Handbook for Student Clinical Practice

Dental Undergraduate Programmes (BSc and BDS)

Academic Year 2025-26

BDS/Resources: BDS Term Dates 2023-2027 | MyQMUL

Version 1.0 10 OCT 2025

Contents

Introduction to this Handbook

This Handbook has been developed in conjunction with academic staff to support undergraduate patient care. Additionally, it is hoped that the Handbook will assist in the establishment of the standardisation and consistency amongst clinical staff including supervising and grading students clinical work on LiftUpp.

The marking rubrics are open to interpretation, based on clinical tutor judgment, but it is suggested that this Handbook can act as a guide when assessing and providing a rationale for the marks awarded.

Handbook Outine

The handbook has been written in sections to aid navigation:

1. Professionalism in relation to Undergraduate clinics
2. LiftUpp Calibration for Staff & Students
3. The Dental Skills Laboratory
4. Local and national guidance and associated links
5. IoD Resources

1. Professionalism in relation to undergraduate clinics

1.1 LiftUpp

Attendance and clinical activity should be logged on LiftUpp via completion of the iPad at the end of every session whether or not students directly have a patient. It is the students' responsibility to ensure that they have logged in and out of LiftUpp. If they do not do this, it will count as an absence.

1.2 Attendance

BDS and BSc students receive evaluation for all clinical teaching using LiftUpp. This means that their attendance on clinic is captured automatically so long as they have been marked "Present". Nonattendance has been problematic to record, so only attendance is reviewed.

Students must ensure that they have signed in and out of LiftUpp for every clinical and laboratory session. Failure to do this will affect their attendance data and may raise professionalism concerns which in-turn may affect their progression. It is important that all students who are assisting or who attend and sent away for whatever reason, be marked as "Present" on LiftUpp as a minimum to allow their attendance to be recorded.
The Student Support Office (SSO) will follow up with students who are not engaging to offer support but will not address professionalism or progression concerns. The year and programme leads should contact students about these, as determined by their attendance policies.

1.3 Lateness

Students should email ugdentistry@qmul.ac.uk if they are running late, so patient care can be managed. This is a professional requirement. Lateness will be documented on LiftUpp and monitored. Students may be asked to leave the clinic / laboratory depending on how late they are, the reason and the frequency of this. This will be up to the tutor and/or nurses' discretion.

1.4 Students treating students on clinic

The practice of permitting undergraduate (BSc and BDS) students to treat each other on clinic as patients has been reviewed. Whilst this can be beneficial in providing students with clinical activity when there is poor patient attendance, on balance there are risks associated with this continued practice relating to confidentiality of medical records as well as ethical issues. This is aligned to the GDC guidance which states that "you must maintain appropriate boundaries in the relationships with patients".

It has therefore been decided that the practice of UG students treating another student (even if they have MRN numbers) should cease and will no longer be allowed moving forward on the clinic.

1.5 Reporting Short notice absence

In order to manage student/staff absence more effectively, we have created a shared email for reporting absence from the clinic. Currently this is ugdentistry@qmul.ac.uk.

1.6 Staff

1. Please electronically report your absence (**before 8am)** so provisions can be made for covering from the on-call staff. Please do so by completing this form: **bit.ly/Unplanned_Absence_IoD**
2. Email your Centre administrator/Centre/UG lead or through MyHR in the usual way so it can be logged on MyHR by your Centre administrator.
3. Email the shared absence inbox bartshealth.ugdentalabsence@nhs.net.

1.7 Undergraduate Email contacts

Please make a note of the following Undergraduate email inboxes to be used. These inboxes are for staff and students only and are NOT to be given out to patients. The aim is to have one central email inbox which will be staffed by the administration teams at all three sites. The students will still be required to use message centre for follow-up appointments; the inboxes are not to be used for this purpose.

bartshealth.dentalugenquiries@nhs.net
This is for all general Undergraduate enquiries for staff and students and can be used for queries at all three sites – RLH, Barkantine, Guttman and Kenworthy Road.

bartshealth.dentalugreferrals@nhs.net
This is to be used for all undergraduate referrals, internal referrals from consultant clinics and screening forms.

1.8 Mandatory Training

There is an expectation that all staff complete mandatory training and keep up to date with this as a condition of the Honorary Clinical Contract. Please check Wired on the Barts Health intranet to review your personal record (https://weshare.bartshealth.nhs.uk/statmand).
In addition, the online portal can be used to review material and to pass the quizzes as proof of compliance with the specific requirement.

Student clinics do not take place during Trust audit sessions. This is an opportunity for staff to attend the Trust audit session and/or to use the time to make sure they are up to date with Trust mandatory training.

https://weshare.bartshealth.nhs.uk/statmand

A similar setup for students is in the process of being set up and information will be released accordingly.

1.9 Email correspondence

Students must check their emails daily. These include junk folders. Students often receive emails from Dental UG Enquiries, Violet or other members of the Trust because their patients have contacted them (usually requesting an appointment). **Students must respond within 24 working hours**.

If students are ill, or away on leave etc. then they can set up out of the 'office' emails stating the date they will return. If they are unable to answer the query immediately, they should acknowledge receipt of the email and inform them that they will get back to them by a certain date / time to allow time to investigate and respond as appropriate. **This is a student's personal responsibility** and is part of good patient care.

Not responding to emails in a timely manner is a **serious professional concern** and would need to be addressed by the Directors of UG Dental Education with escalation to **Professional Capability Committee** or **Fitness to Practice Committee** as appropriate.

Such issues would be a mark on a student's record, would be noted on GDC forms, performer list references and BDS students Educational Transition document (ETD).

