ensuring that all treatment decisions are evidence-based. Adhering to clinical guidelines and keeping up with the latest research helps dental professionals avoid unnecessary treatments and ensures that their recommendations are grounded in science rather than profit. Continuous professional development (CPD), including attending workshops and ethical training, is vital to maintaining this standard.

Implementing financial checks and balances within the practice can also prevent conflicts of interest. Professionals can ensure that clinical decisions are separate from financial management by employing systems that minimise bias, such as having clear policies on treatment recommendations that are based solely on clinical need.

Additionally, peer review and accountability can play a significant role in maintaining integrity.

Engaging in peer discussions about complex cases or seeking advice on ethical dilemmas can provide dental professionals with additional perspectives and help them make sound, patient-centred decisions.

Peer reviews encourage transparency and provide a support system for navigating difficult ethical situations.

DEMONSTRATING INTEGRITY TO PATIENTS

Demonstrating integrity is essential, not only for maintaining ethical standards but also for building patient trust.

Patients must feel confident that their dentist is acting in their best interest. This is especially important in a field like dentistry, where patients often rely on professional recommendations without fully understanding the technical aspects of care.

Dental professionals can demonstrate integrity to patients by practising full

DEMONSTRATING INTEGRITY IS ESSENTIAL NOT ONLY FOR MAINTAINING ETHICAL STANDARDS BUT ALSO FOR BUILDING PATIENT TRUST. PATIENTS MUST FEEL CONFIDENT THAT THEIR DENTIST IS ACTING IN THEIR BEST INTEREST

disclosure. This means providing all the necessary information about a patient's diagnosis, treatment options and costs. Transparency reassures patients that they are receiving honest advice, and that the dentist is not prioritising personal gain. Similarly, maintaining accountability by admitting mistakes if they occur and correcting them promptly helps foster a culture of trust.

Lastly, consistency in care across all patient groups, whether private or public, is another way to show integrity.

Patients should be able to trust that their level of care does not vary based on their ability to pay. Providing the same high standard of care for all patients, regardless of financial considerations, reinforces the professional's commitment to ethical practice.

THE IMPACT OF A GDC INVESTIGATION ON INTEGRITY

A General Dental Council investigation can put tremendous pressure on dental professionals, testing their ability to maintain their integrity. An investigation may be triggered by a patient complaint or an alleged breach of regulatory standards, and it can come with significant personal and professional implications.

The fear of reputational damage, financial penalties, or even suspension from practice can create a stressful environment in which professionals may feel tempted to act defensively or hide information. However, such behaviour can compromise their integrity even further.

During a GDC investigation, it is essential that professionals remain transparent and cooperative. Providing the necessary information and fully cooperating with the investigation demonstrates a commitment to ethical behaviour. Conversely, wny attempt to withhold information or manipulate the process can damage a professional's credibility and worsen the situation.

It is also crucial for professionals to seek legal and ethical guidance early in the investigation process. Legal support helps them navigate the complexities of the investigation while ensuring that they remain compliant with regulations. Additionally, seeking ethical guidance from mentors or professional organisations can provide reassurance and help professionals maintain their moral compass during the investigation.

INTEGRITY IS A FUNDAMENTAL PRINCIPLE THAT UNDERPINS PATIENT TRUST AND HIGH-QUALITY CARE IN DENTISTRY

However, the pressure of a GDC investigation can lead to ethical lapses. Dental professionals may experience intense stress and anxiety, which can cloud their judgment and lead to poor decisions.

To mitigate these risks, professionals should focus on building emotional resilience. This may involve practising mindfulness, seeking counselling, or relying on support networks such as peers or family.

Developing strategies for managing stress not only helps maintain ethical standards but also ensures that professionals can continue providing high-quality care throughout the investigation process.

CONCLUSION

Integrity is a fundamental principle that underpins patient trust and high-quality care in dentistry. Dental professionals, despite facing real-world pressures, must adopt practices that reinforce their commitment to ethical standards.

Transparent communication, evidence-based decision-making, and financial accountability are essential tools for promoting integrity in daily practice.

During challenging situations, such as a GDC investigation, professionals must remain transparent and seek support to navigate the pressures put on them without compromising their ethical values.

By maintaining their focus on patient-centred care and upholding professional standards, dental professionals not only protect their own reputations but also contribute to the integrity of the entire profession. ⬢

HELPLINES AND SUPPORT

Services to help dental care professionals:

- MIND provides supportive and reliable information on mental health issues: 0300 123 3393, mind.org.uk
- Confidental provides help if you're in emotional distress or just need someone who understands to talk to: 0333 987 5158, confidential-helpline.org
- Dentists' Health Support Programme (DHSP) provides dental professionals and dental students with free advice and support on alcohol, drugs, eating disorders and health issues: 020 7224 4671, dentistshealthsupporttrust.org
- NHS Practitioner Health Programme provides free and confidential services relating to mental, physical health and addiction: 0300 0303 300, practitionerhealth.nhs.uk
- Queen Mary, Legal Advice Centre provides free fitness to practise support services: 020 7882 3931, lac.qmul.ac.uk

FURTHER READING

Brooks J (2023) Honesty and integrity in the dental profession. *BDJ In Pract* 36: 12-13

CPD

ENHANCED CPD

Topic: Legal and ethical issues

Educational aims and objectives: To discuss the concept of integrity in dentistry, the challenges that compromise it, and the practices dental professionals can adopt to promote it in their daily work.

GDC development outcome: D
CPD hours: one

Answer the CPD questions online at **dentistry.co.uk/cpd**. Scan the QR code to access the article. Any problems, call the CPD hotline on **01923 851777** or email **cpdsupport@fmc.co.uk**.

QUESTIONS

1. What is the primary definition of integrity in healthcare, according to the article?

- ☐ a. The ability to work quickly and efficiently
- ☐ b. The quality of being honest and having strong moral principles
- ☐ c. Prioritising financial gain over patient care
- ☐ d. Adhering strictly to administrative protocols

2. Which factor is not mentioned as a pressure that challenges integrity in dentistry?

- ☐ a. Financial incentives
- ☐ b. Time constraints
- ☐ c. Patient demands
- ☐ d. Lack of professional development opportunities

3. In a 2021 study by the Oral Health Foundation, what percentage of patients rated trust as the most important factor when choosing a dentist?

- ☐ a. 55%
- ☐ b. 65%
- ☐ c. 87%
- ☐ d. 95%

4. According to the *Journal of Dental Research*, what percentage of dentists reported that time constraints frequently led to reduced patient interaction?

- ☐ a. 30%
- ☐ b. 50%
- ☐ c. 68%
- ☐ d. 80%

Proactive approaches to complaint management

Jennie Jones explores complaint handling and how to prevent escalations in the dental practice setting

Responding and resolving primary healthcare complaints requires a combination of compassion, effective dispute resolution skills and a person-centred process. For those members of the practice team who fulfil this role, that compassion and resolution expertise often extends to colleagues as well as patients.

Healthcare complaints are more emotive than consumer-to-business complaints, and the emotional drivers exist for both healthcare professionals and their patients. Dental patient complaints also involve the interaction between the NHS and private funding of dental treatment, which brings an additional element in sectors like dentistry and optical healthcare.

Communication and timely interactions sit at the heart of defusing issues and avoiding escalation.

The most complex complaints can often be triggered by lower level issues that escalate to major problems, harming the practice's reputation and team cohesion in the process. Research also illustrates the negative impact this has on healthcare professionals' approach to care, where being complained about results in defensive practice, in turn hampering patient interaction, trust and confidence further.

Adopting proactive approaches to communication and complaint management is key to preventing escalation, and also building continuous improvement into the practice culture, which improves retention and staff wellbeing. In this article we look to explore some of the strategies that can help theory to be embedded into practice.

Jennie Jones

Jennie is a partner at Nockolds, and leads Nockolds Resolution, which delivers a complaint resolution service (CRS), providing individual escalated complaint mediation and offering subscription-based service, training and consultancy for regulators, practices and sectors in healthcare across the UK.

EMPOWERING STAFF

The first step in proactive complaint management is maintaining a culture where patients are able to ask questions or voice any concerns easily. Alongside this should sit a confident and compassionate team who receive those queries or concerns as an opportunity to support and assist patients.

