COC: “Let’s start talking again”

Care Quality Commission Director makes commitment to re-engage with the dental profession

At a recent debate on dentistry, the ‘new’ new contract and regulation within the dental sector, Care Quality Commission (CQC) director of operations Aman da Sherlock announced her commitment to reopen dialogue with the dental profession to ‘move regulation to a place where it is proportionate and workable’.

Acknowledging the difficult start to the profession’s relationship with the CQC, Ms Sherlock was very frank and honest about the problems that the regulator has had in getting to grips with registering more than 9,000 dental practices across England, and how there is a high level of mistrust and a low level of confidence within the profession for the CQC.

Calling on all members of the profession to engage with the CQC, Ms Sherlock said: “What I want to do is start a conversation.

“The CQC needs to engage with the profession so that we can develop our services to a place where we want to be. There needs to be a meaningful relationship between ourselves as the regulator and the dental profession as the regulated.”

Discussing the expectations that all stakeholders in the process have, she discussed the current situation from three viewpoints: the regulator, the customer (meaning patient, Ms Sherlock commented that she preferred the term customer as it gave more of a connotation that she was involved in treatment decisions); and a member of the public. She stated that since taking up her post at the CQC in April this year she has become aware of an ‘over-focus’ in regulation. This, she said, is something she wants to address, again making reference to ‘proportionate, simplified and sensible regulation’.

Announcing a wide-scale review of CQC’s processes throughout its systems, Ms Sherlock added: “To further develop, the CQC and the profession needs to establish a real partnership so that there can be understanding about what is necessary to ensure good practice and to stamp out any examples of bad practice.”

Dental Tribune is looking to speak with Ms Sherlock about registration and regulation of dentistry, and would like to put your views and queries to her. Email lisa@dentaltribune.co.uk using the subject line of CQC questions with any questions or comments you may have for the regulator, and we will endeavour to get as many as we can answered.
COC forced to defend dental registration

On the 28th June 2011, Care Quality Commission (CQC) Chair Dame Jo Williams DBE was forced to defend the organisation’s handling of the registration of dental providers.

After some intensive questioning by the House of Commons Health Select Committee, Conservative MP David Tredinnick (Bosworth) reminded the committee of the British Dental Association’s view that that registration had been “shambolic”; he also asked whether she thought that assessment was fair.

Dame Williams acknowledged that there had been difficulties with the application of the CQC registration to dentistry, and she explained that even though the organisation has a single process for registration, using it for dental practices had been cumbersome. Dental practices are being faced with constraints due to the regulations even though some of them apply less to dental practices than to hospitals.

Following sustained questioning by Labour MP Rosie Cooper on the CQC’s failure to publish up-to-date information about its investigations on its website, the CQC Chair also faced a suggestion from Select Committee Chair Rt Hon Stephen Dorrell MP that the public should have been a higher priority than registering dentists. However there was no explanation behind why the registration of doctors has been delayed to 2014.

Throughout other areas of healthcare, confidence in the industry regulator is also slipping fast. Workers in the dental care home sector have recently signed a petition of no confidence in the CQC, saying they had no confidence the CQC could effectively “regulate” health and social care.

The issue was discussed after BBC Panorama alleged vulnerable adults at a unit near Bristol were being abused; however, the CQC said no regulator “could stop all unacceptable behaviour”.

In one report, delegates were quoted saying that “robust and effective regulation” of the industry was essential but they had “concluded that they have no confidence that the CQC is capable of delivering an effective system of regulation for health and social care”.

Smoking ban to be revised

A recent report has stated that three MPs have joined forces with campaigners to call for the smoking ban in UK pubs and clubs to be relaxed. The ban on smoking came into effect in 2007 to protect pub staff and non-smokers and according to Conservative Greg Knight, Lib Dem John Hemmings and Labour’s Roger Godsiff, the ban has had a devastating impact on the pub industry.

Over the past few years thousands of pubs across the country have closed and many believe that the ban has played a huge role; the Save Our Pubs and Clubs campaign says that after three years, Scotland had lost 467 pubs (71.5 per cent of the total estate), Wales 274 (75 per cent) and England 4,148 (76 per cent). According to certain campaign groups, working men’s clubs have been hit the hardest, with many closed and the remaining ones struggling to survive.

However, the three MPs are appealing for a change in the law, claiming that the current law is excessive and should be relaxed. If it goes ahead it will mean that landlords will have the choice of how they manage smoking on their premises, such as whether they want a smoking room.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter spoke out against any relaxation of the ban, saying: “The repercussions of a relaxation of the smoking ban would clearly have a detrimental effect on oral health and increase the risk of oral cancer.”

“The Foundation strongly suspects the reasons for the MP’s campaign for such a move are driven by vested interests in the licensing trade. It is highly unlikely should this motion be brought to the House of Commons that it would be passed, as less than 12 months ago they voted on this issue and it was overwhelmingly defeated.”

“The reduction in levels of smoking since the ban was introduced and the health dividend that has already been seen would therefore represent a backward step in the oral health of millions.”

Mick McGlasham, general secretary of the Clubs and Inns Union, which represents more than 2,000 working-men’s clubs, said in a BBC report: “The ban was passed because politicians wanted to protect staff and non-smokers, but there is no reason why we cannot have a separate smoking room in what are private premises, especially with modern ventilation.”

Other supporters of the campaign include the think tanks Progressive Vision and the Adam Smith Institute, and the campaign group Forest, which fights for greater freedom for smokers.

Continuing with the smoking debate, Alex Cunningham, MP for Stockton North, recently proposed a smoking ban in private vehicles when there are children present.

According to one report, Stockton North ranks fifteenth in the UK according to British Lung Foundation research, meaning the children in Mr Cunningham’s constituency are at high risk from the dangers of passive smoking.

Mr Cunningham should be applauded for his concern on this serious health issue confronting children in Britain today. A study by Aberdeen University showed that smoking in a car exposes children to levels of smoke comparable to levels in a smoke-filled pub, meaning that children can be exposed to seriously dangerous concentrations of passive smoke.

Antimicrobial surgical masks gain clearance

According to a recent report, Filligent has received US Food and Drug Administration (FDA) marketing clearance for the BioFriend BioMask for sale in the US as a class II medical device.

The surgical facemask is both antimicrobial and antiviral and incorporates a hydrophilic plastic material along with an antimicrobial inner layer; according to the company the coating and inner layer does not restrict air-flow and is totally safe.

The white outer white shield is reportedly formulated from a mixture of food additives and the inner blue layer uses ingredients for biomedical use that are supported by the FDA.

The masks are reportedly effective against 18 strains of human, avian, and animal influenza. Filligent noted how they are also effective against tuberculosis and resistant Staphylococcus aureus (MRSA), and other dangerous diseases.

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Masks are currently used for any dental procedure by members of the dental team.

MPs are trying to pass a law for smoking in pubs.

Antimicrobial surgical masks gain clearance

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Grant awarded for first oral bacteria database

A team of researchers at King’s College London and the Forsyth Institute have been awarded a large grant by the US National Institute for Dental and Craniofacial Research (NIDCR) to continue their work on compiling the first comprehensive list of oral bacterial species. The Human Oral Microbiome Database provides descriptions of each species together with tools for analysis of their DNA.

Most bacteria living in the mouth are thought to be important for maintaining the health of teeth and gums, as well as for general human health. A smaller number are potentially disease causing. The database helps scientists studying the role of specific bacteria in human health and disease, and paves the way to constructing similar databases for other body sites such as the skin and the large intestine.

The NIDCR grant will enable the researchers to continue cataloguing the Human Oral Microbiome and describing the 1,000 different bacterial species found in the human mouth. The information is available on the Human Oral Microbiome Database website (www.homd.org) and has been a valuable resource for the dental and medical research communities since 2008.

William Wade, Professor of Oral Microbiology at King’s College London, comments: “The new work will focus on extending the database to include newly described oral bacteria, many of which are being discovered at King’s and the Forsyth Institute.”

In addition, new methods developed at King’s to cultivate bacteria that have not been grown in the laboratory before will be used to obtain cultures of these organisms to deposit in culture collections for the benefit of other researchers. DNA purified from these cultures will be submitted to the National Institutes of Health Human Microbiome Project for genome sequencing.