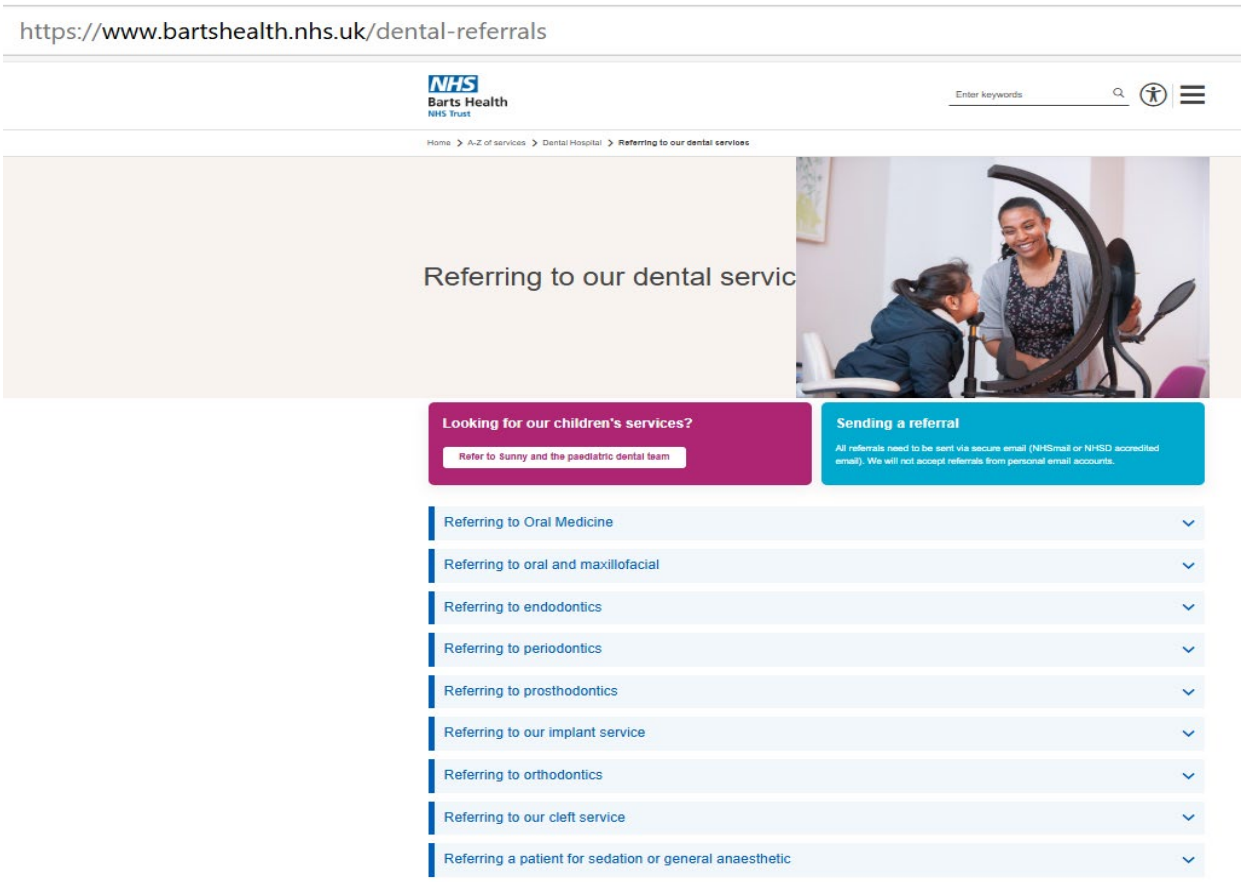
We do NOT want this to be the case for ANY student, and all staff are here to help support students with patient care or management of the patients.

If you or a student have any queries about patient bookings, discharge, etc. then please do speak with **Violet Edwards** and **Sam Corleys (UG Service Delivery Manager) at** bartshealth.dentalugenquiries@nhs.net

1.10 Staff NHS email

It is essential that you have one as a clinical tutor when communicating any patient related information. It is not secure to communicate using your QMUL email address and so it is essential that you have one. Please contact Amine Sidi amine.sidi@nhs.net, Kolchum Begum kolchum.begum3@nhs.net who can help get you signed up with an NHS email, should you not have one.

You will also need an NHS email for onward referrals of patients.
www.bartshealth.nhs.uk/dental-referrals



1.11 Staff dress code for clinics

Staff need to show best examples of punctuality, appropriate and clean uniform and shoes (blue scrub top and black trousers, unless consultant), no jewellery or watches (only small stud earrings), no mobile phones, hair tied back, no lanyards, name badge visible, and washing of hands when arriving on clinic.

Dress code for clinics can be found in the Clinical Governance part of this Handbook

1.12 Clinical, Academic and Professionalism Concerns Policy

Elements from the IoD "Clinical, Academic and Professionalism Concerns Policy" are summarised below for the purposes of this Handbook:

1.3 This policy is applicable to **all** students registered on the BDS and BSc Oral Health programmes (from now on referred to as 'students') as they are training for a professional qualification that **requires full competency and knowledge in the teaching and learning objectives delivered throughout their programmes**.

3.3 BDS/BSc are vocational programmes, where students learn through active in-person learning. Students are **expected to attend all timetabled teaching.** This

includes online teaching, small group seminar teaching, practical sessions, lectures and clinical sessions and any other timetabled activity.

3.7 **Students are expected to attend 100% of timetabled activities. If a student misses more than 10% of teaching across one or more components in a term, or absence concerns have been raised at any point during the academic year,** a professionalism concern will be highlighted.

3.8 If a student has 3 or more periods of absence during one term, a professionalism concern will also be highlighted. A period of absence is considered a single continuous absence which may vary in duration.