Team members who interact with patients at all touchpoints need to feel confident about having open conversations around complaints or dissatisfaction.

Practical, focused training on communication and complaint handling builds confidence and encourages staff to manage situations 'in the moment'. This training should cover active listening, empathy and problem-solving skills.

Empowering colleagues to resolve low-level issues at the first point of contact builds confidence and creates a sense of ownership.

Often, this early dialogue helps manage issues as part of the 'everyday' patient interaction whenever possible. Doing this reduces the need for escalations and can lead to faster resolutions, enhancing customer satisfaction in the process.

Regular scenario and insight-led training sessions and updates on company policies and procedures can keep the team prepared to handle complaints proactively and consistently. Even in a busy practice without full team cover, we can see the time, energy and cost savings of earlier conversations and resisting the auto-pilot response of 'email the practice manager'.

ESTABLISH CLEAR COMMUNICATION CHANNELS

A clear complaint policy that encourages early resolution can establish a sturdy framework and bring clarity – but it must also encompass a human and compassionate response.

Where complaints need to enter a more formal process, clear communication channels must be established and communicated to patients. This can be done through various touchpoints, including websites and in practice, but regardless of hether it's a dedicated helpline, online form, or a customer service email, accessibility and responsiveness are crucial.

Prompt acknowledgment of complaints can reassure patients that their concerns are being taken seriously.

When patients know how to raise and communicate concerns, this helps the complaint stay focused on the complaint issues rather than having it erupt in a more public channel when patients feel dismissed or without a voice.

Making feedback channels readily available, and sharing complaint and feedback procedures, encourages patients to share both positive and negative feedback, as well as managing the escalation from informal dialogue to formal complaint process.

Having a transparent complaint resolution policy that is easily accessible to patients can set clear expectations and reduce frustration. This policy should outline how complaints are handled, the steps involved, and the expected timeframes for resolution.

Transparency can build trust and demonstrate a commitment to addressing customer concerns effectively.

FOSTER A PATIENT-CENTRIC CULTURE

Cultivating a person-centric culture within the practice can significantly impact how complaints are handled.

When all team members understand the importance of patient satisfaction, put people over process and are encouraged to prioritise it, they are more likely to take proactive steps to address issues. The most effective practice teams work as 'one': their different skill sets and strengths complement each other, creating a positive culture for patients.

There are multiple benefits in managing complaints from a 'customer' perspective – the 'NHS Friends and Family' test is a simple concept that helps to remind us all to stand in the patient's shoes.

We live and breathe our professional shorthand. We sit more comfortably in our practice environments. We have the reassurance of our knowledge and clinical experience. Understanding an interaction from the client's perspective helps to identify the 'why'.

RESOLUTION THROUGH MEDIATION

There are a number of alternative dispute resolution (ADR) approaches. Mediation is one of these, which has been found to be effective in healthcare complaints.

Mediation seeks to understand the circumstances of the complaint and to then gain a deeper understanding of the root cause, the drivers and the barriers to resolution to help the parties to find a mutually agreeable way forward.

This empathetic approach encourages healthcare professionals to listen, ask and watch and avoid assumptions, jumping to solutions that may unintentionally inflame the situation. As Stephen Covey points outs most people listen to respond, very few listen to understand!

Active and engaged listening is a fundamental ingredient in a customer-centric culture, and a key part of mediation techniques.

Using open questions to explore the complaint and the wide context of the patient's concerns, and then summarising your understanding help to gain a greater understanding of what is going on beneath the surface of the complaint – particularly where the practice feels the complaint is unjustified or the patient's reaction is disproportionate.

ACKNOWLEDGE THE IMPACT

By truly understanding the 'why', we can acknowledge the issues and the impact on the patient.

Within this early stage of complaint management, trust and rapport are important as we are looking to rebuild or strengthen the complainant's trust in the practice.

This is also key in exploring explanations and reasoning as the complainant will be more inclined hear and understand the information shared.

At this stage, my experience suggests an important element of this early interaction is to ask the patient 'what is their desired outcome?' or 'how do they see this complaint being resolved?'.

The shared understanding of the situation, the individuals involved, and potential ways forward helps to identify and manage unrealistic expectations from the outset.

It can also identify any early opportunities to resolve the issue 'in the moment' without risking escalation by making assumptions about what the patient needs.

ANALYSE AND UNDERSTAND THE ROOT CAUSE

Once the root cause or key triggers are understood, we can consider whether this is a 'situational', 'systemic' or 'behavioural' scenario. By understanding the underlying issues, practice teams can address not just the symptoms but the core problems, preventing recurrence and improving overall operations.

This can also provide insight that helps practice teams to improve the assistance provided to vulnerable patients or those who would benefit from reasonable adjustments in terms of what and how information is conveyed and how practice procedures can be made more accessible.

For many complainants, a driving motivator is 'I don't want anyone else to be in this position'. A good understanding of the root cause and the patient's perspective on the causes can help to focus on the quality improvement output of a complaint, which can often be very impactful on patients.

ADDRESSING THE ISSUES

Patients can become frustrated with complaint responses, whether on the phone, in person or in writing, that seek to showcase the clinical care and skill of the practice but do not address the key points raised. Analysis of healthcare complaints indicate that the underlying causes relate to communication and expectations, and dental complaints also reflect this.

Having clarity around the points raised by the patient and confirming this by bulleting the issues to be covered helps to ensure we address the issue raised and not the complaint we would prefer to answer.

Where the number of points raised is extensive, it is worth exploring with the complainant if the points can be 'themed' or if there are three fundamental issues that are priority for the complainant. If it is agreed at the outset that the complainant would be satisfied with those points being addressed, this can provide both the patient and the practice with clarity.

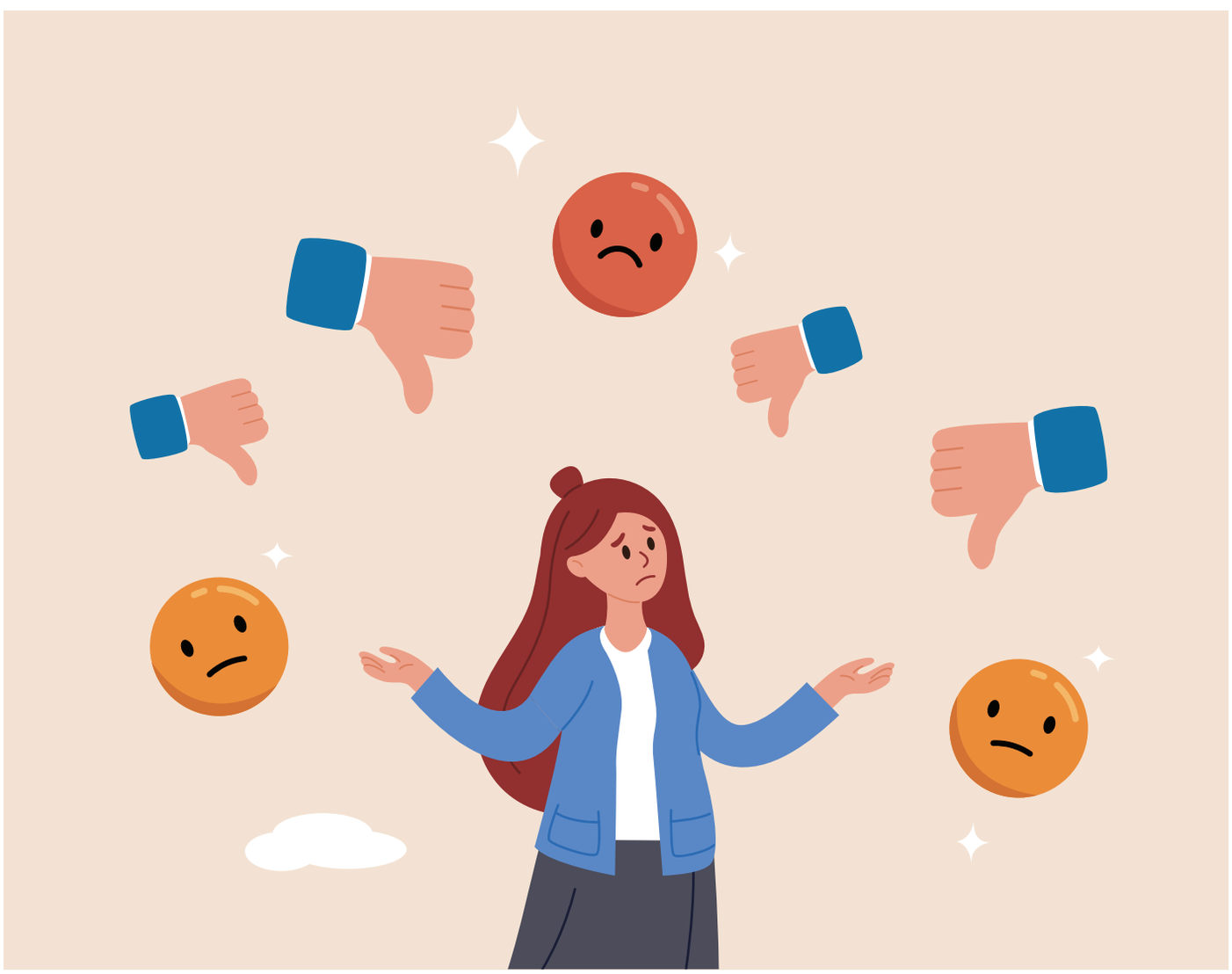
Mediation insight suggests that a practice's assessment of the most critical issue may be very different to that of the complainant's.

