

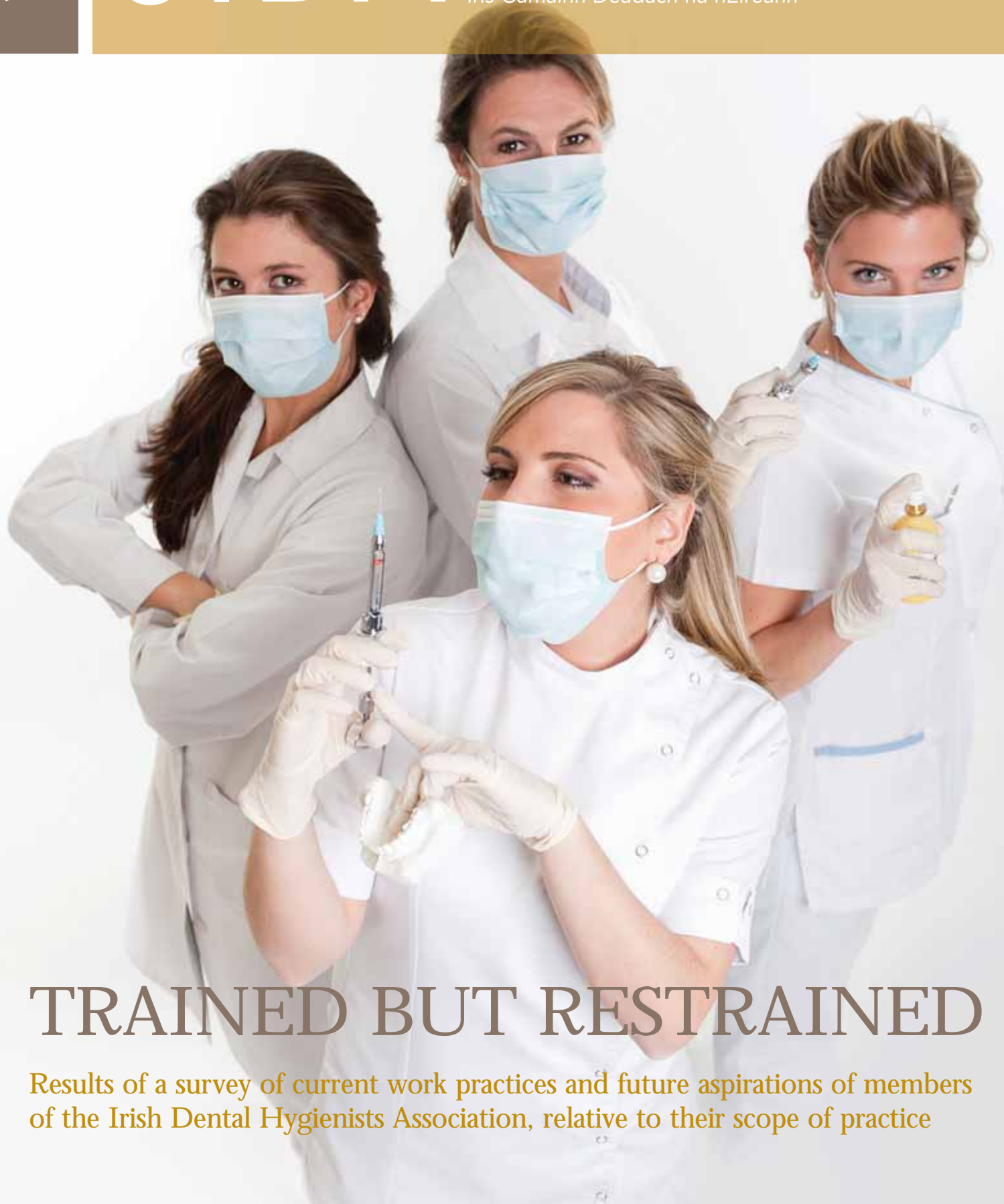
DENTAL SCHOOLS SPECIAL

Volume 62 Number 1
February/March 2016

IDA
irish dental association

JIDA

Journal of the Irish Dental Association
Iris Cumainn Déadach na hÉireann



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Results of a survey of current work practices and future aspirations of members of the Irish Dental Hygienists Association, relative to their scope of practice

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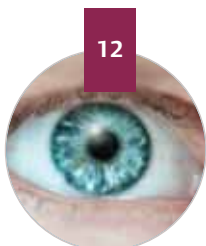
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7



12



20



23

EDUCATION SUPPLEMENT

We visit the Cork and Dublin schools in this special supplement

5 EDITORIAL

7 PRESIDENT'S NEWS

8 NEWS
Learning Management System launched; new Dental Council; and, booking opens for Annual Conference.

14 BUSINESS NEWS
Periodontal health; why you need income protection; and, new products.

20 CLINICAL FEATURE
Dental decontamination in pictures

47 PRACTICE MANAGEMENT
Education – six themes that make a difference

49 PEER REVIEWED
Results of a survey of current work practices and future aspirations of members of the Irish Dental Hygienists Association, relative to their scope of practice
C. Waldron, B. Pigott-Glynn

55 Prospective audit of postoperative instructions to patients undergoing root canal treatment in the DDUH and re-audit following introduction of a written patient information sheet
A. Moorthy, A.F. Alkadhimi, L.F. Stassen, H.F. Duncan

60 ABSTRACTS

62 CLASSIFIED

66 MY IDA
Marcas Mac Domhnaill

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Prof. Leo F. A. Stassen
Honorary Editor

Our future in good hands

There is good reason to be confident about the future of dentistry.



It is hard not to feel an element of pride when reading of the current state of, and developments in, dental education as described by Professors Kinirons and O'Connell in this special edition of the *Journal*. Despite all the difficulties faced by dentistry in recent years, our dental schools continue to attract a high calibre of student from three streams – the Irish school-leaving cohort, overseas students, and a small number of mature students. The standard of education and clinical training that they are receiving in Cork and Dublin ensures that we have a steady flow of well-trained dentists coming into the profession each year. IDA President Dr Anne Twomey comments in her introduction on the need to augment this education with an appropriate vocational training scheme, a sentiment with which all the main players in the profession are in agreement. The *Journal* is very grateful to the staff and students in both Cork and Dublin for their time and work in co-operating with us for this special feature which, taken with our 2011 feature, ensures that we have a full record of ten years of dental students in Cork and Dublin.

Decontamination

One of the benefits of co-operation between our Association and the Irish Dental Trade Association was the decision to run a practical seminar on decontamination at Identex last autumn. At that seminar Drs Nick Armstrong and Jane Renehan, along with senior HSE dental nurse Siobhan Corrigan, and Peter Gibbons of Henry Schein, demonstrated in the most practical way possible the sequence of decontamination of instruments in a dental practice. Dr Armstrong has put that knowledge into an easy-to-follow photograph-led clinical feature in this edition.

Dental hygienists' practice

Catherine Waldron and Bairbre Pigott-Glynn carried out a survey of the members of the Irish Dental Hygienists Association asking questions on the

range of skills employed, and their views on their future in practice. The answers received are reported in the first of our two scientific papers in this edition. Having had a strong response, they report that a high percentage of dental hygienists never or hardly ever use the skills of local anaesthesia, dental radiography, placing temporary dressings or refitting crowns. However, they are enthusiastic about the future, and most would like to continue working in a team setting.

Our second paper demonstrates how the introduction of a postoperative leaflet significantly improved the content and consistency of advice given to patients undergoing root canal treatment.

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This *Journal*, as with all issues, has carried out an important editorial function. In this instance, it is the photographic recording of all dental students and staff in the Cork and Dublin dental schools and hospitals. We only have the resources to do that because of the revenue from our advertisers. The Editorial Board is very grateful to those companies that make the decision to market themselves, their products and services through our publication. Please be sure to note which companies they are and to support them with your business in return.

Members only

Members of the Association will find a dedicated Members' News enclosed with this edition. It contains a report of the seminar on practice management held in Croke Park recently. It reports the contributions of all the speakers and several comments from the floor. There were excellent presentations from Drs Peter Gannon, Tom Feeney, Harry Barry and Kevin Lewis, as well as from Chief Executive Fintan Hourihan, accountant David McCaffrey, and pharmacist Oonagh O'Hagan. They provided terrific information and advice for dentists in general practice.



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Dr Anne Twomey
IDA President



Promoting dentists in the community

With an election on the horizon, this is a vital time to advocate for oral health.



Advocacy on dental health issues by voices from outside the profession is simply invaluable, as evidenced by the recent RTÉ documentary *Sugar Crash*, fronted by Dr Eva Orsmond.

The focus of the discussion was the impact on our health of rising sugar intake. It was particularly noteworthy that there was a very strong link in *Sugar Crash* to the impact on dental health. I was very pleased to participate in the programme to explain the impact on dental health and the importance of a better understanding of the many hidden sugars in food and beverages consumed on a daily basis. Many colleagues have told me that in the days and weeks after the programme they were inundated by parents and children who wanted to learn more about diet and nutrition. It bolsters the case for integrating and understanding the pivotal role of oral health in overall general health, and is a tremendous advance for our advocacy efforts.

In the wake of the programme, we are in discussions with a number of advocacy and professional representative groups to spread the message further. We have had very productive discussions with the Irish National Teachers Organisation, the Irish Nurses and Midwives Organisation and the Irish Sports Council. This can only be good for the profession and for our communities as a whole. I would encourage members to follow through at local level and make contact with local community groups such as schools, health professionals and sports organisations to convey the expert role and assistance that can be provided by dentists to the community.

Supreme Court

After a very long wait, the appeal of the Reid and Turner High Court Judgment was heard by the Supreme Court on January 13. I was delighted to see a strong group of representatives in attendance to offer their support, including Drs PJ Byrne, Peter Gannon, Ryan Hennessy, Sean O'Seachnasai and Maher Kemmoona. Prior to the Supreme Court hearing there was unanimous support among our large team, comprising Council and GP Committee members, when we met with our legal advisers to review our prospects. There was a very strong sense of unity apparent, and all were agreed that this type of behaviour by the

HSE is simply intolerable and cannot be allowed to proceed. We are fully cognisant of the significant financial risk associated with supporting this challenge and we will face serious difficulties in the event that the appeal is not upheld, but so vital are the issues at stake that we feel it was simply not tenable for us to consider anything other than offering our full support to this challenge. Hopefully, the Supreme Court's Judgment will be handed down shortly. This will be a critical development as regards our relationship with the HSE and we will discuss the implications with members fully once the Judgment is handed down.

Election fever

As we go to press, the Taoiseach has announced the date for the General Election. The Association has already made contact with all of the main political parties and alliances, and sought their views on a number of critical issues as regards dental health. We are also circulating information to members on how they can convey their concerns about dental health to those who seek their votes. Every member has a vital role to play in explaining the serious impact decisions of the outgoing government have had on the state of our dental health.

Croke Park seminar

It was very noticeable at the recent Croke Park Practice Management Seminar that there is a determined resolution on the part of our members to avoid reverting to a situation where dentists are reliant on the State, given the damage that can be caused where the State simply slashes schemes without any consultation or prior notice. There was a refreshing optimism apparent at the meeting and it bodes well for the year ahead when we hear such optimistic forecasts about the economy.

In addition, I am delighted to see such an attractive programme for our Annual Conference in Galway, where Dr PJ Byrne will assume the Presidency. I have no doubt but that there will be a huge attendance in Galway this year and I very much look forward to seeing you all there.

First Irish orthodontic therapists graduate



Course Director Dr Darius Sagheri (far left) and Dean of the Dublin Dental University Hospital, Professor Brian O'Connell (far right), are pictured with the six graduates of the new Professional Diploma in Orthodontic Therapy, who graduated in late 2015. From left: Alma McNally; Marie Malone; Michelle Hutcheson; Aine Power; Lynn McCarthy; and, Linda Flanagan.

Nomination to ICSTD

At its recent meeting, Council decided to nominate Dr Ciara Scott as its representative on the Irish Committee for Specialist Training in Dentistry. This is a three-year term and Dr Scott will report regularly to the Council of the Association.

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Professor Norman Butler

All in the Association were very saddened to hear of the passing of Professor Norman Butler. A former President of the Association and a distinguished member of the academic staff in the Dublin Dental School and Hospital, Professor Butler played an outstanding part in developing the School and educating countless generations of dentists, as well as playing a pivotal role as President of the Association. May he rest in peace.

Click to learn

The IDA's online Learning Management System is now up and running and available to members as a fantastic resource to support dentists in tracking their CPD and providing easy access to courses, events and literature that attract CPD credits. Using the system, dentists can see a calendar of events, book IDA courses, and access peer-reviewed articles from the *Journal of the Irish Dental Association*. The system also provides access to online courses/videos, and listings of third-party courses. The system has been designed to be simple for both dentists and IDA administrators to use, and will be continually updated with new features. IDA members can:

- ▶ book and pay for IDA events/courses online;
- ▶ automatically update their CPD records for IDA courses/events;
- ▶ manually update their CPD record with credits earned from non-IDA courses/events; and,
- ▶ read peer-reviewed articles in the *Journal of the Irish Dental Association* and automatically record CPD credit for this.

To access the new system, IDA members should simply log in to www.dentist.ie and go into the members' section. Go to the CPD section of the site by selecting the 'CPD' tab at the top of the page, and enter the Learning Management System by clicking the 'IDA CPD' button in the centre of the screen.



A booklet with detailed information on how to use the Learning Management System has been produced.

Supreme Court ruling awaited

Judgment in the Supreme Court ruling is awaited as we go to press. The day-long hearing on January 13 took place almost five years after the initial High Court ruling in the case of *Reid & Turner v The HSE*. Decision is keenly awaited and will be examined thoroughly after the Judgement is handed down. Detailed briefing will issue to members in due course.

GP Committee 2016

At its Annual General Meeting in Croke Park on January 30, the newly appointed GP Committee took office. The Committee includes a number of new members, including Drs Tim Lynch, Clodagh McAllister and Paul Hooi. The full membership of the committee is: Drs Andy Kelly, Clodagh McAllister, James Turner, John Nolan, Kieron O'Connor, Neysan Chah, Paul Hooi, Peter Gannon, Ryan Hennessy, Sean O Seachnasai, Stephen Moore, Tim Lynch and Tom Rodgers. The election of the Committee Chair will be decided at its inaugural meeting, to take place shortly.



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References:

1. Bleeding Index Reduction DOF 1 – 2013 (LAEBBA0001), 50.9% reduction in whole-mouth mean Bleeding Index at 4 weeks.
2. DOF 2 – 2013 (UNKPLT0006).

IRE/LI/15-1170

Advanced Defence against gum disease

New Dental Council 2015-2020

The newly appointed Dental Council had its initial meeting at the end of 2015. Most of the positions on the Council have been filled at this stage.

Dr Gerry McCarthy has been appointed as President of the Council and Professor Leo Stassen as Vice President. Dr Bernard Murphy has been appointed as Chair of the Fitness to Practice Committee, Dr Frank Burke as Chair of the Education and Training Committee, and Dr Rory Fleming as Chair of the Auxiliary Dental Workers Committee.

Elected dentists (seven members)

Dr Bernard Murphy	Dr Liam Lynch
Dr Gerry McCarthy	Dr Rory Fleming
Dr Danielle Colbert	Dr Ray McCarthy
	Prof. Leo Stassen

Nominated by the Medical Council (two members)

Mr Declan Carey	Dr John Barragry
-----------------	------------------

Nominated by University College Cork (two members)

Prof. Martin Kinirons	Dr Frank Burke
-----------------------	----------------

Nominated by the Royal College of Surgeons in Ireland (one member)

Dr Gerry Cleary

Nominated by Trinity College Dublin (two members)

Prof. Brian O'Connell	Dr Claire Healy
-----------------------	-----------------

Nominated by the Department of Health

(four members, including two representing the public interest*)

Dr Eleanor O'Higgins	Ms Muireann A. O'Neill
----------------------	------------------------

Ms Marie Henson* (re-appointment)	Mr James Doorley*
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Nominated by the Department of Education and Skills (one member)

Outstanding

Auxiliary Dental Workers Committee. Representing:

Technicians: Mr Colum Sower	Hygienists: Ms Yvonne Howell
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Nurses: Ms Michelle Spearman-Geraghty	Orthodontic therapists: vacant
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Be part of 'Dentistry into the Future'

This year's Annual Conference returns to the Radisson Hotel in Galway for what promises to be yet another outstanding event, with excellent educational and academic content, a busy trade show, and a strong social element.

The theme of this year's event is 'Dentistry into the Future', and from Thursday to Saturday, April 21-23, a host of national and international speakers will share their experience and expertise with delegates in lectures, workshops and pre-conference courses.

International speakers will include Dr Charles Goodacre, Professor Tara Renton and Dr Bob Genco, and they will be joined by well-known Irish speakers. The dental trade show will showcase new and advanced products, equipment and technology, and the social programme will include our 5k Fun Run and our Annual Dinner. Watch out for a detailed Conference preview in the next edition of the *Journal of the Irish Dental Association*, and be sure to put the dates in your diary – April 21-23, 2016.

IDA Roll of Honour

The Association has decided to elect Dr Terry Farrelly to its Roll of Honour following nomination by the Board of Directors. The decision to elect Dr Farrelly to the Roll of Honour is in recognition of his outstanding and exceptional service to the profession and to the Association. The election of Dr Farrelly to the Roll of Honour will take place at the Annual General Meeting on Thursday, April 21, in the Radisson Hotel, Galway.

AGM notice

The AGMs for the Association and Union commence on Thursday, April 21, in the Radisson Hotel, Galway. Members are reminded to send notice of motions for the Annual General Meeting or nominations for the position of Honorary Treasurer Elect by return to IDA House no later than March 4.

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*Source: A survey of dental hygienists in the UK, Eaton et al. (2012).

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Quiz

Submitted by Ruth Moore, IDNA representative



Question

- What do these images represent to you as a dental professional or to your practice as a whole?
- Each image is linked and should not be treated individually. Without one, the others may fail.
- What do you think?

Answers on page 61



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The University of Dublin



Diploma in Dental Nursing

Cork University Dental School & Hospital and Dublin Dental University Hospital are now accepting applications for the Diploma in Dental Nursing. This is a sixteen month evening programme commencing August of each year.

Successful students will be awarded a Diploma in Dental Nursing (level 7) by the University College Cork or Trinity College Dublin – depending on which governing centre the student is registered.

Application forms are available from f.grant@ucc.ie for the Cork, Waterford, Limerick and Tralee centres and from www.dentalhospital.ie/education/undergraduate-students/dental-nursing/national-dental-nurse-training-programme-of-ireland/ for the Dublin and Galway centres.

For further information please contact Siobhán Shakeshaft on 021 4901160 or Karen Dinneen on 01 6127341 (Dental Nurse Tutors).

Diary of events

FEBRUARY

23 Maryborough Hotel & Spa, Cork
Munster Branch IDA – Meeting
Speakers are Dr Richard Lee Kin and Dr Ronan Allen.

26 Alexander Hotel, Dublin 2, 2.00pm
Metropolitan Branch IDA – extended meeting: Wellbeing and eliminating stress
Speakers are Dr Garry Heavey on consent, Dr Brid Hendron on controlling stressful situations, Eamonn O Muircheartaigh on preventing back pain and Tony Kerins on Employment Law. Guest after-dinner speaker is Jim McGuinness, sports consultant and former manager of Donegal.

26 Ormonde Hotel, Kilkenny
IDA South Eastern Branch – Annual Scientific Meeting
For further information, please contact Ronan Fox, Tel: 086-122 9276, or Barry Power, Tel: 086-372 4344.

MARCH

3 Manor West Hotel, Tralee, Kerry, 7.00pm
Kerry Branch IDA Probiy Roadshow

7 Maryborough House Hotel, Cork, 7.00pm
Munster Branch IDA Probiy Roadshow

10 Alexander Hotel, Dublin 2, 7.30pm
Metropolitan Branch – Meeting and AGM

15 Ormond Hotel, Kilkenny, 7.30pm
South Eastern Branch IDA Probiy Roadshow

22 Hilton Hotel, Charlemont Place, Dublin 2, 7.30pm
Metropolitan Branch IDA Probiy Roadshow

23 Harlequin Hotel, Castlebar, 7.30pm
Western Branch IDA Probiy Roadshow

24 Clarion Hotel, Sligo, 7.30pm
North Western Branch IDA Probiy Roadshow

29 Strand Hotel, Limerick, 7.30pm
North Munster Branch IDA Probiy Roadshow

APRIL

2 IDA House, Sandyford
Hands-on implants course

6 Nuremore Hotel, Carrickmacross, 7.30pm
North Eastern Branch IDA Probiy Roadshow

13 Sheraton Hotel, Athlone, 7.30pm
Midland Area IDA Probiy Roadshow

21-23 Radisson Hotel, Galway
IDA Annual Conference

MAY

12 Finntown House Hotel, Lucan, Dublin
Irish Society of Dentistry for Children – Annual Scientific Meeting
Theme: 'Staying alive: the pulp in trauma and caries'.