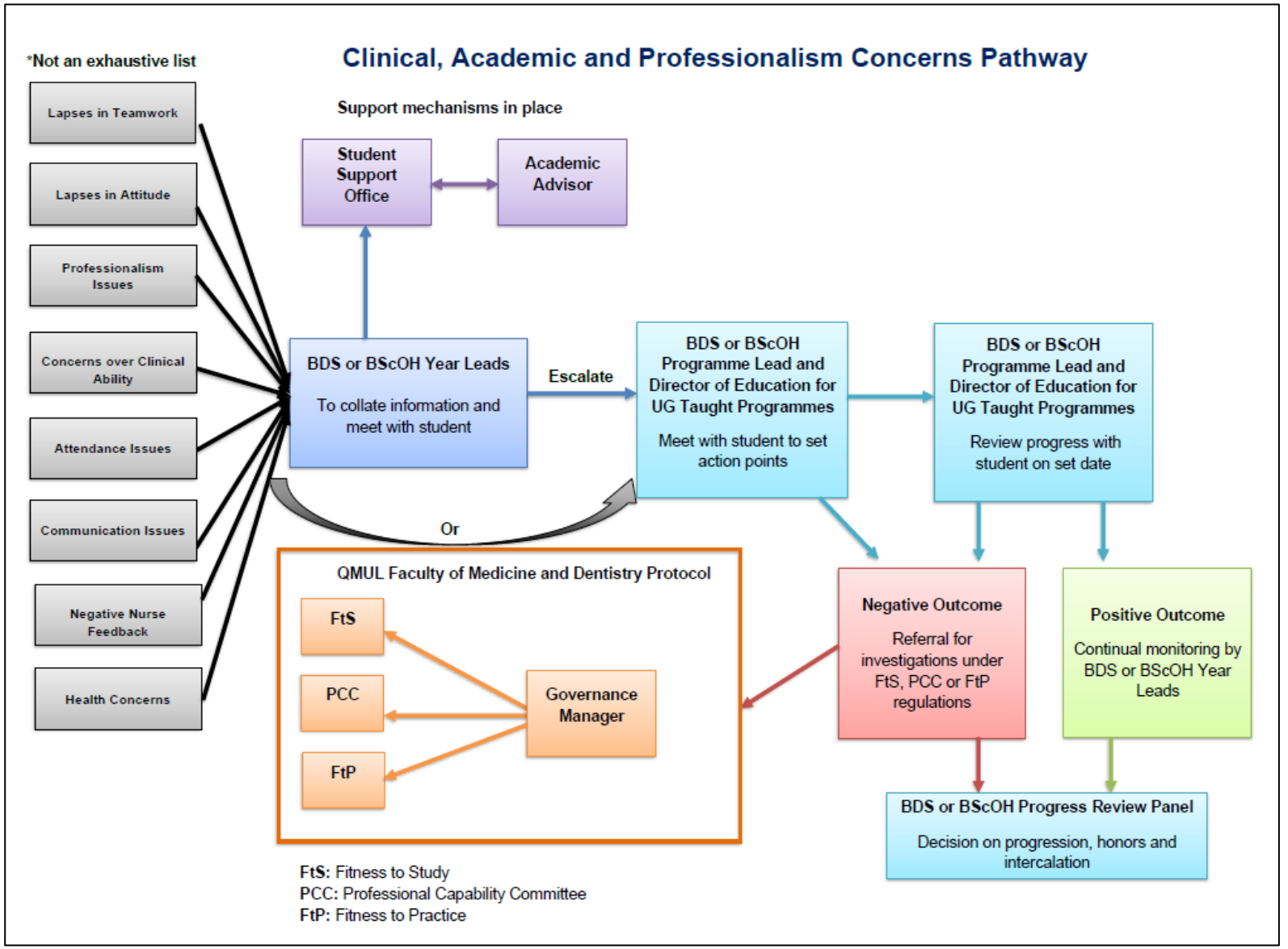
6.1 Concern for a student will be **identified by the appropriate BDS or BSc Year Lead**. Concerns may be raised by other members of staff to the Year Lead, but it is the Year Lead who will collate any information about the student and decide how to best proceed.

6.2 The Year Lead should liaise with the Student Support Office about the concern(s) raised. **Information held by the Student Support Office will be treated in the strictest confidence.** The Student Support Office can decide whether a meeting should be arranged with the student to decide if there are any extenuating circumstances for the concern, and whether it is appropriate to put support mechanisms in place.

6.3 The Student Support Office will liaise with the student's **Pastoral Advisor** to explore if there is any **information to explain the student's absence, non-engagement, lapse in professionalism or inadequate performance.**

6.4 The Year Lead will meet with the student and discuss the concerns raised. The Year Lead may then decide to put support mechanisms in place. This is Meeting 1 in the flowchart *(p.4).* Regular meetings may be scheduled to monitor the progress of the student. At the end of the academic year, the current Year Lead will be expected to share students' academic and professionalism data with the subsequent Year Lead as part of the consignment/or handover process.

1. Professionalism in relation to undergraduate clinics



2. Clinical Governance

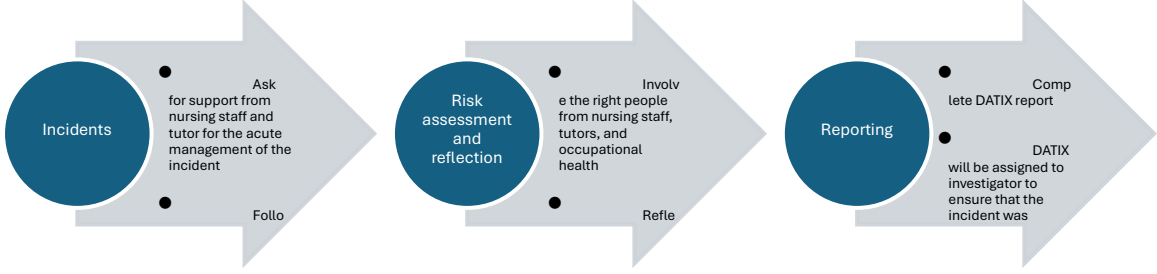
COR/POL/082/2025/001

Clinical Governance

Clinical governance is a system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Barts Health NHS Trust has a sound clinical governance structure for each directorate. Dentistry and Oral and Maxillofacial surgery directorate are classified under the surgery division. Any incident, involving staff/student or patient working in any of the clinics, should be managed according to the relevant protocol (protocols are available on the clinical governance folders in each clinic and also in the internet through WeShare) then it gets registered in an electronic database called DATIX by the reporter. The incident triaging stage is conducted by the directorate governance team, assigning it to an investigator to conduct an initial investigation within two working weeks. The initial investigation is conducted to ensure that the protocol is followed, harm is prevented, people involved in the incident are safe, and learning are identified (**Fig 1**).

Fig 1: Stages to manage incidents when happening in clinical settings.



