

# Scotland, United Kingdom



## Oral and Dental **Care**

Stevenson College Edinburgh



Lifelong Learning Programme

Education and Culture DG

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*It is likely that the Vocational Training programme that you are studying will be similar to ours, however this is has been included in the pack as there is more than one training route to becoming a dental nurse in Scotland although all dental nurse students sit the same national exam.*

*Most European countries are facing the same challenges in ensuring that they are training an efficient and competent workforce for the future. There are concerns regarding the fall in the birth rate and with people living longer that there will be skills shortages. Having transferable skills is what will be required in the future and work is being undertaken in some subjects to streamline courses so that they will meet the needs of different countries.*

*I hope you find this information pack useful and we wish you every success with your studies.*

# 1. Guidelines on Oral and Dental Health Policies of WHO and EU

◆ Oral health is not to be seen just as a specific of health care and promotion of well-being – it means more than just good teeth, it is integral and essential to general health. This viewpoint has been identified in the World Health Organisation's (WHO) 'The World Oral Health Report 2003' resulting in 'Continuous Improvement of Oral Health in the 21<sup>st</sup> Century' – the approach of the WHO Global Oral Health Programme.

The future oriented disease-preventing and health promoting policy is based on the following common facts: oral health as an integral and essential factor of general health implies being free from chronic oro-facial pain, oral and throat cancer, oral tissue lesions and other diseases and disorders that affect oral, dental and craniofacial tissues. Oral health problems and general health problems are primarily the result of the same common risk factors that are interrelated. Although these points capture the wider meanings and target it does not take away from the relevance of major global oral problems such as caries and periodontal diseases.

Preventative work and early detection of oral diseases with proper treatment is crucial and positive is crucial and has positive as in the reduction of premature mortality, microbiological

infections and immune disorders to mention a few.

From a broad based viewpoint such as common oral health issues like caries and periodontal diseases are global problems as well as other oral diseases too, they are to be considered as major public health problems. This applies both to industrialised countries as well as developing ones. According to WHO's global estimation some five billion world-wide have experienced dental caries. Such estimation is convincing evidence that oral health is an integral part of general health and any person's well being.

What makes oral care and combating the most common problem, dental caries, challenging is that dental caries has been perceived in developed countries, e.g. Member States of the EU, as a problem that has already been overcome. The true situation however is that it affects 60-90% of school children and the vast majority of adults. In a similar manner dental caries is also the most prevalent disease in several Asian and Latin American countries as well.

While it appears to be less severe in most African countries, the report states that with changing living conditions, dental caries is expected to increase in many developing countries in Africa,

particularly as a result of the growing consumption of sugars and inadequate exposure to fluorides.

According to WHO's Global Oral Health Programme the prevalence of oral cancer is the eighth most common cancer of men worldwide. In south central Asia, cancer of the oral cavity ranks amongst the three most common types of cancer. The sharp increases of oral/pharyngeal cancers have also been reported in several countries and regions such as Denmark, Germany, Scotland, central and Eastern Europe, and to a lesser extent, Australia, New Zealand, Japan and the USA. Smoking, smokeless tobacco, chewing betel and alcohol use are all risk factors.

The major priorities and components of WHO's Global Health Programme focus on not only to addressing modifiable risks such as oral hygiene practices, sugar consumption, lack of calcium and micronutrients and tobacco use, but also to major socio-cultural factors. These include: poor living conditions, low education level as well as lack of traditions supporting oral health. Globally countries should ensure the appropriate use of fluorides for the prevention of caries, while unsafe water and poor hygiene are environmental risk factors for oral as well as general health.

Oral health systems need to be focused towards primary health care and prevention. WHO's Global

Scholl Health Initiative, which seeks to mobilise health promotion and education levels at local, regional, national and global levels, has recently been strengthened by an oral health technical document. Increasing emphasis has also been placed on targeting the elderly; by 2050, there will be 2 billion people over the age of 60, 80% of them living in the developing world. The Oral Health Care Programme will make an important contribution to early diagnosis, prevention and treatment of HIV/AIDS, which often shows up first in oral fungal, bacterial or viral infections and lesions.

Poor oral health can have a profound effect on general health and the quality of life. The experience of pain, endurance of dental abscesses, problems with eating, chewing and missing, discoloured or damaged teeth, has a major impact on people's daily lives and wellbeing.

### **European Strategy for Oral Health**

In 2007 the European Council of European Dentists outlines recommendations at a conference in Lisbon; 'Health Strategies in Europe'. The recommendations are parallel to the WHO's Oral Health Programme are based on the same socio-epidemiological surveys.

Oral health is an integral part of general health and well-being. Good oral health

enables individuals to communicate effectively, to eat a variety of foods, and is important to the overall quality of life, self-esteem and social confidence. A range of diseases can be classified as oral diseases, including dental caries, periodontal disease, oral pathology and cancers, dentofacial trauma and dental erosion. These diseases, although largely preventable, affect a significant proportion of the European Union population and exact a heavy burden on the individuals quality of life and costs to the health care system.

The major risk factors for oral diseases are the same as for major chronic non-communicable diseases such as obesity, heart disease, stroke, cancers, diabetes and mental health illnesses. Rather than attempting to tackle each chronic disease in isolation, a more effective approach is needed with greater emphasis on prevention and promotion, directing action at the common risk factors – diet, smoking alcohol and stress improvements.

## 2. Oral Health Services in Scotland

### 2.1. History of Oral Health Care in Scotland

◆ Oral Health care in Scotland has not had a positive history. It has advanced far more slowly than any other kind of health care and it is only within recent times that it has been made a health priority in Scotland and well as the rest of the UK.

Prior to, and throughout part of the 19 century dentistry was a totally unregulated and practices by today's standards would be considered barbaric. As with many medical practises of the time, procedures were generally carried out by those who appointed themselves as the practitioner within their village or town. As there were no alternatives people would seek their services for payment or payment in kind i.e. food etc. Many lost all of their teeth prior to reaching middle age and the associated illnesses contributed to premature ill health owing to lack of good nutrition through the inability to eat certain foods. Basic prosthesis were attempted to replace lost teeth but were mostly unsuccessful and were associated with infection.

In the middle of the 19 century, the practice of dentistry was completely unregulated. Most people found it difficult to know who do go to and who

was actually skilled in this field. There were several grades of practitioner at work, these included; surgeons who practised dentistry as a speciality; surgeon dentists, but the majority practising dentistry at the time were chemists and druggists who were not sufficiently trained and those with no specific training. There are many stories of dentistry being carried out after the patient had consumed a large amount of alcohol so to ease the pain. In many cases the wrong teeth were extracted and there was a very high percentage of infections resulting from the use of unhygienic instruments.

Many dentists were trained in the mechanics of dentistry but had little or no specialist knowledge of surgical procedures. Some of those who practised dentistry were often proficient craftsmen in their own trades eg. goldsmiths, silversmiths and watch repairers. Although not surgically trained they could easily make appliances and instruments required in the surgery and laboratory. Many skilled operators took on apprentices and revealed their secrets and gave instruction on extracting teeth, filling cavities with gold foil and other chair side practises. At this time there was no formal training in place for those wishing to practise dentistry.

Dr John Smith, a surgeon-dentist and later the President of the Royal College

of Surgeons of Edinburgh, was the first in Scotland to conduct a course in dentistry with clinical instruction for medical students of the college. Concerned about the dental health of the population of Edinburgh, Dr Smith with other colleagues set up and funded the Edinburgh Dental Dispensary in 1860 to provide for those in need of dental care and for the provision of clinical instruction in dentistry.

Major reform finally led to the Dentists Act of 1878. This act ensured that only those who had undergone recognised training could call themselves 'dentist' or 'dental surgeon' and be admitted to the Register. A weakness of the act was that there was no requirement to actually be on the register so it was difficult to control the practice of dentistry. It was still possible to practice dentistry as long as the titles 'Dentist' or 'Dental Surgeon' was not used. In 1984 the Dental Dispensary changed to the Edinburgh Dental Hospital and School.

The 1921 Dentists Act finally raised the standards by requiring all of those who practised dentistry to be on the dental Register. Only those who had trained at the Dental School could be on the register and only registers dentists could practise dentistry. In 1948 the Dental School became part of the Faculty of Medicine of the University of Edinburgh and students were awarded the university degree of bachelor of Dental Surgery (BDS). The Dental

Hospital and School were rebuilt and modernised between 1952 and 1956 and the opening was carried out by the Secretary of State for Scotland.

Although the beginnings of modern dentistry started in Edinburgh, these advances impacted on the rest of Scotland and dental hospitals and schools were set up in other Scottish cities.

Currently there are two dental schools at Glasgow and Dundee which train new dentists. Dundee and Glasgow are developing additional flexible teaching options in a range of settings for students, known as 'dental outreach schemes'. Outreach training offers an opportunity to provide a range of dental training settings, out with the traditional 'dental school' model.

The Edinburgh Dental Institute undertakes postgraduate dental training and the training of dental hygienists.

Two new dental therapist schools opened in Glasgow and Dundee in 2003 and 2004. A further training facility was opened in Edinburgh in 2005. Rapid expansion of the dental therapist workforce will have a great impact on the dental workforce.

## **The Future of Oral Health Care**

One of the objectives of the National Health Service (NHS) dental service is to improve the oral health of the nation and to improve the services

offered so that people can easily access these services. The services provided should be of a high quality and their main focus should be on prevention. Childhood is the most important time to learn the essential skills to maintain good oral health for the rest of life. This should be in association with high quality dental health services supporting individuals to maintain their own dental health.

The following ten key principals outline the way ahead:

- ◆ Oral health as part of overall health improvement, Free dental examinations available for all population groups.
- ◆ The focus for children and young people should be on prevention ensuring the needs of the most disadvantaged are met.
- ◆ Patient led standards ensuring high quality services.
- ◆ A strong well paid dental service aimed at those most in need.
- ◆ An easy to understand payment system for patients.
- ◆ Practices receiving support and incentives for providing NHS services.
- ◆ Support given to encourage recruitment and retention of all the dental team members.
- ◆ A dental workforce trained to deliver dental services in a way which is effective and complements and supports a preventative approach to care.
- ◆ A national framework allowing for local dental needs to be integrated

within the broader NHS Team.

- ◆ An education and training plan to deliver more high quality dental provisions.

### **Oral Health Care in Scotland**

- ◆ Although oral health has improved for adults there has been little change in improvements for children,
- ◆ 18% of adult Scots have no teeth, compared to 44% in 1972. (Adult Dental Survey 1998).
- ◆ 55% of Scottish 5 year olds show some signs of decay (2003 survey). This has remained unchanged from a 1999/2000 survey conducted by the Scottish Health Boards Epidemiological Programme Survey.

### **The Way Forward**

- ◆ This following targets have been set for March 2008:

#### **Dentists**

- ◆ NHS dental services to increase the number of working dentists by at least 200 at an average rate of 50 per year, in salaried and independent practices.
- ◆ Increase the number of dental students by 15% to deliver an output of 135 per year.
- ◆ Increase the number of vocational trainees to 135 per year.

#### **Professions Allied to Dentistry**

- ◆ Increase the number of therapists in training to 45 per year
- ◆ Increase the number of dental nurses in training to 250 per year.

The factors that are likely to have direct influence on the increasing demand on oral health services in the future are:

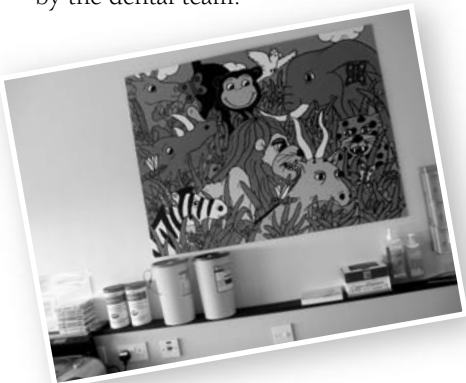
- ◆ More people keeping their teeth into old age.
- ◆ Increased early retirement of dental professionals.
- ◆ Increased part time working.
- ◆ Increase in non NHS working.

### Children's Oral Health

Surveys have shown that there are high levels of dental caries in young children in Scotland and that most of these come from disadvantaged communities.

- ◆ By the age of 3, over 60% of children from areas of deprivation have dental disease.
- ◆ By the age of 5, over 56% of all Scottish children have dental disease.
- ◆ By the age 14, 68% of children have suffered from dental caries in their adult teeth.