OCTOBER

7-8 HSE Dental Surgeons Seminar TBC

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Consensus on periodontal health

A group of oral health professionals met with a team from Johnson & Johnson in Dublin last year to advise on the topic of 'Improving the periodontal health of the Irish population – prevention and treatment'. The *Journal* reports and obtained PROFESSOR FINBARR ALLEN's comments on the meeting.

At the meeting, held in Dublin, the following oral health professionals were in attendance: Professor Finbarr Allen, former Professor of Prosthodontics and Oral Rehabilitation at University College Cork; Professor Noel Claffey, Professor of Periodontology at Dublin Dental School and Hospital; Professor Anthony Roberts, Professor of Restorative Dentistry (Periodontology) at Cork University Dental School and Hospital; Dr Rory Maguire, Principal of Clarendon Periodontics and Implant Dentistry in Dublin; Dr Mark Condon, Principal of the Leeson Dental Clinic in Dublin, specialising in restorative (prosthodontics) and implant dentistry; and Louise Fleming RDH, President of the Irish Dental Hygienists Association.

Agreed statement

All present agreed on the following periodontal health consensus statement:

- effective plaque and calculus removal is key to oral health;

- dental healthcare professionals have a responsibility to educate patients on their disease status and to direct patients appropriately;
- patients should receive tailored oral hygiene instruction and demonstration;
- patients have a responsibility to act upon the advice given by dental healthcare professionals;
- for effective management, optimal patient home care and professional debridement are both essential;
- long-term periodontal maintenance with continuity of care is critical for successful treatment; and,
- clinically proven mouthwashes, gels and pastes should be considered for recommendation to those individuals who are not achieving optimal levels of plaque control in their home care routine.

Johnson & Johnson has stated that it will use this consensus statement as it continues to work in partnership with dental professionals.



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Professor Finbarr Allen, former Professor of Prosthodontics and Oral Rehabilitation at University College Cork.

Practical ideas

Professor Finbarr Allen spoke to the *Journal* about his role in the event. "I think that innovation in healthcare is important and best achieved when clinical academic experts and industrial partners work together to develop ideas that might ultimately be implemented in clinical practice. Johnson & Johnson has been active in developing products for preventing disease, and this fits with my own interest in a preventive approach to healthcare.

"If implemented effectively, we should see a marked reduction in disease, improved tooth retention, less replacement of tooth restorations, fewer dentures and a better oral health-related quality of life."

Oral disease is highly prevalent, and the treatment costs are spiralling. We have to change the way we look at oral healthcare, and we cannot continue with the old surgical model of disease management that we have been using for decades. We need to find a way to deliver quality preventive care and remunerate providers appropriately. Patients have a major role in this, and we have to promote our message in a more effective way than we are currently doing. If we can achieve this goal, then I believe our healthcare will be more effective and costs of oral healthcare can be contained.

Spreading the message

"Most, if not all, oral healthcare professionals understand that caries and periodontal diseases are preventable. However, our understanding of the recovery powers of teeth and periodontal tissues is continually evolving. Oral healthcare professionals need to keep up to date with advances in the field, and the consensus statement can guide them on what we know about gingival and periodontal diseases and their response to treatment at the present time. I think the statement can also be used to advocate for appropriate funding mechanisms for prevention-focused healthcare.

Patient motivation can be a problem, and regular dental attendance is not the

norm. We do need to use other means of getting oral healthcare messages across rather than solely relying on patients visiting a dentist. We should look to other means of promoting the message, e.g., general medical practice and pharmacies.

It works – it can reduce disease

I think dentists need to be convinced home care works, and shown the evidence that it does. However, they need to be remunerated appropriately for this approach. Patients will also need to be educated that paying for such advice is in their interests, and this will require effective communication. Their expectation that they should only be paying dentists for surgical intervention (e.g., drilling a cavity) needs to be moderated, and this can be achieved via effective communication about the role of prevention in disease management. If the statement was embraced by our profession, I would hope to see a reduction in disease and greater levels of tooth retention in the Irish population over time. It will require us to develop a new approach to undergraduate dental student training and continuing education courses to promote the concept of prevention-focused oral healthcare. This will keep me busy!

If implemented effectively, we should see a marked reduction in disease, improved tooth retention, less replacement of tooth restorations, fewer dentures and a better oral health-related quality of life."

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Nobody thinks it will happen to them

Professionals who are self employed need income protection. Here's a story (courtesy of Omega Financial Management) of one professional for whom it was vital.

"As a doctor you think if something serious happens you will feel it; in my case, that didn't apply." Dr Vladka Vilimkova from Castleknock in Dublin managed an extremely busy career as a Consultant Paediatrician with clinics in Crumlin Children's Hospital, Mount Carmel and Roselawn Private Clinic. This was in addition to her teaching/examiner post at RCSI. Her days were hectic but she was happy with the variety and responsibility of her workload.

In December 2012, following a standard check-up, she received the difficult news that she had breast cancer. With no family history of the disease and good general health, the diagnosis came completely out of the blue. When her doctor mentioned the term cancer she knew that something would need to be done immediately. A treatment plan was developed and within a few days of the news she had her first surgery. Her demanding work schedule came to a complete standstill.

Vladka went on to have four extensive surgeries over the next two years, each one resulting in a recovery time of up to three months. However it was the consequence of the treatments rather than the cancer itself that had the greatest impact on her future. Following a full mastectomy, procedures to relocate muscle and ligament tissue were required to balance her spine and aid movement. Unfortunately this resulted in a major loss of shoulder/arm mobility and significant pain. Driving, swimming, even typing on a keyboard became extremely difficult, requiring ongoing physiotherapy.

Financial implications

A life-changing diagnosis results in a multitude of emotional, physical and practical implications so having a strong support structure in place is highly beneficial. For Vladka, the financial implications did not cause additional stress due to the decision she had taken two years prior to arrange income protection cover. She had looked at a number of providers and was drawn to DG Mutual's non-profit model that invests back into the peer community, rather than a larger PLC-generated policy. Their client support ethos was vital when the time came to file her claim.

Following her initial diagnosis, Vladka was assured by Omega Financial Management that it would be totally taken care of and received her letter of approval straight away. This was a big relief not only due to the ease of the process; she had just discovered that she would not be entitled to any State illness benefit. The Dept. of Social Protection had informed her that self-



Dr Vladka Vilimkova from Castleknock in Dublin advises professionals to protect their income.

employed individuals are not covered in the same way as employed workers. Vladka comments: "People assume when they pay such a high level of tax that they will be covered in the same way as employees but this is not the case." Vladka's income protection payments provided her with a level of financial independence, which she describes as paramount to her state of mind.

"People assume when they pay such a high level of tax that they will be covered in the same way as employees but this is not the case."

Another benefit of DG's structure is the personal nature of the claims process. Vladka avoided having to divulge the personal details of her case to a variety of people as DG managed the full process with a designated case manager.

Furthermore, when she looked into returning to work, she contacted DG to let them know her intentions and was assured that no matter the outcome, she would be covered. When a return to work was ruled out, payments continued without question.

Positive outlook

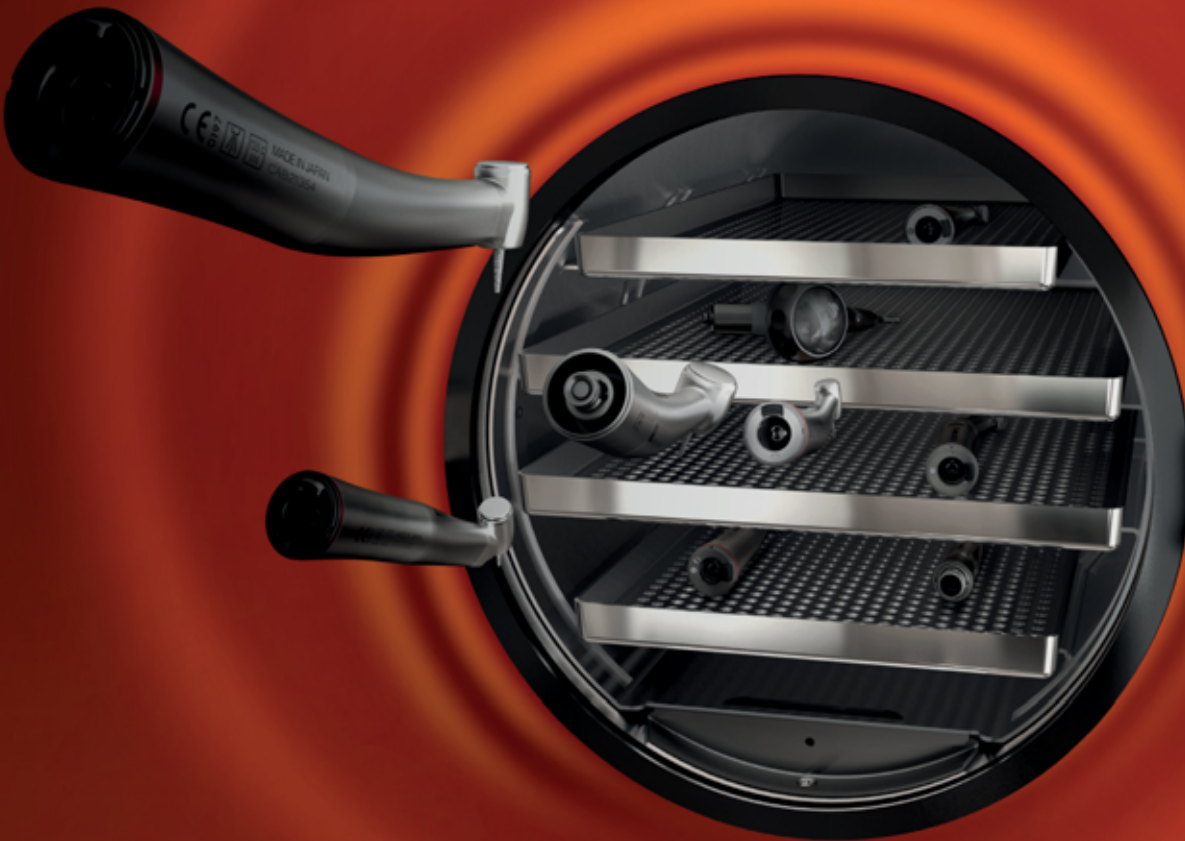
With treatments ongoing it is hard to formulate future plans but Vladka's outlook is very positive: "I'm not putting myself under pressure to be like before as it will never be the same again." She is focusing on her family and her new day-to-day life. Her condition has more or less ruled out the possibility of ever returning to work in her former capacity. DG has confirmed that she will be covered as long as she needs to be, providing her with the time and space needed to recover, reset and plan accordingly.

She advises her colleagues, young and old, to think about their situation and what would happen if, very suddenly, they couldn't work anymore: "As a doctor and a responsible person, you should be covered."

Overall, income protection was an essential part of reducing the stress created by the unforeseen situation Vladka found herself in. She would recommend it to anyone looking to protect their personal finances, particularly medical or dental professionals who have invested heavily in their education.

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Liz Madden, Dental Nurse, Abbeyglebe Dental Practice, Donegal

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NSK launch iClave+



According to the makers, the NSK iClave+ is a powerful partner in your practice as it is quick, reliable and cost-effective. Made of advanced materials and components, the iClave+ was previously known as the Domina from Dental X and has sold more than 60,000 units worldwide. It incorporates a copper chamber and has an increased chamber volume that is 20% higher

than comparable systems. Combined with fast cycles of less than 20 minutes the NSK iClave+ can save time and money. According to Liz Madden, Dental Nurse at Abbeyglebe Dental Practice, Donegal: "Our previous autoclaves kept breaking down and were expensive to repair. Morris Dental recommended the NSK iClave+ to us and we now have four in the practice – and they've been great. We use the fast cycle a lot, as we're a big practice, and the large chamber allows us to autoclave four trays at a time. We highly recommend the NSK iClave+; it's excellent and very easy to use."

For more information or to arrange a visit from Jonathan Singh, NSK's Specialist/Technical Services and Support Engineer for NI & ROI, contact NSK or your preferred dental dealer.

DMI makes final



Pat O'Brien,
Chief Executive, DMI.

Pat O'Brien and the team at DMI are celebrating having been made a finalist in the Small Firms Association (SFA) Small Business Awards 2016. There are seven categories with an average of only five finalists in each category, and DMI has been short-listed in the Services category. DMI was invited to take part in the Small Business Showcase event in Dublin in February and will be present for the Gala Awards in the RDS in early March. A supplement with the *Irish Independent* will profile all the companies that are finalists in March.

The Small Firms Association is part of Irish Business and Employers Conference (IBEC) and is based at the IBEC offices in Dublin.

Flowable, light-curing nano hybrid Ormocer restorative material



According to its maker, Voco, Admira Fusion is the world's first purely ceramic-based universal restorative material. The innovative combination of tried-and-tested nano hybrid technology and Ormocer technology means that

silicon oxide forms the chemical basis for both the fillers and the resin matrix. This unique pure silicate technology brings a number of benefits. These include a high filler content, as well as extremely low polymerisation shrinkage and a particularly low level of shrinkage stress. At the same time, says Voco, Admira Fusion is characterised by excellent biocompatibility and very high colour stability.

The launch of Admira Fusion Flow means there is now a flowable version. Thanks to that pure silicate technology, this material also demonstrates very low polymerisation shrinkage and a low level of shrinkage stress. Just like Admira Fusion, Admira Fusion Flow offers excellent biocompatibility and very high colour stability. The 12 Admira Fusion Flow shades are optimally coordinated to the shade range of the packable version of Admira Fusion. The shades Bleach Light (BL) and White Opaque (WO) are also suited to special cases such as use in paediatric dentistry, with bleached teeth or discoloured dentine areas or in core build-ups.

According to Voco, Admira Fusion Flow covers a wide range of indications. These include restoration of class III to V cavities, restoration of small cavities, and use during extended fissure sealing, blocking of undercuts, linings or coating of cavities, repairing fillings as well as veneers and temporary restorations, luting of translucent prosthetic pieces, and the interlocking and splinting of loose teeth.

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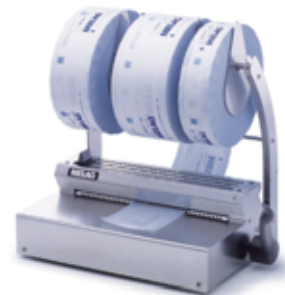
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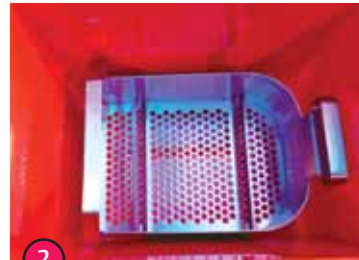
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This article presents in sequence the processing of dental instruments in an LDU (local decontamination unit). The same sequence of steps applies to an LDA (local decontamination area).



1



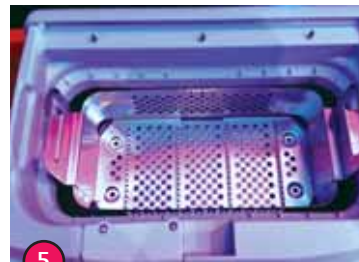
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Dental decontamination in pictures

Dental decontamination is a process with five steps (Dental Council Code of Practice Relating to: Infection Prevention and Control [COP] para 3.2.3):

1. Transport.
2. Cleaning and disinfection of instruments.
3. Inspection and packaging.
4. Sterilisation.
5. Storage.

Figure 1: Transport box (dirty)

Contaminated instruments must be transported safely to the decontamination area (LDU). The box pictured is the correct type of box – secure lid, easily cleanable, with a carrying handle. The box should contain some water or a cleaning solution such as an enzymatic cleaner to keep the instruments wet, as it more difficult to clean instruments with dried blood and protein on the surface.

Figure 2: Inside transport box

The box illustrated has a tray inside, in which the instruments are placed. Puncture-resistant/heavy-duty gloves should be used when removing the tray of instruments. The instruments should then be rinsed (in the dirty sink if two sinks are present) and placed in an ultrasonic cleaner or loaded into a washer-disinfector. Handwashing of instruments should be carried out if necessary after

mechanical cleaning of instruments either in an ultrasonic cleaner and/or washer-disinfector.

Figure 3: Personal protective equipment (PPE)

This picture shows appropriate PPE for use in the LDU, which includes mask, visor/protective glasses, gown and gloves.

Figure 4: Ultrasonic cleaner (COP para 3.2.4.2)

This is a small bench top ultrasonic cleaner. Use according to manufacturer's advice and an annual validation should be carried out. Service as advised. Fill with enzymatic cleaner and turn on for a few minutes to degas. Set the temperature as advised by the manufacturer to suit the solution used.

Figure 5: Inside ultrasonic cleaner


Instruments transported into the LDU should be transferred from the dirty box to the ultrasonic tray (as in Figure 4), rinsed, and then the tray should be replaced in the ultrasonic cleaner. After cleaning, the instruments should be removed.

Figure 6: Sink

The sink pictured is the type of sink recommended for cleaning/rinsing instruments. There is a wrist-operated tap, the plughole is not under the tap spout and there is no overflow. There is also a separate tap (optional) in this sink. This delivers reverse osmosis water, which can be used for rinsing instruments after cleaning in the ultrasonic cleaner. In some LDUs, if there is space, two sinks can be installed – one for rinsing/washing dirty instruments (dirty sink), and a second sink for rinsing the cleaned instruments (clean sink).

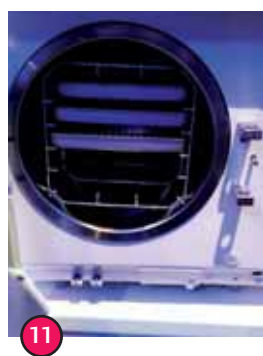
Figure 7: Washer-disinfector (COP para 3.2.4.1)

Whenever possible, a washer-disinfector should be used to clean the instruments, as this is the most effective means of cleaning, and also disinfects the instruments (e.g., final rinse at 90°C for one minute). This renders the instruments safer to



Dr Nick Armstrong
BA BDentSc MSc

Nick has a special interest in infection prevention and control (IPC). Since retiring from the HSE, he continues to advise, lecture and research in IPC, and is a member of IDA Quality and Patient Safety Committee.



handle after cleaning. Washer-disinfectors must be commissioned and validated annually or as advised by the manufacturer.

Periodic testing by the operator is also advised:

- daily tests – spray arm rotations, spray nozzles, remove and clean strainers and filters as advised by manufacturer; and,
- weekly tests – soil or other cleaning efficiency test.

Figure 8: Inside the washer-disinfector

If there is a washer-disinfector in the LDU, then after bringing the instruments from the surgery in the transport box (Figures 1 and 2), load the instruments into the washer-disinfector using the baskets and stands, with sharp ends pointing down, and forceps and other hinged instruments open. Handpieces should be attached to lumen cleaners in the washer-disinfector. Choose the cycle most appropriate to the load (follow the manufacturer’s instructions) and remove clean, dry instruments after the cycle.

Figure 9: Inspection light (task light)

After cleaning (ultrasonic or washer-disinfector), inspect the instruments under a bright light such as the one pictured here. Any instruments that are not clean should be put through the cleaning process again. Cement or other material adhering to instruments can be safely removed at this stage. Dry, clean instruments can be packed at this stage. The cycle number of the autoclave and the date of sterilisation should be recorded on the pouch/pack.

Figure 10: Autoclave

Pictured here is a B cycle autoclave (COP 3.2.5.1). Other types of autoclave cycles are S cycle (COP 3.2.5.2) or N cycle (COP 3.2.5.3). N cycle autoclaves are

only used for sterilising unwrapped instruments for immediate use. All autoclaves must be commissioned, periodically tested and annually validated.

Figure 11: Inside the autoclave

It is important that the autoclave is properly loaded. Pouches must be window facing tray and must not overlap. De-ionised, sterile, distilled or reverse osmosis water should be used in autoclaves – town water must not be used (see manufacturer’s instructions). The cycle record must be read after each cycle to ensure that the cycle passed.

Figure 12: S cycle autoclave for handpieces and instruments

The autoclave in the picture is designed for sterilising handpieces or a small number of instruments. A device such as this can also be used in combination with an N cycle autoclave, as an N cycle does not sterilise lumens in handpieces.

Figure 13: Clean transport box

A clean transport box can be used to transport sterile instruments for storage. All instruments must be stored in a clean and dry drawer or other enclosed space. They can be stored, if necessary, in the LDU on the clean side or, if there are two rooms in the LDU, in the clean room. Unwrapped instruments must be used on the day of sterilisation. Storage of unwrapped instruments is not allowed. Storage of wrapped instruments for up to a year is permitted under clean and dry conditions.

.....
 These photographs were taken at a workshop that took place at Identex 2015 and was presented by Dr Nick Armstrong, Ms Siobhan Corrigan, Peter Gibbons (of Henry Schein) and Dr Jane Renehan.