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page? If so don’t hesitate to write to:
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Or email: lisa@dentaltribuneuk.com

Editorial comment

I have a confession to make: when listening to Amanda Sherlock from the CQC speaking about how registration for dental practices had been difficult and that it had not been an easy relationship to get started, I only just managed to resist the urge to stand up and shout a certain well known phrase that would have fitted nicely with the speaker’s surname!

To be fair, she was trying to put the current situation in context and she does have the greatest excuse in that she only began work at the regulator in April of this year, thereby exonerating her from any and all previous actions by the CQC.

Now, like any normal human being I want to think the best of people and take Ms Sherlock at her word that there will be a new era of dialogue and cooperation between the profession and the CQC. I would also like to think that the profession will welcome this opportunity to re-engage with the CQC to put right what is clearly wrong.

However, the cynical journalist in me is wondering if it is really too good to be true. Let us put this to the test – send me your comments and queries and I will put them to the CQC and Ms Sherlock. Let’s be the change we all want to happen.

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Queen's dental school could lose teaching status

It has been revealed that Queen's University in Belfast, is currently being inquired regarding concerns about the level of resources and teaching. The university, which is the only dental school in Northern Island, has not only found itself at risk of losing its teaching accreditation which it requires from the GDC, but also having to make £11m in efficiency savings and absorb 200 job losses.

The Belfast Telegraph revealed the GDC's chief executive and registrar, Evlyne Gilvarry, wrote to the vice chancellor at Queen's following concerns about the level of resources being dedicated to teaching dentistry. The letter was followed with an inspection and the report is due to be published.

Just three years ago Queen's University was named as having the top dental course in the UK by the Times Good University Guide. At the time, Professsor Paddy Johnston, Dean of the School of Medicine and Dentistry at Queen's, was quoted as saying: “This is a wonderful achievement by our dental colleagues, especially as we drive towards the development of an international research-led dental school in the next few years.”

One report stated how Jim Wells, deputy chair of the Stormont health committee, was disappointed to learn about the inspection, and was quoted saying: “We don’t know what the findings of the inspection will be but it is extremely worrying that professionals felt the need to raise concerns in the first place.”

“This is a blow for the university and hopefully will not result in the closure of the dental school, which would be an absolute disaster.”

A spokesman from Queen's said: “We can confirm that the GDC undertook an inspection as is normal every four or five years. We are awaiting the report.”

However, a GDC spokeswoman said: “From time to time the GDC is contacted by dental professionals who are concerned that a dental school is not up to standard for the GDC to use the university or education provider in question for further information and a response.”

“The GDC’s chief executive and registrar, Evlyne Gilvarry, has written to the vice chancellor at Queen's University Belfast following concerns about the level of resources being dedicated to teaching dentistry. An inspection was carried out earlier this month and a report from the inspectors will be available in due course.”

Could Vitamin D lower susceptibility to gum disease

Recent research in the United States has revealed that Vitamin D could lower susceptibility to gum disease and other oral infections.

The research – instigated by Gill Diamond, of the New Jersey Dental School in Newark – shows that Vitamin D can help prevent gingivitis, which affects more than a quarter of adults.

Diamond’s earlier research has shown that Vitamin D – absorbed by the body through exposure to sunlight and foods such as fish and egg – stimulates lung cells to produce natural antioxidants that kill bacteria. The latest research has highlighted that specific genes – previously thought not to be in part of the Vitamin D pathway – are now also likely to play a vital role in fighting infections and killing bacteria. This discovery is likely to lead to new Vitamin D treatments, which will help those suffering from gingivitis and other medical illnesses, possibly cyclical fistrosis.

The study has also suggested that cells within the body – such as lung cells and the epithelial cells in the gums – can activate in active forms of Vitamin D. Upon discovering this, Diamond stated “this means that we may even be able to use vitamin D therapy topically, if that proves true.”

The Food and Nutrition Board in the United States has established guidelines, recommending that children and adults need 700 International Units (IU) of Vitamin D, with the elderly recommended a high 800 IU. However, other experts have recommended a much high intake is needed, with 5,000 IU being recommended for adults and teenagers. Those with health issues may be recommended a high Vitamin D intake.

Vitamin D has been a research area of interest recently; recent studies suggest that Vitamin D can also help protect us from some forms of cancer and autoimmune diseases, as well as targeting infections and gingivitis.

First graduates to help fill North West dental gap

It’s smiles all round for the first 50 dental students who have completed their studies at the University of Central Lancashire’s (UCLan) £5.25million School of Dentistry.

During their training the students have seen over 5,000 patients, undertaken nearly 9,500 fillings and providing treatment ranging from preventative advice up to quite advanced procedures. The students are the first to complete their course in an entirely new model of dental education based on training in community.

UCLan’s School of Dentistry came about as a result of a close cooperation between the University and the NHS who were keen to support the training of dentists in the local area. Not only would the students provide dental treatment during their training; but it was envisaged that many of them would stay and work in the locality after qualification.

21 of the 50 graduates have secured their mandatory training places in the North West and hope to remain in the region to enhance local NHS dental services. When it opened its doors in September 2007, it was one of two new schools to be created in England for over 100 years.

To help mark their achievements the graduates were joined recently by Barry Cockcroft, Chief Dental Officer from Northern Ireland Department of Health, at a celebration dinner, held at UCLan’s Westleigh Conference Centre.

Professor Lawrence Mair, Head of the School of Dentistry at UCLan, said the University’s new dental school has been a huge success: “Clinical experience has been at the root of our approach because dentistry is a skill and skills develop through practice.

We have, of course, also provided an excellent academic foundation for our students and I’m very grateful to all the teachers, specialists and consultants who have helped established the school. We are all very grateful to all our dental nurses, receptionists and technicians who have supported the students through what can sometimes be a challenging experience.”

Barry Cockcroft, Chief Dental Officer for Northern Ireland Department of Health, said: “I’m delighted that the first dental students from the new School of Dentistry at the University of Central Lancashire have graduated.”

Shreena Mistry, 24, trained at the Morecambe DEC working in Ormskirk said: “I feel ecstatic to have graduated from the course. I wanted a profession that was practical, science based and gave me the opportunity to interact with people.

The course has been ideal preparation, we were drilling on practice teeth from the first day and advising patients from the end of year one. In fact, our lab equipment is state-of-the-art and the student/staff ratio is excellent.

In the future I plan to continue my studies and may look for a postgraduate course in implant or root canal treatment.”

Artificial nose smells out oral cancer

Scientists at the Israel Institute of Technology have created an artificial nose that holds the key in detecting head-and-neck cancer (HNC).

The artificial nose, which was built by Professor Hossam Haick and his team, can detect molecules in human breath that are characteristic of head and neck cancers, meaning it will become a critical tool in identifying hard-to-detect cancers in their early stages.

According to one report, the Nanoscale Artificial Nose (NA-NOSE) has shown that it can distinguish between not only head-and-neck cancer patients, but also lung cancer patients; it can also distinguish those who are free of oral cancer simply by sampling a breath test.

The Nanoscale Artificial Nose (NA-NOSE) consists of five gold nanoparticle sensors, which are linked to software. The software is capable of detecting patterns of molecules that are found in the breath of people with head, neck or lung cancer.

Although NA-NOSE produced remarkable results, there are fears that the device may not be common enough for widespread use in doctor’s offices.

Nanoscale Artificial Nose

The study was published in the American Society for Microbiology.
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Convenience
The majority of the learning resources on this programme will be online. The masters will combine interactive distance learning, webinars, live learning and print.

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

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

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A new accreditation scheme has been launched by the British Lingual Orthodontic Society (BLOS), as a demonstration of an orthodontist’s skill and ability and their commitment to specialist post-graduate education. BLOS members can now apply to become BLOS accredited.

The UK is one of the countries where lingual practice is most advanced and the aim of BLOS and its dedicated membership is to achieve equivalence with other leading lingual organisations. Both the World and European Societies of Lingual Orthodontics already run accreditation schemes. The standard of BLOS accreditation is designed to be as high, in order to celebrate the achievements of its members.