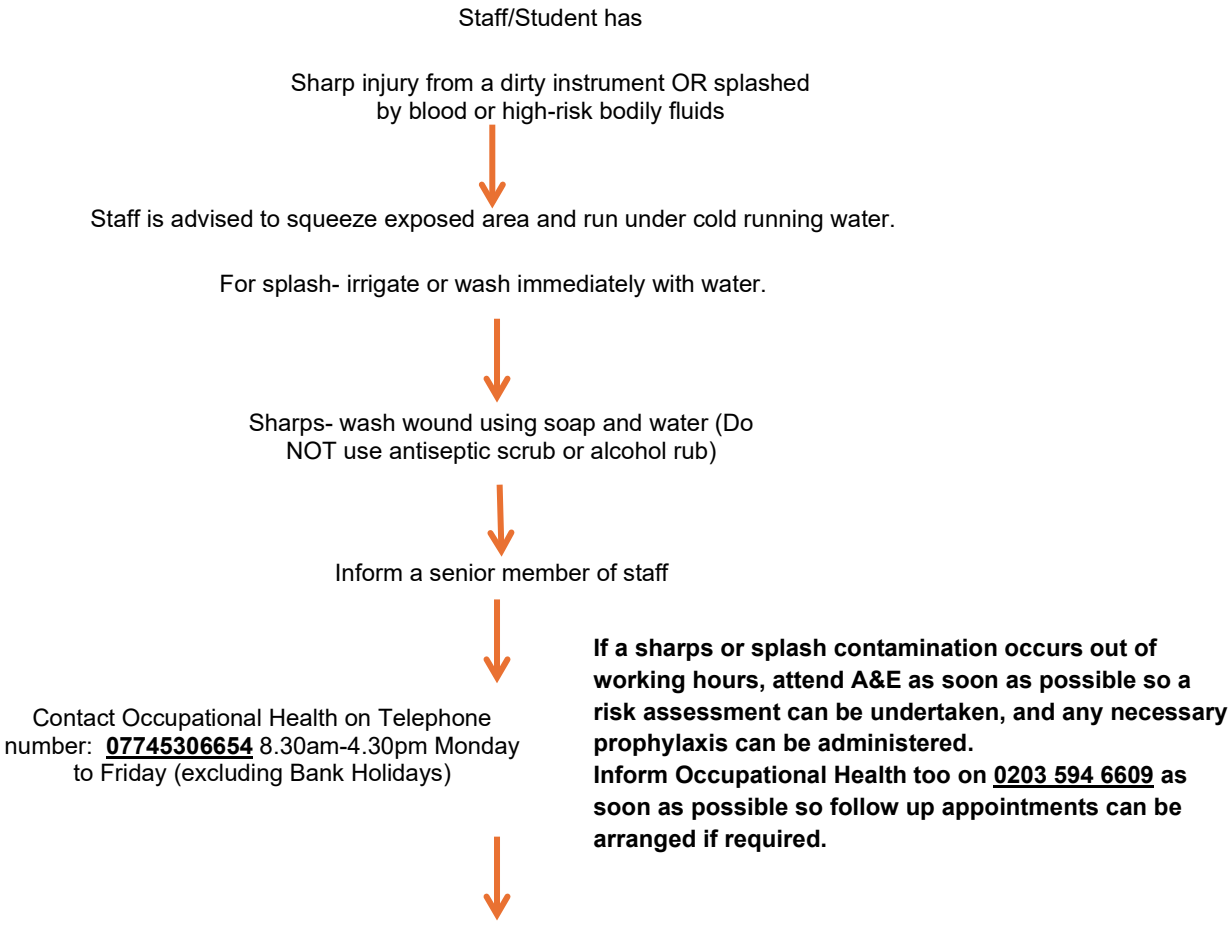
If harm identified, incidents get escalated appropriately according to its nature to try to reduce the harm as possible, and to learn from it to avoid similar scenarios in the future. The Patient Safety Incident Response Framework is implemented throughout Barts Health NHS Trust. All incidents involved patient fulfilling the national and local priorities get investigated in more detail in huddles, after action review, or multidisciplinary meetings to implement changes to avoid future similar incidents. Reported incidents and complaints help the directorate to identify risk and develop a proportionate response by designing relevant action plan to mitigate the risk and reduce it.

The clinical governance at Barts Health NHS Trust works very closely with the clinical governance in the institute of dentistry. A report is generated every month identifying incidents involving staff and students. This get shared with the institute of dentistry to communicate possible interventions required to avoid it from happening in the future. There is a website dedicated for dental clinical governance which can be accessed through the following link: Dental Clinical Governance - Institute of Dentistry - Faculty of Medicine and Dentistry. All staff and students are also enrolled in a module on QMPlus on Dental Clinical Governance which is accessible through a link on the above-mentioned website.

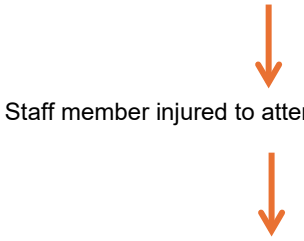
Two of the main incidents that staff and students are facing in dentistry are: (1) sharp and splash injuries, and (2) violence and abuse incidents. It is very important to be trained on how to manage these incidents.

1. Sharps and Splash injuries training are available on the following link Dental Clinical Governance - Institute of Dentistry - Faculty of Medicine and Dentistry. It is also delivered as part of year 1,2 and 3 curriculum. The policy is available in each clinic and it is also available on WeShare and the Dental Clinical Governance module. The below step by step summary is a quick aid memoire but you should consult the policy for detail (**Fig 2**).

Fig 2: Sharps and Splash injury step by step guide (please also refer to the policy in the sharp and splash folder in the clinic).



- Senior clinician or nurse, other than the injured person, should approach the patient to discuss the patient information sheet, gain verbal consent from patient for a blood test to be taken, order blood test on CRS then either (1) take the sample, if local facility and staff competency allows **(flow chart in the pack);** OR (2) send patient to a main site phlebotomy service; OR (3) refer the patient to their GP (use suggested letter proforma).
- Where possible, the same senior clinician should take some details of the patient whose blood is involved. A questionnaire provided in the Trust SOP appendix 2.
- With the patients' previous consent (which should have been documented in the patient record at the initial discussion) in case of positive results, the senior clinician who ordered the blood tests is responsible for informing the patient's GP.