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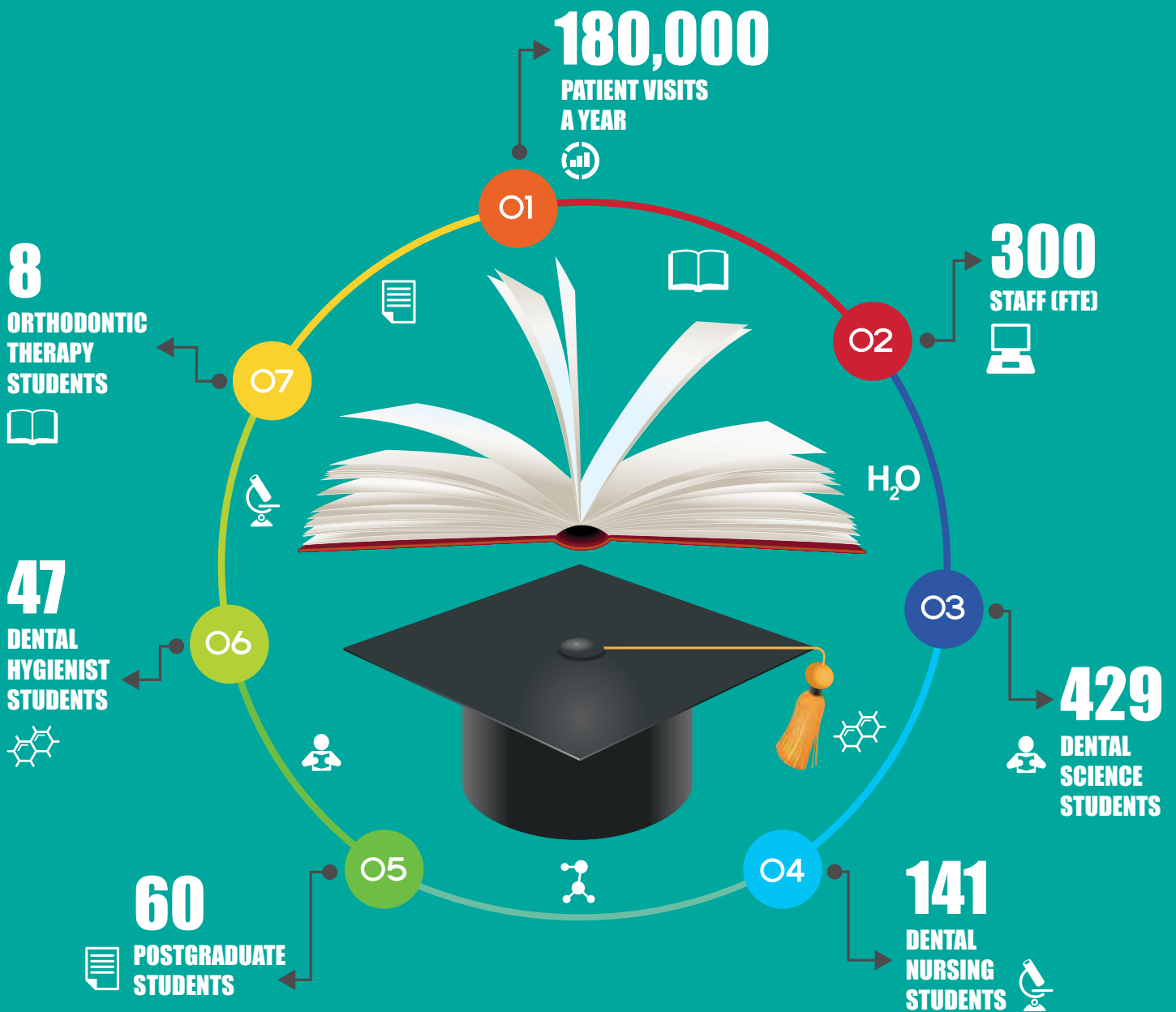
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A matter of record

President of the Irish Dental Association Dr Anne Twomey introduces a special feature on the state of dental education in 2016.



Professor Martin Kinirons, Dean of Cork.

This *Journal* has a very progressive Editorial Board. It has developed our publication steadily, over many years, to become the leading publication for dentists in Ireland. Two major surveys carried out in the last five years have established and quantified that fact.

One of the reasons it has become an essential read for dentists is because of its work as a journal of record. Five years ago, the *Journal* obtained great help and co-operation from the Cork and Dublin university hospitals and schools to record all of the students (and staff) at that time. By repeating the process again exactly five years later, again with great co-operation, the *Journal* has been able to record a full ten years of dental students in the Republic of Ireland. While doing this, the Deans of the time have graciously shared their time and views on the state of dental education. In 2011, it was Professors Allen and Nunn, and now we have Professors Kinirons and O'Connell. They share with readers the developments in dental education in the last five years, and the challenges that are emerging due to the rapid developments in the science and technology of dentistry.

Unity on the vocational training issue

While it is university-based training, it has to be clinical as well as academic. It is worth recording that the hospitals collectively are treating more than 150,000 patients every year. This affords our senior cycle students the chance to avail of real clinical experience – under close supervision, of course. And the standard of dentist that our universities are producing is very high. They are ready to practise (as opposed to being well-trained beginners, which is the case in some countries in Europe) but all parties in dentistry agree that they would



Professor Brian O'Connell, Dean of Dublin.

benefit from a vocational training scheme. The Irish Dental Association, together with both UCC and TCD, and the RCSI, have met with Ministers Varadkar and Lynch and collectively argued for the reintroduction of the vocational training scheme. It appears that it is being considered under the auspices of the development of the National Oral Health Strategy, in which case we say: the sooner we have that policy the better, because our graduates are losing out because of the lack of an appropriate scheme.

Your future colleagues

I invite you to read the views of the Deans of the Schools and to reflect on the diversity of dental students in the Cork and Dublin dental schools at this time. It may also be very useful to put this *Journal* away somewhere safe as you may enjoy looking back on it in years to come – it may well contain photographs of your future colleagues. Most of all, enjoy the sense of vibrancy and vitality that it gives to our profession by knowing that we can look forward to years more of high-calibre, well-trained professional colleagues.

Dr Anne Twomey
President, Irish Dental Association



Ahead of the curve

Cork University Dental School and Hospital (CUDSH) works hard to stay ahead of the educational and technological needs of its students.



CHAIRS OF COMMITTEES

Prof. Declan Millett; Siobhan Lynch; Prof. Martin Kinirons; Dr Christine McCreary; Dr Frank Burke.

The Dean of the School of Dentistry at University College Cork, Professor Martin Kinirons, says that in the last five years the standard of student entering the school has continued to rise. How does he measure that? In simple terms, the points level of students has risen. "Five years ago about one-fifth of our Irish Leaving Cert entry cohort would come in with maximum points from the Leaving Cert. That figure is now at about 30%." The School also takes about one-third of each class from overseas and the Dean says that this is very healthy for the class and for the University. There are usually a further three mature students in the class and these have included students from a wide range of backgrounds including a PhD in pharmacology, law graduates and business graduates.

So it tends to be an impressive group of people and Professor Kinirons says: "Our job as a university school and hospital is to match bright students with good outcomes." At postgraduate level, the School provides masters, clinical doctorate and PhD degrees.



Paul O'Grady
Journalist and managing editor
at Think Media
paul@thinkmedia.ie

How does the School monitor and improve its standards? "We undertake an annual monitoring exercise, we are inspected and accredited by the Dental Council every five years and are also reviewed by the Irish Universities Quality Assurance Programme. We also undergo a University Research Quality Review every five years. In recent years we have continued to develop strengths in our publications, research-related activities, and the level of research income that we achieve. The second part of that is very important as we have innovated well in the area of training and education with research. My predecessor, Professor Finbarr Allen, deserves great credit for initiating the Clinical Dental Fellows programme, which allows us to produce the clinical dental educators of the future. In fact, the Clinical Dental Fellowship has proven to be a

Cork University Dental School and Hospital

Founded in 1913

Part of the College of Medicine and Health in University College Cork.

Dean: Professor Martin Kinirons

Disciplines: Restorative Dentistry; Oral Health and Development; and, Oral Surgery, Medicine and Radiology.

Offers	Number of students
Bachelor of Dental Surgery (Hons)	220
Diploma in Dental Hygiene	28
Diploma in Dental Practice	45
Masters in Public Health	9
Doctorate in Clinical Dentistry	6
PhD	9
CPD courses	20

Number of staff: 135 (95 full-time equivalents) including: consultants; NCDs; full- and part-time lecturers; hygienists; nurses; and, administrative staff.

Patient visits: 60-65,000 per year

Research Some major strands: oral epidemiology and health services research; fluorides and caries prevention; biomaterials; dentofacial imaging and outcome studies; trials of implant-retained prostheses and care of the elderly; and, assessment of systemic disease in the oral cavity using quality of life measures and clinical indices.

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The student experience

Dr Frank Burke, a Leinster-supporting Dubliner, is a Senior Lecturer and Consultant in Restorative Dentistry, Vice-Head of College (Academic Affairs) and Chair of Teaching and Curriculum at the Dental School. He graduated from TCD in 1982 and spent more than a decade in London before joining UCC in 1998.

Frank deals with the incoming students and with their expectations of how to succeed. "The students in our intake are in the top 2% of Leaving Cert results. They are hard-working high achievers. They come in with highly structured and rigid thought processes; they are driven by exams and their expectations are that if they learn the notes, they will do well. Our objective is to have them graduate in five years' time with communication, problem-solving and clinical

very successful pathway into the professional teaching of dentistry. Dr Gerry McKenna is a great example of the success: he trained in Dundee, came to us for the Fellowship and is now a Senior Lecturer/Consultant in Belfast. The success has been down to both the quality of the personnel coming into the programme, and the desire and ability of the College and University to recognise professional skills."

Geographical circulation

The dental profession, and especially the academic part of the profession, has a very healthy tradition of geographical circulation, something noted by the Professor. "That's certainly the case here now as most of the senior clinical staff were trained outside of UCC. Against that UCC has produced the current Deans of four dental schools: UCC, TCD, Leeds and Singapore. So it is important to make a contribution to the wider profession and Cork Dental School and Hospital can certainly claim to be doing that." (For the record, the UCC-trained Deans elsewhere are: Professor Brian O'Connell in Dublin; Professor Helen Whelton in Leeds; and, Professor Finbarr Allen in Singapore.)

Research focus

"We have made good progress in the research culture here and especially its integration into the teaching in the School. An over-arching research group is now active, providing a structure and a forum for collaboration," says Professor Kinirons. He is pleased with that progress and cites two areas of active research in the School and Research Centre: HRB-funded research on oral disease prevention and management; and, the impact of oral health on people's quality of life.

New technology

School and Hospital Manager Siobhan Lynch is streamlining administrative processes and overseeing the introduction of new technology. In recent times, the School and Hospital has installed 40 new dental chairs in the adult restorative dentistry clinic. Additionally, students and staff now have chair-side screens for digital radiography, as well as continuous and upgraded wifi access. "Having brought in chair-side digital radiography, we are just about to go to tender for the supply of cone beam technology. Once that is in place, our plans are to introduce digital charts within about three years."

skills. The adjustment in thinking can be a shock and they sometimes get frustrated because they cannot get it perfectly right as they have done up to then. In fact, many have no experience of failure. However, our class sizes are small, our mix of Irish, mature and overseas students is very good, and we have an excellent mentoring system here. This helps the students to overcome those challenges."

At a wider level, Frank notes that while accommodation for first years and overseas students is a priority, the facilities at UCC are very good. Cork City has a population of 120,000 people, 20,000 of whom are students. "We place a big emphasis on student experience, with student health and well-being being at the core of our concern. Drink sponsorship is not tolerated on campus, for example, and the University is very proactive in the areas of student physical and emotional well-being.



ADMINISTRATIVE STAFF

BACK: James Keane; Paula McCarthy; Lisa Morgan; Ann-Marie Doran; Terry Cullinane; Niamh Kelly. FRONT: Jane Ahern; Mary Doherty; Mary Keelan; Ann Casey.

Clinical governance

Dr Christine McCreary is the Chair of Clinical Governance at CUDSH. A senior lecturer and consultant in oral medicine, she is a native of Belfast, originally graduated from TCD, and trained in Dublin. "Our Service Level Agreement is with the Health Service Executive (HSE). That means we come fully under the remit of the Health Information and Quality Authority (HIQA). So we have to serve two masters – the University and the HSE – and that in turn meant we had to have a close look at our governance structures. Having done that, we are putting in place the recommendations of the HSE's Quality Improvement Programme." Christine acknowledges that has meant a lot of extra work (including for her) but says CUDSH has achieved a lot in the last two and a half years. She gives credit to the Hospital Manager Siobhan Lynch and her team, including Director of Nursing Mary Moloney, for those achievements.

"We now have a Patient Safety Improvement Group meeting every two weeks, and a group of younger staff on the Practice Development Group who are responsible for developing policy for the future. That Group is made up of several of our DClinDent and PhD students, all of whom are under 35. They are developing the policy that they will likely have to apply in future years."

International links

The Netherlands: UCC has an academic and student exchange (under the Erasmus programme) with Nijmegen University. Each year there are fifth year students on exchange for the August to December term.

USA: There is research collaboration as well as staff visits with Tufts University in Boston, and the clinical fellows and lecturing staff have research exchanges with universities in Pittsburgh and Seattle.

United Kingdom: The University of Manchester and CUDSH operate a clinical training exchange.

Canada: UCC is the only centre in Europe hosting the National Dental Examination Board examination for accreditation to work in Canada.

Patient safety

There has, he says, been a renewed focus on the skills required for patient safety, with students being given extra skills in patient communications and the fundamentals of ethics. "We continually strive to improve the skills of our graduates so that their career pathways and prospects are improved." And speaking of career pathways, it is evident that the vocational training scheme for dentists is badly missed. "It needs to be re-instated. We are keen on that; our colleagues in the Dublin Dental School are keen; the Faculty of Dentistry at RCSI is keen; and the Irish Dental Association is keen to see it develop. We have even met with Ministers Varadkar and Lynch and they certainly seemed interested." So why isn't it happening? It appears that the process of developing a National Oral Health Strategy includes defining the needs of the patients and the profession. So that process includes consideration of foundation training and specialist areas of practice as well as a wide range of other matters.

A Dub gone native

Professor Martin Kinirons was born and raised in Glasnevin in Dublin until the age of 14, at which point his family moved to Cork. He went on to study dentistry in the School of which he is now Dean, qualifying in 1976. Despite the fact that his wife, Collette, is from Cork, he only spent one year in UCC after graduation before returning in 2003 as Professor of Paediatric Dentistry. His training included two years in practice in the UK, a year in Manchester Dental Hospital and that year in Cork, before he went to the Royal Hospital for Sick Children in Belfast where he got his training in paediatric dentistry for four years. He subsequently obtained a consultant's post in the Royal Victoria Hospital and while there acted as Postgraduate Dental Adviser for Northern Ireland and completed a PhD in Queen's University. Queen's University then offered him a post in their Dental School and Hospital, where he stayed for ten years as Head of Paediatric Dentistry. Ten years after returning to UCC, he was made Dean of the School.

Collette and Martin have three sons: Michael who works in business in London; Ross who is an engineer in Cork; and, Rick who is a business consultant in Dublin. Michael and his wife Sarah have a daughter, Amelia, making Martin and Collette very happy grandparents.

In his spare time, Martin loves trekking and hill walking. He has completed four of five parts of the Camino and intends to walk the final part this year. He has, though, gone native and supports Munster in the rugby.

Changes in dentistry

Reflecting on the changes in dentistry generally, Professor Kinirons observes that the big move is away from the dentist deciding exactly what happens to managing the patients' expectations. "The challenge now is geared around marrying the oral health aspect of care with what the patient wants. Handling that can be difficult."



TEACHING STAFF

BACK: Dr Martina Hayes; Dr Patrice James; Dr Antonios Theocharopoulos; Dr Mairéad Harding; Dr Chris Stewart; Dr Joe Hallissey; Dr Cristiana da Mata.
MIDDLE: Ms Caroline Horgan; Ms Anne O'Keeffe; Ms Mary Harrington; Dr Catherine Gallagher; Dr Denis Field; Dr Sharon Curtin; Dr Patricia McDermott; Dr Kieran Doran; Mr Keith Evans; Ms Siobhan Shakeshaft.
FRONT: Dr Eleanor O'Sullivan; Prof. Anthony Roberts; Dr Frank Burke; Prof. Martin Kinirons; Dr Christine McCreary; Prof. Declan Millett.



DENTAL NURSING AND CSSD STAFF

BACK: Eimear O'Dwyer; Nellie Healy; Muriel O'Connor; Judy Riordan; Maire Kiely; Kate Cronin; Laura O'Donnell; Amelia Spillane; Maria Gorman.
MIDDLE: Julie Rothwell; Jackie Kirby; Colette Murray; Trish Bourke; Eileen Foley; Pam Binks; Sinead Lane; Cian O'Callaghan; Margaret McStay.
FRONT: Mary Horgan; Vanessa De Vere; Catherine Morrissey Moran; Cait McCarthy; Deirdre O'Shea; Gillian Surgenor (standing).



**Masters Degree in Dental Public Health –
MDPH 2016-2017**

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For informal discussion, please contact:
Dr Máiréad Harding, Tel: (+353) 21 4901103
Email: m.harding@ucc.ie

Applicants are required to have a BDS degree of the NUI or equivalent degree. (Note: Health care professionals holding relevant degrees may also be considered).
Closing date for EU applicants is: June 1st, 2016.
Applications should be made online at <http://www.pac.ie/ucc>
Application queries should be directed to the Graduate Studies Office, University College Cork, Tel: (+353) 21 4902876
Fax: (+353) 21 4901897 Email: graduatestudies@ucc.ie



DIPLOMA IN DENTAL NURSING

Kayla Benson; Sarah McCormack; Danielle Browne; Katie Cleary; Maria Brennan; Rosezita Bergin; Rebecca Thornton.



POSTGRADUATE AND PHD STUDENTS AND TEACHING STAFF

BACK: Dr Makiko Nishi; Dr Tara Beecher; Dr Paul Brady; Dr Eimear Hurley; Dr Martina Hayes; Dr Elaine Kehily; Dr Miriam Crowley.
FRONT: Dr Junaid Nayar; Dr Graham Quilligan; Dr Caroline McCarthy.

INNOVATION IN DENTISTRY

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MAINTENANCE:

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KINCARE

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calcium



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WHITENING

KIN
WHITENING
TOOTHPASTE
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DIPLOMA IN DENTAL HYGIENE – YEAR 1

BACK: Trish Fahy; Aisling Conway; Sharon Moloney; Deborah Graham; Fiona Campbell; Stacey Lyons; Ailbhe Hinks; Tracey Corcoran. FRONT: Sarah Byrne; Sarah O'Brien; Eimear Staunton; Stephanie Purcell; Claire Palmer; Louise Kelly.



DIPLOMA IN DENTAL HYGIENE – YEAR 2

BACK: Grace McCarthy; Noelle Joyce; Claire Hession; Gillian Kenny; Laura Gibson; Jenna Howley; Linda Casey; Gemma Sexton. FRONT: Sarah Kelly; Noelle O'Leary; Ursula O'Neill; Elaine Cass; Orla Harrison.



BDS (FIRST YEAR)

BACK: Adrian Hofmann; John Neville; Nick Lubbe; Daniel Dilworth; Armin Yaghoubian; Terrence Myers; Ryan Warren; Robert Giamotti. MIDDLE: Mishaim Mian; Sarah Lee; Máirín Minahan; Lauren Chandler; Ern Jie Yeo; Lieu Yentung; Hengjia Zhang; Andrew Irvine; Yi Khuan; Ho Shu Ming; Aoife Fitzpatrick; Gráinne Ryan; Trishna Prashar; Jenny Forde. FRONT: Rosie Donnellan; Alana Power; Maeve O'Farrell; Saoirse O'Connor; Edel McSweeney; Claire O'Leary; Ellen Desmond; Anne Marie O'Connor; Caroline O'Shea; Min Seo Jung; Layal al Fardan.



BDS (SECOND YEAR)

BACK: Jun Xiang How; Eoghan Flynn; Armin Yaghoubian; Suzanne Kennedy- O'Shea; Lisa Daly; Victoria Babarinde; Saoirse Cantillon; Conor Lynch; Grzegorz Brycki; Bogdan Coca; Michael Zhao; David McMahon; Richard Adepou; Kyle Pritchard; Jason Tupper. SECOND: Daniel Chia; Janine Koutsaris; Elizabeth Ross; Síofra Murphy; Patrice Curtin; Danelle Doyle; Méabh Mulcahy; Sydney Saikaly; Anthony Bui; Oonagh Coughlan; Niamh O'Gorman; Caoilfhionn Ní Choileain; Eliza Caminschi; David Charrette. THIRD: Denise Choong; Aisling Wallace; Aisling O'Sullivan; Alizeh Zaffar; Sarah Jameel; Aisling O'Regan-Reynolds; Sana Khan; Alison Quirke; Maeve Barry; Laura Murphy; Laura D'Arcy. FRONT: Sinéad McKenna; Laura Baker; Christelle Erdmann; Marcia Domingos; Lindsay Raoufi; Hassan Al-Saffar; Chee Hon Chan; Daniel Browne; Denny David.