These problems start at an early age and the main reasons are poor oral hygiene and diet. Their needs to be improved education for parents and children lead by the dental team.



### Adults

Scottish adult's dental health has improved over the last 30 years with one million more adults having some teeth compared to 1972. These improvements have been due to improvements in services and an increased awareness of oral hygiene practices. Despite these improvements, oral disease is still a problem for many Scottish adults and access to dental services is increasingly problematic in many areas in Scotland.

The Adult Dental Health Survey (1998) showed that:

- ◆ The average adult aged between 35 and 44 years of age had lost 8 adult teeth and 10 teeth filled.
- ◆ 41% of Scottish adults reported some dental pain in the last 12 months.
- ◆ 56% of Scottish adults over 65 years had no teeth.

The 2008 targets will include:

- ◆ A free dental check for all adults.
- ◆ Scotland's Health at Work programme module on oral health will be used by NHS Boards to promote workplace oral health.
- ◆ Oral Health Care preventative support programmes will be developed and delivered by NHS Boards and targeted at pensioners and the homeless.

For adults over the age of 60:

- ◆ A free dental check for all adults.
- ◆ NHS Boards will have appropriate oral health care and support programmes for all elderly

care homes and will introduce performance indicators to measure their compliance.

- ◆ Registration levels for 65-74 year olds to increase from 40% to 60%.
- ◆ Registration levels for people aged 75 years and over will increase from 28% to 40%.
- ◆ Older people with special needs will have individual care programmes.

### **The Way Forward - Oral Health Improvement**

Targets will continue to be set to further improve the oral health welfare of adults and children.

The following gives a breakdown of what is hoped to be achieved by 2010.

- ◆ 5 year old children (Primary) 1 - 60% of children will have no signs of dental disease in permanent teeth.
- ◆ 11/12 year old children - 60% will have no signs of dental disease in permanent teeth.
- ◆ 90% of adults will have some natural teeth.
- ◆ 65% of adults aged between 55 and 74 will have some natural teeth.
- ◆ Revise current declining trends in oral cancer 5 year survival, for males, by 2015.

### **Children**

- ◆ The school and community and home will play an important role in improving the dietary habits of children.
- ◆ Parents and carers to establish good

oral hygiene practice at a young age

- ◆ Free Toothbrush and toothpaste schemes in schools to support good oral hygiene practice whilst at school.
- ◆ A consistent approach by professionals to promote good dietary habits within the community.
- ◆ To introduce a range of measures to improve healthy food options in schools and to reduce unhealthy foods.
- ◆ To improve public education on healthy eating with clear, consistent and achievable messages.
- ◆ Dental services should be based on the notion of prevention, supported by a modern and effective service.

### **Infants and Pre-school Children**

By March 2008.

- ◆ All children will have access to dental care on starting nursery school and together with their parents and carers will have access to dental advice.
- ◆ The number of children aged 0-2 years old under dental care/supervision will increase from 35% to 55%.
- ◆ The number of children aged 3-5 years under dental care/supervision will increase from 66% to 80%.
- ◆ All pre-school children in areas of greatest need will be offered dietary advice, dental advice, support and preventative packs through community based organisations.
- ◆ All nursery schools will offer supervised fluoride tooth brushing schemes and support healthy eating and drinking water policies.



### 0-2 - Pre-nursery

- ◆ Midwife and public health nurse contact and advise on health and dental care.
- ◆ Giving out toothbrushes, toothpaste and information to all infants aged 6-8 months, with additional distribution to older infants in the communities with greatest need.
- ◆ Community based programmes providing dietary advice, water fountains and fresh fruit linked to the Diet Action Plan.
- ◆ All health professionals emphasising the significance and importance of breastfeeding and early infant feeding to health and dental health.

## 2.2. Variety of Clinics

◆ Within Scotland there are Dental Practices which are under the NHS and there are those which are Private. Although both Practices have the same responsibilities in the promotion of dentistry and oral health care and have to meet the targets set by the government. Both have to meet the same standards in relation to patient

care and good working practices. The main difference between the two is the business structure and the financial arrangements.

Patients who access NHS practices still have to pay towards their treatment, although this is subsidised. Private patients have to pay much more for their treatment. The number of dental practices choosing to remain within the NHS is small, so the majority of Practices are private, This has caused a great deal of concern as there is a significant proportion of the population who cannot access an NHS dentist and therefore receive minimal or no treatment at all. Within rural settings the situation is no better owing to the shortage of dental practices, or only having those that are private.

The majority of dental practices are spread throughout the community and range from small to large group practices. Depending on the size of the practice will depend on the range of treatments being offered, but most of the practices will be able to offer the usual range of services. Should a patient require more invasive or a complicated procedure they may be referred to the Dental Hospital, as in the case of Orthodontics or Oral Surgery. Minor surgical procedures such as tooth extraction, requiring sutures or root canal treatment can easily be carried out within the dental practice. All of the practices employ dental nurses who assist the dentist as part of their role.

Dental Hospitals are equipped to deal with the whole range of dental treatments and have facilities for dealing with any complex problem that may arise. The dental hospital is generally a teaching hospital for dental students and dental nurses and hygienists and is attached to the University. They employ dentists, dental consultants, dental nurses and dental hygienists.

'*Primary Care*' means, local dental services available directly to patients. This would include care provided in the patient's own home.

'*Secondary Care*' refers to hospital or specialist care. The patient may have been referred from primary care.

## **NHS Primary Care Services**

### **General Dental Service**

90% of dental care takes place in HNS general dental practices. These practices include private dental care. Services can be provided in a patient's own home if necessary. Some prisons in Scotland have their own dental surgeries. 49% of adults and 65% of children are registered with a dentist.

### **Community Dental Service**

These are based within Health centres or within the patient's own home. These meet the needs of NHS patients who may have medical problems making it difficult for them to attend surgery. They also meet the needs of those who have special needs, including children, people with Learning and Physical

Disabilities and elderly people in residential care.

The dental nurse can work in a variety of settings and may choose to work with a specific type of patient as with any other health related profession.

The dental nurse working with those with special needs require to have excellent communication skills and patience. All dental nurses need to have these skills but they are tested more when working with those with communication and understanding difficulties.

### **Salaried Dental Service**

These are based in dental practice, dental access centres, health centres and the patient's own home. This allows access to dental services where there is a local shortage of NHS dental treatment.

## **Private Dental Services**

### **Primary Care Services**

Totally private dental practices or clinics that also include NHS dental practices that provide private treatment. These are for anyone that chooses private dental care and treatment.

### **Private Secondary Care Dental Services**

These are totally private dental practice or clinics. This is for anyone who chooses to have private dental care and treatment. The patient may be referred from their own NHS or private dentist.

## 2.3. Organisation of Oral Health Care for Special Groups

### The Prison Service

Dental health has been found to be significantly worse within the prison population than in the rest of society. Reasons for poor oral health within society is related to the socio-economic circumstances in which people live.

- ◆ Prisoners have significantly more decayed teeth than the rest of society.
- ◆ Severe tooth decay was three times higher than the rest of society, usually needing extraction of the tooth.
- ◆ Pulpal decay was found to be fourteen times more common in women in prison than in the rest of society.
- ◆ Poor oral health has also been linked to the misuse of drugs, especially opiates. Long time drug use, poor oral hygiene and an inadequate diet promotes tooth decay. 74.5% of mandatory drug tests carried out were positive. (Scottish Prisons Service Report 1999/2000)

### Recommendations

- ◆ To ensure that prisoners have the same access to public health services to reduce any inequalities in general health and dental health.
- ◆ To prescribe sugar free methadone to recovering drug addicts.
- ◆ Free toothbrushes and fluoride toothpaste should continue to made

available to prisoners.

- ◆ The Scottish Prison Service should consider redesigning prison dental services to make better use of the dental skills of dental hygienists and therapists in helping to prevent dental ill health.
- ◆ Oral health promotion, including oral hygiene, self care and dietary advice should be an important part of general health promotion within prisons.

### Oral Health Care for Long Stay Patients and Residents

There is higher rate of periodontal disease and a lower standard of oral health care amongst institutional elderly people.

The main reasons given are:

- ◆ A lack of understanding by the residents of their oral health care needs.
- ◆ Residents not able to explain what they need.
- ◆ Family members not considering dental care as a priority.
- ◆ Care staff not recognising oral health care as a priority.
- ◆ Care staff workloads are heavy and they feel that they have other more important duties to perform.
- ◆ Chronically inadequate oral hygiene practices.
- ◆ Local dental personnel unable or unwilling to provide adequate dental care.
- ◆ Difficulty in obtaining dental care.

There are many needs that have to be addressed in improving the standards of oral health care and the quality of life for residents in continuing care.

The main issues identified for improvement:

- ◆ Oral and dental needs and access to personal oral care.
- ◆ Improvement in attitudes to oral care and knowledge by health professionals and health care workers.
- ◆ Improvement in oral hygiene practices which are inadequate.
- ◆ Appropriate oral hygiene equipment to meet individual needs.
- ◆ Access to appropriate general and specialist dental services.

Improvements should include:

- ◆ Oral health care assessment on admission
- ◆ Training programmes for care staff
- ◆ Access to emergency dental services
- ◆ Contact with appropriate dental services
- ◆ Basic principals of good infection control practised by all health care workers involved in oral care.
- ◆ Awareness at manager level of the risks to health from poor standards of infection control in mouth care.
- ◆ Development of standards which can be audited to promote improved quality of care and assist with the identification of problems.
- ◆ A multi-disciplinary approach to encourage communication between the professions and the quality of oral health care delivered should be

included in the criteria for registration of care facilities.

- ◆ Oral hygiene equipment readily available and staff made aware of appropriate use.
- ◆ Offer facilities which allow for privacy, ensuring dignity is maintained.

### **Oral Health Care for people with Mental Health Problems**

This category would cover all those who have mental health problems in all areas, this includes, Psychiatric hospitals, General hospitals, Secure units, Prisons, Hostels, Residential homes, Group homes, Sheltered accommodation, Drug and alcohol rehabilitation centres, Households, Homeless people.

#### **The main factors that influence oral care:**

- ◆ Type, stage and severity of mental illness. This can include facial pain, excessive palatal erosion, self-inflicted injury, enamel erosion through bulimia nervosa.
- ◆ The individuals mood, motivation and self esteem. This can include those suffering from dementia or memory loss and depression.
- ◆ Lack of personal understanding of oral health problems.
- ◆ The individual's habits, lifestyle and ability to sustain self-care and dental attendance. The factors that affect positive oral health are related to

inability or unwillingness to accept dental treatment. Poor diet and an increase in sugar drinks, housing conditions, homelessness and access to privacy for personal hygiene. Alcohol and drug abuse can lead to mineral deficiencies as well as increases in periodontal disease.

- ◆ Socio-economic factors that reduce the individuals choice to health living
- ◆ Language and culture
- ◆ Lack of information on how to access information or dental services
- ◆ Oral side effects of medication that dry the mouth. The condition increases the risk of dental caries, periodontal disease and oral infections such as candidiasis, glossitis, generalised stomatitis and in extreme cases may cause acute inflammation of the salivary glands. This can present itself in difficulty with speech, chewing, swallowing and poor denture tolerance.
- ◆ Attitudes and knowledge of oral health care by health care professionals. This has been identified by low tolerance by the dental team in dealing with the patients lack of compliance with oral hygiene and the care of prosthesis.
- ◆ The dental teams attitude and understanding of mental health problems
- ◆ Local dental staff unable or unwilling to provide adequate dental care.

### **Recommendations for the Development of Oral Healthcare for People with Mental Health Problems.**

- ◆ Accessible and acceptable dental services.
- ◆ Services that target clients with limited access to HNS dental provision.
- ◆ Oral assessment to identify the risk factors for oral health.
- ◆ To develop a personal oral care plan.
- ◆ To have appropriate equipment
- ◆ To identify preventative measures
- ◆ Identification of dietary needs to promote good oral health.
- ◆ To address techniques for plaque control and the maintenance of gingival and periodontal health.
- ◆ Address issues relating to the side effects of oral medication.
- ◆ Procedures for ensuring access to pain relief, appropriate general and specialist dental services, oral hygiene advice and support.
- ◆ To offer support for oral hygiene and health care practitioners.
- ◆ To ensure that dental care continues after discharge from hospital
- ◆ Establish co-operation between all of the multi-disciplinary team.
- ◆ Continued research and study to ensure appropriate strategies are in place.
- ◆ Training care professionals in the scientific basis of oral health and disease as well as assessment, identification of oral health risk factors. Also to provide oral care to motivate, encourage, support and assist patients in their oral and denture hygiene.
- ◆ The dental team should undertake training in mental illness and mental health awareness.