Assumptions are the root of many escalating complaints. In my role as the head of the Optical Consumer Complaints Service and in handling other healthcare complaints, I have found the saying 'clarity is kindness' to be a real mantra.

Whether the complaint relates to expectations around outcomes, durability of treatment, or the interaction with practice team members as opposed to alleged clinical 'errors', the patient's assessment of 'value for money' will play a part in how satisfied a patient feels after attending the practice, and whether they raised a complaint.

With access to dental care currently under pressure, there is a potential barrier to patients raising issues early. Patients may disproportionately fear implications on future treatment or even their status as a patient of the practice.

This can inadvertently increase the



complexity of complaints as patients hold off raising some issues: these build up until the patient 'erupts' because of a perceived 'minor' or administrative issue.

REASSURANCE

Conflict resolution research highlights the importance of reassurance and its role in moving from dispute to resolution.

When considering the root causes of a complaint and why earlier attempts to resolve the issues have failed, understanding the complainant's unmet need at that time and in that situation is often the key to resolving a complaint effectively.

OWNING THE RESOLUTION

We must see the process through. Complaint resolution will succeed or fail due to trust and rebuilding a connection between the patient and the practice, often on a one-to-one level.

Keeping to agreed timelines is important to complainants: when we miss indicated timelines, patients feel let down and unimportant. The trust and rapport built up during the complaint process can then be lost very quickly, escalating the complaint.

The complainant links what they see as an inability to follow through or 'keep our word' with earlier perceived failings and it reinforces those views. From the practice perspective, not meeting those expectations is rarely intentional, but due to other pressing priorities –but keeping in contact and explaining any delay will go a long way to maintaining trust.

Keeping patients informed about the steps taken to address their concerns can significantly enhance their trust and satisfaction. Follow up with them to explain the actions implemented and how these changes are working to prevent similar issues in the future.

This shows patients that their feedback has led to tangible improvements, reinforcing the value of their input.

The stretch is 'can we overdeliver and delight this complainant?' If we aim for this, we have a greater chance of some complainants becoming goodwill ambassadors for the practice. It can feel a real stretch but it is worth a shot!

THE LEARNING LOOP

Following up within the practice as we deal with a complaint, and once it has been resolved, is important for many reasons. It demonstrates that the organisation values feedback and is committed to continuous improvement. This proactive approach can turn a potentially negative experience into a positive one, increasing loyalty and trust within the team.

A patient-centric culture should enhance a 'one team' and team-centric ethos. The two should not be mutually exclusive. Compassion, clarity and understanding 'why' are as important for colleagues as for patients. This is also a foundation for service-related quality improvement.

A shared, one-team approach to understanding why the practice may have agreed to resolve a complaint in a particular way helps colleagues to see the resolution as a person-centric and 'win/win' outcome, which brings matters to an end and allows the practice to invest the insight, rather than reinforce an adversarial patient versus practice mindset. These approaches will support staff wellbeing, trust in the leadership team, and overall staff retention at practice and sector level.

MANAGE THE ESCALATION

When local resolution is not possible, it is then important to have clear escalation pathways. In recent years we have seen social media and online reviews being used to escalate concerns and hasten responses.

This was once more prevalent in service sectors rather than healthcare. However, consumer behaviour has also developed and, increasingly, a proportion of patients will see social media platform as being the way to raise a concern. Accepting this and having clear pathways to bring those concerns into your process will help the team to act quickly as response time expectations are far shorter than we saw even five years ago, prior to the COVID-19 pandemic.

Public-facing online responses also help to demonstrate to other patients how you handle complaints, and the commitment to delivering excellent standards of care and service.

Complainants should be guided to the most appropriate forum, whether that is a regulatory or legal pathway or more proportionately, to an independent process such a complaint mediation or resolution service. These can help to keep complaints in the most appropriate forum and avoid disproportionate escalation – which rarely benefits either the complainant, the practice or the individual healthcare professionals involved.

FURTHER INFORMATION

To find out more, visit www.nockolds.co.uk/services/nockolds-resolution-adr/complaints-resolution-service.

SUMMARY

Through my 25 years' involvement in resolving healthcare complaints, I believe that complaints, when approached constructively, can be a powerful driver of positive change within an organisation.

By embracing a positive mindset, listening actively, analysing the root cause, developing and implementing an action plan, communicating with consumers, and fostering a culture of continuous improvement, organisations can transform challenges into opportunities for growth and excellence.

CPD

ENHANCED CPD

Topic: Complaints handling

Educational aims and objectives: To discuss proactive approaches to complaint management in dentistry.

GDC development outcome: A
CPD hours: one

Answer the CPD questions online at **dentistry.co.uk/cpd**. Scan the QR code to access the article. Any problems, call the CPD hotline on **01923 851777** or email **cpdsupport@fmc.co.uk**.

QUESTIONS

1. According to the author, what should practical and focused training in communication and complaint handling cover?
- ☐ a. Active listening
- ☐ b. Empathy
- ☐ c. Problem-solving skills
- ☐ d. All of the above

2. What does ADR stand for in relation to this article?
- ☐ a. Alternative dispute resolution
- ☐ b. Average dental remuneration
- ☐ c. Altered defensive retaliation
- ☐ d. Angry disagreement response

3. According to the author, what is a fundamental ingredient in a customer centric culture?
- ☐ a. Team cohesion
- ☐ b. Active and engaged listening
- ☐ c. Company policies and procedures training
- ☐ d. Standing in the patient's shoes

4. What saying has the author found to be a real mantra?
- ☐ a. Act, watch, listen
- ☐ b. Clarity is kindness
- ☐ c. Two ears for listening
- ☐ d. None of the above

Detecting head and neck cancer

Michelle Vickers discusses the importance of early detection in curbing head and neck cancer cases

Head and neck cancer cases are rising at a staggering 30% per decade, meaning we are fast approaching a crisis. Early detection of oral cancer by dental professionals can help curb this rise, but sadly, current statistics show only a third of head and neck cancer cases are diagnosed at stages one and two.

Most individuals are unaware of the signs and symptoms to look out for. With the nature of these types of cancer, this can be detrimental to the chances of recovery.

Oracle Head & Neck Cancer UK is pushing for more awareness around this life-threatening disease. The charity supports patients diagnosed with head and neck cancers, invests in pioneering research and raises awareness of signs and symptoms.

Head and neck cancer is the fifth most common cancer in men and the eighth most common cancer overall in the UK.

WHAT IS ORAL CANCER?

Oral cancer is a form of head and neck cancer that affects the lip, tongue, lining of the mouth and gums, and the area of the throat at the back of the mouth, and it continues to pose a significant health threat in the UK.