BDS (THIRD YEAR)

BACK: Shannon Godfrey; Brídóg Griffin; Aoife Barry; Rachel Sinclair; Danny Coghlan; David O'Farrell; Michael Healy; Thomas Minkov; Róisín Phelan; Carmel Canavan; Greta Fitzgerald. THIRD: Eva Taaffe; Li Ying Mah; Iomar Kearney; David Askan; Aidan Ahern; David McDonnell; Garibaldi Lazaryev; Irtaza Malik; Leanne Houlihan; Jacqueline Dineen; Meabh Long; Clare O'Connell. SECOND: Divya Moorthy; Oscair Connolly; Damien Smith; Amanda Louise; Aleena Bhatti; Aoife Lynch; Bebin Ní Chéilleachair. FRONT: Nur Amalina Malek; Geraldine Gilman; Aoife Brouder; Eyllsa Chan; Shannon Hoi; Veronica Ghazarian; Aylin Uretici; Maeve Ní Bhriain.



BDS (FOURTH YEAR)

BACK: Gráinne Hurley; Máiréad Hennigan; Daniele Ryan; Deirdre Ní Donnchaha; Paul Hanlon; Sunil Persaud; Brian Ryle; Adib Salleh; Neil Bermingham; Damian Brycki; Sam MacCarthy; Mat Mook Sang; Mohammed Hamza; Pouya Bagheri. THIRD: Lisa Madden; Eimear Neilan; Aideen Buckley; Niamh O'Mahony; Allison Walsh; Samantha Michael; Jane O'Regan; Krystell Chiu; Nadine Smith; Ozma Khusbakth; Narina Maharaj; Wani Roslan; Musfir Mohammed; Vafa Lightfoot; Sana Askary; Eamon O'Farrell. SECOND: Rhona Lynch; Hanan Al Qatari; Andrea Cheung; Conor Gill; Yong Yong Foo; Jasjyot Panesar; Jeorme Koh. FRONT: Kaumal Baig; Dora Sarrouf; Niamh Moore; Máire Flanagan; Laura Shepherd; Jill O'Driscoll.



BDS (FIFTH YEAR)

BACK: Philip Doherty; Conor Cremin; Ali Khan; Bernard Mullan; Patrick O'Connor; Kieran Moriarty; Jamie O'Doherty; Bobby Tan Chein; Musab Madi; Simon Treacy; Chris de Souza. MIDDLE: Farrah Awan; Ellen-Gene Long; Marie Donnelly; Maeve McElligott; Nisha Sandu; Rohshini Vennu; Claire Neville; Maria Hughes; Shauna McCarthy; Claire Murphy; Jenny McCarthy; Ciara Drummond; Helena Casey; Alexandra Hunter; Kathryn Traynor; Anita O'Connor; Aysha Khan; Karen McQuail. FRONT: Kok Yin Li; Lim Li Shan; Nicole Fraser; Sofia Shaik; Bojana Ivanisevic; Gabrielle O'Donoghue; Kevin O'Connell.



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The complete dentist

The demands on today's dental students – and dental educators – are high, but Dean of the Dublin Dental University Hospital PROFESSOR BRIAN O'CONNELL feels that the future is bright.



Professor Brian O'Connell.

From his third-floor office in the Dublin Dental University Hospital (DDUH), Professor Brian O'Connell can see both the green spaces and historic buildings of Trinity College Dublin, of which the Dental School is part, and the buildings and rooftops that represent the wider city, where the 100,000-plus people who seek treatment every year in 'the Dental Hospital' are drawn from. It's a fitting illustration of the dual function of the institution he represents as Dean – where academic considerations meet the day-to-day practicalities of offering excellent dental care to the public. The role of dental education in preparing students primarily to care for people, and to be a crucial part of general healthcare in Ireland, is extremely important to Professor O'Connell, and is a theme we return to several times during our conversation.

Ann-Marie Hardiman
Journalist and sub-editor with
Think Media



A well-rounded education

Unsurprisingly, he praises the calibre of student coming to the School, and is proud of its diversity, with one-third of students coming from non-EU countries.

"I think the graduating students are better than they ever have been. They've a better, more rounded education, and are generally well equipped to go out into the world."

These days, providing that well-rounded education means more than just covering the clinical topics, vital though that is. The need to ensure that graduates have the communication and business management skills to complement their clinical skills is something Professor O'Connell is very conscious of. The Dublin School's efforts in this regard will include a module on preparing for life after college, and involvement in the GradLink Programme in TCD, which links final-year students with volunteer mentors in the community. "It's just a start and something we would like to build on, but you're constrained by the curriculum – there are so many other things to do."

Dublin Dental University and Hospital

Founded in 1899
Part of Trinity College Dublin

Dean: Professor Brian O'Connell

Disciplines: Public and child dental health; Restorative dentistry and periodontology; oral surgery, oral medicine and oral pathology; and, oral biosciences.

Offers	Number of students
Dental Science	209
Diploma in Dental Hygiene	19
Diploma in Dental Nursing	46
Professional Certificate in Ortho Therapy	8
Dental Technology (BA)	15
D Ch Dent	16
Research Postgraduate	20
Diploma in Concious Sedation	8
Clinical Dental Technology Diploma	8
Certificate in Dental Radiography	11

Number of staff: 210 FTE including: clinical and non-clinical academics, consultants; NCDs; dental nurses and support staff.

Patient visits: 123,000 c. per year

Research Major strands in basic and translational research, especially oral microbiology, dental materials sciences, and periodontology with implantology.



DIVISION I PUBLIC AND CHILD DENTAL HEALTH ACADEMIC AND CLINICAL STAFF

BACK: Dr Alison Dougall; Dr Caoimhin MacGiolla Phadraig; Dr Darius Sagheri; Dr Brett Duane.

FRONT: Dr Thérèse Garvey; Kirsten Fitzgerald; Dr Anne O'Connell, Head of Division; Helen Farrelly; Karen Dineen.

The curriculum takes up a massive 5,000 hours, so finding space for everything is an ongoing challenge. Sometimes, the question is not what to include, but what to let go, and the School is currently undertaking a major review.

"We're looking at every part of [the curriculum], so we can get a better handle on exactly how it maps on to the areas of competence that we're trying to deliver. For example, you might find that something like prevention, or salivary health, is taught two or three times in different areas, so you might change that to one area, and use that time for something else."

This is the first time in some years that such an audit has been carried out in the School, but Professor O'Connell says that the staff have taken it on enthusiastically.

"We're all very aware that there are fewer people now trying to do more. It's not just that we have more students, but we have more areas to cover; during the recession we had a lot of staff retire early, and most have not been

Specialty training and CPD

The School runs an impressive range of specialty training programmes – in oral surgery, orthodontics, paediatric dentistry, prosthodontics and periodontics, among others. These three-year taught doctoral degrees are a big part of the School's offering, and have measurable benefits, as Professor O'Connell explains.

"Firstly, it generates a lot of research because all of those students do a thesis. Secondly, in contrast to the undergraduates, most of the postgraduates stay in Ireland and teach, and they are among the best teachers that we have."

The School also has a refreshingly modern and collaborative approach to CPD. "We haven't emphasised it quite so much in recent years because, quite honestly, a lot of other groups – the IDA, the RCSI, the IFPDC – are providing excellent continuing education, particularly of a less formal type. So we made a conscious decision not to try to compete in that space and to focus on things that we are good at, for example running hands-on courses."



DIVISION II RESTORATIVE DENTISTRY AND PERIODONTOLOGY ACADEMIC AND ADMINISTRATIVE STAFF

BACK: Rose Glacken; Dr Ioannis Polyzois; Dr Philip Hardy; Dr Michael O'Sullivan; Dr Jeff O'Sullivan; Dr Peter Harrison; Dr Brendan Grufferty.

FRONT: Deborah O'Gorman; Cathy Dillon; Prof. Brian O'Connell; Dr Denise MacCarthy, Head of Division; Cathy Gorman; Yvonne Howell.

replaced. Everybody wants to make the best use of their time."

This is the first mention of the dreaded 'R' word, and Professor O'Connell is keen to say that while losses during that period were difficult, recruitment is beginning, and there are advantages to the 'new broom'.

"We've lost a lot of institutional memory, but every institution has to go through periods of rebuilding, so there's a genuine opportunity now to bring in a new generation who will take things forward, hopefully to an even better place."

Training the team

The student cohort now comprises the dental team of dental nurses, hygienists, clinical dental technologists and orthodontic therapists, and integrating these disciplines is an important element of education here.

"I think this is probably the only place where we train everybody in the dental team together, so we try very much to give everybody an exposure to working in the dental team. It's something we want to develop for the future."

He speaks very highly of the enthusiasm and passion of the students in the 'newer' disciplines.

"The people involved with some of the newer programmes are amazingly enthusiastic about what they're doing, maybe because they are the newcomers in a sense. They have a passion for what they do and an excitement that sometimes in dental science we would do well to be reminded of."

Professor O'Connell sees teamwork as extending beyond the doors of the School, or even the dental practice.

"I would hope that the dentists of the future will be seen more as part of a primary care team for patients and my dream, if I were to have one, would be that the public will view their dentist as someone who is involved in looking after and promoting their health, as well as somebody who can do wonderful things to make your teeth look nice!"

He feels that this is already beginning to happen.

"Anecdotally, I hear that a lot of doctors, since the introduction of free GP care for under sixes, are seeing more children with dental problems, and they don't know what to do with them. If we had a bit of joined up thinking here [in regard to healthcare policy] and dentists could be seen as part of that health spectrum, I'd be very happy."



DIVISION III ORAL SURGERY, ORAL MEDICINE AND ORAL PATHOLOGY
 BACK: Tanya Nolan; Dr Anna Beattie; Robert Weld-More; Prof. Leo Stassen; Saleh Al Kadi; Kiera Malone.
 MIDDLE: Dr Veronica Fisher; Dr Mary Clarke; Dr Mary Collins; Daphne Halley.
 FRONT: Katherine Gray; Dr Claire Healy, Head of Division.



DIVISION IV ORAL BIOSCIENCES.
 BACK: Dr Gary Moran; Dr Hannah Boyle; Prof. Derek Sullivan; Alexandros Lazaris; Dr Maria Boyle; Dr Emily Deasy.
 MIDDLE: Aoife O'Connor; Peter Flanagan; Megan Earls.
 FRONT: Prof. David Coleman, Head of Division; Dr Mary O'Donnell.
 Not pictured: Dr Anna Shore; Dr Peter Kinnevey; Dr Gary Fleming.

Life after school

Of course, in order to be part of this vision, dentists must first graduate and begin their practice. The vast majority of dental science graduates become general dental practitioners, but a sizable number begin their careers outside Ireland, and this is a source of concern. "We still unfortunately lose too many graduates early on who emigrate. Most of them come back, but it says something about the state of dentistry at the moment that we don't have enough attractive opportunities for graduates, at least at first."

There has been much discussion about the lack of a vocational scheme for graduating dentists, and it's worth asking if this is a reason for the high emigration rates, but for Professor O'Connell it's not so simple.

"I think that's part of it, but a lot of people go to places where there isn't a vocational scheme. I think that having some sort of transition to practice after graduating would be useful. That's where I would really like to see the business training and mentoring, in a supervised year where people could have support. They do it in other professions, such as law, accounting and so on: you're in the workplace but you're still completing part of your training. I think something like that could be more suitable to the Irish situation."

He acknowledges that graduates now are entering a very different business environment, and a different regulatory environment, than existed heretofore, and this presents particular challenges for them, and for the educators who prepare them. He is all too aware that students see their ambitions and future prospects very differently to their predecessors'.

"A lot of dentists are looking at a model, be it a company or a multiple, that takes care of the business side, so they can focus on the dentistry. For some people that's very attractive. There's no one size fits all anymore."

There is also the small matter of rapidly advancing technological change, and the need to adequately prepare students for that. Indeed, on the day of our interview, the School was taking delivery of its second digital system, and there are plans to introduce a digital workflow over the next couple of years.

"Hopefully in five years' time almost everything will be scanned and digitised in the same way that 10 years ago we were still doing film radiographs and now everything is done electronically. You have to try to give people enough of the old skills that they can get out in the workplace, but also at least an insight into the new skills so they can adapt when they graduate."

There are, of course, huge costs associated with these innovations.



DENTAL NURSING TEAM

BACK:
 Carol Edmonds; Louise Madden; Helen Farrelly; Hayley Glynn; Jannette Lantry; Sean Phelan; Alistair Coogan-Martin; Natasha Smith Kennedy; Elaine M. Byrne; Emily Hayes; Karen Dinneen; Elaine Byrne; Eleanor Greene.

FRONT:
 Carol Treacy; Pascaline Fresneau; Joan Brennan; Marinele Uldedaj.

"We need everything and we need lots of everything! That's part of the challenge of running an institution like this. We're constantly struggling for funding from our different funding bases."

Where to now?

The DDUH, as stated earlier, is engaged in a process of rebuilding, not unlike dental practice in the community, and Professor O'Connell is aware of the parallels. "We've managed, like many other places, to do more with less and people have been fantastic and have found new ways of working and so on. But in the last six months there's definitely a sense that we're looking more forward than back." "I do sense also that practices are getting busier again. Patients have always been aware of their oral health but are now maybe a little more confident of spending their discretionary income on it."

So if he got a blank cheque tomorrow, what would be the priorities?

"We would focus on keeping the curriculum up to date, making sure we have the skills in place to deliver across the board."

He is confident about the young people that the DDUH is sending out into the world, and has strong views on what makes a good dentist.

"A good dentist I think is somebody who is professional – they put the patient's interest first, and they're genuinely interested in helping people. The rest is small stuff! If dentists engage with people, I think they will serve the public extremely well. Our students are extremely bright, extremely capable and want to do a great job. I think you can have faith that they'll look after us."



SUPPORT SERVICES COMMITTEE

BACK: Joan Brennan; Susanne Hanlon; Grainne Broderick; Katherine Grey; Isobel Fleischman; Robert Mulhall; Ita Goggin; Cheryl Judge-White; Dave Barry; Dr Mary O'Donnell. MIDDLE: Jimmy Swan; Audrey Nolan; Deborah O'Gorman; Emer McManus; Susanne Bushe; Cathy Doyle; Gemma Cassidy. FRONT: Joyce Power; Pat O'Boyle, CEO; Paul Walters.



CSSD SERVICES

Edel Dunning; Noemi Carnevale; Inga Sirvinskaite; Niamh Balfe; Agnes Wayda; Susan Fleming; Suzanne Hannon, Manager; June Dowling.



CORPORATE SERVICES AND SUPPLY AND PURCHASING TEAM

Stephen Ryan; Cathy Doyle; John Lambe; Joyce Power.



IS SERVICES

Ciaran McCarthy; Robert Mulhall, IS Manager; Stephen Cahill-Kennedy; Phelim Lunny. Not pictured: Neil McDermott; Eamonn Byrd.



FACILITIES MANAGEMENT TEAM

Declan Clarke; Tony Foster; Jimmy Swan; Damien Geoghegan; Mark Rooney; Paul Scanlon.



HOUSEKEEPING AND PORTERING SERVICES TEAM

Frank Keane; Laurence Shannon; Christy Kavanagh; Tommy Shannon; Pat Murray.



PATIENT SERVICES

*BACK: Catherine Lambert; Derek Brunell; Hilary Boylan; Gabriella Haltichi; Emer McManus; Ian Fox; Shona Battigan; Paschal Browne.
FRONT: Lyndsey Farrell; Breda McCann; Bernadette Hennessy; Susanne Bushe, Patient Services Manager; Laura Wall; Carol Spain; Lina Yin.*



X-RAY TEAM

Caroline O'Shea; Susan Anderson; Michelle Scott.



PROFESSIONAL DIPLOMA IN ORTHODONTIC THERAPY

*BACK: Kasia Gorczynska; Aoife McGlade; Laura Dunning; Trish Cawley.
MIDDLE: Natalie McGettigan, Course Administrator; Norita Owens; Rachel Noonan; Lynsey Dyer.
FRONT: Dr Darius Sagheri, Course Director; Niamh Dowling.*



ADMINISTRATION SERVICES

*BACK: Margaret Forbes; Ann-Marie McGrath; Audrey Nolan; Catherine Creagh; Mandy Lockhart; Cheryl Judge-White; Claire Fitzpatrick.
MIDDLE: Fiona O'Neill; Sharyn Long; Natalie McGettigan; Paul Walters.
FRONT: Sarah O'Loughlin. INSET: Diana Grove.*

Research and rankings

On the research front, the School continues to perform strongly in terms of publications and citations. This is vital in these days of international rankings, which place enormous pressure on institutions. Characteristically, Professor O'Connell sees the positives.

"I think in general our dental education is very good and stands up to anywhere in Europe, but of course what rankings measure is mainly research output, so smaller schools will always tend not to do as well. But we're very flexible – we can change things and be responsive to the needs of the students, which is something you don't always see in bigger systems."
"One of our strategic priorities over the next four or five years is to increase

the momentum in regard to research, to replace some of what we lost and get the ball rolling again."
The Dublin School has traditionally performed strongly in areas like microbiology, dental materials, and quality of life and special care. Professor O'Connell hopes that an upcoming staff retreat, where research priorities will be reviewed, will help to set the agenda for the next five years.



POSTGRADUATE STUDENTS

BACK: Saleh Alkadi (oral surgery); Robert Weld-Moore (oral surgery); Michael O'Sullivan (Postgraduate Director of Teaching & Learning); Mark McLaughlin (periodontics); Mohammad Alotaibi (periodontics).

MIDDLE: Rory Boyd (prosthodontics); David McReynolds (prosthodontics); Catherine Creagh (Postgrad Administrator); Lina Khasawneh (prosthodontics).

FRONT: Areej Alqadi (paediatric dentistry); Samira Al Anqdi (prosthodontics); Daphne Halley (oral surgery); Fatimah Meshikhes (restorative attachment).

Not pictured: Keira Malone (oral surgery); Thikrayat Bani Hani (paediatrics); Nurul Ishak (special care dentistry); Lubna Al Ghazal (periodontics); Aida Ben Cheikh (orthodontics); Fatmah Aljumah (orthodontics).



DENTAL TECHNOLOGY YEAR 1:

David McCarthy; Bernadette Shannon; Kiran Mehdi; Sarah O'Connor.



DENTAL TECHNOLOGY YEAR 2:

Cristina Timbaliuc; Sean Foley; Dana Klavina; Kaja Kasperski (seated); Cristina Rodina. Not pictured: Iga Bialek.



DENTAL TECHNOLOGY YEAR 3:

Emma Delaney; David Flannery; Marta Ratajczak; Paulina Buczowska.



DENTAL HYGIENE, YEAR 1:

BACK: Meaghan O'Loughlin; Sonia Ani; Louise Howard; Maeve Kenny; Ieva Simaite; Mustafa Shirzi. MIDDLE: Natalie McGettigan, Course Administrator; Aoife Malone; Stacey Shortall; Ieva Ragulyte. FRONT: Shauna White; Yvonne Howell, Course Director.



DENTAL HYGIENE, YEAR 2:

BACK: Sviatlana Anishchuk; Cliodhna Caffrey; Lukas Bauza; Natalie McGettigan, Course Administrator; Delia Maierean. MIDDLE: Erhuvhu Agbanobi; Rebecca Carey; Ruth Metcalfe; Christine Duffy. FRONT: Sharon McDonagh; Yvonne Howell, Course Director.



DIPLOMA IN DENTAL NURSING YEAR 1
 BACK: Lorraine Sharkey; Ruth Hanlon; Mercy Tennyson; Sarah Quigley; Klaragh Fitzpatrick; Stacey Carter; Janet Babalola; Sarah McDonald; Lisa Browne; Lisa Nica; Carine Tiesoh; Daniella Kooh; Tosin Adebayo.
 MIDDLE: Katy Moylan; Faye Rooney; Ayah Malapad; Karen McEvatt; Diana Molocnaja; Vilte Jankunaite.
 FRONT: Melissa Maharaj; Sinead Farrelly; Aoife Wilson; Helen Farrelly, Dental Nurse Tutor; Karen Dinneen, Dental Nurse Tutor; Samantha Aldemita; Jamae Ardinez.