In order to apply for accreditation, the orthodontist must be a member of BLOS. Three cases are required for the examination, with a treatment need of IOTN 4 or 5. At least one must be an extraction case, to demonstrate complex, sliding mechanics and arch-form control. Cases will be submitted electronically using atemplate designed in conjunction with the European and World Lingual Orthodontic Societies.

There will be two independent judges and a Chief Examiner, all internationally recognised lingual orthodontists. The examination documents and models will be presented for viewing at the BLOS annual meeting. The deadline for application is October 14th 2011 and cases will be on display at the BLOS study group meeting on November 5th. The Chief Examiner for 2011 will be Dr Dirk Wieschmann.

Several orthodontists have already expressed an interest in applying for accredited status. Paul Ward, BLOS chairman, said: “We are designing the accreditation process so that it is an achievable and worthy challenge; a clear demonstration of the clinician’s commitment to excellence in lingual orthodontics.

The case submission templates have been designed in conjunction with the other International Societies of Lingual Orthodontics and the examination standards are of an equally high level to ensure parity between the groups.”

Small increase in clinical academic staffing numbers

Data published by the Dental Schools Council revealed a 4 per cent increase in the number of clinical professors, senior lecturers and lecturers in dentistry during the 2009-10 academic year, to a total of 590 Full Time Equivalents (FTE), and a 20 per cent increase in the number of senior clinical teachers and clinical teachers to a total of 155 FTE.

Whilst dental schools are positive about the increase in total number of clinical academic staff for the fourth consecutive year, the number of research-active clinical academic dentists (Professors, Senior Lecturers, Readers and Lecturers) remain 28 per cent lower than in 2000. Since 2005, with the smallest number of dental clinical academics (435 FTE) in the decade, there has been a 25 per cent expansion in student numbers and the creation of three new dental schools (Peninsula, Aberdeen, UCLan); the number of clinical academics has increased by 21 per cent in this time, but the number of research-active clinical academic dentists has shrunk by a further 10 per cent (to 390 FTE).

The recent survey of Oral Health in England, Wales and Northern Ireland (Health & Social Care Information Centre 2011) highlighted the importance of oral health to the health of the population. Although oral health has improved overall, dental care is becoming much more complex with older populations retain teeth, whilst severe periodontal (gum) disease has increased slightly in the last decade. Dental schools and the dental clinical academic staff therein are responsible for training and preparing future generations of dentists to provide care in this changing and increasingly complicated world. They are also responsible for most of the research, innovation and technological development that will help improve health and reduce costs in the long term.

The survey can be accessed online at www.dentalschoolscouncil.ac.uk/clinical_academic_staffing_survey.htm

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Following the success of the initiative since 2009, members of the dental team will be able to gain verifiable CPD hours for reading the Show Guide which accompanies BDTA Dental Showcase.

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BDTA Dental Showcase 2011 takes place between 20-22 October 2011 at the NEC, Birmingham. To secure your free of charge entry to the show, register for your ticket at www.dentalshowcase.com, call the registration hotline on +44 (0) 1494 729559 or text your name, address, occupation and GDC number to 07786 206 276. Advance registration closes on 17 October 2011. On-the-day registration: £10 per person.

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Oral diseases may be reclassified

Oral diseases may be reclassified into the list of noncommunicable diseases (NCDs) after the FDI World Dental Federation called for the change within the United Nations and World Health Organisation (WHO).

During a hearing at the UN headquarters in New York in June this year, Jean-Luc Eiselé, FDI Executive Director, suggested that the current list should be extended. At present the list comprises of cancer, diabetes and respiratory and cardiovascular diseases.

Alongside the four major NCDs, including unhealthy diet (particularly high sugar consumption), tobacco, and harmful alcohol use, it has been reported that all oral conditions share common risk factors and it has been stated that oral health professionals play a vital role in the prevention, early diagnosis and treatment of the disease.

During a proposal on behalf of the World Health Professions Alliance (WHPA) campaign on NCDs, Dr Eiselé made a warning call of the global epidemic of diseases, which were later echoed by Dr Habib Benzian, Director of the NGO ‘Fit for School International’, who stated how: ‘the most common disease worldwide is dental caries, tooth decay. It has large impact on societies, on children, on each and every one of us … don’t forget oral diseases in the context of NCDs.’

Dr Eiselé also stressed the vital role of health professionals, and explained how they play a key part in reducing the global NCD burden through health promotion, disease prevention, patient care and rehabilitation.

Protecting patient confidentiality

A new software which monitors who is accessing a patient’s medical records is being piloted in West Wales as part of a wider information security initiative.

The pilots, which are planned to run for six months, are being run by the NHS Wales central information governance team and the Hywel Dda Health Board.

The software, called the Fair Warning privacy monitoring software, will be used to ensure that only the right health staff are seeing patient information.

It will also monitor who they are treating and check that information is not be accessed when it shouldn’t be.

According to a report, the NHS Wales Information Service pilot will evaluate whether this kind of software could be successfully used to ensure that the Individual Health Record, Welsh Clinical Portal and other initiatives are securely and safely used.

Brush baby founder named Entrepreneur of the Year

Child oral health company Brush-Baby is celebrating success after its founder Dominique Tillen was awarded an Entrepreneur of the Year award for her pioneering and innovative work launching Brush-Baby.

The recognition demonstrates the company’s fantastic commercial success and unrivalled product offering. Indeed, Brush-Baby products can be already be found in Waitrose, John Lewis, Mothercare, Sainsbury’s, baby shops, pharmacists and dentists nationwide, and also has a growing presence in Europe, the Middle East and Australia.

Brush-Baby’s concept of an ‘oral care pathway for babies and young children’, is built around a highly original, contemporary product range whose ultimate aim is to ‘improve the oral health of young children’. The company’s first product, the Brush-Baby Chewable Toothbrush launched in 2009. The first of its kind worldwide, it is a combined versatile chewable toothbrush and teether that toddlers can use themselves, satisfying their natural urge to chew. As they do so, it helps to clean teeth, massage gums and soothe tender teething gums.

Commenting on her award win, Brush-Baby founder Dominique Tillen said: “I am really pleased to have won this award and my thanks to the retailers and parents who have put their trust in our products and come on this journey with us. Brush-Baby products fill the gap in the market for appropriate child centred products and are becoming increasingly relevant today as young children’s oral health becomes a real cause for concern with parents, the dental profession and policy makers alike.”

Brush-Baby unveiled its oral care pathway at The Dentistry Show in March 2011 and is now available to order. The complete range includes DentalWipes™, innovative toothbrushes and Xylitol / Fluoride toothpastes for babies and children aged from birth to six years.

Eye-catching packaging is backed by stand-out POS graphics and engaging pack photography, and offers significant cross-selling opportunities to further energise consumer demand.

To discuss retail opportunities, please contact Brush-Baby on 0845 520 2229 or email dominique.tillen@brushbaby.co.uk. For more information, visit www.brushbaby.co.uk.
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**Stuart Lutton**
Principal Dentist,
Ivy Dental Practice, Edinburgh

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Social media is seen by many as an excellent new marketing tool. However, because it is new, many practices are struggling to figure out how to use it properly. As with all marketing activities, it is best to be informed so you can manage your efforts well and achieve desirable results. Here is a list of three common social marketing mistakes and how you can avoid or overcome them.

Mistake number one - Social marketing delegation
Use caution if delegating your social marketing 100 per cent. Why? It’s like telling someone to answer your phone, have conversations with your patients, and then not bother to tell you what was said.

The biggest benefit you get from using social media is the ability to connect with people on a human level. It’s simply not possible to connect — long term — with your patients unless at least one person within your practice is actively participating at some level. Be sure that someone in your practice can answer the following questions:

• What is being said on your Facebook page or being tweeted on your behalf?
• How to access your Facebook page — who are the administrators of your page? (Also know that administrators can currently delete your account with the click of a button).
• How to access your Twitter account. Do you know what your username and password is?
• Who is responding to patient testimonials and inquiries? What language is being used and what voice does your Facebook page or Twitter account have? Knowing what is being posted or tweeted on your behalf will develop the voice or personality for your social platforms.