Over the last five years, the incidence of oral cancer has risen sharply, with the latest statistics from the Care Quality Commission (2024) revealing that approximately 8,300 new cases are diagnosed each year. This represents a 34% increase in cases compared to five years ago. Alarmingly, the mortality rate has also grown by 21%. According to the Oral Health Foundation (2024), 3,637 people in the UK lost their life to mouth cancer last year.

Mouth cancer is typically categorised into four stages. Stage one and stage two are considered the early stages of cancer. This is when it is generally smaller and has not yet spread to nearby lymph nodes or distant organs. Tumours at this stage are typically less than 4cm in size.

Stage three and stage four are advanced cancers, in which the tumours are larger than 4cm or have spread to surrounding tissues, lymph nodes, or other parts of the body.

These stages often require more intensive treatment and are associated with poorer outcomes.

THE IMPORTANCE OF EARLY DETECTION

Early detection is crucial in the fight against oral cancer. Patients diagnosed at stage one or stage two have a five-year survival rate of up to 85%, whereas those diagnosed at later stages face much lower survival rates, dropping as low as 40% by stage four.

Delayed diagnosis often results in more aggressive treatment, including surgery, radiation and chemotherapy, which can significantly impact patients' quality of life.

Recent statistics show that only 13% of all head and neck cancer cases are caught early. Most oropharynx cancers are diagnosed late, with only 12.5% being diagnosed at stage one and two. Meanwhile, 41.7% of oral cavity cancers and 44.5% of laryngeal cancers are diagnosed in the early stages.

For comparison, 76.5% of breast cancer cases are diagnosed at stage one and two and 81.5% of melanoma skin cancers are diagnosed early.

Raising awareness about the importance of early detection through regular dental check-ups, self-examination, and public education campaigns like the Sign Away Cancer initiative by Oracle Head & Neck Cancer are key to reversing these alarming trends.

Early intervention dramatically improves survival rates and treatment outcomes, making it one of the most critical aspects of managing oral cancer.

ORAL CANCER: SIGNS AND SYMPTOMS

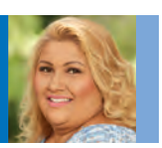
Head and neck cancers are classified into several types based on where they develop. Oral cancer develops in the lip, tongue, lining of the mouth and gums, and the area of the throat at the back of the mouth. Early signs and symptoms can include any one or more of the below that last for three weeks or longer:

- Mouth ulcers or sores
- Persistent lumps
- Red or white patches
- Bad breath
- Ear ache
- Difficulty swallowing
- Unexplained bleeding.

Several lifestyle factors can increase an individual's risk of developing head and neck cancer. Risks include tobacco use, including smoking tobacco or smokeless tobacco, and excessive alcohol consumption. Poor oral hygiene can also increase the risk of developing cancers and sun exposure can increase the chances of lip cancer.

Men are also generally more likely to develop head and neck cancers than women, though this is changing with rising human papillomavirus (HPV)-related cancers and thyroid cancers are more common in women.

An estimated 80% of people come into contact with a high-risk HPV infection in their lifetime. While most of the time HPV causes



Michelle Vickers

Michelle is chief awareness officer at Oracle Head & Neck Cancer UK.

no harm, high-risk HPV infections can result in head and neck cancer, cervical cancer, genital cancer, anal cancer and genital warts.

Oracle Head & Neck Cancer UK has launched the Sign Away Cancer campaign, advocating for parents and caregivers to sign their child's HPV vaccination form. Once offered only to girls, the HPV vaccine is now available to all 12- and 13-year-olds as a vital tool in preventing cancers in both genders, including cervical, and head and neck. However, the uptake of the vaccine remains low, with only 52% of boys and 56% of girls receiving the vaccine in 2022.

Around 700,000 people a year worldwide are diagnosed with HPV-related cancers. Cases have doubled in the last two decades, making HPV the fastest-growing cause of cancer in the UK. HPV cancers are one of the few to have a vaccine. The vaccine could prevent more than 100,000 cancers by 2058, so it is critical that the uptake increases.

ADDITIONAL HEAD AND NECK CANCERS

Other head and neck cancers include pharyngeal cancer, also known as throat cancer. Subsets of this cancer include oropharyngeal cancer in the middle of the throat, including the back of the mouth, tonsils and soft palate, and hypopharyngeal cancer can be found in the lower part of the throat. Signs and symptoms include any one or more of the below for three or more weeks:

- Difficulty or pain swallowing
- A lump or mass in the neck
- Ear pain or difficulty hearing
- Changes in voice including hoarseness
- Unexplained weight loss
- Persistent cough.

Similar to other head and neck cancers, tobacco and alcohol use and HPV infection can increase the risk of developing cancer. Meanwhile, the Epstein-Barr virus, poor nutrition and exposure to certain chemicals or wood can also increase risk.

Another type of throat cancer is nasopharyngeal cancer, which can be found in the upper part of the pharynx, behind the nose. Signs and symptoms of nasopharyngeal cancer include any one or more of the below for three or more weeks:

- Blurred or double vision
- Headaches
- A lump in the neck
- Difficulty hearing or a feeling of fullness in the ear
- A persistent blocked or bleeding nose.

Risks include Epstein-Barr virus infection, a family history of nasopharyngeal cancer, and smoking. Dietary factors – including a high consumption of salted fish – can also increase an individual's chances of developing this cancer.

Meanwhile, laryngeal cancer is cancer of the larynx (voice box). It is associated with a persistent hoarseness or change in voice, difficulty or pain swallowing, a lump or

swelling in the neck, a persistent cough or sore throat, ear pain and shortness of breath. Again, one or more of these signs would last for three or more weeks.

Occupation exposure to substances like asbestos and gastroesophageal reflux disease can increase the risk of laryngeal cancer. So too can tobacco use, excessive alcohol consumption and HPV infection.

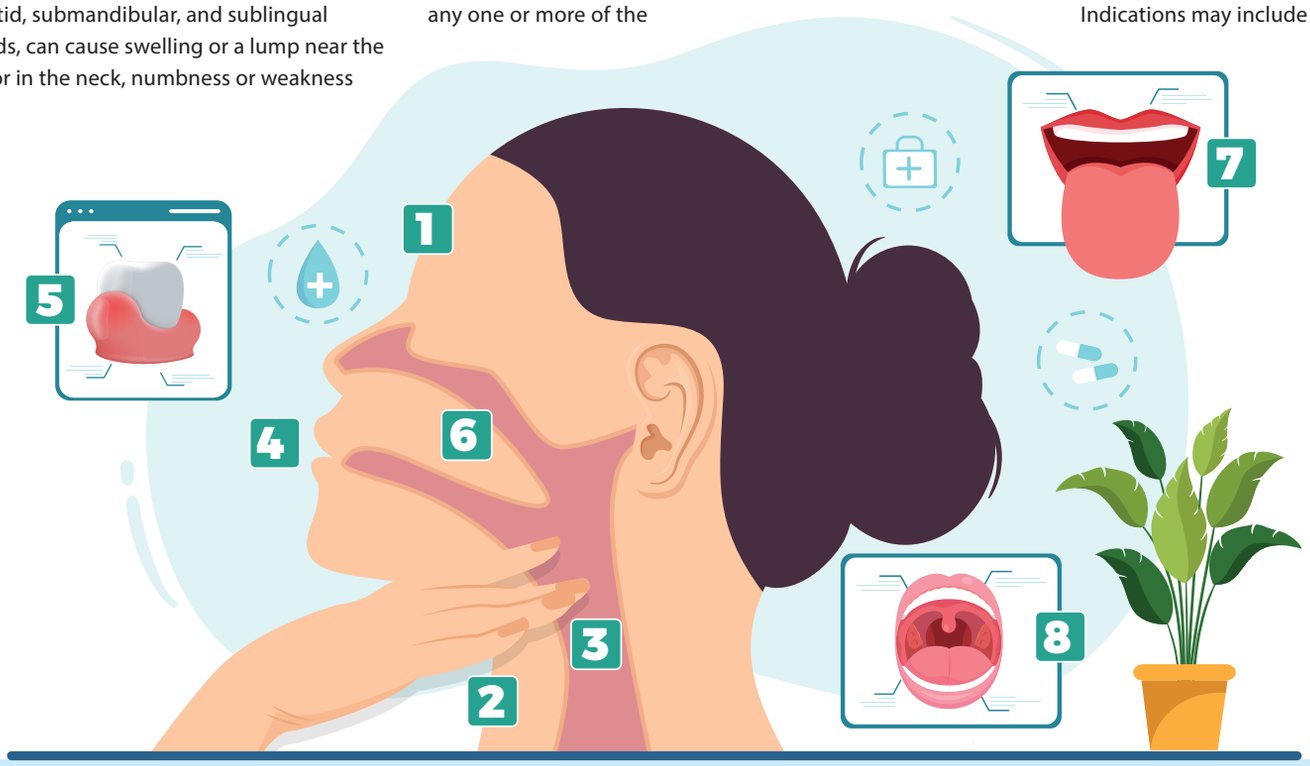
Salivary gland cancer, including the parotid, submandibular, and sublingual glands, can cause swelling or a lump near the jaw or in the neck, numbness or weakness in the face, pain in the area of the salivary glands and trouble opening the mouth fully or swallowing for three or more weeks.