## Oral Health Care for Dependent, Dysphasic, Critically and Terminally Ill Patients

There are specific difficulties for those who have little or no control in maintaining their own oral health and

are totally dependent on others. This applies to those in intensive care who may be on percutaneous endoscopic gastrostomy (PEG) and nasogastric feeding. Patients who can feed orally have less oral health care issues than those who are tube fed. The effects of

### ORAL ASSESSMENT ON ADMISSION

ARE THERE ANY ABNORMALITIES  
Eg, colour of the mouth, texture of soft  
Tissues, lesions, bleeding.

Yes - refer for further examination	No - move on to next stage
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IS THE PATIENT INTUBATED?	IS THE PATIENT INTUBATED?
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Yes - reposition tube frequently and secure before carrying out oral care.	No - move on to next stage
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DOES THE PATIENT HAVE THEIR OWN TEETH?	DOES THE PATIENT HAVE THEIR OWN TEETH?
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<p><b>Yes</b></p> <p>Place patient in the appropriate position. Cover patient Moisten lips (petroleum jelly) Retract lips/tongue with gauze Brush all surfaces of the teeth with a fluoride toothpaste/chlorhexidene gel. Rinse with water (10ml syringe) Aspirate using Jenker Clean patients face Lubricate lips</p>	<p><b>No</b></p> <p>Patient's mouth still needs oral care Place patient in the appropriate position Cover patient Moisten lips Retract lips/tongue with gauze Gently brush palate and soft tissue If not possible, use a finger soaked in chlorhexidene gel. Rinse with water (10 ml syringe) Aspirate with Jenker Clean patients face Lubricate lips</p>
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DOES THE PATIENT HAVE DENTURES?	DOES THE PATIENT HAVE DENTURES?
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<p><b>Yes</b></p> <p>Always store dentures in cold water as hot water will misshape them. Clean dentures over a basin of water to prevent them from breaking. Clean with unperfumed, household soap and a denture/nail brush.</p>	<p><b>No</b></p> <p>Continue with oral care, as above, every few hours.</p>
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Rinse well before replacing  
Clean after each meal  
Dentures will bleach/discolour with over use of denture cleaners

nasal oxygen, mouth breathing, suction of the airway, intubated patients whose mouths are continually open and those who are not eating or drinking orally. Many ITU patients are often therapeutically dehydrated to maximise respiratory, renal and cardiac function. Below is an example of an oral care procedure which would be carried out on admission.

### **Oral Health Care for People with Physical Disability**

Approximately 3% of the population of children aged 16 and under are estimated to have one or more disabilities of which more than a quarter have limitation affecting mobility. Over four million adults of the UK population have mobility problems and around two and half million are reported to have difficulty with personal care. As people get older there is an increase in mobility problems. These difficulties affect access to services and the maintenance of oral health care.

Physical disability can have a huge affect on individuals accessing health care as it offers restrictions that are not experienced by more able bodied people. The main problems are access to surgeries by the use of stairs, having no ramps in place, small spaces that cannot manage wheelchairs. It is often the case that dental treatment is only sought when the patient is in crisis from dental pain requiring emergency treatment.

Upper limb disability may affect the individuals ability to manage their own oral hygiene.

## **2.4. Insurance Arrangements**

◆ The UK has the National Health Service (NHS) and dental treatment is either funded through the NHS or privately. The patient can get treatment from their Practitioner of choice and pay them directly.

NHS dental treatment differs from private practice in the range of treatment provided and the method of payment for the treatment.

There are treatments that are readily available in private practices but are limited in NHS provision and payments to the dentist are set by the NHS, with patients paying either nothing or a set maximum.

The cost of the NHS is borne by the government and the department responsible is the Department of Health and falls into the category of Primary Care.

# 3. Oral Health Care Teams

## 3.1. The General Dental Clinic

### The Dentist

Dentists have to train for 5 years at a University Dental School and on successfully completing their studies they gain a Bachelor of Dental Surgery (BDS). Their names have to be entered on the Dentists Register before they can use the title of dentist or practice. After qualifying all dentists are legally required to continue their professional education until they retire from practice. This would include attending conferences and updating themselves on new procedures.

Dentists have many professional opportunities that may include; working within a general practice, community dental nursing, university teaching and research, industrial dental service and the armed forces. They may wish to undertake higher level qualifications and work within a specialised branch of dentistry. These qualifications come under the faculties of dental surgery, and the faculty of general dental practitioners of the royal colleges of surgery.

Having the higher qualification, dentists will be on the Specialist List for their particular speciality. This includes:

- ◆ Oral and Maxillofacial Surgery

- ◆ Surgical Dentistry
- ◆ Dental and Maxillofacial Radiography
- ◆ Dental Public Health
- ◆ Oral Medicine
- ◆ Oral Microbiology
- ◆ Oral Pathology
- ◆ Orthodontics
- ◆ Periodontics
- ◆ Prosthodontics
- ◆ Restorative dentistry

### The General Dental Council

The General dental Council (GDC) is the governing body of the dental profession and its duties are set out in legislation. These duties include the promotion of high standards of professional education and professional conduct amongst dentists and the professions complementary to dentistry (PCDs) throughout their careers. It therefore ensures that the status of the profession in the community is upheld and that a proper code of conduct is maintained for the protection of the public.

Listed below are some of the GDC's responsibilities:

- ◆ To be satisfied that both undergraduate and post graduate study programmes at dental schools and examinations are adequate.
- ◆ That all dentists, after qualifying undertake one year of vocational training before starting independent practice.

- ◆ To remove or suspend from the register any dentist who has been convicted of a criminal offence or is guilty of serious professional misconduct. They can also suspend any dentist who is causing concern through physical or mental impairment.
- ◆ To be responsible for the other professions who can offer dental treatment i.e. dental hygienists and dental therapists. After they qualify they must register with the GDC and be put on the PCD role.

### **The Dental Team**

The training that a dentist undertakes allows them to carry out, without assistance, all treatment for patients that includes the construction of dentures, crowns and bridges etc. Much of the work carried out by a dentist can be done by others except for the actual treatment done in the patient's mouth. A chair-side dental nurse assists in preparing and mixing filling and impression materials, and helps with suction, retraction and illumination to keep the treatment field clear and dry for the dentist and more comfortable for the patient. The dental technician can make dentures, crowns and bridges ready for the dentist to fit. Dental hygienists and therapists are permitted to undertake limited forms of dental treatment.

By having a team working with them the dentist can practice in a more efficient way, allowing the dentist to

perform the tasks only they can do and by delegating the other tasks to the dental team.

The dental team can now comprise of the following:

- ◆ Dental nurses
- ◆ Dental hygienists
- ◆ Dental therapists
- ◆ Orthodontic therapists
- ◆ Dental technicians
- ◆ Clinical dental technicians
- ◆ Maxillofacial prosthetics and technologists

### **The Dental Nurse**

The dental nurse plays a key role within the practice so much so that it would be very difficult for any practice to operate effectively without dental nurses. Until recently there was no mandatory requirement for dental nurses to be formally trained, many learnt their skills within the practice, but were never tested or examined on their skills. Now for dentists to be registered with the GDC all dental nurses must undertake formal and examination based training.

The qualities of the dental nurse are very important to any practice not only to assist the dentist but also as the first contact for the patient. Their roles extends to managing documentation, communicating to all of the dental team, external agencies and to the patients.

Ethical practice

The dental team are required to:



- ◆ Put the interests of the patient first
- ◆ Respect the choices of the patients
- ◆ Respect the dignity of the patient
- ◆ Protect the patients' confidential information
- ◆ Co-operate with other members of the dental team and other healthcare colleagues
- ◆ Keep updated in professional knowledge and competence
- ◆ Be trustworthy

### *Office duties*

The following is a brief outline of the administrative duties a dental nurse is responsible for:

- ◆ Supervision and cleanliness
- ◆ Reception of patients and dental company representatives
- ◆ Organising appointments and patient recalls
- ◆ Completing and filing patient records
- ◆ Recording all attendance and treatment
- ◆ Ordering and storage of supplies
- ◆ Management of financial records
- ◆ Correspondence
- ◆ Knowledge of NHS regulations and organisation

Many of these duties are now carried out by computer and many practices employ a Level 2 nurse for these duties.

### **The Dental Hygienist**

After two years training at a dental hospital, hygienists gain a Diploma in Dental Hygiene. They are registered by the GDC and have the title of Enrolled Dental Hygienist. They are trained to carry out a number of dental procedures, prescribed by the dentist.

These procedures include:

- ◆ Scaling and polishing teeth
- ◆ The use of local anaesthesia
- ◆ Applying fluorides and fissure sealants
- ◆ Treating patients under conscious sedation, provided that the dentist is present.
- ◆ Replacing of dislodged crowns, using temporary cement in an emergency.
- ◆ Removal of excess cement
- ◆ Applying temporary fillings if one becomes dislodged whilst being treated.
- ◆ Taking impressions

As well as their treatment roles, hygienists are also trained and efficient dental health educators.

### **Dental Therapists**

After two years training at a dental hospital, therapists gain a Diploma in Dental Therapy. They are registered by the GDC and have the title of Enrolled Dental Therapist. They are trained to carry out the same procedures as

hygienists but can undertake a wider range of procedures, such as;

- ◆ Simple fillings
- ◆ Pulp treatment of deciduous teeth
- ◆ Extraction of deciduous teeth
- ◆ Fitting preformed crowns on deciduous teeth

Both hygienists and therapists are previously qualified as dental nurses.

### **Dental Technicians**

Dental technicians are skilled craftsmen who construct dentures, crowns, bridges, inlays, orthodontic appliances, splints and replacements for fractured or diseased parts of the face and jaws. They carry out the prescriptions ordered by dentists.

The training consists of a full time course in a dental hospital or technical college, or through an apprenticeship at college.

### **Dental Nursing and Education**

All of those within the dental team have a responsibility for promoting good oral hygiene and the prevention of caries, The training of dental nurses, hygienists and therapists include the promotion of positive oral health care and as part of their everyday job. Government targets place huge importance on promoting good oral health care for all. The dental team are obliged to promote this in a variety of settings such as:

- ◆ dental practices
- ◆ schools
- ◆ hospitals

- ◆ care homes
- ◆ hospitals
- ◆ prisons
- ◆ hostels

Dental practices and dental practitioners will have to show how they are helping to reach the targets, This would include:

- ◆ having visible health promotion leaflets and posters displayed in the surgery
- ◆ having a range of oral hygiene products available to patients
- ◆ offering hygiene advice to all patients but especially to parents and children
- ◆ offering advice on nutrition
- ◆ going into schools to work with children and teachers
- ◆ working with patients with disabilities and their carers

It may well be that with the new government initiatives there may be specialist prevention dental nurses appointed in the future.

## **3.2. Dental Specialist**

*This will be described in more detail in Chapter 6.*

### **Orthodontic**

Orthodontics is the branch of dentistry that deals with the correction of irregular teeth. When the permanent teeth appear they may be crooked or sticking out. The condition known as malocclusion is often treated to improve a child's appearance.

### **Aims of the treatment**

The orthodontists' job is to reposition the teeth so that appearance is improved and a good functional occlusion is obtained. This type of dentistry does not deal with disease but aims to improve appearance although in some cases this treatment will be carried out with surgery if the jaws need to be realigned where braces alone will not correct the problem. Surgery is generally necessary if an over or under bite prevents normal chewing.

### **Oral Surgery**

This form of surgery within the dental practice is classified as minor oral surgery and includes the following:

- ◆ Removal of impacted lower teeth
- ◆ Unerupted teeth
- ◆ Retained roots
- ◆ Cysts
- ◆ Alveolectomy
- ◆ Frenectomy
- ◆ Apicectomy
- ◆ Gingivectomy
- ◆ Biopsy

Others forms of oral surgery are more radical and may include aspects of plastic surgery such as jaw realignment in conjunction with braces. The dentist, dental surgeon, the dental hygienist, technician and the dental nurse are all involved.