Most importantly, legal advisors recommend you monitor and be aware of activity on your Facebook page. Unfortunately, many of them are also breaking Facebook’s Terms of Service and risk having their pages removed. If you are running a contest or drawing competition on Facebook, or considering running one, you must at least be aware of Facebook’s guidelines. See www.facebook.com/promotions_guidelines.php for the details. In short, Facebook’s guidelines are clear — you should not collect contest or drawing entries or announce winners directly on your Facebook page.

However, you may run a contest using a third party application, such as WildFire Promotion competition on Facebook. Unfortunately, many of them are also breaking Facebook’s Terms of Service and risk having their pages removed. If you are running a contest or drawing competitions on Facebook, or considering running one, you must at least be aware of Facebook’s guidelines. See www.facebook.com/promotions_guidelines.php for the details. In short, Facebook’s guidelines are clear — you should not collect contest or drawing entries or announce winners directly on your Facebook page.

Mistake number two - What you need to know about contests on Facebook
Many practices are running some type of contest or drawing...
Builder (visit www.wildfireapp.com), I often have team members approach me and say: “Yeah, but so and so’s practice is holding contests directly on their page...” This comes down to many businesses, not just dental practices, who are either unaware of these guidelines or who are willing to take the risk. Be aware of the rules and determine how much risk you are comfortable with. If you have a thriving Facebook community, it would be a shame to lose it for something you could prevent.

Mistake number three - How focusing on numbers can mislead you

What is your primary objective for being on Facebook or Twitter? Are you interested primarily in link-building, solely for search engine optimisation or “SEO” purposes? Perhaps you are interested in acquiring as many friends and people who will “like” your Facebook Page as possible, because we’ve always been taught that more is better...

A traditional marketing mind-set was to acquire more. Let the numbers show how effective our direct mail piece was, how many new patient phone calls we got from our phone book ad, or how many hits we got to our website. However, without quality none of those numbers really matter. Some practices have had the experience of running a marketing campaign and getting a great response, yet then having a large percentage of those new patients be unwilling or unable to accept, pay for, or follow through with treatment... Those experiences painfully illustrate the difference between quantity and quality.

It is our intentions that drive our actions. If we intend to build up a certain number of fans, whether it be 500 or 2,000 fans, we are focused on the numbers. On the other hand, if we focus on winning the interest, praise, and appreciation of our followers, we build strong relationships that lead to loyalty and referrals.

Remember that social media marketing is unlike any other marketing tool we’ve ever had access to. Discard your old marketing mindset. Be thoughtful about your objectives. Consider what is more important to you—a high quantity fan base or a high quality fan base. I’m not saying you can’t have both, but in social media, typically numbers as a primary goal can sabotage quality.

First and foremost, set your intention to build trust and relationships with your followers. Strive to make your social media platforms a place you can talk with your patients and followers. Imagine when patients come into your office. What is the social conversation you have with them? It is that type of exchange that can make your social marketing efforts a success.

It may take more time and energy to consider what your ideal social media community could look like. The easy way out is to set a number as a goal and walk away. A better objective—that will return more positive word of mouth and referrals—is to put interaction, authentic “liking”, and relationship building at the top of your list. Decide today what improvements you will make based on the information provided here—or what risks you intend to avoid; stay informed and take precautions to protect your communities. Take advantage of all the opportunities that social marketing has to offer. Make human connections with your patients and potential new patients, focus on genuine relationships, and treat your efforts as you would a living garden—you’ll then find positive word of mouth and referrals will flourish.

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Do something fantastic this Autumn!

Philip Lewis looks forward to the 8th ESCD Annual Meeting

Which of the following is true for you?

• I’d like to be more successful
• I’d like to really enjoy attending postgraduate education
• I love to travel and appreciate a little pampering
• I like to take my team with me to postgraduate events so that they come back as motivated as I am. I don’t like spending an arm and a leg!

If you answered ‘yes’ to even one of these questions the ESCD Annual Meeting is for you!

ESCD?
What?
The European Society of Cosmetic Dentistry is a truly international association with members throughout Europe and beyond.

It’s not a faceless society; you probably know a number of its leading members already as they’re household names in the UK as well! ESCD is different. It’s a Society that welcomes the whole dental team, its meetings attract truly world-class speakers but there’s a friendliness and intimacy about it rarely equalled elsewhere.

The 2011 Meeting will be held in the picturesque medieval city of Dubrovnik on the shores of the Mediterranean on September 30th and October 1st. ‘Little Summer’ as it’s known in the area. A time when days are still warm, the sea still inviting and the town quiet after most of the summer visitors have returned home. Sounds good? That’s only the start! Have a look at the program:

Keynote speakers include Professor Dr Nasser Barghi from San Antonio USA speaking on bonded all-ceramic restorations. A true legend of operative dentistry, not everyone has had the privilege of attending Dr Barghi’s lectures as they are usually over-subscribed and rarely presented on this side of the Atlantic. Be amazed about what is possible in modern dentistry and be inspired as Dr Barghi explains how many of his apparently complex techniques are easily accessible for all practitioners.

Many UK practitioners are familiar with Drs Tif Qureshi, James Russell and Lennart Jacobson through the innovative and practice-changing Inman Aligner. In this lecture they will be explaining and introducing the concepts of the most popular modern approach to dentistry among both clinicians and patients; minimal intervention.

One of the UK’s leading innovators is joined one of the nation’s top dental technicians in this presentation on Internet Marketing; probably the most pertinent method for practice expansion of the decade.

That’s just a few. There are many others; Wolfgang Richter, President of ESCD and expert in composite bonding, Martin Jorgens and Marcel Wainwright whose experience in lasers and other advanced techniques has to be seen to be believed. Noam Tamir from Smile-On as well as other eminent speakers. Professors, clinicians and experts from around Europe. The ever-popular clinical tips session; lectures and workshops and of course, social events.

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"Would you like a new relationship? One you can rely on".

Dental Air has one of the best customer service reputations in the dental industry and with our fast call out times, it is no surprise that we are the leading supplier of oil-free compressed air packages.
These are challenging times in dentistry. The sort of education provided by ESCD can transform practices; new techniques, new treatments, new ideas. You’ll learn things that can help put you on the leading edge of the profession. You’ll be able to offer things other practices simply can’t offer. How’s that for a competitive advantage?

It gets better. The philosophy of ESCD is to make top-class dental education affordable for everyone. Fees for membership and events are kept to a minimum. You don’t even have to be a member to enjoy the meeting but you get a great discount if you join.

With budget airlines offering inexpensive flights to Dubrovnik from airports across the UK it’s an opportunity not to be missed. Then there’s the networking.

Great education, fun social events, a superb location and unequalled camaraderie. All this at a fantastic price.

Some colleagues may be worried about attending an event in a foreign country. They may be concerned there’ll be nobody there they know. Don’t be! I’ll be there and I’ll be happy to arrange a little get-together for UK delegates the night before the Conference. Just email me if you want more information.

The official language of ESCD is English so don’t worry about not being able to understand lectures given by European colleagues.

As you might have guessed by now, I’m a great supporter of ESCD. I’ve been attending their events for years. As a member, I’ve been enjoying all the membership benefits and calling upon the advice and expertise of the directorship which has really helped me develop my practice. Why don’t you do the same?

Do something fantastic this Autumn! You’re guaranteed to have a great time and you experiences could well lead to a fantastic future!

Philip Lewis can be contacted at: Philip-Lewis@btconnect.com ESCD  www.escdonline.eu
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Venus Diamond - The diamond class

Heinrich Middelmann presents a case report

Posterior restorations can be easily and durably built up directly using composite without having to dispense with the reconstruction of an ana-tomical surface and, consequently, physio-logical function.

Though resin-based composites have been used for the restoration of posterior teeth for decades, they were often subject to compromises. Increased patient demands for natural restorations combined with the public debate regarding amalgam and the associated health risks as well as the aim of dentists to treat patients as minimally invasive as possible have greatly accelerated the development of composites in the past ten years. As a result, composites have become an indispensable material in conservative dentistry both in the anterior and posterior regions.