Risk factors include radiation exposure, old age and workplace exposure to chemicals, including rubber manufacturing or plumbing industries.

Nasal and paranasal sinus cancer can be found in the nasal cavity and paranasal sinuses. Signs and symptoms include any one or more of the following that last for three weeks or longer: a persistent blocked nose or nasal congestion, nosebleeds or unusual nasal discharge, facial pain, numbness, or swelling, pain or pressure in the ear and difficulty seeing or double vision.

Chronic sinus infections and occupational exposure to wood, dust, nickel or certain chemicals can increase risk.

Thyroid cancer occurs in the neck. Indications may include



1 FACE

Look at the whole face – are there any swellings you haven't noticed before? **Inspect your skin** – has anything changed recently? Have moles become larger or started to itch or bleed? **Turn your head from side to side** – this stretches the skin over the muscles making lumps easier to see.

2 NECK

Run your fingers under your jaw and feel along the large muscle either side of your neck. Are there any unusual swellings, such as a hard, painless lump on the side of the neck? Does everything feel the same on both sides?

3 THROAT

Have there been any recent **changes in your throat** that have **lasted longer than three weeks**? Has your throat been **sore** or have there been **changes in your voice**? Has there been a **cough** or **pain in swallowing**?

4 LIPS

Use your fingers and thumb to feel the inside of your mouth. Pull your upper lip upwards and bottom lip downwards. Look inside for any sores or changes in colour.

5 GUMS

Use your thumb and forefinger. Examine your gums feeling around the gum for anything unusual.

6 CHEEKS

Open your mouth and pull your cheeks away, one side at a time, with your finger. Look for any red or white patches. Does everything feel the same on both sides? **Use your finger in the cheek** to check for ulcers, lumps or tenderness. **Repeat on the other side**. Your tongue can be helpful to locate sore areas, ulcers or rough patches.

7 TONGUE

Gently stick out your tongue and look at one side first and then the other. Look for any swelling, ulcers or change in colour. **Examine the underside of your tongue** by lifting the tip of your tongue to the roof of your mouth.

8 FLOOR AND ROOF OF MOUTH

Tilt back your head and open your mouth wide to inspect the roof of your mouth. Look to see if there are changes in colour or ulcers. Check for changes in texture with your finger. **Lift your tongue up and look underneath at the floor of your mouth**. Look for any colour changes that are unusual. **Gently press your finger along the floor of your mouth and under your tongue**. Feel for any lumps, swellings or ulcers.

Figure 1: Self-check guide (Oracle Head & Neck Cancer)

a lump or swelling in the neck, difficulty swallowing or breathing, persistent cough not associated with a cold and hoarseness or voice changes. Any one or more of these signs would last for three weeks or longer.

A family history of thyroid cancer and certain inherited genetic conditions can increase an individual's level of risk. Females are more likely to develop thyroid cancer.

Other risks to be aware of include exposure to radiation, especially in childhood.

THE DENTAL PROFESSIONAL'S ROLE

Oracle Head & Neck Cancer UK recognises the role of dentists in diagnosing head and neck cancer. The charity has produced a range of resources including video guides on how to perform oral cancer screenings and examinations, available to dental professionals to offer in practices.

These tools are often provided by professional dental associations, health organisations and cancer charities. Oracle Head & Neck Cancer UK has also produced a self-check video (headneckcheck.com), which offers a practical, step-by-step demonstration to help dental teams identify early signs of oral cancer during routine check-ups.

The key professionals in the dental team who can perform these checks include dentists, dental nurses, hygienists and therapists. Dentists are the primary healthcare providers responsible for oral cancer screening. During routine exams, it is essential to visually inspect and palpate the mouth, tongue, throat, and jaw for any abnormalities, lesions, or lumps.

Hygienists and therapists are also trained to perform oral cancer checks as part of their overall patient care. During appointments they can detect suspicious changes that need to be referred to the dentist for further examination. While dental nurses generally assist in clinical settings, they play a vital role in patient education, supporting the dentist and hygienists in ensuring thorough examinations are conducted. They can also inform patients about self-checks at home.

It is important for all members of the dental team to be well-trained in identifying potential signs of oral cancer and to know when to escalate concerns to a dentist or specialist for further investigation. Video guides and continuing professional development (CPD) courses can be valuable tools for ensuring dental professionals are up to date with the latest screening techniques. Dentistry CPD (dentistry.co.uk/CPD) is one such source of information.

REAL-LIFE SITUATIONS

Harvey Deaton from Leeds went backwards and forwards with his GP in 2022 with an earache that had lasted nine months. After taking the maximum number of painkillers, a visit to his dentist saw him being referred back to his GP.

Harvey had mentioned to his dentist that he had a sore mouth and tongue. It was clear that Harvey had inflammation under his tongue and on the left side of his mouth. He was later diagnosed with a stage four tumour in the base of his mouth.

Harvey said: 'In discussion with my oncology consultants, dentists and nurses who have cared for me at the two hospitals, it is clear that my story is very common. The symptoms of ear pain and sore mouth and tongue are classic signals for mouth and throat cancer. Note that I had no loss of hearing capability throughout this period.'

Denis Howes from Surrey was also supported by his dentist after he developed a lump on his neck. An initial appointment with Denis' GP saw the lump being put down to a glandular or tooth-related problem. However, when Denis went to see his dentist, the examination found no tooth-related issues and an appointment was booked for him to see a consultant at his local hospital.

After more consultations including an MRI scan, biopsies and several teeth removals Denis was finally diagnosed with stage three advanced left tongue base cancer. Denis said: 'When I was told this, I was naturally devastated, and thought the end of the world was in front of me, I looked so fit and healthy, so it never entered my mind that I had such an awful disease.' He underwent three sessions of chemotherapy and a six-week daily radiotherapy treatment, putting him on the road to recovery.

DRIVING BEST PRACTICES

There is still plenty of progress to be made in the head and neck cancer space, with 34 people being diagnosed with a form of the disease in the UK every day. This is coupled with high levels of inequalities in diagnosis and variation in treatment.

Incidence in women is 64% higher in the most deprived groups and for men, incidence is 101% higher in the most deprived group in England.

FURTHER INFORMATION

For more details about Oracle Head & Neck Cancer UK, visit oraclehnc.org.uk.

Head and neck cancers receive significantly less research funding than other cancer types. Once diagnosed, only 50% of patients start treatment within 62 days, the NHS target, making it the cancer with the longest average wait time in England.

In a bid to understand the current situation and drive best practices, Oracle Head & Neck Cancer UK is backing a two-year audit in response to a growing crisis in diagnosis and treatment of this devastating disease in England.

The charity has donated £40,000 towards the £270,000 cost of a two-year study to identify areas for improvement in care and outcomes, using existing data to drive change in this critical field.

CPD

ENHANCED CPD

Topic: Oral cancer: early detection

Educational aims and objectives: To discuss the importance of early detection of head and neck cancer and the role dental professionals play in curbing cases.