### **Implantology**

For a patient to undertake an implantology procedure a team of oral or periodontal surgeon, prosthetic

specialist and the hygienist examine and assess the patient. They are then in a better position to plan the preparation, construction and maintenance of an implant procedure.

The patients who undertake this procedure are carefully selected as they have to be rigorous with their oral hygiene before and after the procedure and that is why this procedure is expensive. Sessions with the hygienist will help them to understand what they have to do. The dental nurse will assist the dentist.

### **Prosthetics**

Prosthetics, as with much of dentistry involves a team approach and the work of the dental technician is very important to ensure that the prosthetics that they make is as individual as the patients needs. The dental practitioner undertakes these procedures within the dental practice with the assistance of the dental nurse. The types of prosthesis include crowns, bridges and dentures.

## **3.3. Dental Laboratories**

◆ Dental laboratories in Scotland can be located in a variety of settings. These can be within a hospital and some larger clinics may have their own facilities and employ dental technicians. These laboratories may be under the NHS or be privately run.

# 4. Status and Position of the Dental Nurse in Scotland

## 4.1. The Law and Ethics

◆ The dental nurse has many responsibilities, as well as assisting the dentist they may also act as chaperone and witness. Sometimes dentist can be accused of improper conduct or behaviour. They may be accused of carrying out poor dental treatment and for this reason a dental nurse must always be present when a patient is receiving treatment. The presence of the dental nurse helps to protect the dentist and patient.

The practice carried out by the dental nurse and all dental practitioners require to be registered and as such they have to adhere to the accepted practices of the profession.

Dental nurses are expected to obey their own code of ethics which was introduced before the middle of the last century. These ethics include:

- ◆ They must be honest and loyal and work to the best of their ability.
- ◆ They must ensure that they maintain confidentiality of the patients records. The details of the professional services of their employers must be held in confidence as this is an ethical practice as well as a legal one. To break confidences can result in dismissal.

- ◆ They should ensure that they keep up to date with practice and improve their skills. If they feel unable to carry out certain procedures they must tell their employer.
- ◆ If there is a circumstance which compromises appropriate patient care then this should be passed on to the appropriate person/authority.

The Dentists Act states that the General Dental Council (GDC) has the function of ensuring high standards of professional conduct among dentists and Professions Complimentary to Dentistry (PCD), with the responsibility to their patients as their first priority. Anyone found guilty of a criminal offence or serious professional misconduct is liable to be suspended or removed from the register kept by the GDC and will therefore be legally forbidden to practice.

All members of the dental team are required to.

- ◆ Put the interests of the patient.
- ◆ Patients dignity and choices must be respected
- ◆ Patients confidential information must be protected
- ◆ In the interests of the patients the dental nurse must co-operate with other members of the dental team and other health care colleagues.

- ◆ Maintain their professional knowledge and competence.
- ◆ Be trustworthy.

### Applying Ethical Principles

This requires the dental nurse to:

- ◆ Apply these principles whether they are working directly with patients or not.
- ◆ Be accountable and responsible for all of their actions.
- ◆ Ensure that the interests of the patients are put before those of colleagues.
- ◆ Ensure that the principles are applied when dealing with queries and complaints and in other areas of non-clinical practice.
- ◆ Maintain GDC registration and work within knowledge, professional and physical competence.
- ◆ Take action to protect the patient from risk from nurses own health, behaviour and professional performance, or those of a colleague or by any aspect of the clinical environment.
- ◆ If unsure seek help from a senior member of staff, professional body or the GDC.
- ◆ Always treat patients with respect and dignity and be aware of their rights.
- ◆ Understand and promote patients responsibility in decision making and always obtain their consent before any treatment is carried out.
- ◆ Ensure the patient has all the information, including risks, benefits, costs and alternative options to assist them to make a decision.
- ◆ Make sure that no form of discrimination is tolerated against patients, such as race, ethnic origin, age, sex, disability, special needs, sexuality, life styles, beliefs and economic status.
- ◆ Ensure all patients information is kept confidential and only used for its stated purpose.
- ◆ Ensure all confidential information in a secure place.

All dental premises are covered by the Health and Safety at Work Act 1974.

This legislation aims to protect staff and patients from any dangers at work and encouraging staff to ensure that the premises are safe. All practices have to:

- ◆ Ensure that the working environment for staff has no risks to staff, has adequate facilities and is safe.
- ◆ Ensure that the practice is maintained.
- ◆ Ensure that all equipment is in proper working order and is maintained and that staff are provided with proper seating and eye protection for staff using computer keyboards and monitors.
- ◆ Ensure that staff are properly trained and supervised.
- ◆ Ensure that the Health and Safety poster is displayed where it can be easily seen.

There are many Acts and Regulations that apply to clinical dental practices and employers must hold records to show that all staff are aware of these and that they applied appropriately. As there

are so many these they have been listed and is you would like to find out more you can find further information on the internet.

### **Acts and Regulations**

- ◆ NHS and Community Care Act 1990
  - The main aims of the Act are to provide services and support for people who are affected by problems of ageing, mental illness, mental handicap, or physical or sensory disability to stay in their own homes.
- ◆ Community Care Act (Scotland) 2003
  - the main points of the Act are: fairer charging of services, greater choice, greater independence, increased support for carers, more effective working between the NHS and Local Authorities.
- ◆ The Equal Opportunities Act 2005
  - The main aims of the Act is to promote equal rights for men and women in matters relating to work.
- ◆ Health and Safety at Work Act 1974 and 2008 – All the main aims of the Act are to ensure that all employers take all reasonable measures maintain the health and safety of their employees and to provide any necessary to training to assist with this.
- ◆ The Sex Discrimination Act 1970
  - The main points refer to how it is unlawful for any employer to discriminate an individual from others because of their sex, marital status or if the person has had/is having gender reassignment.
- ◆ The Data Protection Act 1998 – The basic principals of the Act relate to protecting privacy. This would relate to patient information and documentation.
- ◆ The Freedom of Information Act 2002 – the main aim of the Act is to allow access to all types of 'recorded' information of any age held by Scottish public authorities. There are certain conditions and exemptions but as a rule any person making a request for information is entitled to receive it.
- ◆ Disclosure Scotland ( Part V of the Police Act 1997) – This is a Police check for anyone working with children and adults at risk, administration of a law, firearms, explosives and gaming licences, professional groups in health, pharmacy and law and senior managers in banking and financial services. This also supports the Protection of Children (Scotland) Act 2003.
- ◆ Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 – There is a legal duty on employers, self-employed people and people in control of premises to report work-related deaths, major injuries, work related diseases and near miss accidents.
- ◆ Control of Substances Hazardous to Health Regulations (COSHH) 2002. These Regulations places on employers the responsibility to minimise the risk of exposure to hazardous substances by their employees.

- ◆ Ionising Radiations Regulations 1999 – These Regulations contain an approved code of practice and guidance for employers so that risk is minimised for employees.
- ◆ Hand Washing Policy – these are implemented across all Health Boards in Scotland and follow the Health and Safety Executive's (HSE) Guidelines. The main aim of these Policies is to reduce the percentage of cross infection.
- ◆ The Consumer Protection Act 1987 – Allows individuals to sue for negligence and claim damages.

Dental nurses undertake First Aid training so that they will know what to do in an emergency. They also undertake Risk Assessment training as this is now mandatory for all premises where people are employed and the general public access. All premises have to document their Risk Assessment strategy.

All premises must display signs for the following:

- ◆ Fire Exits
- ◆ Health and Safety at Work Regulations
- ◆ Hand washing instructions

## 4.2. Some Facts

### Working Hours

The dental nurse is the first person on the premises and starts work at 8.30 am. Their working day finishes at 5.30

pm. Their working week is generally from Monday to Friday. Working hours within a practice may vary depending on whether there are full-time or part time staff. The average working hours for a full time dental nurse is 37 hours per week.

It must be noted that working hours may vary greatly depending on where that are employed. The above is a general guide.

Private clinics may vary their hours and will work at weekends and have late working evenings.

Dental Nurses are paid approximately £16800 - £20200 per annum. NHS Dentists working as self-employed contractors can earn between £60000 and £120000. Salaried dentists working for the NHS can earn between £36000 and £78000. Dental Hygienists earn between £25000 and £30000.

Scotland has a population of approximately 5.5 million. There are currently 500 Dental Practices in Scotland with 1500 Dental Practitioners on the GDC Register and 1200 Dental Nurses in employment.

# 5. The Dental Nurse in the Work Place

## 5.1. Hygiene and the Maintenance of Equipment.

### Duties of a Dental Nurse

- ◆ Maintaining a high standard of cleanliness
- ◆ Ensure that there is an adequate supply of heating and ventilation
- ◆ Having an efficient appointment planning and recall system
- ◆ Maintaining strict confidentiality at all times by ensuring that medical histories, conversations, financial transactions and treatment are not overheard or disclosed.
- ◆ Effective in communicating information to patients and dentist, including producing quickly filed records, radiographs, model and correspondence.
- ◆ Having a good level of communication and spelling, legible handwriting, proper typing format, keeping written records of telephone messages and back-up copies of computerised records.
- ◆ Have the contact details of emergency, building and equipment maintenance services, taxis, public transport and welfare facilities at hand.
- ◆ Well managed stock and maintenance records so that there is never a lack of stock.
- ◆ To ensure that all equipment is working properly and that spares are

available if required.

- ◆ Orders for materials are properly logged and filed
- ◆ Ensure good communication with technicians so that there is no delay in receipt of goods and that all work ordered is properly described.
- ◆ All staff are trained and regularly practice safety procedures concerning infection control, X-rays, mercury hygiene, resuscitation, emergency procedures and fire drill.

### Surgery Duties

It is the dental nurses responsibility to prepare the surgery before the day starts, between patients and at the end of the day.

The following is a brief outline of some the duties undertaken by the dental nurse in the surgery:

### Beginning of the Day

- ◆ Attend work well groomed, clean nails and uniform and no jewellery
- ◆ Switch on power, water and air supply to all equipment. Check ventilation, lighting and temperature.
- ◆ Check that the practice has been cleaned thoroughly by cleaning team
- ◆ Run and record the result of the autoclave test
- ◆ Disinfect all working services
- ◆ Run water for two minutes through three-in-one syringe and hand pieces with water spray. Refill the ultrasonic cleaner with fresh liquid.

- ◆ Put out clean uniforms and linen as necessary
- ◆ Check all other equipment is in working order
- ◆ Make sure that the appointment book, day book, patients notes, radiographs, laboratory work, emergency kit and other materials are ready for the day
- ◆ Prepare the surgery for the first patient; new disposable covers, protective spectacles and disposable masks and gloves.

### End of the Day

- ◆ Instruments that were used on the last patient are cleaned and sterilised. Hand pieces are cleaned and lubricated according to the manufacturers instructions and sterilised
- ◆ The aspirator bottle is emptied and the whole drainage system is disinfected. The spittoon, unit and work surfaces are cleaned and disinfected. All non disposable instruments and materials put back in place
- ◆ Laboratory work is disinfected and checked for proper documentation and are ready to send to the technician
- ◆ Exposed X-rays are checked with proper documentation and processed
- ◆ Patient notes and records are filed and back up copies of computer records are made.
- ◆ Ordinary domestic waste is bagged
- ◆ Non-sharp waste that may be contaminated with blood, saliva, including empty plastic local anaesthetic cartridges to be stored

and labelled in special hazard labelled containers.

- ◆ Sharp waste, (glass anaesthetic containers, syringe and suture needles, scalpel blades, burs, metal matrix bands, root canal instruments and anything else that is sharp) must be stored in puncture proof containers.
- ◆ Special waste must be stored in separate rigid containers. This would include prescribed medicines, harmful, irritant, toxic and corrosive substances.
- ◆ For the disposal of mercury and amalgam waste rigid containers must be used and collected by authorised contractors and full records kept.
- ◆ Setting up the next days appointments.
- ◆ A security check of drug cupboards, filing cabinets, doors and windows.
- ◆ All electric, gas, water and air services to the surgery equipment is switched off.

The role of the dental nurse can be found in Chapter 8, this will be from the view point of a dental nurse and her role on a daily basis within her practice.