DIPLOMA IN DENTAL NURSING YEAR 2
 BACK: Karen Dinneen, Dental Nurse Tutor; Mariam Kheshelashvili; Rayan Abdi Rehman; Harcel Sastrodemedjo; Amy Byrne; Pricilla Adalakun; Kayleigh Nolan; Shareen Doherty; Daisy O'Sullivan; Valerija Goga; Helen Farrelly, Dental Nurse Tutor.
 FRONT: Kelsey Bolger; Catherine Courtney; Rebekah Conlon; Noelle Shebani; Laura O'Rourke; Brona Evans.

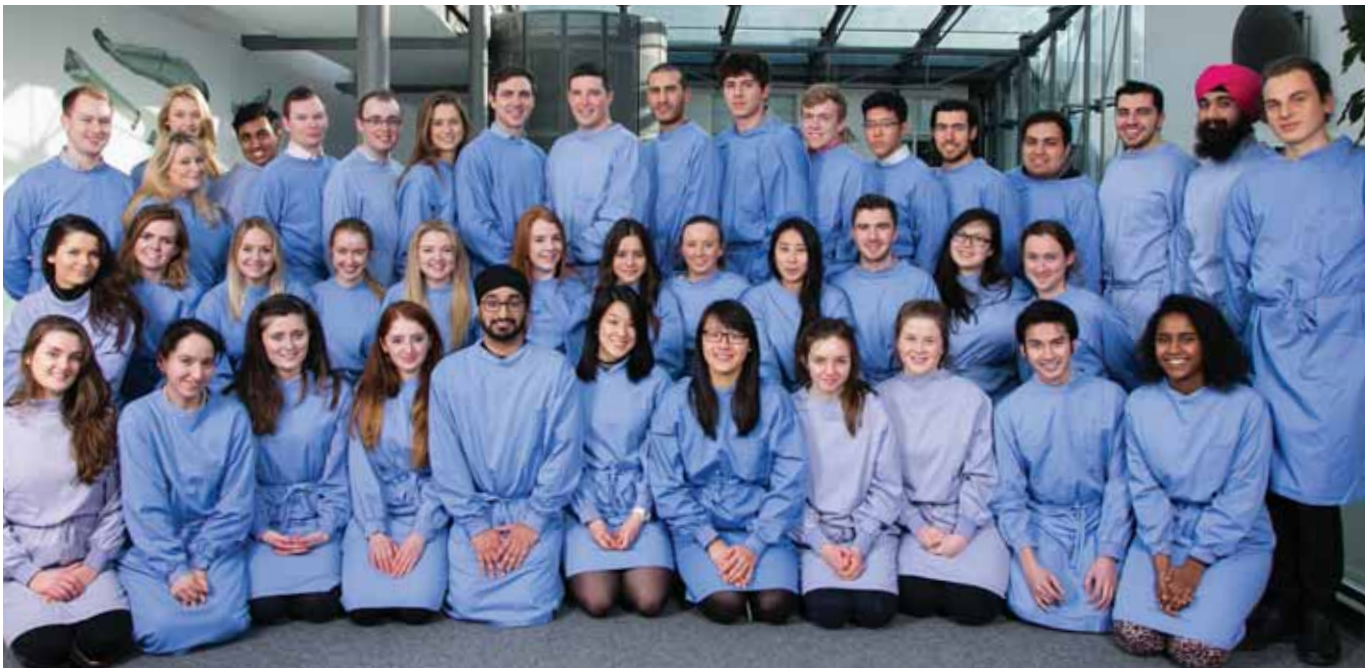


DENTAL SCIENCE YEAR 1
 BACK: Christina Van Bakel; Daniel Merrick; Holly Porter; Aoibhinn Joyce; Samher Jassim; Summit Patel; Mukthar Fadl Elseed; Safeena Niazi; Ayushi Anna Dinesh; Lubna Abouhajar; Daniel Kane; Maitray Varma. THIRD ROW: Hermela Teclé; Natalia Toiu; James Guinness; Matin Tohidi; Rehman Javed; Rayan Kosnik; Emily Sheehan; Cormac Hegarty; Michael Clarkson; Aoife Burke; Alison Long; Afzal Muhammad Ismail; Hanan Husain; Simbiat Ainike Sanni; Isabelle Xing Yi Lim. SECOND ROW: MD Shahed Ahmed; Chieun Wei Foo; Lulu He; Grainne Gillespie; Iriene Sebastian; Aoife Hutchinson; Muhammad Saad; Amna Saqib; Emma Hanson. FRONT: Fiona Rickard; Aoife Catriona Burke; Yang Gin Ting; Katie Duffy; Eabha Cronin; Stephen Taylor; Mary Finnegan; Jeevan Mattu; Taylor McLean; Wei Shyan Tan; Shin Ling Yip; Valerie Valiquette.



DENTAL SCIENCE YEAR 2

BACK: Astbrak Alkadhimi; Jia-Liang Eow; Nathan Nitsopoulos; Ciaran Ryan; Mohammed Jalal Khan; Mohamed El Azrak; Roisin Meade; Siobhan Gardiner; Rachel Birt; Caoimhe Hanna. THIRD ROW: Emma Mulville; Adeen Solaiman; Usman Hussain; Abdullah Jamal; Leonardo Collazo; David Hendrick; Marc Sweeney; Michael McClure; Christopher Coakley; Mazin Mohamed; Mohamad Kadhim. SECOND ROW: Maria Farag; Grace Girgis; Kanan Patel; Gayatri Madhukumar; Alice Bowen; Martha Keaney; Niamh O'Kelly-Lynch; Natasha Lemasney; Catherine O'Neill; Jelena Djokic. FRONT: Orla Askin; Annie Hughes; Madeleine Edmonds; Roumaissa Slami; Mihaela Stamatova; Rawan Kahatab; Jade Quearney; Katherine McKee; Mary Diffley; Shauna Quigley. Not pictured: Joshua Cheng; Re Na Ang; Cornelius Tan; Fiachra Maher.



DENTAL SCIENCE YEAR 3

BACK: Liam Costello; Grace McClintock; Roisin Brady; Vignesh Eswara Murthy; Conor Lynch; Barry Patton; Caoimhe McKenna; Barry Comer; Michael O'Halloran; Omar El Baradie; Mohammed Emin Shiren; Cian Lambert; Hyeongin Lee; Matteo Cremonese; Jamshaid Butt; Rafik Zaky; Jeeven Singh Dooa; Enea Nastri. MIDDLE: Alison Browne; Bronagh Keane; Lyndsay Aiello; Grace Daly; MollieAnn Gallagher; Ciara Sweeney; Ioanna Politi; Mairead Kelly; Lily Wang; Maurice Treacy; Rebecca Ngo; Robyn Crowley. FRONT: Jenna Pierce; Zeena Hassoon Al Sarraf; Alison Ryan; Sarah Behsanger; Shubhkaran Panesar; Shi Rui Chua; Yee Shi Yin; Delia Smyth; Orla McPhillips; Aliff Syazaryl Azhar; Hamna Maheen. Not pictured: Tatiana Lie Kumagai; Lauren McHugh; Hamna Maheen; Emma McShane.



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When I'm not working I enjoy spending time with my husband Colin and, being quite a social person, I love catching up with friends. To de-stress I also enjoy going to the gym and circuit's classes and love my holidays and weekends away!

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MIKE

For anyone who may not know or have not met me yet my name is Mike Connolly and I am the sales representative covering Dublin and the surrounding counties. I have been with BF Mulholland for the last year and I have been active in

the dental industry for the last 12 years. I find the dental field a constantly changing and challenging industry and love to be a part of it.

I am married to Audrey and have two lovely children Alex aged 10 and Ellie aged 6 and they keep us both busy and keep me young at heart but leave little spare time at the weekends. However in my spare time I am a movie buff and enjoy hill walking and outdoors activities with the children.

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NOEL

My name is Noel Lucy and I am a field sales representative for BF Mulholland. Having worked as a Pharmaceutical Medical representative for 18 years, I transferred into the dental industry in 2007. I have really enjoyed the new challenges. It has been great to work with BF Mulholland as there is a very nice family atmosphere within the company. Our competitiveness and next day delivery has given me a good advantage.

I live in Cork city with my wife Rosemary and our four year old Springer spaniel dog "Millie." We both love sport and play tennis regularly. Munster rugby is one of my great loves and I travel regularly to matches home or away. I have refereed Rugby for over 25 years and latterly have been involved in Schools and juvenile refereeing, which gives me great satisfaction as many of these players have gone on to gain representative honours. I am also an avid Skier and like foreign travel.

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CHGBI/CHSENS/0038/14(2)



Education – six themes that make a difference

A personal view on education and training.

One of the first questions colleagues from Dental Protection ask delegates when they are delivering education is “why are you here?” The response is frequently: “To avoid being sued or avoid complaints”. It is hardly surprising that one of the most challenging events in a dental career is to be the subject of a patient complaint or a claim. For most dentists, this distressing event might arise once or twice in a career. Unfortunately, for some the frequency is significantly greater. The key to reducing or avoiding complaints or claims is, in my view, education and training.

When deciding what to include in your professional development plan to help you reduce risk, the variety of education programmes can be daunting. Should you choose areas where you have acknowledged weaknesses or the areas that interest you most? When it comes to risk, a broader approach will bring into focus a more comprehensive understanding of the various areas where such challenges arise.

What really creates risk?

Clinical competence is a key prerequisite to successful dentistry; however, the real drivers of risk, as far as litigation is concerned, are frequently referred to as predisposing factors. These will often arise from the interpersonal relationship between the healthcare provider and the patient. The relationship between negligence outcomes and litigation are poorly documented. There is, however, evidence to suggest that those dentists with poorer interpersonal and risk management skills get more complaints or claims. In a way, this is good news



because these are skills that can be learned by most people. That is the approach taken by Dental Protection in designing its current educational programmes.

What are the most effective strategies?

There are six key areas for professional development that support the educational foundation built up through undergraduate training. These are illustrated in the graphic above.

In summary, six key areas of education and training can make a very significant difference to your risk profile. Most of the subjects above are optional, but if you are going to take a holistic approach to risk, they are all an important part of that professional development cycle.

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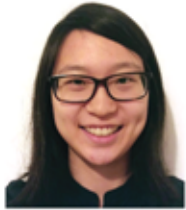
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John Tiernan BA BDentSc DGDP(UK)

John is the Director of Educational Services, for Dental Protection.



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The role of saliva in promoting oral health

Denise Choong, Second Year Dental Undergraduate Student, Cork University Dental School

Abridged version of the winning submission to the Wrigley Oral Healthcare Programme 2015 Dental Undergraduate Essay Competition at Cork University Dental School and Hospital. Edited by Denise Choong and Prof. Anthony Roberts, Professor of Restorative Dentistry, Cork University Dental School & Hospital.

Oral health is an indispensable component of the overall well-being of an individual and an important determinant of oral health is saliva. Saliva, a dilute fluid made of 99% water, is mainly secreted by the parotid, sublingual and submandibular glands (90%), although minor salivary glands also contribute (10%).¹ The remaining 1% comprises inorganic and organic molecules, such as electrolytes and proteins, respectively. Diet, circadian cycles and olfactory stimulation influence saliva flow rate, which in turn affects salivary content and function.

Saliva has a broad range of functions, which may be summarised as:

Maintaining tooth integrity: Saliva maintains the integrity of hard tissues of the oral cavity, defending against dental diseases such as caries by balancing demineralisation and remineralisation of the hard tissues. Salivary proteins such as histatins and acidic proline-rich proteins inhibit the formation of calculus² and protect the teeth against dental caries.³

Digestion, taste, protection and wound healing: The viscous and adhesive nature of mucin in saliva lubricates the oral cavity, speeding up physical and chemical digestion of food through the digestive system. Furthermore, saliva dissolves food substances, allowing the taste buds to recognise the foodstuff. Saliva keeps the oral cavity moist, thereby protecting the tissues of the mouth against irritants such as proteolytic and hydrolytic enzymes.⁴ Additionally, salivary proteins enhance wound healing by accelerating blood coagulation and influencing wound contraction.

Antimicrobial action: Saliva secretes immunologic and non-immunologic agents that protect the teeth and soft tissues. Immunoglobulin A (IgA) is the largest immunologic component of saliva. It enters the oral cavity through the duct cells of the salivary glands. IgA inhibits bacterial attachment to host surfaces⁵ and prevents foreign antigens from entering the mucosa.⁶ The production of IgA is boosted by α -defensins and β -defensins,⁷ and these defensins disrupt the cellular and mitochondrial functions of bacteria. Non-immunologic peptides such as salivary mucins form a protective layer over tissues of the oral cavity. Together with histatins, they aggregate bacteria and reduce its ability to adhere to these tissues.⁸ Enzymes such as lactoferrin and lysozymes destroy microbes by depleting their food source⁹ and breaking down their cell walls. These enzymes also aggregate bacteria, hence promoting its clearance.

Buffering action and oral clearance: The buffering systems in saliva

allow the rapid adjustment of the pH within the oral cavity to inhibit the growth of pathogens, and maintain the equilibrium between remineralisation and demineralisation throughout the day. Saliva plays a role in oral clearance by diluting and removing bacteria and food debris from the oral cavity. Disturbances in buffering and oral clearance have the potential to lead to caries due to a shift towards demineralisation. Further, the pH changes that accompany changes in salivary flow rates influence the antimicrobial actions of saliva, having a direct effect on putative bacterial pathogens.

Clinical relevance

The importance of saliva is clinically illustrated for patients who present with xerostomia (mouth dryness). Approximately 20% of the population suffers from insufficient saliva flow, resulting in xerostomia. Dry mouth is becoming increasingly common in older populations, possibly due to age-related salivary gland degeneration, but often as a side effect of medications or therapies such as radiotherapy. Xerostomia may lead to periodontal disease, desiccation of the soft tissue, halitosis, dental caries and denture retention/comfort issues, which can affect quality of life.

Conclusion

Saliva is critically important in promoting oral health given its wide-ranging and important functions.

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Results of a survey of current work practices and future aspirations of members of the Irish Dental Hygienists Association, relative to their scope of practice

Précis: Dental hygienists are not given the opportunity to use all of their skills, are enthusiastic about the future, and most would like to continue working in a team setting.

Abstract:

Background: Dental hygienists (DHs) in Ireland have a choice regarding undertaking further training to update their skills to the current scope of practice. No data exists in relation to how many DHs have updated their skills, how often they use these new skills and how confident they are in using them.

Purpose of the study: To identify the percentage of DHs who have the full range of skills currently included in the scope of practice for DHs, and how regularly and confidently they are using these skills. It was opportune to also ascertain if DHs have encountered any barriers to using these skills, and their work practice aspirations for the future.

Materials and methods: An online survey was offered to all members of the Irish Dental Hygienists Association in August 2014 (n=189). The survey, which was piloted and revised, contained 13 questions relating to the profile, current work practices and future aspirations of the DHs.

Results: There was a 52% response rate. Most DHs were confident in their ability to carry out their skills. Some 22% had not updated their skills to include block local anaesthesia (LA). A high percentage of DHs reported never or hardly ever using the skills of block LA (40%), dental radiography (62%), placing temporary dressings (73%), or re-fitting crowns (82%). Reasons for not using these skills were provided by the DHs.

Conclusions: DHs rarely use some of their current skills; however, they are still interested in adding more skills to their scope of practice.

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Catherine Waldron RDH MSc MA (Health Promotion)

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TABLE 1: The questionnaire

1. How long are you qualified?

Less than one year	1-3 years	4-6 years	7-9 years	10-12 years	13-15 years	16+ years
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How regularly do you work as a dental hygienist?

- I am not currently working
- I work less than 1 day a week
- I work between 1 and 2 days a week
- I work between 3 and 4 days a week
- I work 5 days a week
- Other _____

3. Did your original qualification include the following skills

Tick all that apply

- Infiltration local anaesthesia
- Dental radiography
- Re-fitting crowns temporarily
- None of these
- Block local anaesthesia
- Temporary dressings
- CPR

4. Since qualifying have you undertaken a course to update your skills in any of the following? Tick all that apply

- Infiltration local anaesthesia
- Dental radiography
- Re-fitting crowns temporarily
- Other (please give details in the comments section)
- No
- Block local anaesthesia
- Temporary dressings
- CPR

To make it easier when determining how often you use your skills, please base your answer on your last year in practice.

5. Approximately how often do you use the following skills?

Pick the closest answer per row.

Answer	Never	<once in 6 mths	<once in 3 mths	<once a mth	<once a week	<once a day	many per day
Infiltration local anaesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Block local anaesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental radiography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporary dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-fitting crowns temporarily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. How confident are you performing these skills

How confident	Not at all	Fairly	Confident	Very	I don't perform this skill
Infiltration local anaesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Block local anaesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental radiography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporary dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-fitting crowns temporarily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Have you encountered any difficulties/barriers to using your skills in practice – if yes, please indicate in the comments box what difficulties you have encountered.

	Yes	Yes	Yes
No	sometimes	regularly	all the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Have you found it difficult to access courses to update your skills?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	Yes somewhat	Yes very difficult	I have travelled outside Ireland to access a course

9. If the following skills were introduced and training was provided do you think you would use them?

- Suture removal
- Impression taking
- Tooth whitening
- Diagnosing dental caries
- Diagnosing periodontal disease
- Treatment planning within your scope of practice
- Treating patients directly, i.e., without a referral from a dentist
- Prescribing dental radiographs
- Prescribing medications within your scope of practice, i.e., fluoride solutions, antibiotic cover

10. If direct access was to be introduced, how do you see your work practice changing? Please tick your most likely choice.

- I would be an employee of a dentist
- I would work under the supervision of a dentist in a practice but be self-employed
- I would work in a practice with a dentist with both referrals and direct access
- I would set up my own dental practice with direct access
- I would set up a group practice with other dental hygienists with direct access
- I'm not sure
- Other (please give details in the comments section)

11. Have you ever been asked to carry out duties that were outside your scope of practice?

Please list the duties or state 'no' in the comments box.

12. If you have answered YES to Q11 and these duties are not already listed in Q9, do you think these duties should be included in our scope of practice?

13. Are there other duties you would like to be able to carry out?

Please give details.

Introduction

In 1992, as a consequence of the establishment of a register for dental hygienists (DHs) by the Dental Council in Ireland, the first training programmes for DHs were established in the Cork and Dublin Dental University Hospitals. The scope of practice of the DH has expanded to include a number of additional skills since then. These are infiltration anaesthesia (1997), dental radiography (2001) and, most recently, block anaesthesia, placing temporary dressings and re-fitting crowns temporarily (2007). Training courses are provided by the training schools to allow DHs to acquire these new skills.

In Ireland, a DH must be registered with the Dental Council and dental hygiene treatment may only be carried out under the supervision of a registered dentist who has first examined the patient and who has indicated to the DH the course of treatment to be provided. The term “supervision” means that the dentist ultimately retains clinical responsibility for the patient and has a responsibility to ensure that the DH is competent to carry out the treatment indicated in an efficient manner. Direct supervision is required when local anaesthesia is used, or when a patient is being treated under sedation or general anaesthesia. The term “direct supervision” means that the supervising dentist must be on the premises in these circumstances.

Subject to these conditions, the current scope of practice of a DH as stated by the Dental Council is as follows:

1. Confirm medical and dental histories.
2. Record the soft tissue and periodontal status.
3. Clean and polish teeth.
4. Provide supra- and subgingival scaling, including comprehensive root surface debridement, and apply medicaments when indicated.
5. Apply appropriate prophylactic materials, including solutions, gels and sealants, to the teeth and/or gums.
6. Give advice in relation to oral health, including the planning and implementation of oral health promotion programmes, smoking cessation and diet analysis in relation to the prevention of dental caries and personalised plaque control programmes.
7. Re-fit crowns with temporary cement and place temporary dressings when crowns or fillings become dislodged in the course of treatment by a DH.
8. Take and process dental radiographs to the prescription of a dentist (having completed a Dental Council-approved course in dental radiography).
9. Administer local infiltration and block anaesthesia to patients they are treating, to the prescription of a dentist (having completed a Dental Council-approved course in local infiltration and block anaesthesia).¹

The current guidelines on professional behaviour from the Dental Council state that all dentists have an obligation to maintain and update their knowledge and skills through continuing professional development (CPD). There is currently a voluntary scheme for dentists to monitor their CPD while waiting for legislation to make this scheme mandatory.² The Irish Dental Hygienists Association encourages DHs to follow the CPD guidelines provided for dentists by the Dental Council. While anecdotal evidence suggests that DHs are extremely motivated to maintain and update their knowledge, they ultimately have a choice regarding attending further training.

A public consultation process was undertaken by the Department of Health in 2013 in relation to new legislation to replace the Dentists Act (1985) and discussions continue to this day.³ The new Dental Act may introduce some changes to the scope of practice of DHs. Other countries have expanded the

role of the DH and introduced independent practice. No research has been carried out in relation to the extent to which DHs in Ireland use their current scope of practice, how many DHs have updated their skills to include the new skills, and if they would like to see more skills added to their scope of practice. The objectives of this study were:

1. To assess the extent to which DHs in Ireland use the skills in their scope of practice, with particular emphasis on the new skills added.
2. To assess their confidence levels using these skills.
3. To identify any barriers experienced in using these skills.
4. To identify any difficulties in accessing training courses for new skills.
5. To determine if DHs would like additional skills added to their scope of practice.
6. To determine if DHs’ work practice might change if given the option to practice independently.