GDC development outcome: C
CPD hours: one

Answer the CPD questions online at **dentistry.co.uk/cpd**. Scan the QR code to access the article. Any problems, call the CPD hotline on **01923 851777** or email **cpdsupport@fmc.co.uk**.

QUESTIONS

1. How many stages is mouth cancer typically categorised into?
- ☐ a. Two
- ☐ b. Three
- ☐ c. Four
- ☐ d. Five

2. Recent statistics show what percentage of most oropharynx cancers are being diagnosed at stage one and two?
- ☐ a. 12.5%
- ☐ b. 41.7%
- ☐ c. 44.5%
- ☐ d. 76.5%

3. Which of the following is a risk factor for salivary gland cancer, including the parotid, submandibular, and sublingual glands?
- ☐ a. Radiation exposure
- ☐ b. Old age
- ☐ c. Workplace exposure to chemicals
- ☐ d. All of the above

4. According to the author, once diagnosed, what percentage of patients start treatment within 62 days?
- ☐ a. 25%
- ☐ b. 50%
- ☐ c. 75%
- ☐ d. 100%

An overview on the Prevent duty

Preetee Hylton presents an overview of the Prevent duty, focusing on the identification and prevention of radicalisation and extremism

Safeguarding is a fundamental duty of all dental professionals, which encompasses the responsibility to protect our patients from harm and ensure their wellbeing; this goes beyond the provision of clinical care and involves us addressing any signs of abuse, neglect, and vulnerability.

Additionally, we play a significant role in implementing the Prevent duty, which aims to safeguard people from being drawn into terrorism or extremist activities.

Our responsibility is to collaborate with various authorities, through initiatives like the Channel programme, so that early support can be provided to those susceptible to radicalisation, therefore reinforcing our commitment to safeguarding patients, colleagues, and local communities.

WHAT IS THE PREVENT DUTY?

Prevent duty highlights the responsibility to mitigate the risk of radicalisation and extremism amongst people – especially children and vulnerable young people.

In England, Scotland and Wales, there are some organisations that are mandated by law and designated as specifies authorities, according to section 26 of the Counter-Terrorism and Security Act 2015, to identify and support vulnerable children and young people, aiming to prevent their involvement in acts of terrorism (NSPCC Learning, 2021).

'Prevent' is also one of the of the four work streams of the UK government's counter-terrorism strategy, CONTEST, which was created to decrease the risk from terrorism to the UK, its citizens, and interests overseas (Home Office, 2023).

These four work streams are commonly known as the four Ps:

1. Prevent
2. Pursue
3. Protect
4. Prepare.

WHAT IS RADICALISATION?

Radicalisation is the process through which a person comes to support or be involved in extremist ideologies. It can result in a person becoming drawn into terrorism and is in itself a form of harm (NSPCC Learning, 2021).

WHAT IS EXTREMISM?

According to guidance from the Department for Levelling Up, Housing and Communities (2024), extremism is the promotion or advancement of an ideology based on violence, hatred or intolerance, that aims to:

- Negate or destroy the fundamental rights and freedoms of others
- Undermine, overturn, or replace the UK's system of liberal parliamentary democracy and democratic rights
- Intentionally create a permissive environment for others to achieve the results in (1) or (2).

WHAT IS TERRORISM?

The Terrorism Act 2006 defines 'terrorism' as an action or threat designed to influence the government or intimidate the public. Its purpose is to advance a political, religious or ideological cause (Department for Education, 2023).

Prevent has three objectives:

1. To address the ideological roots of terrorism
2. To provide early intervention for people who are risk of radicalisation
3. Support the disengagement and rehabilitation of individuals who are already involved in terrorist activities (HM Government, 2021).

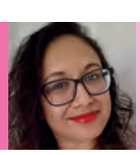
OUR RESPONSIBILITY IN DENTISTRY

Prevent aligns with our safeguarding responsibilities in dentistry towards children, young people and vulnerable adults, with its core purpose being to support individuals in keeping themselves safe by preventing them from getting involved in terrorism-related activities and making informed decisions.

Healthcare providers, including dental professionals, play an essential role in Prevent initiatives as we are sometimes the first point of contact for individuals (family members, friends, acquaintances,

HEALTHCARE PROVIDERS, INCLUDING DENTAL PROFESSIONALS, PLAY AN ESSENTIAL ROLE IN PREVENT INITIATIVES

Preetee Hylton



Preetee obtained her NEBDN National Certificate in Dental Nursing in 2010, followed by her BDA Education Certificate in Dental Radiography in 2013, and then her Preparing to Teach in the Lifelong Learning Sector (PTLLS) qualification in 2015. Currently, Preetee works full-time as a dental nurse and safeguarding lead at a private practice in London.

colleagues, and patients) who could possibly be vulnerable to radicalisation.

Our interactions with such individuals go beyond people who lean towards violent extremism and include vulnerable individuals and those susceptible to non-violent extremism, which may be linked to terrorist activities (HM Government, 2023).

VULNERABILITY VERSUS SUSCEPTIBILITY

Vulnerability refers to a state where a person will need particular attention, help, or safeguarding due to factors such as age, disability, susceptibility to abuse, or risk of neglect (Office for Health Improvements and Disparities, 2022).

Susceptibility often intertwines with emotions such as anger, frustration or confusion, which may lead to some people experiencing feelings of insignificance, marginalisation and even invisibility – they may not feel that themselves and their feelings are acknowledged and/or accepted.

While susceptibility to radicalisation can be linked to vulnerability, these above-mentioned vulnerabilities may not always factor into the early intervention strategies of the Prevent duty.

INCREASED VULNERABILITY TO RADICALISATION: FACTORS

According to Action Counters Terrorism, factors contributing to heightened vulnerability to radicalisation include:

- Identity struggles and having no sense of belonging
- Perceived threats – personal and/or communal
- Anger towards domestic and/or international conflicts
- Mental health challenges
- Traumatic life events such as bereavement or divorce
- Encounters with discrimination, racism and bullying
- Issues related to family
- Feelings of neglect or social exclusion
- Community tensions
- Being associated with people expressing extreme views or being affiliated with extremist organisations.

RAISING CONCERNS: THE NOTICE, CHECK, SHARE PROCESS

We implement the notice, check, share procedure when we suspect that an individual may be radicalised and/or involved in terrorism. It is essential that we have a consistent and proportional approach to addressing concerns about possible involvement in radicalisation and terrorism; our concerns should:

- Be well-informed.
- Be well-intentioned.
- Elicit a thoughtful and proportionate response.

NOTICE

Context is key when noticing a drastic behaviour in an individual; not all changes mean that an individual is being radicalised – we must apply context before jumping to conclusions. Action Counters Terrorism lists potential indicators of risk relating to changes in behaviour in individuals being radicalised as:

- Displaying unusual online behaviour such as spending an increasing amount of time online, creating several online (possibly fake) identities, interacting with and access extremist content, sharing extreme views on social media
- Displaying aggressive behaviour when expressing their points of view, to the

point of being abusive and justifying the use of violence to push for 'change to happen' or 'something to be done'. This also includes blaming others for their own thoughts and actions, instead of taking responsibility for them

- Altering relationships, such as moving from one group of friends to another, modifying their dress sense or appearance in accordance with an extremist group, using new and unfamiliar vocabulary and isolating themselves from family and close friends. This may be due experiencing a personal crisis and/or mental health issues, therefore having an urge to finding meaning to their lives and seeking a sense of belonging; this could lead to individuals being manipulated and controlled by a (extremist) group
- Developing antisocial behaviours, therefore not willing to interact with individuals who are different and who hold different views and opinions on certain subject matters. They become secretive and unwilling to reveal where they are going and may embrace the use of symbols and merchandise associated with extremist organisations.

CHECK

If or when we notice any behavioural changes that suggest a potential involvement in terrorism, we must consult colleagues, and/or our designated safeguarding leads discreetly to identify those concerns.

Checking ensures that comprehensive background information is gathered and understood, before involving authorities and the police – we must be able to evidence why this is relevant to Prevent. Prevent referrals should comprise of radicalisation concerns and ideological indicators (HM Government, 2022).