## 5.2. Documentation and Administration

- ◆ NHS Regulations demand that dentists are expected to keep appropriate records. It does not matter whether the dentist is private or NHS records taken are legally valid documents and if they

lack content or inadequate it could cause serious legal problems.

The dental nurse must make sure that they record all of the patient's information accurately or may dictate given by the dentist. The dental nurse must file the records properly and have them available for each patient arriving for their appointment. The records should be signed by the patient and the dentist.

Nurses must understand that on no account must any of the information contained in patient's records be disclosed to anyone unless it is for medical reasons and with the consent of the patient. Records may also be disclosed to carers where the patients is no longer able to make decisions for themselves – but this would relate solely to treatment being required.

The legal requirements for practice records include those pertaining to:

- ◆ Staff
- ◆ Patients
- ◆ Materials and equipment

Clinical records must be:

- ◆ Accurate
- ◆ Relevant
- ◆ Kept securely
- ◆ Not disclosed to unauthorised persons

Back up copies of computer records have to be made and stored along with manual records and kept in fire proof containers.

The Act also demands that records are kept on equipment purchases and maintenance, materials and laboratory work.

This part of the dental nurse role is extremely important and the nurse requires to ensure that the practice is well organised. Some larger dental practices employ a Dental Nurse Manager who is responsible for the efficient running of the practice as well as ensuring that dental nurses are exposed to good training opportunities.

When a new patient arrives at the practice she has to take the following information:

#### **Personal details**

- ◆ Name and address.
- ◆ Age
- ◆ Occupation
- ◆ Travelling distance to the practice
- ◆ Convenient appointment times
- ◆ Whether they live in a fluoridated area.

*Please see Appendix 2*



### **Clinical records**

- ◆ Past and present medical history.
- ◆ Dental history
- ◆ Present condition
- ◆ diagnosis and treatment

The nurse must ensure that all of the patient's personal details are accurate especially in relation to their medical records as this could affect the treatment given i.e. allergies to medicines. How patients feel about attending the dentist is something that the dental nurse can find out. This is an important factor as it can influence the patient's attitude to their own dental health. Dental phobia is common and the dental nurse can assist the patient in making them feel more relaxed.

*Please see Appendix 1*

### **Administrative records**

- ◆ Correspondence
- ◆ Accounts
- ◆ Stock control
- ◆ Equipment, supplies, materials and drugs prescribed
- ◆ Laboratory work
- ◆ Practice personal files

The dental nurse plays an important role in gathering information that may affect the treatment given, but they are also in a good position to offer advice to the patient relating to their oral health.

Using information from the patient's records assists the nurse in preparing for the patients next visit and treatment.

### **X-rays**

Dental surgeries are able to take x-ray images to assist with diagnosis and to help in selecting the appropriate treatment. Although the dentist takes the images, the dental nurse will assist in setting this up, will ensure that the images are stored appropriately and consider all aspects of Health and Safety while the images are being taken. The dental nurse will also ensure that cards are sent out to patients to remind them of their check-up appointments.

## **5.3. Promotion of Oral Health Care**

◆ Oral hygiene is one of the key priorities in leading the fight against dental decay and loss of teeth. Prevention is one of the governments objectives as dental caries in children lead to continued problems in adulthood. An example is given below:

### **Childsmile**

Childsmile is a programme funded by the Scottish government and consists of three main parts:

- ◆ A Core Toothbrushing programme
- ◆ Childsmile West, providing oral health from birth.
- ◆ Childsmile East, providing preventative programme for children aged 3 and upwards.

All children in Scotland will be given free fluoride toothpaste and brushes at

least six times in their first five years of their lives. Support is given to nurseries to encourage the children to brush their teeth.

The programme is a Scotland wide initiative to improve the health of children's teeth.

Both local authority and private nurseries and in high priority communities daily supervised toothbrushing will be offered in both Primary 1 and Primary 2. Children who are considered to be at greater risk will receive further toothbrushes and toothpastes from their Health Visitor or other health workers.

Those children during their first year will be given a free cup to help with healthy weaning.

Toothbrushing is promoted to all groups and the same basic rules apply regarding care and frequency of use of toothbrushes. All care establishments have a duty to ensure adequate facilities for the promotion of oral hygiene and to offer assistance where individuals have difficulties managing their own oral hygiene.

### **Diet and Nutrition**

One of the main causes of dental caries along with poor oral hygiene is nutrition. In Scotland obesity is becoming one of the most prominent health concerns and this also relates to dental decay. The foods that are eaten

have a high sugar content particularly non-milk extrinsic sugars (NME) and although brushing between meals may help to prevent supra-gingival periodontal disease, it cannot prevent caries unless a strict dietary regime is also followed and snacking between meals is stopped. This is a difficult problem as fast food and snacking now seems to be a part of everyday life. Re-education programmes are therefore specifically aimed at the young so that they will not continue to have the same problems as their parents. This however is a multi-disciplinary approach requiring all health care professions to play their part in promoting health. Although part of the dental hygienists role is an educational one, they do not work in isolation and the information that they gather from the patient is shared with other professionals involved in the overall treatment.

### **Oral Hygiene**

The main aspects of preventative dentistry includes:

- ◆ Information and instruction in oral hygiene including brushing properly and flossing.
- ◆ Regular dental checkups assessing oral hygiene and early signs of oral disease.
- ◆ Visiting the Dental Hygienist.
- ◆ The use of disclosing tablets to assist the patient in identifying problem areas and how to maintain a clean mouth.
- ◆ Carrying out treatment for prevention to deal with plaque control.

- ◆ Caries prevention i.e. fissure sealing and topical fluoridation.

### Community health

It has been identified that pregnant and nursing mothers, parents of schoolchildren and young teenagers are those that are most in need of dental care.

### Some Basic treatments

#### Fluoridation

Water containing about one part per million (1ppm) produces a 50% reduction in dental caries.

Most places do not have the correct natural level in their water supplies so some areas add fluoride at the waterworks to bring the level up to 1ppm.

Until all areas have artificial fluoridation in their water supplements are available, such as:

- ◆ Fluoride toothpaste
- ◆ Fluoride supplements
- ◆ Topical fluoridation

Sealants – Are widely used in the prevention of dental caries and other forms of tooth decay. This is done by applying a plastic material to one or more teeth. This procedure is carried out in the dental surgery with the assistance of the dental nurse who must ensure that the tooth/teeth are clean and dry before the liquid plastic material is applied. The plastic is cured using a blue spectrum natural light, after which

the plastic becomes a hard thin layer. Sealants may remain effective for up to five years but do wear down naturally and may become damaged, the risk of this is bacteria and food particles becoming trapped and causing decay. For this reason regular checkups should continue.

Chlorhexidine – This is the active ingredient that is often used in the mouthwash used in the dental surgery as it is designed to kill dental plaque and bacteria. It is also used to combat or prevent gum diseases such as gingivitis.

## 5.4. Treatments, Assisting the Dentist

- ◆ The main treatments that the dental nurse assists the dentist with are:
  - ◆ Cariology - (fillings)
  - ◆ Oral Surgery - (extractions, gingivectomy, flap operations, complicated extractions, apex resections, implants)
  - ◆ Endodontology - (root canal and crowns)
  - ◆ Parodontology - (scaling and pocket treatment)
  - ◆ Prosthetics - (crowns, bridges, splint therapy, over dentures and Bruxism)
  - ◆ Orthodontology - (fixed and removable)
  - ◆ Cosmetic dentistry - (laminates and whitening)

As with many procedures carried out within the surgery, local anaesthesia is often used for the comfort of the patient and to allow the dentist to carry out what can be painful procedures. Conscious sedation has replaced, for some treatments, the need for General Anaesthesia (GA) and allows the dentist to administer local anaesthesia to highly anxious patients, verbal contact is maintained and the patients is able to understand commands and is aware of what is happening. The patient does not have to undergo a GA which has risks and there is not the need for long periods of starvation beforehand.

The GDC has strict guidelines in relation to the experience and training of all surgery staff involved. The dental nurse has a responsibility for:

- ◆ Ensuring that each patient has a full medical history is taken before using or referring for conscious sedation.
- ◆ The type of sedation proposed and alternatives are explained – the dentist will do this initially but the dental nurse will go over this.

- ◆ Pre and post-operative instructions must be provided and written consent obtained, before the procedure.
- ◆ Records must be kept of the procedure itself as well as the technique and drugs used.

The dentist also has strict guidelines in relation to having the appropriate skills within the limit of their training and experience, including post graduate training. There must be a second appropriately trained person to assist the dentist – a dental nurse who has undergone the National Examination Board for Dental Nursing (NEBDN) Certificate in Dental Sedation Nursing could assist. *(the information given is a brief overview as more necessities and guidelines are in place for this).*

## 1. Cariology

The dental nurse is vital to the dentist in assisting with the different types of fillings that are required i.e. amalgam, gold, composite or glass ionomer. The nurse must have knowledge of the preparation that the dentist must make to the tooth/teeth as they are responsible for setting up the surgery, setting out the correct instruments and preparing the filling for the dentist. The dental nurse has to ensure that all of the instruments that require to be sharp are kept in top working condition. They must also ensure that safe and hygienic practices are adhered to at all times, especially when dealing with the safe handling of mercury.



## 2. Oral Surgery

The dental nurses' duty is to ensure that the instruments are sterilised and placed in a sterile dish ready for use. The patient is given a sterile, waterproof disposable bib, a disposable beaker of mouthwash and a napkin to wipe their mouth after the extraction.

The nurse may have to hold the patient's head steady during the extraction.

After the procedure the nurse has to carefully clean the instruments to remove all of the blood, oiled if required and then sterilised.

## 3. Endodontology

The dental nurse carries out the techniques of aseptics as with any procedure. Here the nurse has to discuss with the dentist the steps to be taken with each patient as more than one visit may be required. The nurse has to ensure that all of the instruments and fillings required are laid out and ready for use. The patient is provided with eye protection and a waterproof disposable bib.

Sterilisation is essential – endodontic kits are sterilised in the autoclave. Gutta-percha points (GP) are destroyed by heat and usually come in sterile packs although they can be disinfected in the surgery. The nurse is responsible in checking that all instruments are in perfect condition for their intended use and instruments that are defective must be disposed of.

The dental nurse has to be knowledgeable in their field as there are often types of procedures with more than one option as with Crowns – being temporary, jacket, post and veneer. The nurse has to be able to set up the appropriate equipment and materials required for each procedure as well as knowing each step required to efficiently assist the dentist.

## 4. Parodontology

These procedures go hand in hand with the promotion of good oral hygiene the same as the prevention of caries.

Scaling is used for the treatment of plaque and calculus.

Patients are provided with a waterproof, disposable bib and eye protection. A supply of napkins are required to wipe the instruments during the procedure and water spray and suction is required with the dental nurse directing the spray as well as holding the aspirator tube. Full protective clothing must be worn by the chairside staff to prevent cross infection.

After the treatment the patient must be given full instruction on how to continue to care for their oral hygiene. The patient will require further appointments either to continue with their treatment or to check up on the patient's own aftercare.

The dental nurse role is very important as they can help to teach/encourage

the patient and advise them on the best methods to use. The nurse can demonstrate the techniques required for the patient so that they can see what they have to do.

## **5. Prosthetics**

As this covers a wide range of treatments, the dental nurse requires a wide range of knowledge and skill. This includes assisting with the preparation and fitting of crowns, preparation for dental impressions and the fitting of dentures as well as assisting with the bite mould for fitting a splint or mouth guard for those with Bruxism

## **6. Orthodontology**

Being a speciality, orthodontics is generally carried out within a dental hospital or a private clinic. The treatment offered is related to straightening teeth that are rotated, tilted or improperly aligned, correction of crowded or unevenly spaced teeth, correction of bite problems and the alignment of upper and lower jaws. As treatment involves the use of fixing devices, whether they be fixed or removable, it is essential that good oral hygiene is maintained. There are specialist toothbrushes designed to work better with fixed braces and removable braces must be thoroughly brushed along with the teeth. The dental nurse has an important role to play, not only in assisting the dentist but also in encouraging the patient, especially children as this treatment can be very uncomfortable and maintaining

oral hygiene can prove difficult for some patients.