Methods

This study was carried out as a summer research project by a student DH (Bairbre Pigott-Glynn) from Dublin Dental University Hospital, and was supported by a GlaxoSmithKline scholarship. The research proposal was written by the then dental hygiene programme director (Catherine Waldron). The timeframe to complete the project was three months. The study was a quantitative and qualitative cross-sectional study of a convenient sample – DHs who were current members of the Irish Dental Hygienists Association (IDHA) (n=189) – using a web-based online questionnaire. This was judged to be a timely and cost-effective means of accessing a sample of the full register of DHs in Ireland, which numbered approximately 420 at that time.

The survey questionnaire had 13 questions, which included questions in relation to the profile of the DHs, the skills included in their original qualification, additional skills obtained, confidence levels, barriers and future aspirations (Table 1). Given the lack of data on the thoughts of DHs in Ireland in relation to their work practice, comments were encouraged by the addition of free text comment boxes throughout the questionnaire to provide a small qualitative element to the study. The IDHA facilitated the use of its Survey Monkey account for one month. In this time the questionnaire was piloted to a small group of DHs, amendments based on feedback from this pilot were made, and the final survey link was emailed to the current membership and posted on the members’ section of the IDHA’s website in August 2014 for a period of three weeks. The IDHA was very supportive of the initiative, encouraging members to complete the survey via texts and Facebook posts. The survey was open for three weeks, and a reminder email was sent one week before the closing date.

Results

The response rate was 52% (n=99), with 45% (n=85) answering all questions. Question 5, which related to how often they used particular skills, was skipped by 7% of respondents. A possible explanation for skipping this question was that there was no option provided to answer: “I do not have this skill”. Other questions skipped were more complex and required more thought; it is possible that respondents found the questionnaire too long. Research carried out on response rates to electronic surveys determined the mean response rate to be 39.6% (SD = 19.6%), with this dropping to 34.6% (SD = 15.7%) when all questions were answered.⁴ Based on this information, the response rate for this survey was considered to be good.

Profile

The number of years since qualification was spread evenly over the respondents and ranged from less than one year to 16 years or more. The majority of DHs (47.5%) work three to four days per week, 30% work five days per week, and 6% stated that they were not currently working.

Updating of skills

Of the skills not included in the original 1992 scheme for DHs in Ireland, 75% of the respondents had infiltration LA and 76% had dental radiography included in their undergraduate qualification. Dental radiography training can be undertaken by dental nurses, some of whom subsequently become DHs, which might explain why the percentage of those with this skill is greater despite it being added to the scope of practice more recently than infiltration LA. Only 31% of respondents had block LA included in their undergraduate qualification (Table 2). The skill most commonly updated by DHs is CPR (70%). Some 46.6% had undertaken update training in block LA, and 20% had not undertaken update training in any of the skills listed (Table 3). Given the relatively recent addition of the DH to the dental team in Ireland (23 years), and the multiple changes that have taken place to the scope of practice over these years, it is worth noting that all DHs are not the same. Dentists should make themselves aware of the actual skills of the DHs they employ.

TABLE 2: Which skills were included in the DHs’ undergraduate qualification?

Did your original qualification include the following skills?	Percentage	Number
Infiltration local anaesthesia	74.75	74
Block local anaesthesia	31.31	31
Dental radiography	75.76	75
Temporary dressings	39.39	39
Re-fitting crowns temporarily	38.38	38
None of these	11.11	11

TABLE 3: Continuing professional development taken since qualifying.

Since qualifying, have you undertaken a course to update your skill	Percentage	Number
Infiltration local anaesthesia	36.36	36
Block local anaesthesia	46.46	46
Dental radiography	14.14	14
Temporary dressings	40.40	40
Re-fitting crowns temporarily	41.41	41
Fissure sealants	11.11	11
CPR	69.70	69
Other	5.05	5
No	20.20	20

TABLE 4: How often are the individual skills used?

How often do you use the following skill approx?	Never/hardly ever %	<once every 6 months %	<once every 3-6 months %	<once every 1-3 months %	<once every 1-4 weeks %	<once every week %	<once every day %	Several times a day %
Infiltration local anaesthesia	18.82 (16)	4.71 (4)	2.35 (2)	5.88 (5)	7.06 (6)	7.06 (6)	17.65 (15)	36.47 (31)
Block local anaesthesia	40.00 (34)	2.35 (2)	4.71 (4)	2.35 (2)	10.59 (9)	15.29 (13)	11.76 (10)	12.94 (11)
Dental radiography	62.35 (53)	5.88 (5)	1.18 (1)	3.53 (3)	7.06 (6)	8.24 (7)	2.35 (2)	9.41 (8)
Temporary dressing	72.94 (62)	15.29 (13)	4.71 (4)	2.35 (2)	1.18 (1)	2.35 (2)	0.00 (0)	1.18 (1)
Re-fitting crowns temporarily	82.35 (70)	11.76 (10)	2.35 (2)	3.53 (3)	0.00 (0)	0.00 (0)	0.00 (0)	0.00 (0)
Fissure sealants	23.53 (20)	16.47 (14)	7.06 (6)	7.06 (6)	9.41 (8)	16.47 (14)	4.71 (4)	15.29 (13)
CPR	95.29 (81)	4.71 (4)	0.00 (0)	0.00 (0)	0.00 (0)	0.00 (0)	0.00 (0)	0.00 (0)

Other training and continuing professional development (CPD) undertaken by DHs included the Specialist Certificate in Oral Health, the Diploma in Health Promotion, business management, air polishing, impression taking, tooth whitening, periodontal root surface debridement, implant maintenance and oral cancer screening.

Use of skills

Of the skills added to the scope of practice, the most commonly used skill was infiltration LA, with 36.5% using this skill several times a day, and another 18% using it several times a week. The least used skills were re-fitting crowns temporarily (82% never or hardly ever used), placing temporary dressings (73% never or hardly ever used) and dental radiography (62% never or hardly ever used) (Table 4). The skill of applying fissure sealant was included in the list of skills as a comparison, as it is a skill that was included in the original scheme but is used to varying degrees by DHs depending on the type of practice/clinic they are working in.

The reasons given in the free text comments section for not using the skills included: working in a paedodontic practice/clinic so not requiring the full range of skills, especially LA; the opportunity not arising; and, the skill being performed by other team members (dental radiography). The issue of maintaining competence in little used but necessary skills is relevant in many professions, including dentistry. The identification of CPD core topics for DHs, which would include these skills, might help DHs in retaining their competence.

Confidence levels

Levels of confidence appear to be linked to how often the DHs use their skills. There were moderate levels of confidence reported for the lesser-used skills, with only 60%, 66%, 67% and 75% saying that they were fairly confident, confident or very confident performing block LA, re-fitting crowns, placing temporary dressings or taking dental radiographs, respectively. This is compared with 93% being fairly confident, confident or very confident placing fissure sealants (Table 5). These findings highlight the need for CPD to retain competence in the lesser-used skills.

Difficulties or barriers

When asked if they had encountered difficulties or barriers using their skills in practice, 68% responded “no”, 26% said “yes, sometimes”, 4% said “yes,

TABLE 5: Confidence levels.

How confident are you when performing these skills?	I don't use/ have this skill	Not at all	Fairly	Confident	Very
Infiltration local anaesthesia	4.71% (4)	7.06% (6)	7.06% (6)	22.35% (19)	58.82% (50)
Block local anaesthesia	23.53% (20)	16.47% (14)	15.29% (13)	15.29% (13)	29.41% (25)
Dental radiography	24.71% (21)	20.00% (17)	23.53% (20)	17.65% (15)	14.12% (12)
Temporary dressing	23.53% (20)	9.41% (8)	21.18% (18)	27.06% (23)	18.82% (16)
Re-fitting crowns temporarily	23.53% (20)	10.59% (9)	28.24% (24)	23.53% (20)	14.12% (12)
Fissure sealants	7.06% (6)	0.00% (0)	10.59% (9)	21.18% (18)	61.18% (52)
CPR	8.24% (7)	9.41% (8)	41.18% (35)	28.24% (24)	12.94% (11)

regularly” and 2% said “yes, all the time”. Details to explain a positive response given in the free text comments included not being referred patients with a need for the skills, lack of opportunity to use the skills, losing skill and confidence due to lack of opportunity to use the skill, appointment times too short (for block LA, dental radiography), other team members performing the skill (taking dental radiographs, fissure sealants, severe periodontitis cases), the need for a prescription for some skills (LA/dental radiographs), and the need to have a dentist on the premises when using LA.

The DHs were asked if they had ever been asked to carry out duties that are outside their scope of practice and, if so, to give details. They were instructed to include duties that they are permitted to carry out but only under particular conditions, for example re-fitting temporary crowns for patients other than when dislodged during their treatment, or administering LA when there is no dentist on the premises. A total of 30% of respondents indicated that they had been asked to carry out duties beyond their scope of practice. Details of the types of duties asked of them were provided in the free text comments section and included: impression taking; tooth whitening; suture removal; administration of LA without a dentist on the premises; de-bonding orthodontic brackets; placing temporary dressings not dislodged during their treatment; delivering, fitting and instruction regarding bleaching trays; determining their own treatment plan; treating a patient without a referral; and, treating a patient under oral sedation without direct supervision. Those providing details of these duties were asked if they thought these duties should be included in their scope of practice, and all but one DH answered in the affirmative.

Access to CPD

Access to courses to update skills was generally good, with only 37% finding it somewhat difficult and 12% finding it very difficult to access training. Comments in relation to the difficulties accessing CPD focused on the range and type of courses available in Ireland, the distance to travel and costs.

TABLE 6: Interest level in new skills suggested by the IDHA for dental hygienists.

Interest in using these skills in the future	Percentage(n)
Suture removal	76.47 (65)
Impression taking	91.76 (78)
Tooth whitening	81.18 (69)
Removing overhanging margins on restorations	78.82 (67)
Diagnosing dental caries	78.82 (67)
Diagnosing periodontal disease	89.41 (76)
Prescribing dental radiographs within your scope of practice	77.65 (66)
Treatment planning within your scope of practice	85.88 (73)
Treating patients directly, i.e., without a referral from a dentist within your scope of practice (direct access)	68.24 (58)
Prescribing and administration of LA without direct supervision of a dentist within your scope of practice	76.47 (65)
Prescribing medications within your scope of practice, i.e., fluoride solutions, antibiotic cover	74.12 (63)
Treating patients in institutional settings (i.e., nursing homes) without referral from a dentist and within your scope of practice (limited direct access)	71.76 (61)

Extending the scope of practice

A list of skills based on the 2013 IDHA submission to the Department of Health as part of the public and key stakeholders’ consultation process in relation to new legislation to replace the Dentists Act 1985 was provided. The respondents were asked to indicate if they would use these skills if they were included in their scope of practice and training was provided.

The list was made up of skills already permitted for DHs in other countries and was as follows: suture removal; impression taking; tooth whitening; removing overhanging margins on restorations; diagnosing dental caries; diagnosing periodontal disease; prescribing dental radiographs within your scope of practice; treatment planning within your scope of practice; treating patients directly, i.e., without a referral from a dentist, within your scope of practice (direct access); prescribing and administration of LA without direct supervision of a dentist, within your scope of practice; prescribing medications within your scope of practice, i.e., fluoride solutions, antibiotic cover; and, treating patients in institutional settings (i.e., nursing homes) without referral from a dentist and within your scope of practice (limited direct access).⁵

There was general interest in the list of skills. The highest level of interest was for taking impressions (92%) and the lowest level of interest was for treating patients directly, i.e., without a referral from a dentist, within your scope of practice (direct access) (68%) (Table 6).

Work practice of the future

The respondents were asked how they see their work practice changing in the future. In order to give clarity to the range of terms in use to describe work practice options, the following was given to explain the meaning of the terms being used:

“The terms ‘direct access’, ‘independent practice’ and ‘self-employed’ have different meanings in different countries. In this instance the term ‘direct access’ means that a patient can attend you for treatment without first being examined by a dentist and without a referral from a dentist. The term ‘self-

TABLE 7: Most likely work practice of the future.

If direct access was to be introduced, how do you see your work practice changing?	Percentage	(n)
I would be an employee of a dentist	9.41	(8)
I would work under the supervision of a dentist in a practice but be self-employed	5.88	(5)
I would work in a practice with a dentist with both referrals and direct access	48.24	(41)
I would set up my own dental practice with direct access	8.24	(7)
I would set up a group practice with other dental hygienists with direct access	8.24	(7)
I'm not sure	16.47	(14)
Other (please give details in the comments section)	3.53	(3)

employed' means that you would still work under the supervision of, and take referrals from, a dentist but have a contract of service with the dentist, i.e., pay your own taxes, etc."

The type of work practice most likely to be chosen by DHs given the choice was "I would work in a practice with a dentist with both referrals and direct access" (48%). The least likely choice was "I would work under the supervision of a dentist in a practice but be self-employed" (6%). Some 16% were unsure (Table 7). These findings are interesting; similar to countries where direct access is permitted, most DHs in Ireland would not choose to set up their own independent practice. However, only 9% would choose to be an employee, which is the only option available to most DHs in Ireland at the moment, and only 6% would choose to be self-employed, which up until recently was the only other choice available to DHs. It appears that DHs are not happy with their current work practice options.

The final question asked if there were any other duties, not already mentioned, that they would like to be able to perform. A small number of respondents (7%) added some duties. Being able to carry out domiciliary visits without a prescription, and the duties of dental therapists and orthodontic therapists, were the most common suggestions.

Conclusions

Despite the limited guidelines in relation to CPD for DHs, this survey shows that most of the respondents are motivated and proactive in relation to maintaining and updating their knowledge and skills, and are following the guidelines on professional behaviour suggested to dentists by the Dental Council. However, almost one-quarter of DHs (22%) are not trained to deliver block LA to their patients more than seven years after it was added to their scope of practice. Some 10% of DHs are not trained to take dental radiographs, 12 years after this skill was added. There does not appear to be any major issue with access to training for updating these skills.

DHs report that they are only moderately confident performing ID block LA, dental radiography, placing temporary dressings and re-fitting crowns. The most likely reason to explain this lack of confidence is the limited opportunities that arise to allow them to use these skills on a regular basis.

The issue of retaining competence in skills that are not used regularly is common in many professions, including dentistry. The availability of CPD to

update knowledge or retrain in these skills would be helpful. However, dentists may play a role in providing the opportunity for DHs to use their full scope of practice by making themselves aware of the skills the DHs in their employment have and using these skills to the full by, for example, referring patients with prescriptions for dental radiographs and LA if needed, and widening the range of patients referred to DHs to more regularly include patients with moderate and severe periodontitis who may require treatment under LA.

It is worth noting that 30% of DHs in the survey reported that they had been asked to carry out skills outside their current scope of practice by their supervising dentists. Does this indicate that some dentists are unclear about the exact scope of practice of DHs, or could it be that dentists are impatient and ready for new skills to be added as DHs are?

The long-awaited new legislation may add to the scope of practice of DHs. The aim is to improve both the access to and standard of oral care provided to the public.

It is not surprising to find that DHs in Ireland would most like to continue to work as part of an oral healthcare team should direct access be introduced. This follows similar trends around the world, where only approximately 6-7% of DHs opt to set up practice independently where direct access has been introduced.^{6,7} Limitations to this study include the time available to carry out the study and the population studied. However, it might be assumed that DHs who are members of their professional association are more likely to undertake CPD, and in fact the percentage of DHs without these skills might be even higher in the entire population of DHs in Ireland.

This survey highlights a number of interesting issues regarding the range of skills, confidence levels and work practice aspirations of DHs in Ireland. They are a skilled and enthusiastic workforce, and it is important that their skills are fully used in the best interests of the public.

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Prospective audit of postoperative instructions to patients undergoing root canal treatment in the DDUH and re-audit following introduction of a written patient information sheet

Précis: An audit of the delivery and documentation of postoperative instructions to patients undergoing root canal treatment in the DDUH demonstrated unfavourable results compared to the ideal benchmark. Introduction of a postoperative leaflet significantly improved the content and consistency of the advice and will be implemented in future.

ABSTRACT

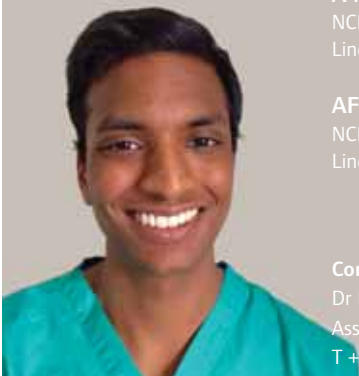
Statement of the problem: Concerns were expressed that postoperative written instructions following endodontic treatment are not available in the Dublin Dental University Hospital.

Materials and methods: Data was collected in three phases: retrospective analysis of clinical notes for evidence of the delivery of postoperative instructions; a randomly distributed questionnaire to patients undergoing root canal treatment prior to the introduction of a written postoperative advice sheet; and, another survey following introduction of the advice sheet.

Results: Some 56% of patients' charts documented that postoperative advice was given. Analysis of phase two revealed that patients were not consistently informed of any key postoperative messages. In phase 3 analysis, the proposed benchmarks were met in four out of six categories.

Conclusions: Postoperative advice after root canal treatment in the DDUH is both poorly recorded and inconsistently delivered. A combination of oral postoperative instructions and written postoperative advice provided the most effective delivery of patient information.

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Introduction

Postoperative advice and instruction leaflets are important adjuncts to verbal communication and serve to reinforce and confirm any information given verbally. They play a vital role in helping patients to deal with postoperative concerns and management.

Concern has been expressed by both dentists and patients that written postoperative instructions following root canal treatment were not available in the Dublin Dental University Hospital (DDUH). The provision of postoperative advice and instructions, and its documentation, is considered best practice. In addition, studies have shown that adequate postoperative education can improve patient satisfaction and reduce postoperative morbidity.¹ Some evidence would suggest that verbal information alone is not retained by patients after they leave the surgery.^{2,3} Failure to deliver appropriate postoperative information can lead to misunderstandings, unnecessary complications, complaints and even allegations of negligence.⁴

At present, a patient information leaflet exists in the DDUH for patients preparing to undergo root canal treatment; however, this leaflet contains no postoperative advice and instructions, and only gives an outline of the root canal treatment as a procedure for patients preoperatively.

Aims of the audit

The purpose of these DDUH clinical audits was to:

1. Retrospectively audit patients' charts to assess the delivery of instructions following root canal treatment procedures (phase one).
2. Prospectively audit the practice of instructions given to patients following root canal treatment procedures (phase two).
3. Design a postoperative patient information leaflet to supply after root canal treatment procedures.
4. Prospectively compare the delivery of instructions to patients following root canal treatment procedures after the leaflet's implementation (phase three).
5. Propose and develop a standardised approach in the practice and documentation of patient postoperative advice and instructions following root canal treatment procedures.

Benchmark

Endodontic inter-appointment emergency is a clinical condition arising after an endodontic procedure is commenced or completed that requires an unscheduled patient visit, during which some treatment procedures have to be performed.⁵ Available literature has shown that its incidence is between 1.4% and 45%.⁶⁻⁸ Despite this, no universally agreed national or European benchmark regarding the practice and documentation of postoperative advice and instructions following endodontic treatment is available. However, the General Dental Council in the UK states that postoperatively a dentist's role is to "communicate advice appropriately, effectively and sensitively by spoken, written and electronic methods, and maintain and develop these skills".⁹ It is generally considered best practice to verbally inform patients of the likely outcome of treatment, what measures should be taken in case of pain or postoperative complication, and to document this advice in the patient's clinical notes. Research has also indicated that this information is better retained by the patient if it is also supplied in written format.^{2,3,10}

The benchmark used in this audit was:

1. The delivery of postoperative advice and instructions should be

APPENDIX 1: Questionnaire used for the audit process in phases two and three.

DUBLIN DENTAL UNIVERSITY HOSPITAL

Patient questionnaire regarding postoperative advice and instructions given following endodontic treatment

Date

Please circle the relevant answer

Age 18-24 25-34 35-44 45-54 55-64 65+

Sex Male Female

Are you having root canal (endodontic) treatment currently?

Yes No

If yes, were you given any information, advice or instructions regarding:

1. The risk of developing postoperative pain? Yes No

2. Managing postoperative pain? Yes No

3. If root canal (endodontic) treatment has been commenced only for emergency pain relief, were you instructed to visit your general dental practitioner for its completion? Yes No

4. Managing a visible swelling inside/outside the mouth if developed at a later stage? Yes No

5. The importance of an intact temporary restoration of the tooth involved? Yes No

6. The need for proper final restoration (filling) of the tooth involved? Yes No

7. Were you given written instructions after the treatment? Yes No

8. Do you find written instructions helpful after dental treatment? Yes No

9. Do you currently have a dentist? Yes No

Thank you for taking part in this questionnaire

TABLE 1: Summary of results obtained in phase 1 (n = 50).