The possibilities for tooth conservation have been greatly extended in the literal sense of conservation with the establishment of minimally invasive adhesive techniques and can no longer be compared with the preparation forms of the amalgam era. In the past components used is just as diverse as the number of composites available. Each of these components influences the handling properties and clinical behaviour.

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Cosmetic Tribune

**NEW**

40% of denture patients are concerned about denture odour¹

Yet many denture wearers fail to keep their dentures clean².

That’s because brushing dentures with ordinary toothpaste can scratch denture surfaces³. And scratched surfaces can lead to bacterial growth⁴ leading to denture odour.

Polgrip denture cleansing tablets effectively remove plaque and tough stains⁵ without scratching¹, to leave dentures clean and fresh. Polgrip Total Care denture cleansing tablets also kill 99.9% of odour causing bacteria.

Recommend Polgrip denture cleansing tablets to help your patients control denture odour.


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durable, first-class restoration. Patients focus on the visual outcome. The shape and shade of the restoration must adapt perfectly to the surrounding tooth structure. The final perceptible shade effect, however, depends on a large number of factors, which a modern composite material must fulfill.

The shade perceived by the eye is a subjective sensation and comprises a variety of individual physical aspects. The main physical aspects are hue, intensity and brightness. Factors such as reflection, refraction, translucency and fluorescence are also important with regard to the appearance of a finished restoration.

The colour perception of the human eye is influenced by the power spectrum of the light which falls on the retina, whereby this light not only originates from the object observed but also from the surrounding area in particular. The phenomenon of metamerism can, however, lead to problems in conservative dentistry: materials can appear to be the same colour or differently coloured depending on the type of lighting. This means that the natural tooth and filling material could appear to match perfectly in certain surroundings but not in other surroundings.

It is therefore important when selecting a material, to choose a composite with physical properties that allow it to adapt to the surrounding tooth structure. The size of the filler particles and the quantity ratio between fillers and matrix play a fundamental role in this case. The nano-hybrid material Venus Diamond has a new, patented matrix and an innovative nano-hybrid filler system, enhancing the aesthetics, durability and handling characteristics. Its outstanding adaptation to the surrounding tooth structure provides for a very natural appearance and is de-scribed as the diamond effect.

Venus Diamond: The

![Image](image-url)
Diamond nano-hybrid composite not only increase the packing density of the fillers but also reduce the volumetric shrinkage, increase the strength and abrasion resistance and enhance the translucency of the material. The new matrix system in combination with the nanofillers results in reduced shrinkage of approximately 1.5 per cent by volume and shrinkage stress of approximately 2.8 MPa.

The mechanical properties of nanofiller-hybrid composites are superior to those of pure hybrid materials and the handling and clinical advantages also outweigh those of pure hybrid materials. The good polishability and durable stability of the polished surface, is a result of the optimised filler system of the composite.

Venus Diamond: The shade concept
A special shade concept was developed for Venus Diamond to meet the requirements of all clinical situations both in the multiple build-up technique and the monochromatic technique. This concept subdivides the shade system into the three levels of translucency of opaque, universal and incisal, which are matched to the Vita shade system and correspond to a respective translucency of 50 per cent, 51 per cent and 55 per cent.

The aesthetic shade concept is simple and logically constructed so that the most attractive high-end restorations as well as efficient restorations, adapted to the shade of the tooth, can be fabricated.

‘The shade adaptation to the surrounding tooth structure is promoted by the optical effect of the nanoparticles’

The shade adaptation to the surrounding tooth structure is promoted by the optical effect of the nanoparticles. They increase the translucency of the restoration material, particularly in thin layers, creating a fluent shade transition. Opaque is available for use as a Dentine shade with low translucency, Universal as an enamel shade with medium translucency and Incisal with a high translucency for the incisal edge. The hues have been adapted to correspond with VITA; the intensity (chroma) is regulated by the layer thickness.

There is a total of 23 shades available. A further four opaque dentine shades, which have increased opacity and chroma,
have recently been introduced to cater for darker and discoloured teeth and more complex aesthetic cases.

The individual shades of the different levels of translucency are freely combinable. Alternatively, the best corresponding translucency level can also be obtained from an overview table or directly from the shade guide.

Venus Diamond has four incisal shades: clear, amber, clear opal and yellow opal. As with Venus, the 2-Layer shade guide consists of layered original material and therefore enables realistic shade selection. The shades of the flowable Venus Diamond Flow, which has been adapted to the system, are matched exactly to Venus Diamond and can be easily combined.

The combination of the opaque dentine shade and the appropriate universal shade is generally sufficient for the aesthetic restoration of Class I-V defects. The incisal shades are mainly required for the incisal edges of adolescent or very translucent teeth. In the case of small restorations it is often sufficient to use only the Universal shade due to the shade adaptive effect of Venus Diamond. With demanding larger restorations in the anterior region it is recommended to build up using shades of different translucency to attain a highly aesthetic result. It is also possible to produce attractive results with an adhesive composite restoration due to a carious defect. The existing restoration appeared clinically sufficient, but was also to be replaced during treatment for the new restoration to avoid a transitional zone and therefore a potential high-risk weak spot. (Fig. 1).

The existing restoration and the aesthetic appearance, it was decided to build up a direct composite using Venus Diamond. Following anaesthesia and tooth cleaning with a fluoride-free paste, the shade was first selected using the Venus Diamond shade guide for the composites to be used; Venus Diamond and Venus Diamond Flow.

The shade systems of the two materials are identical, i.e. the shades match exactly. The shade guide is layered using Opaque shade (dentine) and Universal shade (enamel). The operator consequently sees the result of the ideal layering of two levels of opaque shade during shade selection.

Tooth shade A2 was selected as the final shade during shade determination, i.e. the opaque dentine section was to be built up using shade OM and the enamel shade A2. The incisal shade is not generally required in the posterior region. Venus Diamond Flow A2 or Baseline can be used as a cavity liner instead.

The existing restoration and the region infected with caries on tooth 25 were removed using a minimally invasive technique. Figure 2 clearly shows the dentine caries and the demineralised enamel areas. All affected areas were excavated, including dark discoloured sections of dentine. The preparation depth and the bucco-palatal extent of the cavity were kept as small as possible to conserve the maximum amount of tooth structure. Figure 3 shows the total structure loss. The functional occlusal surface as well as the marginal ridges and proximal regions had to be reconstructed.

Following thorough cleaning using a water spray, the cavity was cleared of surplus water and, beginning at the enamel, conditioned according to the etch-and-rinse technique using the 55 per cent phosphoric gel iBOND Etch 55 (Fig. 4). The reaction time on the enamel was 50 seconds and 15 seconds on dentine. All areas of the cavity were then thoroughly rinsed and cleared of surplus water according to the rules of moist bonding.

During drying, care was taken not to overdry the sensitive dentine to avoid collapsing the exposed collagen network and resulting insufficient adhesive penetration. The conditioned enamel and dentine areas were pre-treated using the nano-adhesive iBOND Total Etch according to the total-bond technique (Fig. 5). The adhesive was applied in one layer to the enamel and dentine, in accordance with the manufacturer’s instructions. The solvent was then air dried and the adhesive film polymerised.

The cavity floor was then lined with a thin layer of Venus Diamond Flow A2 (Fig. 6). Venus Diamond Flow improves the adaptation of the composite to the tooth structure, as it smoothes rough irregularities created by the minimally invasive preparation and lines any undercutts, which are difficult to access for a universal composite (Fig. 7).

Various studies also verify that the flowable composite...
Venus Diamond Flow has thixotropic proper-
\[\text{Composite.} \]

ties. During application with a tip the viscosity is reduced and the material can be applied to the required areas. Immediately after application the material is positionally stable and does

not flow. Venus Diamond Flow is polymerised for 20s.

In the following steps the original tooth shape was recon-
stucted using Venus Diamond. First the dentine core was built up using shade OM, anatomically sculpted and polymerised (Fig. 8). Already at this stage care is taken to ensure a func-
tional build-up of the cusps and fissures. The functional-anato-
tical build-up of the occlusal surface and the marginal ridges is completed using Venus Dia-
mond A2 (Fig. 9).