We should avoid discussing our observations and concerns directly with the person and instead, consult our organisational policies and maintain confidentiality. We must handle any issues of susceptibility to radicalisation with duty and care, to protect people without causing alarm and we must seek diverse perspectives to gain a better understanding in behavioural changes.

(Note: you must immediately call 999 if you believe that someone poses an immediate risk of harm to themselves and/or others!)

SHARE

After gathering and collating relevant information, it is important that we express our concerns and submit a completed Prevent referral form to the police (this form is available to download from the local authorities).

Depending on the situation, we may make a direct referral (if this concerns a family member, a friend or an acquaintance), whereas if it concerns our colleagues and our patients, it is best to inform our safeguarding lead/manager, who will act on our behalf and make a Prevent referral.

AVOID DISCUSSING OUR OBSERVATIONS AND CONCERNS DIRECTLY WITH THE PERSON AND INSTEAD, CONSULT OUR ORGANISATIONAL POLICIES AND MAINTAIN CONFIDENTIALITY

PREVENT REFERRAL AND CONFIDENTIALITY

In the health sector, including dentistry, maintaining trust between patients and the dental team is paramount. However, this trust must be balanced with our professional duty of duty to uphold our responsibility to safeguard and protect our patients and the public. While obtaining consent to share personal data is the ideal approach, there are times where it becomes imperative to divulge information to ensure the safety of individuals or others without explicit consent. If radicalisation is suspected in an individual who is under 18, it is important that consent to share data is obtained from the parents/guardians, unless this places them at a greater risk of danger (HM Government, 2022).

The Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) have strengthened the necessity of getting freely-given consent to share personal date, emphasising the importance of clearly defining the purpose of data processing or sharing with third parties.

These specific regulations also empower criminal justice agencies and statutory partners to process and exchange personal or special category information to:

- Prevent crime
- Prosecute offenders
- Protect those who are vulnerable
- Uphold public safety (Department of Health and Social Care, 2022).

Under the UK GDPR and the DPA 2018, there are provisions permitting the sharing of personal date with law enforcement authorities, who are also referred as 'competent authorities', while they carry out their law enforcement duties.

According to the Information Commissioner's Office, these two regulations allow such data sharing when it deemed appropriate and necessary.

WHAT HAPPENS AFTER A PREVENT REFERRAL IS MADE?

- If you do not receive a confirmation of your Prevent referral within one working day, contact whichever relevant agency the referral was made to
- Counter Terrorism Policing, who have expertise in vulnerability assessment and intervention, will evaluate the referral
- They will respond appropriately to safeguard the individual suspected of radicalisation and the community
- They will also establish if the person is already involved in any ongoing investigations; this is usually completed within five working days
- Other relevant agencies may conduct their assessments (HM Government, 2022)
- If the case is found not to be vulnerability counter-terrorism – related, the case will be referred to mainstream services.

If the case is found to be vulnerability counter-terrorism – related, it will be forwarded to the Channel panel, which is a multi-agency panel, provides early support for anyone who is at risk of radicalisation, supporting terrorist organisations, or committing acts of terrorism, regardless of age, faith, ethnicity or background (Home Office, 2021).

Members of the Channel panel will then assess the individual's risk and decide on case adoption, with statutory interventions happening simultaneously and devise personalised support plans that target:

- General risks to the individual
- Risks associated with extremism and/or radicalisation
- Risk of the individual's involvement in terrorism (Home Office, 2021).

If the referral is found not to be appropriate for the Channel support, the case will be signposted to other authorities and/or safeguarding services.

Acts of terrorism stem from radicalisation and extremism. They evoke a myriad of adverse emotions in diverse communities – anxiety, sorrow, anger, and a deep sense of helplessness.In the realm of healthcare, including dentistry, understanding the extent and the duration of these emotions is vital. There is ongoing research in this area when it comes to safeguarding the public, which sheds light on the impact of terrorism but also creates strategies aimed at reducing violence globally.

REFERENCES

Department for Education (2023) Understanding and identifying radicalisation risk in your education setting

Department for Levelling Up, Housing & Communities (2024) New definition of extremism guidance

HM Government (2021) Prevent Multi-Agency Panel Duty Guidance: Protecting people vulnerable to being drawn into terrorism

HM Government (2022) Get help for radicalisation concerns guidance

HM Government (2022) Making a Referral to Prevent guidance

HM Government (2023) CONTEST: the United Kingdom's Strategy for Countering Terrorism HM Government (2023) Prevent Duty Guidance: guidance for specified authorities in England and Wales

Home Office (2021) Channel and Prevent Multi-Agency Panel (PMAP) guidance

Information Commissioner's Office. Sharing personal data with law enforcement authorities

NSPCC Learning (2021) Radicalisation

Office for Health Improvements and Disparities (2022) Vulnerabilities: applying All Our Health Guidance

ENHANCED CPD

Topic: Safeguarding children and young people

Educational aims and objectives: To provide dental professionals with an overview of the Prevent duty, focusing on the identification and prevention of radicalisation and extremism, as essential components of dental professionals' safeguarding responsibilities.

GDC development outcome: A
CPD hours: one

Answer the CPD questions online at **dentistry.co.uk/cpd**. Scan the QR code to access the article. Any problems, call the CPD hotline on **01923 851777** or email **cpdsupport@fmc.co.uk**.

QUESTIONS

1. What are the essential principles to adhere to during the notice process of the notice, check, share procedure?

- ☐ a. Wait for the individual to ask for help
- ☐ b. Look out for behavioural changes that cause concern
- ☐ c. Call 999 immediately
- ☐ d. Assume that everyone is being radicalised

2. Which behavioural patterns, in the correct context, are most likely to raise suspicion when related to Prevent?

- ☐ a. Fixating on a specific topic
- ☐ b. Rejecting any discussion or challenges
- ☐ c. Declaring an intent to violence
- ☐ d. All of the above

3. Commonly known as the four Ps, what are the four work streams of the UK government's counter-terrorism strategy, CONTEST?

- ☐ a. Protect, Promise, Propose, Prevent
- ☐ b. Prevent, Pursue, Protect, Prepare
- ☐ c. Pressure, Prepare, Prevent, Promise
- ☐ d. Produce, Promote, Person, Pester

4. After how long should we receive confirmation of receipt of a Prevent referral?

- ☐ a. One month
- ☐ b. Five working days
- ☐ c. Two years
- ☐ d. One working day

Oliver McGowan training: learning disability and autism awareness in dentistry

Natalie Bradley considers the legislative duty dental professionals have to ensure equitable quality care is provided for patients living with disabilities and developmental conditions such as autism

Within the world of healthcare, providers and professionals will come across patients who are living with disabilities and developmental conditions such as autism. We have a legislative duty to ensure we provide equitable quality care for these patients, and we are able to provide reasonable adjustments to how their care is delivered as a result of their disability or impairment.

In particular, the Health and Social Care Act was updated in 2022 because of the tragic death of Oliver McGowan. All providers now must ensure they have learning disability and autism training as part of their mandatory training requirements – this includes dentistry.

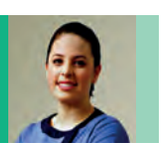
OLIVER'S STORY

Oliver sadly died at the age of 18 after the administration of an antipsychotic medication in hospital.

Oliver had a mild learning disability, autism, and epilepsy. He had been admitted to hospital because of his seizures and while in hospital, the adaptations he needed because of his autism were not provided. His anxiety escalated and he was restrained several times.

The antipsychotic medication was administered despite Oliver and his family refusing it because he had a previous severe reaction to it. This information was also available in his hospital records; however, the medication was still given, and he died as a result.

His parents have campaigned since his death to raise awareness of reasonable adjustments people like Oliver need in healthcare settings, which would mean restraint (either chemical or physical) is less likely to be needed so that preventable deaths like Oliver's would not happen again.



Natalie Bradley

Natalie is a consultant in special care dentistry based in London and clinical director for Dentaid The Dental Charity.

WHAT IS A LEARNING DISABILITY?

According to Mencap, a learning disability (LD) is a reduced intellectual ability and difficulty with everyday activities such as a household tasks, socialising or managing money that affects someone for their whole life.