## **7. Cosmetic dentistry**

This is mainly carried out by private dental practitioners in private clinics. This is a fast growing industry and most towns and cities in Scotland will have clinics specialising in cosmetic dentistry. The main procedures undertaken are dental veneers, dental implants and teeth whitening. The cost of these procedures are very high but despite this the number of people seeking treatment rises year on year.

# 6. Communication

## 6.1. Communication with Patients

◆ One of the most important roles that a dental nurse has is to be able to communicate appropriately with members of the public. They have the ability to build a positive relationship with patients and often patients will confide in the dental nurse if they have any anxieties.

Communication can sometimes prove to be problematic if a patient has a communication difficulty, e.g. dysphagia, language barrier, learning disability limiting understanding, deafness or blindness. The surgery should have procedures in place to deal with all of these contingencies.

For patients who have speech impediments through congenital illness or through illness such as stroke then it may be that they have an advocate who can act on their behalf. The dental nurse has to ensure that if there is an advocate that they have written consent to make decisions for the patient. Access to the patient's records are strictly confidential as they may contain sensitive information. Only with the patients' permission can any of the information be shared with a third party.

### Why does communication fail to develop or break down completely?

- ◆ The individual who is giving the information may easily forget what is familiar to them to not familiar to others.
- ◆ The dental nurse may sometimes take for granted the amount of understanding and knowledge that another person may have.
- ◆ We can sometimes overeat and this may appear as anger or frustration to another.
- ◆ We may respond to a complaint in a defensive manner instead of listening sympathetically.
- ◆ We may not be equipped to deal with or cope with individuals who have communication difficulties.
- ◆ We may appear embarrassed by an individual's disability which in turn makes them feel uncomfortable and lose confidence in communicating with us.
- ◆ Our facial expressions may show more clearly how we feel even if we do not mean it. We may show fear, disgust or anxiety.
- ◆ Lack of preparation prior to the patient's visit can result in being disorganised and rushed when they arrive. Generally those with disabilities find it difficult to cope if they are hurried and rushed. Owing to their daily living problems they require to have confidence in those who have professional dealings with them.

- ◆ It is advisable to have an assessment of needs prior to an official appointment.

Various methods are used to communicate where there are communication difficulties:

- ◆ Sign language – some dental nurses are trained in sign language and this is of great value within a general surgery.
- ◆ Written cards in various languages explaining conditions and treatments.
- ◆ Picture cards – images explaining various conditions and treatments
- ◆ Braille cards – explaining various conditions and treatments.

For those who are in care it is likely that they will be accompanied by a carer or if the dental care is taking place within their place of residence then the staff will be helpful to the dental nurse as they will be used to communicating with the patient.

Children will be accompanied by a parent/guardian and will act on the child's behalf although it is very important that the child is spoken to and that the information is explained in a way that the child understands but being sure not to make them scared. The use of child friendly language as well as the dental nurse wearing cartoon aprons and having child appropriate poster helps to communicate a positive environment.

No matter the background of the patient the dental nurse must treat all patients with dignity and respect within the ethics and values in which the nurses have been trained.

Within dental hospitals how patients' specific diseases are communicated with is an important part of their role. This applies to patients with HIV and Hepatitis. Their personal information is completely private and the dental nurse must not discuss their history with anyone outside the dental team. These patients' treatment, although the same as for any patient, is carried out in a specific unit and the precautions taken in their treatment is critical to protect the dental team. The dental nurse has to be sensitive to the needs and feelings of the patient and must not communicate any differently with them as they would with any other patient. *(this is an distinct area and is not fully discussed in this information pack).*

It is the role of the dentist as well as the dental nurse manager/senior nurse to ensure that all staff interact with their patients in an appropriate manner. If there are communication issues then this should be dealt with quickly and some training offered. Within surgeries where staff are given one-to-one sessions with their dentist/manager, communication and interaction with patients and the dental team should always be discussed and any issues resolved.

Listening is a very important part of communication. Some people will impart information in a round-about way – they will not come directly to the point, or they will give the briefest information, hoping that they will be questioned further.

Observation will also tell much about the person. The dental nurse can pick up if the patient is anxious.

## 6.2. Communication with Staff/Team

◆ Good communication within the dental team assists in the smooth and efficient running of the practice. All members of the team have responsibility in sharing information and raising any issues within the practice.

Communication at the surgery also includes working within multi-disciplinary teams. This is occurring more regularly due to dental practices taking place in a greater variety of settings. The dental team have to ensure that all those involved in the care of the patient have the necessary information.

As part of good management the dental team should have weekly minuted meetings to discuss issues relating to the practice. An example of what this could cover is the following:

◆ Individual feedback from the dental team.

- ◆ Health and Safety
- ◆ Patient caseload
- ◆ Ordering and equipment
- ◆ Any action to be taken

It is also valuable for the dentist/dental manager/senior nurse to have one to one meetings with the team at least once per year. This could be in the form of an appraisal where any targets or developments could be discussed.

As dental nurses are now on the GDC register they have to keep a Continuous Professional Development portfolio. They have to attend appropriate conferences and keep up to date with their professional development. All of this can be discussed within the team and the nurse manager/senior nurse/dentist can check that this is being done. The dental team will have to manage the Practice if a dental nurse is at a conference or training session. They have a card which has to be signed and can be checked by the GDC.

## 7. A Day in the Life of a Dental Nurse in Scotland

◆ My name is Becky, I am a recently qualified dental nurse, I work in a very busy NHS dental practice.

Here is an account of a typical day in my workplace.

**0800hrs** – I arrive early to prepare myself and the surgery for the day ahead to ensure everything runs as smoothly as possible. I change from my outdoor clothes into my surgery tunic, trousers and flat comfortable shoes. I tie back my long hair and remove my watch and ring to prevent cross contamination, and ensure I look neat and tidy as a professional nurse should be.

**0815hrs** – On entering the surgery, I wash my hands with anti-bacterial soap, dry them carefully with paper towels and then begin my day. I switch on all the electrical equipment; the dental chair, autoclave for sterilisation, I test the cycle to ensure it reaches the temperature of 134 degrees centigrade for the required time of three minutes, and record this information. I also switch on the ultrasonic bath for pre-cleaning of instruments prior to sterilisation, the curing light, amalgamator and radio also get switched on.

The cold sterilisation bath is filled with sodium hypochlorite solution for

disinfection of the impressions taken today that will be sent to our dental laboratory.

The computer will be switched on with our day list of patients and treatment plans for today. Now I will enter the x-ray developer room and switch on to allow the chemicals to reach the required temperature before use. Here the compressor is situated and turned on to allow the dental unit to operate.

I will return to the surgery and run water from the coupling of the hand piece tubing and spittoon and three-in-one air syringe to dispel any stagnated water left over night.

I will now check if I need to collect stock items for the surgery for the days procedures. After collection of these items required, I will wipe down the worktop surfaces with an alcohol based wipe to disinfect these areas. I also wipe the dental chair, overhead light, bracket table which hold the instruments within easy reach for myself and the dentist to reach.

I now check the day list for treatment plans for each patient and make sure I have the correct lab work required for the patients attending for dentures or crown fit appointments. I also look out relevant radiographs needed that day.

**0845hrs** – I hear the dentist I work with, John, arrive in the surgery. This is the time we liaise to confirm the treatment plans and patients' specific requirements for the day. I then discuss any issues regarding patients with reception staff that are required, e.g. disabled patients needing assistance into and out of the building or perhaps a patient with an outstanding account which will be paid prior to their appointment.

I now set up the required instruments and materials for the first patient due to arrive at 9am. This morning it is Mrs Jones who is due for a routine examination.

**0900hrs** - Our first patient has arrived. I go to the waiting room and call Mrs Jones by name, smile at her making eye contact, and escort her to the surgery. "Good morning Mrs Jones, how are you today?"

This relaxes her slightly as she is a fairly anxious patient and I know as I have read her records previously.

We are met by John at the surgery door, I offer to take her coat and handbag and place them on the coat hook, and seat her in the dental chair. I explain I am placing protective glasses on and a bib. I have placed the relevant radiographs on the x-ray viewer for John to refer to if necessary, and he picks up the mirror and probe I had put out on the bracket table before bringing Mrs Jones into

the surgery. The patient's record is on the computer screen, John has checked the medical history field and asked Mrs Jones to confirm her medication and any changes in her health with a signature on the sheet of paper provided for this.

John now calls out the treatment required as I record this on the computer for our information. I print out an estimate of cost for Mrs Jones, which will be handed to her when she makes her follow up appointment at the reception desk.

After the examination is complete, I remove the used instruments into the sink, place on gloves and begin the decontamination procedure. I wipe down the contaminated areas which have been touched by

John while using the instrument on Mrs Jones i.e. the bracket table, overhead light, the three-in-one syringe tubing and handle. Mrs Jones is ready to leave the surgery with John now and I say "Goodbye." As John leads her to reception and I prepare the surgery for the next patient Mr Crawford for the fit of his crown. I place a full cons tray (selection of instruments for a clinical procedure), an aspirator tip, mixing slab and spatula and the relevant cement to mix. The lab work is placed for John to view, along with the patient's record on the computer screen for John's arrival back in the surgery with Mr Crawford.

**0915hrs** – “Hello Mr Crawford, How are you today?” I say as they both come through the door. “Hello, fine thanks, looking forward to getting my new tooth in place.” As they both get settled into the surgery, I place articulating paper to check the bite, floss to clean debris from the area after cementation and of course a hand mirror for Mr Crawford to check the shade and shape of the crown before I mix the cement.

He sits down and I place the bib and glasses that I wiped down with alcohol wipes, and explain they are to protect his eyes and clothing.

John and I both place our own gloves and visors on for our protection too.

The temporary crown is removed, the preparation is cleaned using the three-in-one air syringe and I take the high volume suction tip to aspirate the water and debris from Mr Crawford’s mouth, for patient comfort and John’s clear field of vision. I ensure our patient is comfortable throughout the procedure by asking him. I retract the cheek and tongue with a mouth mirror to allow John a better access to place the crown in place. The bite is checked with the articulating paper and seeing there are no high spots, I pass Mr Crawford the hand mirror to check the shade, size and fit of his new crown, he is happy so John asks me to begin mixing the cement. I mix it to the required dropping consistency on a glass mixing slab with a stainless steel spatula

and present it to John for placement into the crown and then cemented in place. After a few minutes it is set and I aspirate the excess cement with the suction tip and John flosses the area to remove interproximal debris. I have placed the slab and spatula in the sink for cleaning and remove my gloves to complete the paper work and computer information. I ask if our patient would like to rinse out, which he does, as I put on another pair of gloves to clean away the used instruments and begin the decontamination process again as John takes Mr Crawford to reception to pay his account.

I wipe down the areas as before, place the contaminated clinical waste into the designated bin for these items (cotton wool rolls, tissues, used mouthwash cups, disposable tips). I place another pair of gloves on and put a new constrictor tray out for our next patient for an amalgam restoration. Local anaesthetic is put in the ash jenker (safety device for sheathing a needle) and suction tip, three-in-one tip, mouthwash cup, lining material, amalgam carrier and dappens dish and siqveland matrix retainer for the next patient Mr Thomas.

**0945hrs** – John has brought Mr Thomas into the surgery on his way back in from reception. “Hi Mr Thomas,” I say. “Hello,” he replies, “bit chilly today.” I nod and place the bib and glasses on him. John is checking the medical history, “Any changes to your health since last visit Mr Thomas?”

“No, no, same as always” replies the patient. As John administers the local anaesthetic, I scrub the previous patients’ instruments using a long handled brush and heavy-duty gloves ensuring the sharp instruments are placed on the bottom of the sink with the sharps pointing away from me. This prevents needle stick injury. I then place them in the ultrasonic bath for fifteen minutes to remove any debris not visible to the eye, and they will then be placed in the autoclave for a full cycle of fifteen minutes, reaching a temperature of 134 degrees centigrade for three minutes. The steam sterilisation process will kill all spores, viruses and bacteria.

