

# The modern day dental nurse: education and prevention (part one)

Rachel Hughes has successfully implemented a nurse-led clinic at her practice based solely on using the extended Scope of Practice to the maximum. In the first of a two-part series, she discusses how nurses can take the lead in education and prevention in relation to children's oral health

Becoming a qualified oral health educator was a key turning point for me, but it was not straightforward; the journey for me had started some years earlier. I had chosen to study the National Examining Board for Dental Nurses (NEBDN) Certificate in Oral Health Education via correspondence (online study was not available at that point) and had completed all the modules, giving me the necessary underpinning knowledge. I now needed to complete a variety of case studies and an oral health themed display. Like many nurses, I had self-funded the course and herein lay a problem—the practice where I worked was not supportive of the qualification. Completing cases studies became a struggle, resulting in not completing the necessary work to go forward and sit the exam.

A few years later, after having settled into a new practice with very forward-thinking, motivated and supportive principals, I found myself feeling passionate to yet again undertake the qualification, this time through the local college who were offering a BTEC Level 4 in Oral Health Promotion. It was very different to the NEBDN course as it focused more on how to deliver the main messages in terms of delivery of health care education and how to create motivational changes. Students were expected to already have the underpinning knowledge—the NEBDN course had given me strong background knowledge compared to other students. With that firmly under my belt, it was time to start asking

the dentists to refer patients to me. Setting up new systems within any practice is hard enough, but when it relies on dentists referring to dental nurses for that service, it feels impossible.

Even forward-thinking supportive dentists are reluctant to release control and are cautious about granting autonomy. However, with some careful vision planning and regular reviews, we not only have a good oral health education system in practice, but also a successful clinical service run by a dental nurse.

## The role of an oral health educator in practice

### Motivating children

Instilling good habits from a young age is the main key to prevention in my opinion, but for this we need to have access to the young. I am fortunate in practice to see most of our younger patients at least once a year. As a private practice, this is a benefit of membership, but it is a service all practices should be offering—the nursing team are best placed to provide such an important service, whether it is working with parents on assisted brushing techniques or giving the child the basic toothbrushing skills.

I ensure I deliver the important messages about chasing the 'sugar bugs' away, and making the right choices when it comes to sugary treats. For anyone who is struggling how to explain oral health to children, I would recommend *Open Wide... What's Inside?* by Alex Rushworth (2012), I find it works really well and can be adapted for all ages.

I will generally tend to chat to parents about the child's dexterity as well—if they cannot tie their own shoelaces or write in joined up writing then they should not be solely responsible for tooth brushing. This can sometimes lead to the parent

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revealing important information about the child, such as coordination and dexterity issues, or a learning difficulty that until now the parents have not thought to be relevant. This is, of course, helpful to know as it means as oral health educators we can tailor the session to the individual needs of the child.

Dental nurses are in a great position to build a good relationship and rapport with families and this is an important key to success. Parents can get very defensive, especially if they feel they are being criticised. It helps to empathise with them about the pressures and strains on a household and discuss some solutions.

One example of finding a solution was when I worked with a family to help improve the oral hygiene of two young girls over several months, but saw no real improvement. This led to the mother reassessing her own priorities. She decided to reduce her very long working hours and adjust her child care arrangements, which meant she could be at home and support their toothbrushing regime. The difference I now see in the girls and the family is amazing, they are both managing their oral hygiene well and understand the importance of limiting sweet treats, as well as drinking more water.

## Disclosing

I will usually disclose at the appointment, unless the child is quite nervous. For this I use Tri-plaque ID gel. It is visually very good for children as it reveals the plaque bacteria in three different colours pink/red for a thin deposit of plaque (less than 24 hours old), blue/purple for thick deposits (more than 48 hours old) and light blue indicates acid production from plaque bacteria and biofilm that have a pH level of 4.5 or lower, or in children's terms 'bugs that are doing a poo'. Explaining this to the parent/guardian and child is a great aid towards gaining cooperation and compliance.

I also find it incredibly useful to take intraoral pictures after I have disclosed, that way at review visits you can compare results visually but also medicolegally helps to create more accurate notes.