Superfinish diamonds are used for the rough preparation. Figure 10 shows the Venus Dia-
mond nanohybrid restoration before polishing. A high lustre

was quickly and efficiently pro-
duced using the Venus Supra polishing system, though conven-
tional polishers can also be used for high-lustre polishing. Figure 11 shows the aesthetic

shade blend between the tooth structure and Venus Diamond, which is highlighted when compared with the adjacent restorations.

Venus Diamond: Summary

The nanohybrid composite Ve-

nus Diamond creates the com-
bination of optimal mechanical properties, durable aesthetics and easy handling. It is ideal for use with both complex restora-
tions as well as the one-layer technique. The shade system is clearly structured and identical to the corresponding Flowable Venus Diamond Flow. Apart from the physical factors, nano-
technology promotes polish-
ability and gloss durability.

Venus Diamond is suitable for universal use and can be combined with all methyl methacrylate-based adhesive systems.
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**Integration of aesthetics and function with composite resins**

Dr Lostaunau discusses functionality and aesthetics

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**Integration of aesthetics and function with composite resins**

Careful integration of the different dental specialties is the basis of modern dentistry, especially when the treatment goal is an aesthetic and functional rehabilitation of the patient. Today, aesthetic oral rehabilitation integrates three basic concepts: biocompatibility, mechanics and, of course, beauty – in order to preserve the anatomical structures of the stomatognathic system and to fulfill functional purposes. At the same time, utmost attention is paid to achieving aesthetic goals in accordance with the current trends in aesthetic dentistry and thus fulfilling the patients’ expectations. With comprehensive oral rehabilitation as our main goal, utilisation of the different areas in dentistry becomes extremely important in order to establish a precise diagnosis, treatment plan and finally treatment. Orthodontics, for example, has clearly defined objectives, such as the establishment of a functional occlusion, the preservation of periodontal health and the achievement of a stable result within the boundaries given by physiology and dentofacial harmony.

When the case is presented to the patient prior to any intervention, individual limitations of that particular case must be considered in order to avoid unrealistic expectations. The patient needs to have a clear idea of the treatment plan, realistic expectations with regard to the final result, and previous and posterior dental needs. Therefore, meticulous examination and good communication with the patient are of utmost importance. There are a number of different cases in which the combination of orthodontics and restorative dentistry is advisable, such as Bolton’s and vertical discrepancies, peg-shaped teeth, discrepancies in height and width, diastemas, agenesis, malformations, extrusions, intrusions, attrition etc. Not solving the problems mentioned above might result in failure of the orthodontic therapy due to relapse, periodontal complications, occlusal instability or overall dissatisfaction.

However, the careful planning and combination of aesthetics and orthodontic functionality in combination with the new restorative materials available today enable us to obtain harmonious results.

This article seeks to demonstrate the manner in which the goals of an orthodontic treatment were fulfilled in a clinical case. A multidisciplinary approach is indispensable for the achievement of the therapeutic goals of functionality and aesthetics, which are obtained thanks to modern direct restorative dentistry as part of a comprehensive treatment plan and followed by an aesthetic and functional execution of that plan.

**Case report**

The patient was unhappy with her dental aesthetics after completion of fixed orthodontic treatment. In addition, she did not like the appearance of her incisal edges, nor the texture or translucency of the incisal third of her central incisors (Figs. 1 & 2). After gaining a clear understanding of the patient’s expectations and having informed her of the therapeutic possibility of treating the case with...
composite, it as decided to make a diagnostic waxup, elongating the height of the clinical crowns to correct the irregularities of the incisal edges. We then proceeded to take a pattern of the future restorations with putty polyvinyl siloxane (PVS). This pattern was then tried in to gain a better idea of the quantity of composite needed to restore the teeth (Fig. 5).

Following adequate cotton roll isolation, and after gaining complete cooperation from the patient, the adhesive protocol for the enamel was followed and restoration with composite resin AMARIS Opaque (VOCO) was decided upon. The pattern that rapidly gave us all the anatomic features of the lingual aspect was then removed to continue stratifying the layers of this composite (AMARIS Opaque), seeking to insinuate the mamelons very slightly at the incisal third but close to the incisal edge itself, and at the same time spreading the composite onto the surface of the enamel, in order to hide the excessive translucent aspect that these teeth showed naturally (Fig. 6). In addition, we applied several brushstrokes of AMARIS Flow High Opaque (VOCO) in areas where it was necessary to hide the translucency, and at the same time it was useful for us to generate small areas of hypoplasia of enamel, resembling the natural characteristics of the lateral incisor. Finally, the whole surface of the incisal edge and the facial surface were covered with AMARIS Translucent again. Thereafter, the whole restoration was brushed up and light-cured for 60 seconds. Next, the occlusion was adjusted and the composites finished (Figs. 7 & 8).

The patient was very pleased with the final result and was informed of the necessary appointments for follow-ups and maintenance, occlusion check-ups, as well as photographic monitoring. The accompanying photographs were taken three months post-operatively, the first one with dry teeth and the second in natural conditions during smile (Figs. 9 & 10).
The most commonly used irrigant in endodontics is sodium hypochlorite. This is a highly alkaline disinfectant that can dissolve pulp tissue and kill most of the bacteria found in infected root canal systems. However, it is a highly caustic solution that can cause tissue damage, especially if forced into the periapical tissues, and can also damage instruments and clothes. Sodium hypochlorite has many undesirable side effects and an alternative is always being sought.

One of the causative agents in failure of root-filled teeth is enterococcus faecalis, which is resistant to the alkaline solutions. Consequently, endodontists encourage the use of chlorhexidine not only as an endodontic irrigant but also as a final rinse to give long-term protection to root canals before obturation.

Chlorhexidine itself is a chemical antiseptic that has been used at a low concentration of 0.2 per cent as a mouthwash for many years, primarily to reduce plaque and gingivitis. Prolonged use can cause marked tooth discoloration as well as altered taste sensation. Higher concentrations have been used as a skin wash, although there are case reports of urticaria and contact dermatitis.

Chemically chlorhexidine is a cationic bisguanide which is highly lipophyllic and interacts with cell membrane phospholipids and lipopolysaccharides and is consequently bactericidal. It is active against a wide spectrum of bacteria especially gram positives, less so on gram negatives and is also active against fungi. It has proved very effective against E. faecalis which has proved resistant to sodium hypochlorite and calcium hydroxide and is found in failing root-filled teeth.

Much research has been done on the ideal concentration of chlorhexidine for use as an irrigant and the results are often conflicting. A few studies have shown 0.12 per cent Chlorhexidine (ie chlorhexidine mouthwash) as effective as 2.5 per cent sodium hypochlorite. As an anti-bacterial, the majority indicate that the optimal concentration is two per cent. At low concentrations it can take many hours to kill bacteria in a tooth. This can be shortened to minutes at a higher concentration.

Interestingly (for endodontists) chlorhexidine has a prolonged bacteriostatic action. This is an action termed ‘substantivity’. Following irrigation the chlorhexidine binds to surrounding tissues and has a slow release effect over an extended period. This can therefore in-...
habit initial bacterial adherence and accumulation of biofilms, giving longer term immunity to bacterial leakage. Although this time period is unknown, some research has indicated that a five minute rinse may give up to 12 weeks’ immunity. However other researchers think that this period is too short and suggest one week is required for dentine adsorption.

Further research has shown a synergistic effect when mixed with calcium hydroxide as an inter-appointment dressing and it is especially effective against E. Faecalis.

This all may appear to suggest that we should swap sodium hypochlorite for chlorhexidine. However there is always a downside.

Firstly not only is sodium hypochlorite very effective against most bacteria but it is also able to act as a tissue solvent, effectively disrupting and dissolving pulp tissue which is ideal in those places our instruments cannot reach. It can also disrupt biofilms. Unfortunately, chlorhexidine has neither of these actions. Secondly, just like so-

‘Most endodontists, therefore, use a combination of sodium hypochlorite and chlorhexidine to have a broad a kill as possible and to take advantage of the dissolution properties of sodium hypochlorite’

with calcium hydroxide as an inter-appointment dressing and it is especially effective against E. Faecalis.