Someone with a learning disability usually tends to take longer to learn and may need support to develop new skills, understand complicated information and interact with other people. Learning disabilities are different from learning difficulties (such as dyslexia) and neurodevelopmental conditions (such as ADHD) as they affect intellect, but each person can be affected differently.

Learning disabilities can range from mild to severe or profound, depending on how much support an individual needs for activities of daily living.

LD can be caused by different things but is lifelong and will be caused before, during or soon after a person is born. Causes of LD include:

- Genetics, such as syndromes like Down syndrome
- Maternal illness/accident during pregnancy
- Trauma during birth (such as restricted oxygen supply)
- Premature birth
- Early childhood illness, accidents, or seizures.

WHAT IS AUTISM?

According to the National Autistic Society, autism is a lifelong development disability that affects how people communicate and interact with the world.

More than one in 100 people are on the autism spectrum, with around 700,000 autistic adults and children in the UK.

Like LD, autism can affect different people in different ways and its definition has been changing over the years as we begin to understand more about autistic people.

Typical characteristics of people with autism include:

- Difficulties with social interactions and communication
- Repetitive and restrictive behaviours with a dislike of change
- Hyper- or hyposensitivity to noise, lights, tastes, pain
- Highly focused interests or hobbies
- Extreme anxiety
- Behaviours such as 'meltdowns' or 'shutdowns' in particular situations.

THE HEALTH OF PEOPLE WITH LEARNING DISABILITIES AND AUTISM

People with LD and/or autism face health inequalities in comparison to the general population. The average life expectancy of someone with a learning disability is 23 years younger in women, and 19 years younger in men than the general population.

A report named Leder looked into the deaths of people with learning disabilities, and found the 42% of deaths of people with learning disabilities were avoidable, like Oliver's.

There are many reasons for the poorer health (including oral health) of people with learning disabilities and autism, such as:

- Poor access to health services such as long distances to travel to a service, lack of support with transport, lack of an accessible building (eg wheelchair access)
- Lack of understanding and training from

healthcare workers in looking after patients with learning disabilities and autism
- Incorrect diagnoses/or diagnostic overshadowing where a symptom is ignored and attributed to a patient's disability
- Inadequate aftercare and follow-up
- Failure to listen to a patient or their advocates/carers
- Difficulties adapting treatments/care where there may be cooperation or consent challenges.

THE EFFECT ON DENTAL CARE

Oral disease is higher in patients with learning disabilities and autism than the general population. According to guidance from Public Health England (2019), these patients have:

- High levels of periodontal disease
- Greater gingival inflammation
- Higher numbers of missing teeth and edentulism
- Higher plaque levels
- Greater unmet oral health needs (eg, chronic pain and infection)
- Have poorer access to dental services and less preventive dentistry.

REASONABLE ADJUSTMENTS IN A DENTAL SETTING

By law (the Equality Act 2010), all public services need to make reasonable adjustments for patients with protected characteristics: this includes disabilities.

All members of the dental team need should be involved and actively provide these adjustments for their patients. In particular, for patients who have autism and/or a learning disability, the most important thing is to get to know the individual and what they may need as part of accessing dental care with your clinic.

As mentioned above, autism and learning disabilities can vary vastly between people: there is a saying within autism communities: 'If you've met one person with autism, you've met one person with autism'.

BEING NON-JUDGEMENTAL IS ESSENTIAL FOR ALL OUR PATIENTS, BUT ESPECIALLY WHEN CARING FOR PEOPLE WHO HAVE DISABILITIES WHO HAVE PROBABLY FACED DISCRIMINATION ALL THEIR LIVES

Never make assumptions about a person because of their disability or condition. A very important part of the Oliver McGowan training is the three words: ask, listen, do.

- Ask – the patient or their advocates what they need to be able to get the care they need
- Listen – really listen to what they say they need and believe them
- Do – take action and try to implement what they ask.

EXAMPLES OF REASONABLE ADJUSTMENTS IN DENTAL PRACTICE

1. Adjusting communication

For example, interpreters (including British Sign Language), asking patients how is best to communicate with them, using Easy Read information or pictures, using additional communication methods such as picture boards or Makaton, avoiding jargon, using clear and literal language.

2. Adapting the environment where possible

For example, handrails along stairs, painting edges of steps to make clearer, widening doorways, increasing signposting, installing ramps, access to disabled parking, creating a calming waiting area for people with sensory issues (such as low lighting, no music, away from the noise of reception).

3. Adapting appointments

For example, booking appointments that are the best time for patients, booking longer appointment slots for people who might take longer to process information, booking first appointments of the morning or afternoon for people with autism who might not cope with being kept waiting, booking with the same clinician each time.

4. Dental treatment and prevention

For example, tailoring prevention messages so they are relevant and achievable for patients which could include recommending non-foaming unflavoured toothpaste for people with sensory issues, engaging carers/relatives with oral hygiene messages if they provide care, prescribing high fluoride toothpaste/mouthwash for those of higher risk. Are you unconsciously discriminating against certain groups or show stigma? Being non-judgemental is essential for all our patients, but especially when caring for people who have disabilities who have probably faced discrimination all their lives.

Much of the information you might need to make reasonable adjustments above may be in a person's hospital passport, if they have one, so always ask if a person has one – it could even be added as a question on your medical history form.

If you come across patients where you are really struggling to provide them dental care, always consider referring them onto a special care dentistry (if they are over 16 years old), paediatric dentistry or a community dental setting.

FURTHER READING

The gold standard for learning disability and autism training within healthcare is the Oliver McGowan training module. Find more information via www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism.

CPD

ENHANCED CPD

Topic: Safeguarding vulnerable adults

Educational aims and objectives: To explore learning disability and autism awareness in dentistry with consideration paid to the Oliver McGowan Mandatory Training on Learning Disability and Autism.

GDC development outcome: A
CPD hours: one

Answer the CPD questions online at **dentistry.co.uk/cpd**. Scan the QR code to access the article. Any problems, call the CPD hotline on **01923 851777** or email **cpdsupport@fmc.co.uk**.

QUESTIONS

1. When was the Health and Social Care Act updated, in light of the tragic death of Oliver McGowan?

- ☐ a. 2002
- ☐ b. 2012
- ☐ c. 2020
- ☐ d. 2022

2. According to the author, how many autistic adults and children are there in the UK?

- ☐ a. Around 500,000
- ☐ b. Around 600,000
- ☐ c. Around 700,000
- ☐ d. Around 800,000

3. What three words make up a key part of the Oliver McGowan training?

- ☐ a. Ask, listen, do
- ☐ b. Listen, act, enquire
- ☐ c. Ask, treat, apologise
- ☐ d. Emphasise, do, sympathise

4. What is an example of a reasonable adjustment in dental practice?

- ☐ a. Adjusting communication
- ☐ b. Adapting the environment where possible and appointments
- ☐ c. Tailoring dental treatment and prevention
- ☐ d. All of the above

Dentistry CPD

CPD FEEDBACK OPPORTUNITY

Quality control

An essential part of continuing professional development (CPD) is quality control.

This part of *Dentistry CPD: Dentist Edition 2024* gives you the chance to provide feedback to us on the quality and relevance of articles. This is not essential, but please feel free to reply using the form below if you have any comments on the enhanced CPD offered in this publication. Remember to include your name, GDC number, address (including postcode) and phone number in the email. You can also submit feedback online at **cpd.dentistry.co.uk** after completing each article.

Author/title of article

Comments

Author/title of article

Comments

Author/title of article

Comments

Author/title of article

Comments

OUR CPD IS NOW ONLINE ONLY.

All CPD must be done through the website cpd.dentistry.co.uk.

Questionnaires cannot be posted in. CPD answers must be input online at cpd.dentistry.co.uk.

Earning enhanced CPD hours with this publication is quick and easy, with the certificates simple to download and print.

You will find questionnaires and a QR code for this publication on each article throughout the issue.

- **Scan the QR code or visit dentistry.co.uk/cpd and follow the instructions**
- **Complete the four-question test**
- **Upon successful completion of each article's questions, a certificate will be generated instantly and stored online in your subscriber account ready for you to view and print at any time.**

If you have any problems or issues, call the Dentistry CPD support team on 01923 851777 or email cpdsupport@fmc.co.uk.