I place on new gloves, and we are ready to begin the procedure for Mr Thomas. I aspirate as John uses the high speed and slow speed hand pieces with the relevant burs. I retract the patients’ cheek and lip as required to allow a better field of view for John and for patient comfort by removing the water from the high speed hand piece. I check to see is not uncomfortable of in distress during the procedure by watching him throughout. I wait for John to ask me to mix the lining material if required, I do so efficiently and speedily and present it to him for placement. I wipe the instrument to remove the cement and pass John the matrix band, which will maintain the natural contour of the tooth and prevent overhang of the restoration. I mix the stated amount of amalgam and pack the amalgam carrier for John to place into the cavity

and restore the tooth. I then use the high volume suction to remove debris, preventing it from falling in the patients mouth causing discomfort. I now remove my gloves, prepare the paper work for signature, treatment plan and computer records filled out correctly. I now return to my patient putting on new gloves and asking if he would like to rinse out, which he does as I begin the clearing process to remove all contaminated instruments and materials and clinical waste. As with the previous patients I do this quietly, efficiently and with care in handling sharp instruments.

John is now ready to take Mr Thomas to reception and this allows me to clean up effectively, and set up for the next patient, Mrs Carmichael for a denture ease.

**1015hrs** – Mrs Carmichael arrives for her denture to be eased. She had the full dentures fitted a few days ago and has returned as they rubbing in a few areas causing some discomfort. I have laid out a straight hand piece with an acrylic trimming bur to trim the acrylic of the denture. I also place a piece of articulating paper to indicate where the high spot areas are, and a mouth mirror for John to check the soft tissue areas. The patient records are on the computer screen for John to view throughout the appointment.

I go to the waiting room to collect Mrs Carmichael, she is hard of hearing, so I walk up to her and smile, offer

assistance from the chair and help her through to the surgery. "Morning Mrs Carmichael." I say, she apologises for taking up our time with her denture causing her bother. I explain that it is perfectly normal for this to happen, and it is no bother for us to see her as often as she needs to come. She looks relieved. John greets her and welcomes her in, and helps her sit in the dental chair. While he puts new gloves on and examines Mrs Carmichael's mouth, then adjusts the denture, I carry on scrubbing the instruments, then into the ultrasonic bath then into the autoclave. Mrs Carmichael is about to leave, so I remove the hand piece and the used instruments and wipe down all the surfaces contaminated as John worked on the denture.

I am now ready to put my feet up for ten minutes and enjoy a coffee break. This is a rare event, as mostly we are running late and don't manage to stop!

**1030hrs** – COFFEE BREAK

**1040hrs** – Back into the surgery, I wash my hands using anti-bacterial soap, wash and dry them properly and put on a new pair of gloves.

I prepare for the next patient who is arriving now as an emergency with a swollen face, in the upper right quadrant.

I place a mouth mirror out and probe, mouthwash and have the record card

on view on the computer screen. There is a previous radiograph from a year ago that can be used as a reference for John. I place it on the viewer.

John brings in Craig, who is seventeen and not a regular attender. I say "Hi." He replies with a nervous "Hello." I explain as I hand him the glasses that they are to protect his eyes and place a bib over his shirt. The swelling is large, his right eye is almost closed, and he is clearly nervous. I immediately place a periapical x-ray film packet out with an x-ray holder for John to place in Craig's mouth for us to have an up to date view of the area. John performs some vitality tests on the teeth of the upper right quadrant, Craig is unable to determine which tooth is causing the problem. John aims the head of the x-ray at the area we need to view, as the film has been placed in the mouth using the holder. John and I stand in the corner of the room to take the x-ray, the safe distance to stand away from the head of the x-ray head is two meters, for the radiation scatter. As I develop the film, John discusses the options available once we have determined the tooth causing the problems - Root canal treatment or extraction. Both procedures are explained in detail to the patient and pros and cons for both are also explained. It takes around six minutes to develop the film, and as I return the decision has been made that the root canal treatment is the procedure of choice. I write the patients details

into the field of information on the prescription pad and await for John to tell me which anti biotic of preference he will want, after checking the patients medical history again for any allergies to medicines. The prescription is written and analgesics are recommended regularly to ease the discomfort until the antibiotics are in the system, usually 48 hours. I chart the treatment plan and prepare the paperwork for reception to make the required appointments.

As John explains the appointments needed, I begin to clear up, removing the used instruments and wiping down the areas contaminated during the appointment. I remove my gloves and prepare for the next patient to attend for a surgical procedure.

**1100hrs** – I have been looking forward to this appointment as I particularly enjoy surgical procedures. This next patient is for the removal of an impacted wisdom tooth. I have the surgical kit laid out which is sterile and ready for use. I have the local, required instruments and have placed them in methodical order for John and I to use them. Medical history is checked and the correct local placed in the syringe. Radiographs are placed on the viewer for John to examine again before beginning the procedure. The correct forceps and elevators, irrigation solution in a disposable syringe and gauze are laid out and the suture silk and scissors.

John is now ready to bring the patient in, Miss MacKenzie, who is a nervous patient and is particularly nervous today, she is quite pale and I smile and say “Hi” as she enters the door. John chats to her as I ensure everything we need is there to hand, to prevent stopping mid treatment for a particular item we should have had out. I have double checked and everything is there.

I place the bib and protective glasses on Miss MacKenzie explaining they are for her own protection. I place a comforting hand on her shoulder and ask if she would like a hand to hold as John is about to administer her local, she gratefully grasps my hand and I talk to her as she has her local.

The procedure goes well, the gum flap is taken, I use the suction to remove the blood as John skilfully removes the alveolar bone to expose the impacted molar, all the while I am observing the patient to check for signs of pain or distress. I pass the required instruments at the exact time to John. We work well as a team. I use the irrigation syringe to clear the debris and allow John a clear field of vision to elevate the roots individually. He then checks the socket for debris as I flush the area again with the irrigation syringe and saline solution. I now pass the sterile suture and silk in the needle holders and as John places the sutures I retract the cheek and tongue to allow him to do this with ease, I then cut the suture silk when John indicates

and aspirate the remaining blood and pass the gauze pack for John to clean the area. I smile at Miss MacKenzie and explain the procedure is complete and how well she coped during it. The relief is obvious and she smiles at last. As John gives the patient the post operative advice, I being the process of decontamination and clear away the contaminated instruments and clinical waste into the designated areas, sharps into the sharps bin, clinical waste and start to scrub the instruments for sterilisation as with the other procedures. I now put on another pair of gloves and start to wipe down all the contaminated areas, paying particular attention to the spittoon area for blood traces. I run disinfectant suction cleaner through the suction tubes to clean the blood from them.

I now prepare the surgery for the first patient after lunch.

### **1200hrs – 1245hrs LUNCH**

**1245hrs – 1545hrs** – This is the time that John has planned to see children for very basic orthodontic appointments, some may require referral onto an orthodontist for their opinion and possible fixed appliances to be made. I will need to write the referral letters for these patients and John will dictate to me.

The children will have radiographs taken and study models for John to assess.

I set up the surgery with alginate material, mixing bowls, spatula, fixative adhesive, water measure, laboratory prescription sheets and plastic bags for the impressions to be placed. I also have a kidney bowl to hand, in case the patient vomits. I will talk the patient through the impression procedure, asking them to breathe deeply through their nose and out through their mouth to prevent them feeling sick, this is usually successful – but, not always!!

The impressions will be placed in the disinfection bath for ten minutes in a solution of diluted sodium hypochlorite, rinsed, wrapped in damp paper towel and sealed in a plastic bath with the lab prescription sheet attached with all details included for the dental technician to carry out.

There are six patients booked into this time slot and they will all have the same procedure undertaken.

Each child is seen and I greet them and their parent or guardian and ask them to jump up onto the chair and place the bib and glasses on explaining as I do so they are to protect their eyes and keep their school uniform clean. John examines their mouth, I record the information on the computer records, and fill out the paperwork. Radiographs are taken, and I place these in the envelopes to be developed when John has finished. John dictates the referral letter and I write the information down, which I will record on the correct letter

to the orthodontist when John has finished.

After the last child has left the surgery, I again begin the decontamination process I have carried out after every child has left the surgery this afternoon. I wipe down the work surfaces, to prevent cross infection. After the impressions are disinfected in the bath, I empty the bath, drain the autoclave chamber, drain the ultrasonic solution, empty the clinical waste bins into the collection bag clearly marked, and orange in colour for collection by a registered collection contractor for incineration. These will be kept in a locked cupboard out of view and harm from the public.

I now switch off the dental chair, and raise it to the highest point in an upright position to allow domestic staff to clean the floor area efficiently.

I will now take the patient records from the surgery and file as required.

**1545hrs – COFFEE BREAK**

**1600hrs – 1700hrs** – John now leaves the practice as he is on call this evening. I now go into the surgery with the dental hygienist, who has been working unassisted since she started this afternoon at 1pm.

The dental hygienist will scale and polish the teeth and provide oral hygiene instruction to the patient.

There are a variety of hand scaling instruments she will use. These are sickle scalers, curettes, jaquettes, push scalers and periodontal hoes. The ultrasonic is also used which attaches to the dental unit, and sprays water. It is the vibration of the tip of the ultrasonic which removes the tartar and calculus from the teeth. The use of a disposable saliva ejector is used to remove the water from the spray. Prophylaxis polishing paste is used remove staining, on a slow speed hand piece with a rubber cup. There are various types of interproximal cleaning aids available, e.g. interdental brushes, floss, superfloss, woodsticks. These will be demonstrated to the patient by the hygienist.

While the hygienist is doing her job, I will have placed the instruments required for each patient onto a treatment tray, the materials needed and supplied the patient with a mouthwash cup and tissue, bib and protective glasses.

I am now able to leave the dental hygienist to work. I will develop the x-rays taken previously by John, for the orthodontic cases.

I keep the films in their own envelopes to avoid mixing them up. I will leave them for John to examine, along with the referral letters to correspond with that patient, ready for his signature and posting.

I go back and forth from the developing room to the dental hygienist surgery,

ensuring the patient is comfortable and the hygienist is catered for. I can clear away the used instruments and clinical waste as previously mentioned, and set up for the next patients for the dental hygienist.

When the dental hygienist has finished for the evening at 5pm, I will shut down the surgery for the day.

I will have placed the used instruments in the sink for scrubbing with a long handled brush and heavy duty gloves, carefully scrubbing with the instruments on the floor of the sink with the sharps facing away from me for safety reasons. Then the instruments will be placed in the ultrasonic bath, rinsed them and then have placed them in the autoclave for sterilisation.

After the cycle had finished I would remove them and drain the chamber. The clinical waste bags would be emptied into the clinical waste bags in their designated area out of sight of the public in a locked cupboard. All surfaces would be wiped down with alcohol based wipes to disinfect the areas contaminated. All electrical equipment will be switched off and the dental chair raised for the domestic staff to clean effectively.

### **1700hrs – FINISH**

Although the working day is set at 0815-1700hrs, very often the day ends much later as we cannot leave at

5pm if the dentist or dental hygienist is still working, and running late. We must stay to take care of our patient and ensure the surgery is cleaned and prepared for the start of the following day.

**1725hrs** – I am finished my working day in the surgery.

My evening is just about to begin.

I am now attending college, an evening class for dental radiography. This is a post qualification course. I am thoroughly enjoying my class, and know it will benefit me and the dental practice.

I will be able to take radiographs for the dentist.

This I will take great pride in my achievement and I will enjoy the patient contact.

It is extremely hard work, working full-time and studying and attending evening classes, but the benefits will be so worthwhile.

I look forward to a long and happy career as a registered professional dental nurse.

# 8. Scottish Educational System

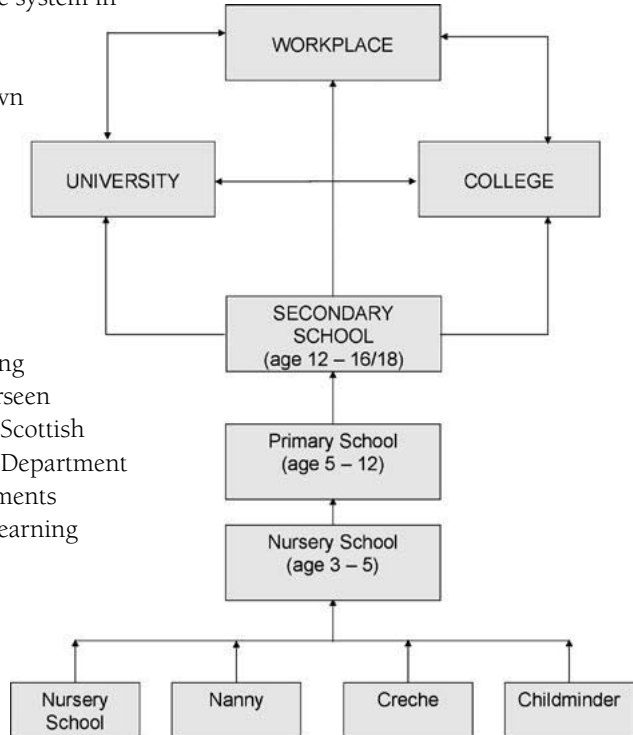
◆ Scotland's education system is quite different to that of the rest of the United Kingdom as well as to the system in your own country.