Occupational Health
Health and Wellness Centre
The Royal London Hospital
31-43 Ashfield Street
London E1 2AH
Tel: 0203 594 6609

2. Violence and Abuse training is very important and available through the educational academy. The policy is available at the QMPlus Dental Clinical Governance module. It is very important to be trained on conflict resolution and how to de-escalate these incidents but please be reassured that all nursing staff are fully trained and will be able to help you. Additionally, post incident support can be provided through the students support team at QMUL and the Barts Health wellbeing team. It is very important to report these incidents to receive the right level of support. The below is the Barts Health Trust flow chart for violence and abuse management and how to flag offenders on the CRS system (**Fig 3-4**). Please refer to the full policy in the QMPlus Dental Clinical Governance module and in the WeShare website.

Fig 3: Barts Health Violence and Abuse policy flow chart (please refer to the full policy).

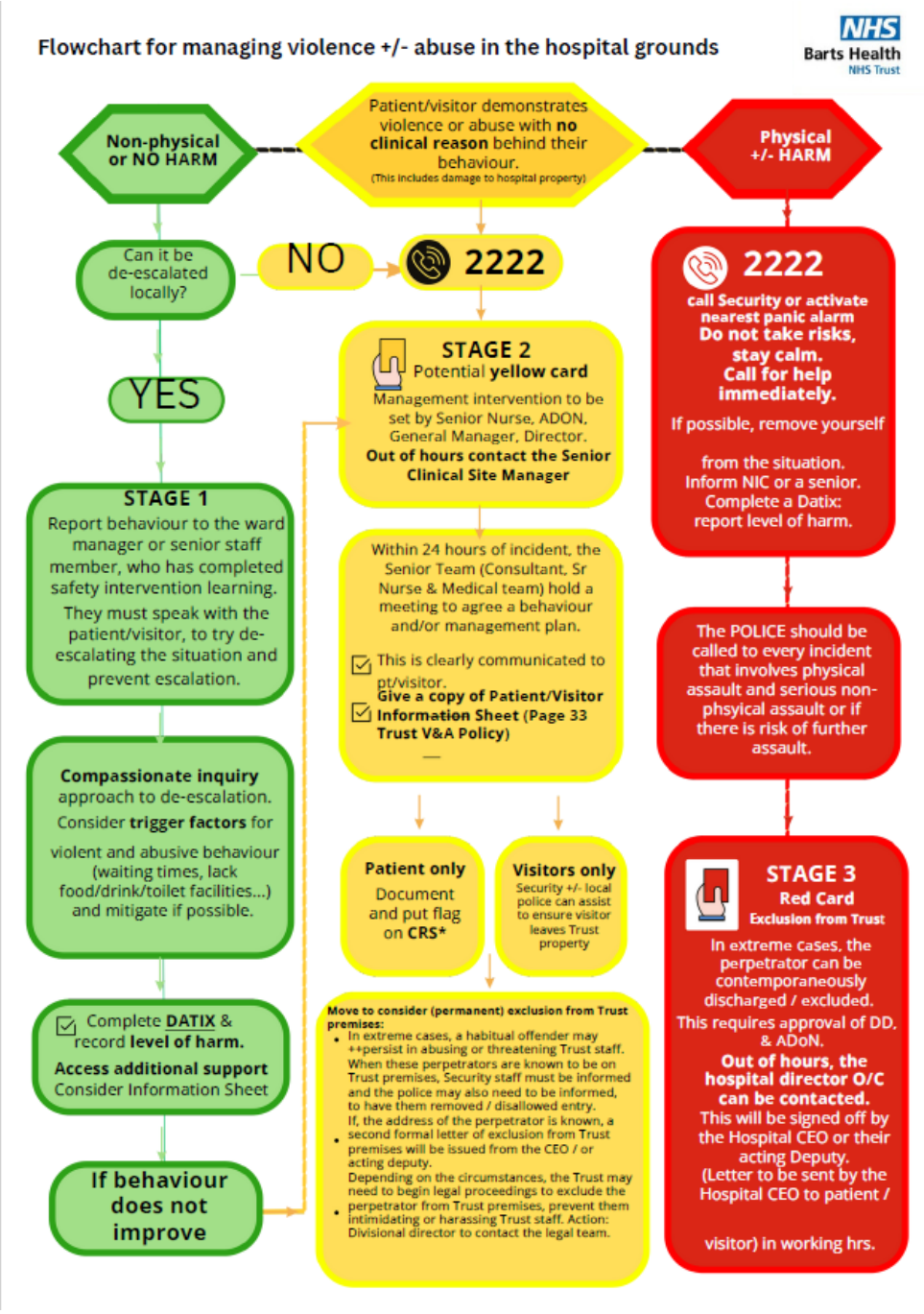
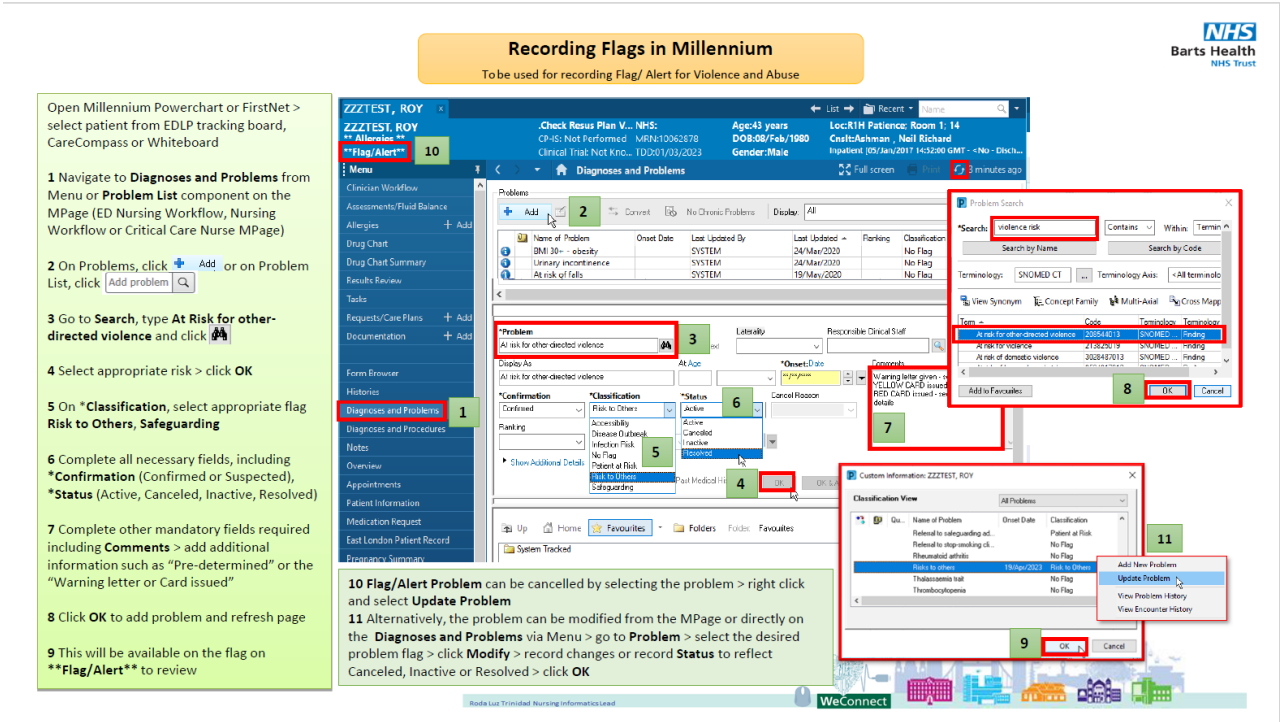