% of clinical notes that had evidence of documentation of postoperative advice and instructions	% of clinical notes that had no evidence of documentation of postoperative advice and instructions
56	44

documented in 100% of clinical notes.

2. The advice and instructions given to patients should include six categories:
 - 100% of patients should be given advice regarding the risk of developing postoperative pain;
 - 100% of patients should be given instructions on how to manage postoperative pain;
 - if root canal treatment has been commenced in the DDUH only for emergency pain relief, 100% of patients should be instructed to visit their general dental practitioner for its completion;
 - 100% of patients should be advised that development of a visible swelling inside and/or outside the mouth requires emergency attention;
 - 100% of patients should be advised on the importance of an intact temporary restoration in the access cavity of the tooth involved; and,
 - 100% of patients should be advised of the need for an adequate final restoration of the tooth involved.

Method

Patients undergoing root canal treatment in accident and emergency clinics and/or undergraduate restorative dentistry clinics in the DDUH during the period of December 2014 to March 2015 were randomly selected to participate in this audit. As this study was an audit project to assess current hospital practice and compare to best practice, ethical approval was not sought. All patients had non-surgical *de novo* root canal treatment carried out. In the first phase of the audit process, the clinical notes for the chosen patients were retrospectively evaluated to check for any documentary evidence of postoperative advice and instructions given to the patient.

In phases two and three, in order to evaluate the nature of the postoperative patient advice (verbal, written or a combination), prospective data collection through the use of a questionnaire was completed (Appendix 1). The questions asked were based on the six proposed benchmark standards (listed earlier). Participants were also asked whether they find written instructions helpful or not. In addition, a written postoperative advice and instruction leaflet was developed (Appendix 2) for use in phase three.

Phase one dealt with the evaluation of a sample of randomly selected patient clinical notes (n = 50) in their respective electronic dental records (EDR) following root canal treatment procedures. These clinical notes were examined to check for any documentary evidence of postoperative advice and instructions. In phase two, immediately following the completion of scheduled/emergency appointments, patients (n = 50) were asked verbally if they would like to participate in the audit process. If agreeable, patients were given the mentioned questionnaire to complete in designated patient waiting areas. Patients included in phase two were not exposed to the newly designed postoperative information leaflet (only to verbal information). Patients (n = 50) included in phase three were given the newly designed leaflet by the treating clinician/student, as well as the postoperative instructions being communicated verbally prior to completion of the questionnaire. Following completion, all anonymous questionnaires were gathered and stored, and the data collected was analysed.

Results

Phase one showed that only 56% of clinical notes examined had evidence of documentation of postoperative advice (Table 1). Phase two, which was undertaken prior to the introduction of written instructions, revealed that the

APPENDIX 2: Designed postoperative advice and instructions leaflet used in phase three.

Postoperative advice and instructions following the commencement of root canal (endodontic) treatment

Root canal treatment has been carried out on your tooth today.

1. **It is normal to experience mild to moderate pain following treatment over the next four to five days.**
 - a. Cleaning of the root canal system inevitably initiates some inflammation of the surrounding nerves and tissue, which can give rise to the discomfort. This is not a sign of treatment failure.
 - b. It is recommended that you take some painkillers for at least 48 hours after treatment to block the onset of the pain.
 - c. Painkillers available over the counter at a pharmacy (such as ibuprofen or paracetamol) are generally adequate, but only if you have taken the medication before with no adverse side effects. In certain medical conditions taking these painkillers is contraindicated.
 - d. If you are in any doubt about the type of painkillers to take, please ask your treating dentist, medical practitioner or pharmacist for the necessary advice.
2. **Root canal treatment is only one step in restoring your tooth to full function.**
 - a. If root canal treatment has only been commenced to provide emergency pain relief, it is important that you visit your own dentist for its completion or risk developing a flare-up of acute pain.
 - b. Teeth that are undergoing root canal treatment, or have had root canal treatment completed, may be prone to fracture. Proper final restoration of the tooth with your dentist is extremely important in ensuring the long-term success of the root canal procedure and protection of the remaining tooth structure.
 - c. Be sure to brush and floss your teeth as you normally would.
 - d. If the cavity in your tooth was filled with a temporary filling material, it is not unusual for a thin layer of this material to wear away between appointments. It is important that if you think the entire filling has come out, contact your dentist.
3. **Contact your dentist immediately if you develop any of the following:**
 - a. a visible swelling (or severe pain) inside or outside your mouth;
 - b. an allergic reaction to any medication that may have been prescribed, including rash, hives or itching (nausea is not an allergic reaction);
 - c. a return of original symptoms after a duration of 10 days; and,
 - d. your bite feels uneven.
4. **Contact details:**
 - a. Your first port of call for advice or treatment following root canal treatment should be your own dentist or the dental hospital. If you have any doubts or concerns please ask your dentist before leaving the hospital.
 - b. If you need any additional advice or develop any problems after you leave the hospital you can contact the hospital by:
 - i Calling XXXXX between 9.00am and 5.00pm and asking for the department in which the treatment was done;
 - ii Attending the triage area of the Accident and Emergency Department in the Dublin Dental Hospital any weekday at either 9.00am or 2.00pm;
 - iii Calling XXXXX between 5.00pm and 9.00pm or at weekends; leave a voicemail message and a dentist will call you back;
 - iv After 9.00pm contact your local hospital; or,
 - v E-mailing XXXXX (it may be the following day before your email is responded to).

TABLE 2: Summary of results obtained in phase 2 (prior to the introduction of the postoperative instruction leaflet [n = 50]).

Advice related to:	% of participants who responded yes
Risk of developing post-op pain	74
Management of post-op pain	62
Visit GDP for completion of the endodontic treatment	46
Management of swelling if developed	38
The need for adequate final restoration	80
Given written instructions after treatment	4
Importance of intact provisional restoration	62

TABLE 3: Summary of results obtained in phase 3 (after the introduction of the postoperative instruction leaflet [n = 50]).

Advice related to:	% of participants who responded yes
Risk of developing post-op pain	100
Management of post-op pain	100
Visit GDP for completion of the endodontic treatment	58
Management of swelling if developed	80
The need for adequate final restoration	100
Given written instructions after treatment	100
Importance of intact provisional restoration	100

proposed benchmark was not met in any of the six categories described (Table 2). However, phase three (after the introduction of written instructions) showed that the proposed benchmark was met in four of the six categories (Table 3). The results demonstrated that 100% of the patients found written instructions helpful following the introduction of the leaflet. However, only 70% of patients thought that written instructions would be helpful when asked in phase two.

Discussion

Notably, the results from phase two fell well below the proposed benchmark. Currently in the DDUH, clinical notes are recorded on the patient's EDR following completion of treatment. Operators have an option of selecting "Yes" or "No" in a dropdown box to state if "Postoperative instructions given?" If prompted "Yes", operators have an option to detail what instructions were given. In only 56% of the clinical notes evaluated, operators opted to select "Yes" and gave any details of the postoperative instructions given to patients. In the remainder of the clinical notes examined, operators left this option blank and did not mention any details of the delivery of any postoperative advice in any section of their clinical notes. Documentation of such information is of paramount importance, not only for medico-legal purposes, but also for clinical continuity ('handover') where, for example, a patient may have been seen by different operators for emergency treatment and subsequent care.

Prior to the introduction of the postoperative advice and instruction leaflet, advice was delivered exclusively by verbal means to patients. Of all the advice and instructions given to patients in phase two, the proposed benchmark was not met for any of the categories. Possible reasons for this include poor retention of information communicated orally postoperatively, or failure of the operator to deliver all relevant instructions and advice to the patient (due to time constraints, lack of knowledge or a combination of these factors).

Following the introduction of the postoperative advice and instruction leaflet, advice was delivered through verbal communication, which was supplemented by written information. This combination resulted in the proposed benchmark being met in four categories, leaving two categories below the proposed benchmark, even though the designed leaflet addressed all categories of the proposed benchmark. Compliance with a verbal walk through of the content of the leaflet

may have been a limitation of this audit and may account for the remaining two categories not being met in the second phase of the audit process.

One of these categories addressed advice given to patients to attend their GDP for completion of root canal treatment if the treatment itself was only completed for emergency pain relief (first stage endodontics). Some 58% of patients in phase three responded "Yes" to having received this advice, compared to 46% in phase two. The reason that there was such a small increase could be that the patients who attend the DDUH usually prefer, for a host of reasons, the DDUH itself to complete the root canal treatment instead of their own GDP, thus stating "No" on the questionnaire. The specific reasons for this were not investigated in this study; however, they may be financial, a preference for hospital treatment, or for reasons of treatment continuity. It is vitally important for the DDUH to advise patients to attend their own GDP for completion of root canal treatment (when undertaken as an emergency treatment option), as not doing this may lead to an increase in postoperative complications and unnecessary repeated visits to the DDUH Accident & Emergency Department.

It is accepted that the current audit may be limited by the small numbers in each group; however, it is uncertain if analysis of larger groups would have revealed further information. In addition, when attempting to extrapolate these findings into general practice some care must be exercised, as although the reported findings are largely universal, the chosen patient samples represent a dental school subpopulation, which may not be reflective of the general population. Furthermore, language difficulties or reduced health literacy may also impede appropriate clinician/patient communication and may have influenced the results for phases two and/or three. This, in combination with post-treatment-related stress or anxiety, may interfere with the patient's ability to concentrate on instructions given.^{11,12} However, these final limitations would further strengthen the argument for supplying written instructions to patients.

Recommendations

The provision of postoperative instructions is considered best practice after completion of clinical treatment. Documentation of such advice in clinical notes, particularly with regard to pain relief and swelling, is also vitally

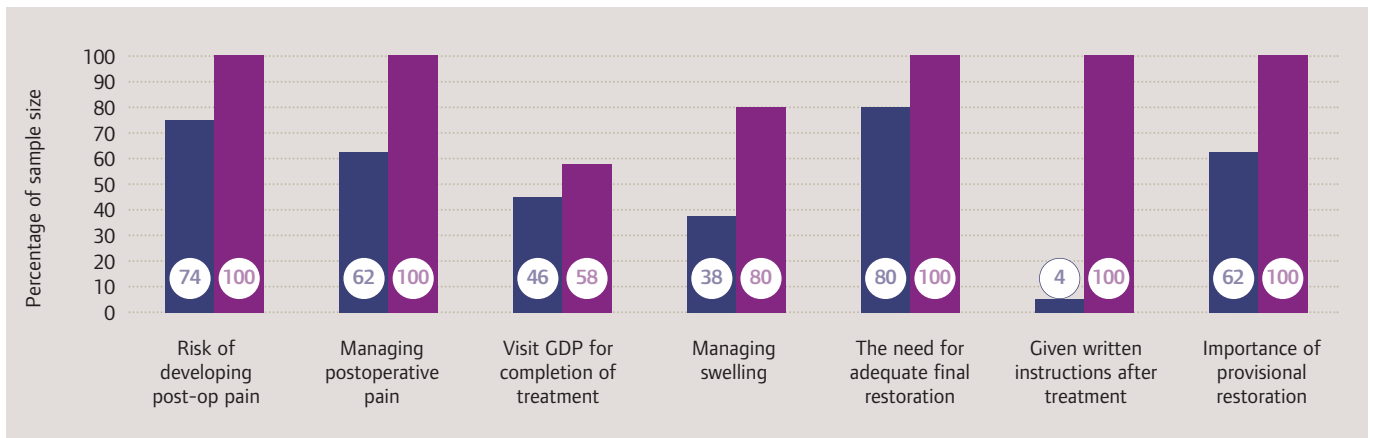


FIGURE 1: Summary of the results obtained in phase 2 compared to phase 3

important. Endodontic treatment is no exception. A lack of standardised advice to patients was noted. The value of a postoperative advice and instruction leaflet to supplement verbal instructions has been demonstrated by this audit. At the end of this audit, the following recommendations can be made:

1. The introduction of a postoperative advice and instruction leaflet following root canal treatment has been proposed in the DDUH.
2. Introduction of a postoperative advice and instruction leaflet should contribute towards a uniform hospital-wide approach to postoperative advice and instructions.
3. The designed leaflet will be widely distributed to the undergraduate/postgraduate/NCHD/Accident & Emergency, and consultant clinics where root canal treatment may be undertaken, and given to patients following completion of root canal treatment.
4. Following its introduction, an audit of patient satisfaction/operator compliance with the use and documentation of postoperative instructions in operator clinical notes will be undertaken.
5. The findings of this audit should be used as a template for GDPs within Ireland to use after root canal treatment in their own practices.

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A systematic review of implant outcomes in treated periodontitis patients

Sousa, V., Mardas, N., Farias, B., Petrie, A., Needleman, I., Spratt, D., et al.

Objectives

To investigate the effect of treated periodontitis on implant outcomes in partially edentulous individuals compared with periodontally healthy patients.

Material and methods

Longitudinal studies reporting on implant survival, success, incidence of peri-implantitis, bone loss and periodontal status, and on partially dentate patients with a history of treated periodontitis, were included.

Results

The search yielded 14,917 citations. Twenty-seven publications met the inclusion criteria for qualitative data synthesis. Implant success and survival were higher in periodontally healthy patients, while bone loss and incidence of peri-implantitis were increased in patients with a history of treated periodontitis. There was a higher tendency for implant loss and biological complications in patients previously presenting with severe forms of periodontitis. The strength of the evidence was limited by the heterogeneity of the included studies in terms of study design, population, therapy, unit of analysis, inconsistent definition of baselines and outcomes, as well as by the inadequate reporting of statistical analysis and accounting for confounding factors; thus, meta-analysis could not be performed.

Conclusions

Implants placed in patients treated for periodontal disease are associated with higher incidence of biological complications, and with lower success and survival rates, than those placed in periodontally healthy patients. Severe forms of periodontal disease are associated with higher rates of implant loss. However, it is critical to develop well-designed, long-term prospective studies to provide further substantive evidence on the association of these outcomes.

Clin Oral Implants Res 2015; Sep 18. doi: 10.1111/clr.12684. [Epub ahead of print]

The Tennessee study: factors affecting treatment outcome and healing time following nonsurgical root canal treatment

Azim, A.A., Griggs, J.A., Huang, G.T.-J.

Aim

To determine factors that may influence treatment outcome and healing time following root canal treatment.

Methodology

Root filled and restored teeth by pre-doctoral students were included in this study. Teeth/roots were followed up regularly, and treatment outcome was evaluated at every follow-up appointment (healed, healing, uncertain or

unsatisfactory). Host (age, immune condition, pulp/periapical diagnosis, tooth/root type, location and anatomy) and treatment factors (master apical file size, apical extension, voids and density of root filling) were recorded from patient dental records. Univariate, bivariate and multivariate analyses were performed to determine the impact of the factors on treatment outcomes and healing times.

Results

A total of 422 roots from 291 teeth met the inclusion criteria, with a mean follow-up period of two years. The preoperative pulp condition, procedural errors during treatment, apical extension and density of root fillings significantly affected the treatment outcome. The average time required for a periapical lesion to heal was 11.78 months. The healing time increased in patients with compromised healing, patients older than 40 years, roots with Weine type II root canal systems, root canal systems prepared to a master apical file size <35, and roots with overextended fillings (P<0.1).

Conclusion

Multiple host and treatment factors affected the healing time and outcome of root canal treatment. Follow-up protocols should consider these factors before concluding the treatment outcome: patient's age, immune condition, roots with overextended fillings, root canal systems with smaller apical preparations (size <35), or roots with complex canal systems. Intervention may be recommended if the treatment quality was inadequate or if patients became symptomatic.

International Endodontic Journal 2016; 49 (1): 6-16.

Performance of fluorescence-based methods for detecting and quantifying smooth-surface caries lesions in primary teeth: an *in vitro* study

Fernandes Novaes, T., Moraes Moriyama, C., Saveriano De Benedetto, M., Kazuo Kohara, E., Minatel Braga, M., Medeiros Mendes, F.

Background

Although smooth-surface caries can be subjectively assessed by visual inspection, quantitative methods would improve the monitoring of these lesions.

Aim

To evaluate the *in vitro* performance of laser fluorescence devices, namely DIAGNOdent (LF) and DIAGNOdent pen (LFpen), and a fluorescence camera (VistaProof; FC), in the detection and quantification of smooth-surface caries in primary teeth.

Design

Two examiners evaluated 99 smooth surfaces of 65 extracted primary molars using FC, LF and LFpen. As a reference standard, the actual and relative lesion depths were determined using stereomicroscopy and polarised light microscopy. Reproducibilities were assessed, and correlation analyses were performed. The sensitivities, specificities and accuracies of the methods were calculated and compared.

Results

There was a significant correlation between the values obtained using the fluorescence-based devices and the actual and relative lesion depths, although the correlation coefficient values were not higher than 0.7 (LF, 0.673; LFpen, 0.646; FC, 0.663). The sensitivities of the devices were similar for the detection of enamel caries, although the LFpen was superior in detecting dentin lesions. The reliabilities of all methods were moderate to low, with similar accuracies at all depths.

Conclusion

Although the fluorescence-based devices showed similar performance in the detection of enamel and dentin lesions, the reliability of these devices and the correlation of their findings with the actual and relative lesion depths were moderate with regard to smooth-surface caries in primary molars.

International Journal of Paediatric Dentistry 2016; 26 (1): 13-19.

An *in vivo* evaluation of the fit of zirconium-oxide-based, ceramic single crowns with vertical and horizontal finish line preparations

Vigolo, P., Mutinelli, S., Biscaro, L., Stellini, E.

Purpose

Different types of tooth preparations influence the marginal precision of zirconium-oxide-based ceramic single crowns. In this *in vivo* study, the marginal fits of zirconium-oxide-based ceramic single crowns with vertical and horizontal finish lines were compared.

Materials and methods

Forty-six teeth were chosen in eight patients indicated for extraction for implant placement. CAD/CAM technology was used for the production of 46 zirconium-oxide-based ceramic single crowns: 23 teeth were prepared with vertical finishing lines, and 23 with horizontal finishing lines. One operator accomplished all clinical procedures. The zirconia crowns were cemented with glass ionomer cement. The teeth were extracted one month later. Marginal gaps along vertical planes were measured for each crown, using a total of four landmarks for each tooth by means of a microscope at 50x magnification. On conclusion of microscopic assessment, ESEM evaluation was completed on all specimens.

The comparison of the gap between the two types of preparation was performed with a non-parametric test (two-sample Wilcoxon rank-sum test) with a level of significance fixed at $p < 0.05$. All data were analysed with STATA12.

Results

In the group with horizontal finish line preparations, the median value of the gap was 35.45m (Iqr, 0.33); for the vertical finish line group, the median value of the gap was 35.44m (Iqr, 0.40). The difference between the two groups was not statistically significant (two-sample Wilcoxon rank-sum test, $p = 0.0872$).

Conclusions

Within the limitations of this study, the gaps of the zirconium-oxide-based ceramic CAD/CAM crowns with vertical and horizontal finish line preparations were not different.

Journal of Prosthodontics 2015; 24 (8): 603-609.

Quiz answer

(questions on page 12)



- Patient communication should be paramount to a dental professional's practice.
- Both verbal and non-verbal communication in the planning, implementation, amending and final stages of a patient's treatment are very important to both the dental professional and the patient. Verbal and non-verbal communication (i.e., body language, eye contact) can have a positive or negative effect on the patient. It can cause or resolve conflict.
- Happy patients that feel welcomed, valued, and that they have been heard and listened to, will return to the dental practice.
- In an Australian paper,¹ it was suggested that patients valued the quality of communication over the quality of a dentist's technical performance. Campbell and Tickle also suggest that patients value communication and continuity of care as paramount to their dental care.²

- The Irish Dental Council also recognises communication with the patient in its standard code of practice – *Professional Behaviour and Ethical Conduct*, 2012.³

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SITUATIONS WANTED

Dentist with nine years' working experience looking for work in the Cork area. Will consider full- or part-time positions. Please email dentistcork1706@gmail.com or call 086-323 7304.

Friendly, patient and gentle dentist with over three years' experience in a dental practice for children and young adults and a strong interest in paediatric dentistry is looking for a job opportunity, preferably in Dublin area. IDC registered. Email happytoothdublin@gmail.com.

Specialist in prosthodontics and implant dentistry seeks part-time employment. All locations considered. Contact specialistprosthodontistie@gmail.com.

SITUATIONS VACANT

Full-time associate position in Singapore. Prime expat area. Minimum one year's experience – mentorship provided. Potential for excellent remuneration. Email: www.smilepoint.com.sg.

Experienced associate dentist required for part/full-time position in Virginia/Ballyjamesduff, Co. Cavan. One hour from Dublin. Hygienist/orthodontist/computerised/OPG/oral surgeon. Medical card/PRSI schemes. Email CV to info@virginiadentalsurgery.com.