This precipitate can be minimised by thoroughly drying the canal and using saline as a rinse between irrigants.

A suggested regime may be therefore to use sodium hypochlorite exclusively in all vital and hyperaemic canals. This takes advantage of its tissue dissolution properties. Chlorhexidine and sodium hypochlorite should be used in non-vital teeth and especially in re-treatment cases. Sodium hypochlorite is the key irrigant but, as a final rinse, chlorhexidine can be used to kill specifically the micro-organisms immune to sodium hypochlorite and to confer longer-term immunity.

What’s Missing?

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For more information or to subscribe please call Joe Aspis on 020 7400 8969 or email joe@dentaltribuneuk.com
With a team of highly trained staff that work tirelessly for their clients, The Dental Directory is a business that truly understands customer care. Sarah Mitchell has been the Practice Manager of Forestmead Dental Practice in Horsham for seven years and has always used The Dental Directory for all her surgery needs. Here she tells us how The Dental Directory has helped her streamline her ordering with its efficient and friendly service.

“At Forestmead we have 6 dentists, 2 hygienists, a large team of nurses and reception staff and myself. We’ve been established for over 30 years and have built up a good reputation in the area, therefore we are very busy. Because of our hectic workload we are always looking for ways to make the surgery run more efficiently and cost effectively.”

When it comes to procuring practice equipment and products however, the Forestmead staff never has to worry about time management, because they use The Dental Directory. With The Dental Directory, any orders made are dealt with quickly and easily, leaving the Forestmead team to administer to their patients. The Dental Directory is a company with over 40 year’s experience in the dental industry and a team of dedicated consultants whose job is to make things go as smoothly as possible within the practice, so Sarah knows that her ordering is in safe hands.

“One of our nurses collates information on the products we need for the surgeries and then passes on that information to me. It’s my job to find the best deals and the best suppliers and, for us, the best supplier is always The Dental Directory. The practice has used the company for over ten years and I’ve been working with them during my seven years here so we’ve built up an excellent relationship with them and have learnt to trust them implicitly.”

The Dental Directory works closely with manufacturers and dentists to ensure that it always has the best products and information available, and the team has amassed an unrivalled knowledge of every aspect of the dental industry. With over 26,000 items in stock, they will either have what you need, or be able to source the item.

“If ever an item is out of stock we are immediately notified with a phone call and given an ETA or offered an alternative. Having said that these instances truly are in the minority; The Dental Directory is extremely efficient and, provided you order before 4pm, products are delivered the next day.”

With outstanding service and excellent prices, The Dental Directory offers a full and professional service. As the UK market leader with over a 50% share of the market, it really knows the industry and ensures that its staff, some of whom have worked for the company for over 30 years, know just as much. The Dental Directory staff are routinely given training, particularly when new products are launched, and are able to pass this information on to their clients.
“The Dental Directory is extremely efficient and, provided you order before 4pm, products are delivered the next day.”

“In the past we have looked around at other dental dealers and were approached by a company a few years ago who suggested we move our account to them. However, even though some dealers seem to be able to offer prices comparable to The Dental Directory, none of them offer the same level of service so in the end we simply stopped looking around! A big part of what makes The Dental Directory so good for our company is our Business Consultant Louise, who is brilliant. She pops by when she’s in the area for a chat or if we have any returns to take and comes by for a working lunch every few months. Louise often brings manufacturer reps with her to discuss new products in which we might be interested and researches everything thoroughly. I understand that The Dental Directory representatives are salaried rather than paid on commission and it really shows, as Louise never tries to give us the ‘hard sell’ or pressure us in any way. She’s always at the end of the phone (or email) when I need her and really puts in the effort to help us with whatever we need.”

As a company truly focussed on customer care, The Dental Directory works hard to provide excellent products at great prices and with unrivalled customer service and it is this attitude and dedication, says Sarah, that really makes them stand out from the crowd:

“The Dental Directory are friendly and caring yet manage to be professional and efficient at the same time. They work hard to make sure our stock is always in and that it’s delivered the next day and always manage to go that extra mile.”

The Dental Directory is not a large corporate concentrating on making vast profits for shareholders, but a family owned company who makes customer care its number one priority. With 40 years of excellent service already under its belt, The Dental Directory will continue to do what it does best, putting their customers first.
Inside out
Glenys Bridges helps put confidence into practice

Having confidence in your daily working life will have positive effects on the dental team.

It is not surprising that others pick up on how we are feeling and respond to us on that basis. A huge amount of communication is through signals picked up subconsciously, from body language projected through how we move our body and walk. Not only does how we move and feel have an enormous effect on our inner confidence levels; it also influences what other people think of you.

Our state of mind is directly affected by how we move and vice versa. As dental care professionals we need to design the image we want to project to patients and colleagues, at times this requires us to replace emotional body language with considered, cognitive actions and responses which can in fact lift your mood and make the image a reality.

Next time you are out walking and you are not in a hurry, lift your head and lengthen your spine. Lift your chin up and look ahead. Let your shoulders come back, and hold your stomach in. Let your arms swing naturally; and then notice how this affects your mood.

Since mood affects how we perceive our world and our responses affect how effective we are, it is important to maintain an upbeat, confident and positive outlook. Therefore, if manage your internal mood throughout your working day this will have a positive impact on your wellbeing and confidence level.

Here are some suggestions about how to lift your mood and confidence levels at challenging times:

**Because we all lead such hectic lives, we can be so busy `doing` that we lose touch with how we are feeling. When you are in a less-than-positive mood, do something to transform it to give yourself the best possible chance of having a good day. Act sooner rather than later as, it is hard to retrieve the situation the longer it goes on and as it continues it will erode your confidence.**

At the start each day, or before undertaking a particular activity write down what you want to achieve from your day, this allows you to focus on positive outcomes.

If you feel low at the beginning of the day, look up and visualise how you are going to handle the day ahead. There is a technique used widely in NLP, visualisation, in which you imagine yourself successfully managing events, or situations that are causing you concern. You will feel much more upbeat.

When life throws us challenges our inner critic can try to undermine us, if successful this will reduce our confidence and resourcefulness. At such times it is helpful to recall previous times when you have successfully managed similar challenges and identify the inner resources you used and remember how good your success felt, then bring those resources and feelings to the current situation.

It is very important to maintain your physical self at challenging times. Eat healthily, drinking sensibly, start the day with a breakfast that sets you up for your day ahead and do everything possible to get a good night’s sleep.

When something knocks you back or your inner critic starts to undermine your confidence and your mood and you become overwhelmed by a negative emotion, you need to transform it. Watch out for physical changes in your body that indicate a change in your thoughts and feelings. The change could be a tensing of your shoulders or your neck, a head-ache, a sinking feeling in your stomach or some other physical change that indicates you are no longer in a confident, positive mood. Be aware of the physical signals that you are slipping into a less-than-positive state?

To quickly snap out of a negative mood or state of mind simply look up, this accesses your visual cortex, bringing two benefits. Firstly, it is almost impossible to experience a negative emotion while looking up and therefore it forces you to feel more positive. Secondly, when you look up and access your visual cortex it is much easier to visualise how you are going to handle things. This is very useful if you are starting to feel anxious, stressed, angry or under confident in a particular situation.

If possible, take time out and physically remove yourself from a situation that is making you feel negative or undermining your confidence, even if this means simply taking yourself off to the toilet. This can help you to disassociate and leave your negative emotions behind. If it is possible to go for a short walk, that will be even better.

It is essential that dental professionals maintain their professional skills and provide patients with the best possible dental care. Before we can offer the best care to our patients we need to care for ourselves and ensure the confidence we project outwardly is sourced from a genuine inner wellbeing.

About the author
Glenys Bridges - For more information, email GlenysBridges@thedentalacademy.co.uk

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have all done it. Attended an amazing, inspirational course which has presented new research and methods which have made sense to us. We then return to the practice full of enthusiasm, ideas and (usually) sporting a large shopping list. Expensive new items of equipment are bought and off we go. So, why is it, around four months down the line, we find that all the stuff is in that cupboard, the one which nothing ever comes out of, and we have returned to our old ways of working? It is simple. We haven’t planned and implemented the change in a manageable way, relying on our own vision and enthusiasm to be sufficient for the change to occur. We become overwhelmed with the day to day and the importance of that change goes further down our list of importance until it drops off the end.