When Scotland got its own parliament in 1999, as a result of devolution, the responsibility for education became that of the new Scottish Parliament.

The education and training policy in Scotland is overseen and administered by the Scottish Governments Education Department and the Scottish Governments Enterprise and Lifelong learning Department.

At a local level it is the responsibility of one of the 32 councils to deliver the education services in preschool, primary and secondary education. The Scottish Government gives a sum of money each year to support education and it is up to each local authority to decide how to allocate the money given to them. Both Further and Higher Education are funded by the Scottish Government. The Funding Council supports both Further and Higher Education.

## The Education System in Scotland



## Scottish Qualifications Authority (SQA)

The SQA is a very important body in Scotland and has responsibility for the vast majority of qualifications which are completed in school and college environments. They **are not** responsible for developing, accrediting, assessing or certification of University qualifications. The SQA can best be described as a 'national body' for qualifications in Scotland. There are many different

types of qualifications which people can undertake and which allow for progression to take place.

SQA is responsible for different qualifications which can be described as: Units, Courses and Group Awards.

Each Unit taught to a student must be assessed and this is marked by the teacher/lecturer and is the cross marked by SQA to ensure consistency and standardisation of the award.

## **Scottish Credit Qualifications Framework**

Each unit is allocated a number of points in relation to how much learning has had to be done to achieve it. This is known as the Scottish Credit Qualifications Framework (SCQF). There are a number of different levels ranging from 1 to 12 with 1 being the least difficult up to 12 which is the most challenging. Each qualification that a student undertakes is allocated a level and a number of credit points.

## **Scottish Vocational Qualification (SVQ) Units/Courses**

Scottish Vocational Qualification (SVQ) units are undertaken by many individuals in care work and are an excellent way for a worker to gain a qualification which is specific to their work role. SVQ's are often described as 'gaining a qualification on the job'. This means that people can continue to work

and achieve a recognised qualification at the same time. These qualifications recognise the many skills, experience and knowledge which an individual has already in the work place.

All SVQ units are based on National Occupational standards. This applies to the Care sector as well as any other industry. These standards are drawn up by a '**sector skills council**' and each of the units which the student studies will assess their level of competency. Each student must produce a portfolio of written evidence as well as being assessed actually demonstrating the particular skill they are being assessed on.

Each SVQ unit which the student achieves will be built up into a SVQ qualification which is transferable qualification in the work place. By law care establishments have to have their staff trained and this has led to an increase in the number of staff undertaking this type of qualification in the work place. Staff who work in the Social Care and Health Care sectors can complete an SVQ qualification.

## **Dental Nurse Education**

Dental nurse training in Scotland does have only one route, but all courses require the dental nurses to undertake an external exam set by the British Association of Dental Nurses (BADN).

The examination consists of 3 papers and the candidates have to pass all papers to be certificated.

Below is an example of two different routes to gaining a qualification in dental nursing.

**Modern Apprenticeship in Dental Nursing**

Scottish Vocational Qualifications (SVQs) are work based qualifications which are based on national standards of competence drawn up by representatives from the industry sector. SVQs are made up of units , which break down a job into separate functions reflecting the different types of activities of a job. SVQs are available at five levels and the dental nurse qualification is set at level 3.

Core Skills – all those undertaking this qualification must complete the following core skills:

- ◆ Communication . . . . . Intermediate 1 level
- ◆ Working with Others . . . . . Intermediate 1 level
- ◆ Problem Solving. . . . . Intermediate 1 level
- ◆ Information technology . . . . . Intermediate 1 level
- ◆ Numeracy . . . . . Intermediate 1 level

Core Skills are the skills that every one needs in their work, in every job and every workplace. As these core skills are captured in other qualifications if they have already achieved them from school they do not need to repeat them.

The following are the units involved in this qualification:

<b>Mandatory Units</b>
Promote, Monitor and Maintain Health and Safety in the Workplace
Prepare and Maintain Environments for Clinical Dental Procedures
Offer Information to Individuals on the Protection of their Oral Health and Support them in doing so.
Provide Chair-side Support During the Assessment of Patients Oral Health
Process Dental Radiographs and Support their Production
Provide Chair-side Support during the Prevention and Control of Periodontal Diseases and Caries and the Restoration of Cavities.
Promote Peoples Equality, Diversity and Rights
Promote Communication with Individuals where there are communication Difficulties
Develop ones own Knowledge and Practice

Candidates must also complete 5 of the following units, 3 from Group A and 2 from Group B.

<b>Group A</b>
Enable Individuals to Protect their Oral Health
Enable Chair-side Support during Prosthetic Dental Treatment
Provide Chair-side Support during Endodontic Treatment
Provide Chair-side Support during the Extraction of Teeth and Minor Oral Surgery
Prepare for and Provide, Chair-side Support during Surgical Periodontal Therapy
Provide Chair-side Support during the Fitting, Monitoring and Adjustment of Orthodontic Appliances
<b>Group B</b>
Monitor Procedures to Control Risks to Health and Safety
Provide Chair-side Support during the Placement of Implant Fixtures
Provide Chair-side Support during the Preparation and Fitting of dental Implant Supported Prosthesis.
Prepare for and Assist in Oral and Maxillo-facial Surgery
Contribute to the Development of Teams and Individuals
Manage and Reconcile Appointment and Payment Systems
Lead the Work of Teams and Individuals to Achieve their Objectives
Promote the Communication with Others through the use of Interpretive Services
Arrange and Evaluate Translating Services
Promote Communication with those who do not use a Recognised Language Format
Promote Communication through Physical Contact
Promote Communication and Developments of Relationships with Individuals who lack Development and Social Understanding and Imagination
Assist with the Movement and Handling of Patients to Facilitate Healthcare Treatment
Enable Clients to Maintain their Physical Comfort
Provide Chair-side Support before, during and after the use of general Anaesthesia in Oral Healthcare Treatment
Provide Chair-side Support before, during and after the use of Conscious Sedation in Oral Health Care Treatment
Determine the Need for and Perform Venepuncture, Intravenous Cannulation and Intravenous Infusion
Assess Candidate Performance
Assess Candidate using Different Sources of Evidence

## National Certificate in Dental Nursing

This qualification is college based with the students attending college on a full time basis with placement as an integral part of the course. The students will undertake the same external NEBDN exam as with all other dental nursing programmes delivered.

NEBDN Syllabus Section	Description
1	Health and Safety and Infection control in the Workplace
2	Emergencies in the Clinical Environment
3	Legal and Ethical Issues in the Provision of Dental Care
4	Anatomical Structures and Systems Relative to Dental Care
5	Oral Disease and Pathology
6	Patient Care and Management
7	Assessing Patients' Oral Health Needs and Treatment Planning
8	Oral Health promotion and Preventative Dentistry
9	Restorative dentistry
10	Oral Surgery
11	Orthodontic Procedures
12	Dental Drugs, materials, Instruments and Equipment
13	Pain and Anxiety Control Dentistry
14	Radiography
15	Communication

# Bibliography

The NHS knowledge and Skills Framework (KSF) – Information for Education providers (2007).

NHS Careers. Available from [www.nhscareers.nhs.uk/dental](http://www.nhscareers.nhs.uk/dental)

The Scottish Parliament Health Committee Report. Available from [www.scottish.parliament.uk/business/committees/health/reports](http://www.scottish.parliament.uk/business/committees/health/reports)

NHS Education for Scotland (NES) – Dentistry. Available from [www.nes.scot.nhs.uk/dentistry](http://www.nes.scot.nhs.uk/dentistry)

British Society for Disability and Oral Health (BSDH) (2000)

Guidelines for Oral Health Care for People with Physical Disability. (BSDH 2000)

Principles on intervention for people unable to comply with routine dental care. (BSDH 2004)

Developing an Undergraduate Curriculum in Special Care Dentistry. (BSDH 2004)

Commissioning Tool for Special Care Dentistry. (BSDH 2006)

Clinical Guidelines and Integrated Care Pathways for the Oral Health Care of People with Learning Disabilities. (BSDH) Available from [www.rcseng.ac.uk](http://www.rcseng.ac.uk)

Clinical Guidelines: The Oral Management of Oncology Patients requiring Radiotherapy, Chemotherapy, Bone Marrow Transplantation.

Scottish Parliament – Treatment Charges and Registration. Available from [www.scotland.gov.uk/Topics/Health/NHS-Scotland/dentistry/charges](http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/dentistry/charges)

Scottish Executive National Standards for Dental Services. Available from [www.scotland.gov.uk/publications](http://www.scotland.gov.uk/publications)

Child protection and the Dental Team. Available from [www.cpd.t.org.uk](http://www.cpd.t.org.uk)

British Dental Hygienist Society. Available from [www.bdha.ig-zh.co.uk/iqs/sid](http://www.bdha.ig-zh.co.uk/iqs/sid)

An Action Plan for Improving Oral Health and Modernising NHS Dental Services (2005) Available from [www.scotland.gov.uk](http://www.scotland.gov.uk)

General Dental Services (Scottish Executive). Available from [www.scotland.gov.uk](http://www.scotland.gov.uk)

Regulating the Dental Team (2007). Available from [www.gdc-uk.org](http://www.gdc-uk.org)

H. Levison – Textbook for Dental Nurses

Report by John Chope on the Education and Training Committee – Dental technologists Association. (2007).

Health Strategies in Europe” On 12-13 July 2007 from <http://www.eudental.eu/index.php?ID=27888>



**FULL MEDICAL HISTORY**

*New Patient / Long Interval* since last treatment and every **TWO** years of regular review



Active Problems & Past Medical History

PMH: .....

.....

Current Medications: .....

.....

Allergies: .....

Systems Enquiry (SE)

Cardiovascular (CVS): .....

Gastrointestinal (GI): .....

Respiratory (RS): .....

Urological / Renal (UT): .....

Dermatological (Skin): .....

Diabetes Mellitus (DM): .....

Have you had Rheumatic Fever:      Yes / No      Details: .....

Have you had Jaundice:              Yes / No      Details: .....

Have you had Thyroid Problems:      Yes / No      Details: .....

Do you suffer from Fits / Faints:      Yes / No      Details: .....

Have you had any abnormal bleeding  
after extractions, surgery or injury:      Yes / No      Details: .....

Family History (FH): .....

.....

Social History: .....

.....

Clinician: .....

Student: .....

# Tayside University Hospitals Dundee Dental Hospital & School



## PATIENT DETAILS - Please print clearly

*On completion, return to main reception when attending your appointment*

Surname .....	Mr
Address .....	Mrs First Names .....
.....	Miss
.....	Birth Surname .....
.....	Sex (please circle):    MALE    FEMALE
..... Postcode .....	Tel. No. ....
Date of Birth .....	Occupation .....
<b>DENTIST'S NAME AND ADDRESS</b> .....	<b>DOCTOR'S NAME AND ADDRESS</b> .....
.....	.....
.....	.....
Have you attended the Dental Hospital previously?    YES    NO	
Approximate date of attendance .....	
Patient has been resident in the UK for the past twelve months?    YES    NO	

### CONFIDENTIAL MEDICAL HISTORY

Prior to any dental treatment being undertaken it is important that we obtain a detailed medical history from you. This is for your own protection as your medical history may have a bearing on the dental treatment we carry out.

Before a medical history is taken, we need you to answer a few preliminary questions:

<u>Please answer each question</u>	Yes or No	Further Details
Are you an expectant mother?	.....	.....
Have you visited your own doctor in the last six months?	.....	.....
Have you been seen by a Hospital Specialist outwith the Dental Hospital in the last year?	.....	.....
Is there any other clinic attendance you wish to discuss in confidence?	.....	.....

Signature: ..... Date: .....

Relationship to Patient: Self / Parent / Other (*Delete as applicable*)







## Oral and Dental Care – Scotland, United Kingdom

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