## Fluoride

I always enquire as to what toothpaste the child is using to ensure that it contains the appropriate level of fluoride, but also because fruity or bubblegum-flavoured toothpastes hinder a child's progression to move onto the toothpaste that the rest of the family uses. They are reluctant to use the toothpaste



*Figure 1. Using the tell, show, do principle helps children to understand the treatment they are about to receive*

because it is too minty or hot, and although there are toothpastes out there that are non-minty and contain fluoride, they are not readily available—it usually requires a special trip to a health shop. I am keen to prevent excuses, so if a parent says, 'Oh they won't brush their teeth because they don't like our toothpaste', I attempt to find out why. I have had success in the past by encouraging these children to try a baby toothpaste, something like Milk Teeth by Aquafresh because it has a very mild mint taste. If they tolerate this, I will move them to the next level and so on until they have settled comfortably into using an adult toothpaste. Also I remind them that toothpaste should only be a smear for under three-year-olds and no more than a pea-sized amount for over three-year-olds, as overloading can also cause a dislike of toothpaste.

An oral health education session is also a perfect time for some topical fluoride application to take place if required. Developing this extended skill is beneficial to strengthening the service. If you have previously been working with the patient then they will be comfortable and familiar with you, as the rapport will have already been established. This makes the application process easier.

## Tell, show, do

It is important that children understand what is going to happen during oral health sessions and what is expected of them. Applying the tell, show, do principle helps with compliance. For example,

with fluoride application, I would tell children about the special fruity flavour paste that will help make their teeth stronger. I will show them the paste, the cotton wool roll and the 'fuzzy brush', as well as the 'puffer'. They can feel the instruments first before you actually do the application. The same principle can be applied to toothbrushing instruction, as seen in *Figure 1*.

## Conclusion

It is important to remember that all the advice we give as dental care professionals is evidence based; as oral health educators we should take our guidance from *Delivering Better Oral Health: An Evidence-*

*based Toolkit for Prevention* (Public Health England, 2014). If you have not seen the third edition, it can easily be downloaded from Public Health England's website; it is an oral health educator's bible and will help you put your clinical protocols in place.

I love being an oral health educator and dental nurses are the key to delivering preventative messages, the role is so much more involved than simply showing someone how to use a toothbrush. DN

Public Health England (2014) *Delivering Better Oral Health: An Evidence-based Toolkit for Prevention*. PHE, London  
Rushworth A (2012) *Open Wide... What's Inside?* Rushworth Publishing, Yorkshire

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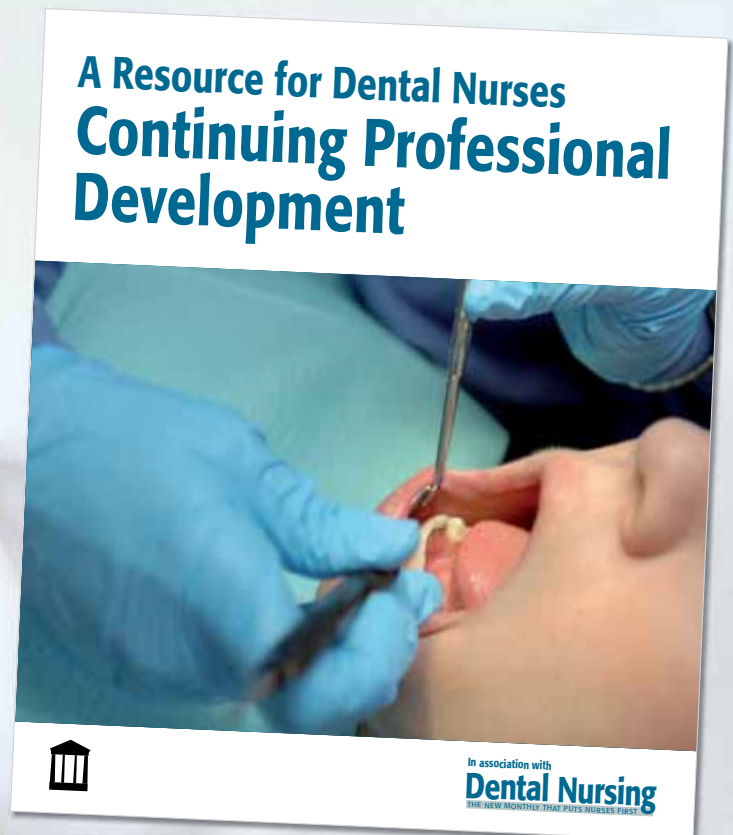
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