Fig 4: Guide to flag offenders on the CRS system.



The above is summary, and you are expected to refer to the full policy for more information. If you need any support in any topic related to clinical governance, please contact Dr Noha Seoudi on n.seoudi@qmul.ac.uk.

3. TRUST CORPORATE POLICY UNIFORM AND DRESS CODE POLICY

TRUST CORPORATE POLICY
UNIFORM AND DRESS CODE POLICY

APPROVING COMMITTEE(S)	Trust Policies Committee	Date approved:	03/03/25
EFFECTIVE FROM	18 March 2025		
DISTRIBUTION	All Staff Via Directors of Nursing, Group Director of People Trust WeShare		
RELATED DOCUMENTS	Hand Hygiene and PPE Infection Control Principles and Responsibilities Smoke Free Policy Loan Worker Policy		
STANDARDS	Department of Health Guidelines		
OWNER	Group Director of People		
AUTHOR/FURTHER INFORMATION	Clinical Operational Lead NHS Uniform Project		
SUPERCEDED DOCUMENTS	COR/POL/082/2022/004		
REVIEW DUE	Usually, 3 years after approval		
KEYWORDS	Uniform, shoes, badges, lanyards, scrubs, hygiene, religion, cultural, scrubs, dress code		

CONSULTATION	*Barts Health*	Site Directors & teams, policies working group, Group Nursing, Infection Prevention and Control Committee, Therapies, Chaplaincy, NMAHP Board, Network Leads and Co-Chairs Trust Policy Committee
	External Partner(s)	*NHS Supply Chain*

SCOPE OF APPLICATION AND EXEMPTIONS	**Included in policy:** *For the groups listed below, failure to follow the policy may result in investigation and management action which may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees, and other action in relation to organisations* *contracted to the Trust, which may result in the termination of a contract, assignment, placement, secondment or honorary arrangement.*
	All Trust staff, working in whatever capacity
	Other staff, students and contractors working within the Trust
	Exempted from policy: *The following groups are exempt from this policy*
	No Staff Group is exempt from this policy
	[Private sector partners (or seconded to them under the Retention of Employment arrangement) : providing Facilities Management services (Capital Hospitals Limited and its Service Providers)]

Table of Contents

UNIFORM AND DRESS CODE POLICY

1 OUR VISION AND VALUES

Our WeCare values shape everything that we do, every single day. They are visible in every interaction we have with each other, our patients their families and or carers.

WeCare includes how we present ourselves in uniform or dress code and how we behave.

All of us are responsible for ensuring WeCare values and behaviors are integral to how we implement this policy. Through this implementation together, we can affect the organizational culture and change lives.

2. AIMS AND OBJECTIVES

To ensure compliance with best practice in the prevention and control of infection.

To ensure compliance with best practice in protecting staff in health and safety matters.

To promote a professional and positive public image, which gives patients their families, and carers confidence in hospital standards and the way in which, the Trust undertakes its responsibilities.

3. PROCESS

The policy applies to all Trust staff whether on site or working remotely, this includes those with honorary contracts, subcontractors, bank, agency and locum staff from all professional, administrative, and managerial groups and volunteers. It also applies to students from all professional groups while working/training on Trust premises. The policy applies to both uniformed and non-uniformed staff groups.

Adherence to the principles of this policy is important for both staff and patient. Failure to comply will initially be managed informally however continued failure to adhere to the policy will be managed in line with the trusts Disciplinary Policy https://nhs.sharepoint.com/sites/R1H_Mexa/published/POL0056.pdf

This policy sets out standards of dress and uniform for all staff groups, as well as standards for use of protective clothing. This policy also recognizes that not all staff are required to wear uniforms, and therefore provides guidance on professional dress codes, which will maintain the positive image the Trust wishes to portray to stakeholders.
This policy has been written in line with the NHS Healthcare Uniform, as Barts Health are an early adopter of this NHS initiative.

The policy has been developed using infection prevention and control and health and safety guidance; and takes account of employer's responsibilities for respecting Human Rights and Equality and Diversity
The policy supports the requirement for a proportionate means to achieving a legitimate aim in the exercise of all decision making in reference to the protected characteristics of the Equality Act (2010).

This policy is written with acknowledgement of the requirement to ensure appropriate application in reference to all the protected characteristics, with some emphasis on gender reassignment and staff with disabilities, The introduction of the NHS Healthcare Uniform supports this further as the uniform's design

considers a range of vital aspects relating to the garment's function, comfort, and appearance- these include: -

The policy supports the requirement for a proportionate means to achieving a legitimate aim in the exercise of all decision making in reference to the protected characteristics of the Equality Act (2010).

This policy is written with acknowledgement of the requirement to ensure appropriate application in reference to all the protected characteristics, with some emphasis on gender reassignment and staff with disabilities, The introduction of the NHS Healthcare Uniform supports this further as the uniform's design considers a range of vital aspects relating to the garment's function, comfort, and appearance- these include:- replacing traditional sizing with a non-gender specific system with options of three different lengths for all garments provision of religious and cultural garments for clinical staff.