Barriers to change in clinical practice - time keeping

Our clinical working day is tightly timed and does not allow for deviation from the day list or room to slow down. Often, when we are trying out a new technique or method in working we will be slower than when we are using techniques we have used for years. That does not necessarily mean that those techniques are better than the new ones. In fact, it is likely the newer techniques will be superior. Like most things, the first time you do it you are generally not so good; awkward even. But with repetition we become good, better and then excellent. Accepting that it takes extra time to learn and being realistic with your implementation rate can make a new method or stick and develop in your clinical day.

Building a new routine in measured stages

A great way to do this is to decide that you will only use the new method once in a session. This will allow you to familiarise yourself with the new thing (working with magnification is a perfect example) without running so late you and your patients become stressed. After a week of this, you might add a second patient to the session being treated this way. The general rule of thumb is it takes six weeks to build a habit and two weeks to break it.

Changing as a team – rising to the challenge

It is my belief that implementation is one of the weakest areas of development in dental teams and, with some basic guidelines; all teams can become more effective at driving change for the better in their practices. What is more, CQC will be pleased to see you do it.

Meetings to bring about change

To move through stages of change, you need to have effective, chaired meetings, with good clear minutes which contain clear action points so everyone knows what they need to do before the next meeting. Ideally, you would have a chair of the meeting and someone taking the minutes. This can be rotated so everyone grows these skills in your team. It allows for small task groups to meet and progress independently if needed. Guess what, CQC like this too.

The chair should feel confident that they have:

• An understanding of the issues and topics being discussed
• Strength of personality and character allowing them to stand their ground and to effectively manage the meeting. Be able to utilise authority e.g. prevent discussions wandering, prevent those without anything new to add repeating the same point, being able to move on when a point is discussed as far as possible etc.
• Be able to sum-up the points made in discussions for the minute taker

The person taking the minutes should:

• Have an agenda and make sure everyone knows about it
• Send out the agenda and minutes so everyone can read them in advance (where possible)
• Write the summaries of points made and initials of the person who has been delegated any task relating to the point
• Feel confident enough to ask for repetition for clarity or to slow the conversation to allow for accurate note keeping.

Building a plan for change

Once you have established the need for change within the practice, discussed and shared the vision; you need to plan its implementation with a realistic time frame to ensure movement. We all know how busy our daily clinical life is and if not pushed to deliver to a deadline, things can just sit in a to do pile for, well, ever.

Create a plan for positive change

Most businesses decide they need to make changes and then begin to implement them immediately. While speedy execution of plans and a positive sense of urgency to change is vital, so is proper planning and forethought. The goal is to create a plan for positive change that inspires employees to embrace the change. Start by identifying every touch point the change will affect and determine how that will impact people. Consider how staff and patients may be threatened or anxious about the changes. Create a message that clearly articulates the benefits and advantages of the change. But, don’t sugarcoat the changes. For example, if you decide you are going to discontinue an old procedure to improve your oral health assessment of the patient, and haven’t done this for years, the patients may not like or understand the change. You need to plan a good communication path that will take all conflict out of visits due to good information and communication.

Provide optimal training and support resources

We often fear change because we don’t know what to expect. Staff worries are that they won’t be able to perform, that they won’t have the skills or abilities. Determine the training and support resources needed and plan how to put them in place. Reassure employees that training will be provided where needed and follow through on that commitment. Establish effective training programs with back-up training and evaluation as needed. Training can include specific skills training, or it can entail creating a new way to look at the business, changing old habits or views, and teaching new leadership skills. Don’t cut training short or overlook how important it is or in the end you will pay more.

Don’t give up!

Any change is hard work but not changing at all is no longer an option in dentistry. The first time we do anything knew we generally suck at it! The next time we are better, the third feels smoother and, around time 47, we generally feel like we are comfortable with the change and are happy to keep it. So, we need to revisit, reassess and discuss out progress with the change to help establish it.

Creating a plan for positive change that inspires employees to embrace the change is a good place to start.
The BACD Conference — The date is the 10th - 12th November 2011, the place is London’s Edgware Road and the event is the return of the hugely popular Annual BACD Conference. This year’s conference will be bigger and better than ever, with talks from world-renowned experts including Dr David Bloom, Dr Christopher Ogden, Dr Jitendra Singh and Dr Ken Harris. Withsubjects ranging from the latest techniques in aesthetic dentistry to implications of elective treatment, the conference promises to be an event to remember.

The conference ‘Something to smile about: maximum aesthetics, minimum intervention’ provides dentists to network, circularize and enjoy the benefits of having the world’s leading cosmetic dentists under one roof.

Don’t miss your chance to be part of one of the biggest events in the dental calendar.

Register online before the end of September and receive a 10 per cent discount. In addition to this, the first 25 people to register online will be entered into a prize draw with the chance of winning a Venus Masters Composite Kit. Portal registration forms can be downloaded from the website or taken from the conference brochure. www.bacd.org.uk and should be sent to Mrs Suzy Rickards, British Academy of Cosmetic Dentistry, 29 Harley Street, London W1G 5QO.

Dentally appoints new commercial marketing manager

DENTALUK Plc has announced that Justin Sisodia, a highly experienced Commercial Marketing Manager, has joined the company. Since the start of his career in the dental industry, Justin has gained a wealth of experience in a variety of sales and marketing roles within the UK, including a previous period with DENTALUK, and has also worked in international sales.

Justin says re-joining DENTALUK offers an opportunity to work on products that are available both in the UK dental market, and also with such an exciting and innovative company as DENTALUK. There is a real hunger for developing and delivering the highest quality products to our customers and doing the right thing for dental professionals, which in turn enables them to provide the best possible level of dental care for their patients. Justin will work closely with both our dental professional customers and our trade partners to continue the growth and development of the DENTALUK brand in the years ahead. A vital part of my role will be to ensure that DENTALUK are able to provide outstanding quality and value to the professionals and DENTALUK Rewards is one way in which we can deliver this. That is something that I am extremely excited about, and can’t wait to get stuck into.

For more information contact DENTALUK UK on 01922 854622 or visit www.dentaluk.com
Product Specialist, call: 0800 072 3313 or visit www.dentsply.co.uk.

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With over 12 years’ experience, they know that every Practice is different and has individual requirements. Therefore they offer a range of options, enabling their clients to make the best choice for them in order to integrate the latest and most appropriate digital tools into their Practice. Not restricted to one or two manufacturers, they believe they supply the best products on the market, products that are clearly superior to those that have tested lower or prove to grow.

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For further information contact Digital Dental on 020 0800 072 3313, email sales@digitaldental.co.uk or visit www.digitaldental.co.uk.
Dentists wondering what the latest trends within aesthetic dentistry really are can find out by attending the 2011 British Academy of Cosmetic Dentistry’s Annual Conference. Taking place from 10th-12th November 2011 at the Hilton London Metropole Hotel and entitled, “Something to Smile About - Maximum Aesthetics from Minimal Intervention,” this year’s event aims to enlighten and uplift dental practitioners keen to introduce more conservative ways to create beautiful smiles that still meet the demands of increasingly discerning patients.

Also on offer will be a first rate line-up of expert lecturers and speakers, an exciting array of CPD-verified workshops and hands-on sessions, as well as a glamorous gala dinner on Saturday the 12th – the perfect networking opportunity.

UK dental professionals keen to sharpen their cosmetic dental skills and stay in touch with the latest aesthetic and restorative techniques should book now for this unmissable event.

For more information, or to book please visit www.bacd.com
Or contact Mrs Suzy Rowlands on 0208 241 8526
Or email suzy@bacd.com

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FOR FURTHER INFORMATION: Professor T.C. Ucer, BDS, MSc, PhD, Oral Surgeon, Oaklands Hospital, 19 Lancaster Road, Manchester M6 8AQ.

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