Co. Kildare. Part-time, experienced associate required. Very busy, well-equipped progressive, modern practice. Sedation qualification preferable. Fully private practice. Busy town. Three surgeries, digital OPG/ceph., hygienist. Cerec computerised. Excellent support staff. Early 2016 start. Email: niall@innovatedental.com.

Excellent opportunity for associate in busy, modern, well-equipped practice in south Dublin. Excellent support staff. Initially part-time leading to full-time in the New Year. Minimum three years' experience required. Please send CV to kieran.davitt@dentalcareireland.ie.

Part-time associate required for fast-growing, busy practice in Dublin City Centre. This position will build to full-time within a year. Computerised, digital x-rays, OPG, etc. Please email CVs to dentaljobsdublin@gmail.com.

Excellent opportunity for associate in a progressive practice in Longford. Practice well equipped and computerised. Send CV to sgdentistlongford@gmail.com.

Expanding practice in South Tipperary seeks enthusiastic associate to join our team – 45 minutes from Cork. Experience ideal but not essential. CV to dentaljobssouthtipp@gmail.com.

Two part-time associate positions and one full-time available to work in our mobile dental division. Surgery sessions also available. Ideal candidate should have a pleasant nature and like to be busy. Please forward CV and cover letter to info@elitedental.ie. Associate required for busy state-of-the-art dental practice. Part-time initially. Must have an outgoing, friendly personality. One year's plus experience in Ireland/UK. Email kilkennydentist@hotmail.com.

Caring, gentle associate required to replace departing longstanding associate in Galway City area end of March 2016. Well-established, well-respected general practice. Experience preferred. Reply to phewatal@eircom.net.

Two positions available for part/full-time associates. Flexible hours/days in an established modern practice in Virginia/Ballyjamesduff, Co. Cavan (one hour from Dublin). Based on a 50% ratio. OPG, oral surgeon, orthodontist, periodontist, hygienist. Please send CV to info@virginiadentalsurgery.com.

Co. Kildare. Associate dentist required in modern, newly renovated surgery. Some experience necessary. Email: monreadental@gmail.com.

Associate dental surgeon required part-time to work in Dun Laoghaire Thursday afternoons and Saturday mornings initially. Hours may change for suitable candidate. Email rkillane@eircom.net.

Associate dentist required for private practice in Dublin 2. We are looking for a candidate with experience, excellent communication skills and a friendly manner. Part-time role over four days. Please email CV to dentaljobs2015@gmail.com.

Opportunity for friendly associate to join well-established and busy practice in Sligo town. Initially part-time with possibility of full-time appointment. Added potential of taking over/buying successful practice in the medium term. Email dentalwinestreet@gmail.com.

Caring, conscientious associate required for maternity leave post in Co. Mayo, running from April 2016 to October 2016. Full-time position in well-established multi-surgery practice. Good equipment, fully digital, OPG, hygienist. Email CV to kieran.davitt@dentalcareireland.ie.

Dental associate required in busy southwest Dublin practice. Ideally with one to two years' post-qualification practice experience. To work Monday and Tuesday 9.30-1.00pm and 2.00-6.00pm. Email query/CV to wmunroe@eircom.net.

Southside dental practice (est. 1979) requires associate dentist for one/two-day week. Position could evolve into partnership/ownership. Please send CV to orwelldental@gmail.com.

Full-time associate required in south east to replace departing colleague. Experience and fluent English required. Long-term options for the right candidate. Good earnings track record here. Reply with CV to dentaljobcarlow@gmail.com.

Dublin – exciting opportunity for a strong, enthusiastic general dentist to join our busy Smiles O'Connell Street practice in Dublin 1. Full-time basis five days per week. Candidates must have general experience and be IDC registered. Email: joanne.bonfield@smiles.co.uk.

Opportunity to work four days a week with a salary scale 28,000 to 36,000. Working with all specialists in a multidisciplinary team. Car parking available/travel expenses for a suitable candidate. CV to lesley@nidm.ie.

Advertisements will only be accepted in writing via fax (01- 295 0092), letter or email (fionnuala@irishdentalassoc.ie). Non-members must pre-pay for advertisements, which must arrive no later than **Friday, March 11, 2016**, by cheque made payable to the Irish Dental Association. Classified ads placed in the *Journal* are also published on our website www.dentist.ie for 12 weeks.

Advert size	Members	Non-members
up to 25 words	€75	€150
26 to 40 words	€90	€180

The maximum number of words for classified ads is 40.

If the advert exceeds 40 words, then please contact:
Think Media, The Malthouse, 537 North Circular Road, Dublin 1.
Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie
Please note that all classified adverts MUST come under one of the following headings:

- ▶ Positions Wanted
- ▶ Practices for Sale/To Let
- ▶ Equipment for Sale/To Let
- ▶ Positions Vacant
- ▶ Practices Wanted

Classified adverts must not be of a commercial nature. Commercial adverts can be arranged by contacting Paul O'Grady at Think Media.

Part-time associate required for long-established dental practice in south Kerry. Email specialjane@eircom.net.

Excellent Dublin City practice requires general practitioner. Position will be as primary dentist to take over a strong existing book. Minimum three years' experience. Training and experience treating Invisalign patients essential. Full support for the dentist – clinical and administrative. Email mark@chathamstdentalcare.ie.

Part-time dentist required in busy practice in Athlone. Great communication skills and minimum three years' experience necessary. OPG, digital x-ray, intra-oral camera, etc. Email CV to dentalvacancy@hotmail.com.

Busy Dublin City Centre clinic requires general dentist/endodontist with five years' experience. Two full days a week with a view to more days. Email info@molesworthclinic.ie or call Dave on 01-661 5544.

Full-time dentist required for very busy, modern, well-equipped, mostly private practice in Limerick City. Experience in implants desirable but not essential. Please email your CV to jennifer.bowedental@gmail.com.

Excellent opportunity for experienced dentist – multiple locations in Dublin. Position will be as primary dentist to take over a strong book. Minimum three years' experience. Candidate must be IDC registered. Invisalign training preferred. Please send CV to info@onsiteservice.com.

Experienced dentist required to work one/two days a week in a busy surgery in Blackrock. Please email CV to carysfortdentalclinic@eircom.net.

Dentist required for busy, modern Killaloe practice. Starting January 2016, one day week, Fridays. Please email CV to Joe@networksolutions.ie or call 087-233 3053.

Dundalk. Smiles Dental is looking for an enthusiastic, passionate dentist to join our well-established Smiles Dundalk practice. Candidates must have general private and public experience and be IDC registered. Working days required are five days per week. Email joanne.bonfield@smiles.co.uk.

Busy private clinic in Dublin requires general dentist for a full- or part-time position with experience in cosmetic and prosthetic work. IDC registration is necessary. Please send CVs to Dublin.rathgar.clinic@gmail.com.

Dentist wanted to cover Tuesdays in April and part-time maternity leave from May. Email info@ballincolligdental.ie.

Part-time dentist required for an expanding modern practice in the north east. Our website – www.frielandmcmahon.ie – will give you an insight into our practice and our team. If you are interested email us on your CV to frielandmcmahon@gmail.com.

Limerick. Ambitious dentist required for part-time role in high-profile, modern, busy clinic. Computerised, OPG/new equipment/excellent staff. Generous terms for right candidate. Email limerickdentaljob@gmail.com.

Dentist required two days per week to replace departing colleague in modern, purpose-built practice in Portlaoise. Fully computerised, digital x-rays, OPG, visiting oral surgeon and orthodontist. Email info@laoisdentist.ie.

Killarney. Friendly dentist required to provide maternity cover starting mid-March 2016. Any queries or CVs to kategleeson@hotmail.com.

We are looking for a part-time dentist to cover some afternoons and Saturday. Fully qualified dentist with Irish registration number. Email dunboynedentallab@gmail.com.

Enthusiastic dentist required for modern Kingscourt practice one hour from Dublin. Two weekdays (9.30-7.00) and every second Saturday (private only). Days are negotiable. Needs IDC number and experience working in Ireland. Email kingscourtdentalpractice@gmail.com. www.kingscourtdental.ie.

Co. Wexford. Smiles Dental is looking for a passionate dentist to join our well-established, busy Smiles Enniscorthy practice in Co. Wexford. Must have general experience and be IDC registered. Position offers four to five days per week. Email joanne.bonfield@smiles.co.uk.

Enthusiastic general dentist required (part- or full-time) in busy practice in the heart of Dublin. Candidates must have general private experience, IDC registration and fluent English. CV can be sent to contact@freedomdental.ie.

Established Dublin-based specialist dental practice invites applications from a suitably qualified endodontist to join our multidisciplinary team. Letter of application and CV to mags@ncdental.ie.

Multidisciplinary practice in east Cork requires endodontist to replace departing colleague, two sessions per month, full book. Email carmel@corabbeydentalclinic.ie.

Orthodontist required to join our specialist orthodontic practice in Dublin 4. Superb facilities, including iTero. www.ortho.ie. Email: hughbradley@gmail.com.

Orthodontist sessions available in busy north Cork clinic to replace departing colleague. Four GDPs, hygienist, fully computerised, digital x-rays and OPG. Tel: 087-621 7151.

Specialist registered orthodontist required to join specialist practice. Candidate to commence treating existing list of new private patients. Part or full-time available for suitable candidate. Fully digital, multi-chair, purpose-built clinic. Reply with CV to bracesjob@eircom.net.

Registered specialist orthodontist required for busy Dublin orthodontic practice. Digital OPG/ceph. Very flexible sessions. Email dentistcodublin@gmail.com.

Specialists wanted. Surgery available part time in Dublin 9 in an established specialist orthodontic practice. Surgery is based in a modern medical/dental centre, good referral base on site. OPG, hygienist. Rental or associate position can be discussed. Enquiries welcome. Email: orthosull@gmail.com.

Dental nurse/receptionist required to join our busy team in modern, four-surgery practice in Ratoath, Co. Meath. Part-time (three days initially). Will likely lead to four days. Flexibility helpful as hours may vary. Experience preferred. CV and references essential. Email: ratoathdental@gmail.com.

Nurse required for full-time position at ortho Donnybrook. Super conditions – great team – immediate start. Contact Elaine, Tel: 01-269 5566, or email: elaine@ortho.ie.

Qualified dental nurse position available. Modern Limerick City clinic. Full- or part-time. Seeking experienced, friendly, reliable candidate. Please send CV to limericksajob@gmail.com.

Experienced dental nurse required. Seeking professional, innovative, efficient, self-motivated candidate. Position will require travel between three clinics in Sandyford, Citywest and IFSC – must have access to a car. Monday-Friday 7.30-5.30. Please send CV to info@onsiteservice.com.

Dental nurse required, Ballymahon, Co. Longford. Thirty hours per week. Pay depending on experience. Please email CV to Exceldentalpractice@gmail.com.

Leinster. Experienced nurse/receptionist for a role in top-class, busy, progressive practice. Applicants must be enthusiastic, caring, empathic team players with good people skills. High-level IT skills crucial. Good remuneration. Immediate start. Contact Niall at niall@innovatedental.com.

Dental nurse required for busy general practice in Blackrock, Co. Dublin. Temporary position covering one full day a week. Must be reliable. Email details to drgarrymcmahon@gmail.com or contact Veronica on 01-288 9161.

Dental nurse required for modern practice in Sligo. Looking for positive, friendly individual with excellent work ethic and team values. Preferred candidate will be enthusiastic, caring and flexible in role. Excellent work conditions. CV to info@westcoastorthodontics.ie.

Enthusiastic, qualified dental nurse required to join a friendly team at a specialist practice. Please send your CV to mags@ncdental.ie.

Dental nurse required for temporary position (maternity leave) in busy practice in Blackrock. Looking for positive, friendly individual with excellent work ethic. Send CV to drgarrymcmahon@gmail.com or phone 01-288 9161.

Part-time experienced dental nurse required in Co. Longford. Email excelandentalpractice@gmail.com.

Dental nurse required, part-time initially (Wednesday-Friday) for busy Dublin 24 practice. Please forward CV and cover letter to oldbawndental@gmail.com.

Qualified dental nurse sought for busy multidisciplinary practice in Cork (general, ortho and oral surgery). Position available from mid-February. To apply, forward your CV and cover letter to hr@smilestore.ie.

Part-time trainee dental nurse required for busy dental practice in north Dublin. Please text or phone 086-365 5524.

Experienced, qualified dental nurse/receptionist required for busy three-surgery practice in Kildare. Immediate start. Full-time hours. CV to co.kildaredental@gmail.com.

Experienced dental nurse for modern Dublin 2 practice. Part-time – Wednesday/Thursday/Friday. Looking for friendly, enthusiastic, computer literate, fluent English, multi-tasker. Small, friendly team. CV to paddygowen@mac.com.

Hygienist required for busy practice in New Ross. Monday/Tuesday and every second Saturday. Reply with CV to info@rogersdental.ie.

RDH required for two to three days, including Saturday, at Abbeytrinity Dental Practice, Tuam, Co. Galway. Please email letter of application, CV and references to reception@abbeytrinitydental.ie.

Motivated locum hygienist required for one to two days per week in busy, fully-computerised practice in Navan, Co. Meath. Position available from mid February. Experienced staff, Kavo scaler, chair/fibreoptics. Email meathdentists@gmail.com.

Dental hygienist required, north west, to replace departing colleague. Full appointment book with high gross. Open to newly qualified as well as experienced practitioners. Applicants must be able to treat to a high standard, communicate well with patients and work within a team. Email innovatedental@yahoo.ie.

Hygienist required for practice in Mullingar, part-time. Days available: Monday, Wednesday and Saturday. Email midlandsdentaljob@gmail.com.

Caring professional RDH required in Carlow Town – days required Tuesdays, Wednesdays and Saturdays. Immediate start available. Please send CV to info@pembrokedental.ie.

Locum hygienist required to cover sick leave for full day on Tuesdays in Dublin 10. Email Sbarnes@ballyfermotdental.ie.

Dental hygienist required to replace departing colleague for hygiene session every Saturday. We are based in Dunlo Street, Ballinalsoe, Co. Galway. Established busy book. Starting date February 20. Please reply by email to rothdent@hotmail.com.

Opportunity for a qualified dental surgery assistant in a busy general dental practice in Clontarf. Experience preferable. Immediate start. Please email your details and CV to Laura at clontarfdentalpractice189@gmail.com.

Busy multi-surgery dental practice requires a part-time receptionist. Initially two days/week. Dental practice/nursing experience ideal but not essential. Suits friendly, approachable person with good organisational skills. Email your CV to info@corkdentalclinic.com.

Cork. Experienced manager/receptionist required for modern practice. Applicants must be enthusiastic, caring, positive team players with good people skills. High level of IT skills essential. Flexibility helpful as hours may vary. Good remuneration. Immediate start. Contact claire.ring@smilesandmore.ie.

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Established practice opened in 2008 for rent from July 2016 in north Dublin. Fully fitted, computerised. Medical card, PRSI and private patients. Excellent and loyal staff. Potential to expand. Enquiries please email drenzlova30@yahoo.com.

Practice with premises for sale Dublin 9. Long-established, busy, single-handed. Three fully equipped, ground floor modern surgeries – OPG, office, waiting room. Good location, potential for expansion. Dentist retiring. No medical card. Overhead accommodation. Email: northdublinpractice@gmail.com.

For sale – mid west. Long-established, walkinable, two surgeries, freehold, leasehold flexible, full planning permission. Excellent, loyal staff. Immediate profits. Very low overheads. Huge catchment area. Very high private element. Great potential for growth. Principal retiring. Suit ambitious associate. Email niall@innovatedental.com.

For sale – south Dublin. Very busy, long-established, high-profile location with superb footfall. Excellently equipped, fully walkinable. Fully compliant, HSE, computerised. Two surgeries – expansion possible. Great potential for income growth. Low medical card. Good profits. Dentist retiring. Email niall@innovatedental.com.

South Dublin – high-profile, well-established general practice, excellent passing trade and high visibility. Top-class equipment. Room for expansion. Strong potential. Low medical card. Excellent condition, externally and internally. Priced to sell. Please email niall@innovatedental.com.

Surgery available to rent for dental specialist in Rathmines, Dublin 6. Enquiries please telephone Máirtín, on 086-834 2281, or email mbrennan@belgravedentalclinic.ie.

South Dublin. Very busy, long-established practice, superb location. Two surgeries. Ample room to expand services/hours, low overheads, loyal staff, hygienist service. Very high new patient numbers. Principal remaining as associate. Negotiable price. Contact Niall at niall@innovatedental.com.

Midlands/west. Long-established, two surgeries, freehold, busy town close to motorway, modern equipment, walkinable, excellent, loyal staff. Very low overheads, immediate profits, great potential for growth, principal retiring, suit ambitious personality. Priced for speedy sale. Email niall@innovatedental.com.

Purpose-built medical centre commencing in west Dublin. Rooms suitable for walk-in dental surgery and consulting rooms. High street location adjacent to Aldi store. On-site parking – limited competition. For further information contact aidanobrien101@gmail.com.

Established medical aesthetic/dental clinic for sale, Dublin 2. Five surgeries, circa €500,000 turnover. Two doctors and two dentists. three support staff and ample parking. Lease (12 years fixed) and superb terms/rent. Fantastic opportunity for clinician and/or potential lifestyle business practitioner. Email premiummedicaldentalsale@gmail.com.

Dental practice for sale, long established, Tralee, Co. Kerry, Ireland. Modern, progressive, busy, fully private since 2000. Good equipment, excellent support staff. Ideal opportunity for well-qualified, dynamic personality. Email germannix@gmail.com.

Practice for sale, west Cork town. Principal retiring. Lease or freehold. Very reasonable terms and conditions. Suit experienced person who would like to work in a cosmopolitan area near the sea. Flexible options available. Further details from munsterdental@gmail.com.

Practice for sale – Cork. Well-established practice, good footfall on busy high street; modern/walkinable premises, HSE compliant. Expansion possible. Excellent equipment. Busy hygienist. Low overheads. Good private percentage. Computerised. Good new patient numbers. Priced to sell. Email niall@innovatedental.com.

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Muinín agus pobail

Confidence and community

What led you to first get involved in the IDA?

When I returned to Ireland from the UK I wanted to get to know other dentists in the area. I made enquiries about the Kerry Branch and went to a few meetings. In Ireland, practices are smaller and there are not so many opportunities to meet, so meetings are very good socially as well as educationally.

What form did that involvement take?

I volunteered my services to join the Kerry Branch Committee, and then became the Kerry Rep on the IDA's GP Committee. I was Chair of the Branch for two years, and Treasurer for two years. There was a lot involved in being Chairperson, but I really enjoyed organising venues for meetings and arranging sponsorship. I was able to get back in contact with people I knew from college, etc., to invite them to come and speak. It's very time-consuming, but I was rewarded by what I gained – both in my organisational skills and personally in gaining the confidence to set up my practice.

What has your involvement in the IDA meant to you?

Many dentists shy away from even attending lectures, but they are losing out professionally and personally. We can get very insular in our own practices, but local branches are great. *Chabhraigh sé liom le fhorbairt pearsanta agus gan dabht, tá an oideachas go hiontach chomh maith.* (It has helped me in terms of personal development, and of course the educational aspect is brilliant as well.)

What has been the single biggest benefit of IDA membership for you?

The biggest benefit for me has been broadening my horizons. It spurred me on to do a postgraduate diploma in sedation. It was a huge change – after 15 years

Tralee-based general dentist and committed Gaeilgeoir Dr Marcas Mac Domhnaill gained valuable confidence from IDA membership.

out of college it was totally different from what I remembered. Everything was brand new to me, and it was brilliant. The year and a half worked wonders for me. You can lose confidence in trying new things after being in practice for a few years, but IDA membership gave me the confidence to get learning again.

How would you like to see the Association progress into the future?

Tá athraithe ollmhóra tagtha ar an slí a riartar léachtaí ón uair a bhíos ar an gcoiste. (There have been significant changes to the way lectures are organised since my time on the Committee.) Everything has to be submitted for accreditation three months in advance, and unfortunately this has led to fewer lectures taking place. It would be great if something could be done to make the process more seamless, particularly for small local branches. Perhaps a pre-approved list of lecturers and lectures could be provided, or more events along the lines of the IDA Roadshows.

It is fantastic to have the standards for accreditation – but the system needs a little tweaking to make it easier for smaller, more remote branches.

.....
 Marcas considers himself extremely lucky to live in the West Kerry Gaeltacht, and this is a very important part of his life, as 40% of his patients speak Irish, and he offers dental services as Gaeilge. He also devotes a lot of time to the Chernobyl Children's charity, and has travelled to Belarus to provide dental services to children in an orphanage there. His commitment to his patients at home and abroad was recognised last year when he was named as the Munster winner of the Sensodyne Sensitive Dentist of the Year. As if that wasn't enough, he is also a member of two choirs, one as Gaeilge, of course!

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