Lighter weight fabric while be made for responsibly sourced products.

This code does not form part of any contract of employment or other contract to provide services, and the Trust may amend it from time to time.

4. DEFINITIONS AND ABBREVIATIONS

Term/abbreviation	Definition/meaning
Clinical Area	Any area after the entrance to a ward, critical care or operating theatres area and entrance to a clinic room or clinical department
Clinical Care	See 4.1 for definition and examples
IPC	Infection Prevention and Control
Lanyard	Strap worn around the neck to display Trust identity (ID) badge
PPE	Personal protective equipment, specific items worn to protect the health and safety of the wearer, over and above ordinary work clothes or standard uniforms, for example, gloves, aprons, masks or theatre footwear
Uniform	Outfit prescribed by the Trust
Workwear	Clothing worn for work

4.1 Clinical Care is performing duties that include:

- Patient contact that involves patient examination resulting in contact with intact skin or carrying out any clinical procedure.
- Patient environment contact.
- Contact with equipment, charts at the end of a patient's bed such as would apply to pharmacists.
- Outpatients: whilst performing duties that involve but not exclusively: patient examination, wound dressing, collecting samples for laboratory tests.
- Working in any interventional or surgical minor procedures rooms.
- Manipulation or adjustment of any piece of clinical equipment or device that is being used in the clinical environment including patients' charts or beds.

5. DUTIES, ACCOUNTABILITIES AND RESPONSIBILITIES

5.1 Trust Board: -

Overall responsibility for ensuring the Trust has appropriate policies and procedural documents in place that are legally compliant and effective in supporting achievement of the Trust's vision and objectives.

5.2 Chief Executive: -

The Chief Executive is responsible for ensuring that the Trust is compliant with legislation and that all staff are aware of their responsibilities.

5.3 Group Director of People

Group Director of People is accountable to the Trust Board for ensuring compliance with this policy in all parts of the Trust and ensuring that the policy is reviewed and updated by the specified review dates.

5.4 Directors and Managers

It is the responsibility of directors and managers to implement this policy and comply with this policy in their area of practice. A letter of expectation should be issued to staff who fail to comply with the requirements of this policy (an editable version of this letter is available in the related document column in Mexa).

5.5 Ward/Department Managers

It is the responsibility of the Ward/Department Managers to ensure compliance with this policy and to ensure that all current and any new staff within their areas are made aware of the content of this policy, including all students and volunteers. A letter of expectation should be issued to staff who fail to comply with the requirements of this policy (an editable version of this letter is available in the related document column in Mexa).

5.6 All Staff: -

It is the responsibility of all staff to comply with the content of this policy.

5.7 Theatre Staff: -

Staff who work in theatre are required to adhere to the dress code set out in Appendix 10

6. GUIDANCE FOR ALL STAFF

At Barts Health we continue to provide the best care possible for all the people who come through our doors. As part of the NHS, it is our responsibility to be completely apolitical and non-biased in our care.

It is also our responsibility to have respect and compassion for each other, in line with our Trust values.

For the reason above it is important that we do not wear badges, lanyards, or anything else that might align us with a particular nation, political party, one side in a conflict or causes that are not directly linked to and supported by the Trust or the NHS.(for further information and clarity please see appendix 4,5&6 of the policy or contact your people advisor).

This also applies to displaying such items on workstations, desks, staff rooms, on equipment such as laptops, iPads etc.

Bart Health has a Smoke Free Policy which includes the responsibilities of staff regarding maintaining a smoke-free working environment and not smoking at work or at any location whilst in uniform (see Smoke Free Policy for details).
Staff must not chew gum whilst discharging the responsibilities of their role at work including providing care away from the hospital in or out of uniform.

All uniformed staff in scope are expected to wear designated NHS Healthcare Uniform for their clinical role this includes Bank Nurses as outlined in Appendix 8

Staff not in scope will continue to wear their trust allocated uniforms as outlined in Appendix 9.

For staff who do not wear uniform they are expected to always adhere to the dress code when at work as outlined in Appendix

Failure to comply will initially be managed informally firstly with an informal conversation, then a letter of expectation if applicable however continued failure to adhere to the policy may be managed in line with the Trust's n; however continued failure to adhere to the policy will be managed in line with the Trust's Disciplinary Policy https://nhs.sharepoint.com/sites/R1H_Mexa/published/POL0056.pdf (an editable version of this letter is available in the related document column in Mexa)

6.1. Unacceptable Clothing

In line with the above principles this policy **does not permit** any employees to wear any of the following items of clothing: -

- Skirts that are shorter than knee length
- Lycra cycling shorts or leggings.
- Leisure shorts
- Low waistband trousers showing the abdomen/lower back or allowing underwear to be visible.
- Camouflage clothing
- Transparent or "see through" blouses, dresses or shirts.
- Tracksuits
- Denim items including jeans and jackets.
- Excessively wide legged/flared trousers
- Clothing with tears, holes, and rips
- Low-cut T shirts or blouses
- Strapless, spaghetti/shoestring strapped or revealing tops.
- Items of clothing bearing logos, slogans, or graphics e.g. sport team related attire
- Baseball caps or hats meant for outside use.

Failure to comply will result in a letter of expectation being issued (appendix 12) however continued failure, e.g., when this occurs more than once, to adhere to the policy will be managed in line with the Trust's Disciplinary Policy.

6.2. Bare Below the Elbows

ALL Staff entering any clinical area or department must be bare below the elbows. This is to ensure staff can undertake good hand hygiene (DoH 2010).

Where for religious reasons staff wish to cover their forearms and wear bracelets they can do so when not in a clinical area. All staff working in a clinical area must ensure sleeves and religious bracelets can be pushed up to the elbow and secured in place to when undertaking hand hygiene and delivery of care.

For Staff in clinical areas removable sleeves are available as part of the national uniform and can either be pushed up above the elbow or removed completely prior to undertaking hand hygiene or delivery of care. They are not disposable and will be laundered in line with the policy.

Disposable sleeves are available if required for the safe delivery of medications.

6.3. Badges and Lanyards

Lanyards are not to be worn by any staff on any of the hospital sites or by trust employed staff in the community as they are an infection control risk and ligature risk to both staff and patients-

ID badges should be attached to uniform or clothing via retractable badge holder this will be provided to staff when their ID Badge is issued.

All staff must wear a valid Trust ID badge clearly displayed while at work.

All staff as well as their trust ID should wear their yellow “hello my name is badge.”

The following badges are approved however only **2** can be worn at any one time.

- The badge of a professional organization or role including a union
- Qualifying badge
- Trust Diversity Network badge-
- National campaign badges-however only to be worn for the period of the campaign, e.g., poppy appeal, black history month.

Staff must take ID badges home after work (but not worn or visible outside of work) in order to regain access to the Trust during a major incident as ID is required to be shown on arrival at the site.

6.4. Allocation of NHS Healthcare Uniforms

All staff will be allocated a uniform based on their professional registration in line with the NHS Uniform

Staff without a professional registration will either be allocated a HealthCare Support Worker Uniform or a Health Science Practitioner uniform dependent on their role in line with the NHS Uniform

The allocation of unform is related to a person’s Role and not Band, and therefore staff of varying Bands can be in the same uniform. As described in appendix 8

The use of Name Badges will identify a person’s job title as well as the use of the Nurse in Charge Badge (or similar)

6.4.1 The allocation of the **Matron’s uniform** will be for staff who fulfil all aspects of the Matrons Handbook and are employed as a Matron within a clinical division- not a single service or specialty.

6.4.2 The **Team Leader** Uniform is only allocated to nursing and midwifery staff as per the NHS National Uniform guidance.

6.4.3 The allocation of the **Team Leader Uniform** will be for staff who manage an inpatient ward or outpatient department and are responsible for the day-to-day management of the unit as well as staff and are the initial point of escalation for staff, patients, families, and carers.
Allocation of the **Advanced Clinical Practitioner Uniform (ACP)** will be for staff who, are employed as an ACP within a clinical area or specialty have an ACP job description or are in an ACP training post with a confirmed ACP Job role at the end of training. All ACPs should be on the Trust ACP Register

6.4.5 All qualified **Allied Health Professionals** will be allocated their professional uniform regardless of their Band unless they fulfill the criteria as stated above and then will be allocated an ACP uniform.

The uniform range includes a variety of cultural garments, reflecting the diversity of the NHS workforce and the communities we serve. This includes removable sleeves, headscarves, turbans and kippahs and these will be provided to all uniformed staff.

6.5 Theatre Scrubs

Theatre Scrubs are not sterile and are not part of the dress code but are worn in designated clinical areas where frequent changes of clothes may be necessary due to infection control hazards and body fluids.

Each hospital will maintain a list of areas where theatre scrubs are to be worn as standard uniform and will be held and updated by the Director of Nursing for the Site. outside of those areas, they should only be worn when instructed to do so by the operational management team, Director of Nursing or the Infection Prevention and Control team.

Scrubs can be worn anywhere within Trust premises by those working in areas authorized to do so however must be covered by a warming jacket.

Staff wearing scrubs must not leave the Trust premises while in scrubs. This includes going to and from work and visiting off site shops and amenities wearing scrubs.

Staff are issued with scrubs daily. After use, scrubs must be placed in designated area to be collected for laundering.

Access to the scrub machine will be limited to staff who are authorized to wear theatre scrubs.

If scrubs are needed due to contamination of a clinic uniform, then the staff will need to speak with the team leader in theatre and request a set. They must be returned at the end of the shift to the department for collection.
Staff who continue to wear theatre scrubs outside of designated areas and therefore are not adhering to the policy will initially be managed informally by being issued with a letter of expectation, however continued failure to adhere to the policy may result in the individual being managed in line with the Trust's Disciplinary Policy
https://nhs.sharepoint.com/sites/R1H_Mexa/published/POL0056.pdf (an editable version of this letter is available in the related document column in Mexa)

6.6 Undergarments, hosiery, and socks

Tights worn with uniforms should be neutral or black in color with no patterns.

If socks are worn by staff members wearing dresses or shorts, they should be neutral in color and not visible (for example trainer socks)

T-shirts or vests worn under uniforms must be clean, short sleeved and if visible the color of the allocated uniform trousers either navy or black.

6.7 Footwear

Footwear for all staff must be well fitting and offer sufficient protection, including impervious soles.

Uniformed staff must wear low heeled, closed toe black shoes or trainers with non-slip soles.

No flip-flops, Crocs or open toed footwear are permitted.
Trainers are to be free of logos.

Fabric shoes must **not** be worn within the clinical area due to the risk of absorbing bodily fluids and risk from sharps, this includes mesh like trainers.

Theatre shoes must be anti-static impervious sole clogs.

Theatre wellington boots must be removed before leaving the theatre complex.

Theatre shoes may be worn when moving between departments or transferring patients but must not be worn outside the hospital building.

Staff should ensure that their theatre shoes are clean before leaving the theatre suite.

Footwear worn in theatres must be cleaned regularly (at least once per week if not otherwise soiled) to remove splashes of blood and bodily fluids.

6.8 Headwear

If wearing a kippah or turban for religious or cultural reasons this must be clean and securely attached to the head. For uniformed staff this will be provided as part of your uniform

If wearing a headscarf (for religious or cultural reasons) this must be securely attached to the head and tucked into the upper clothing.

Headscarves for all uniformed staff will be provided as part of their uniform in line with the new NHS National Uniform Guidance and will be matched to the color of the uniform trousers-navy or black.

6.9 Personal Hygiene

Personal hygiene is important in delivering effective clinical care and the highest standards of hand hygiene including **BARE BELOW THE ELBOWS** (which includes an appreciation of issues of religious beliefs, cultural norms, and disability) must be always adhered to.
Staff are reminded that their role may require close personal contact. All staff must ensure a good level of personal hygiene is observed.

Clean and pressed uniform and non-uniform clothes must be worn when at work and be changed daily.
Soiled uniform or scrubs should be changed as soon as reasonably practical.

6.10 Hair

Hair must be clean, neat and tidy.

For all uniformed staff hair must be off the collar

Long hair must be tied back and secured in a way that prevents it falling forward and ensures it remains above the collar when working in a clinical setting.

Hair fastenings in the clinical area should be minimal and black, navy, or neutral in color and discreet.
Fringes must be above the level of the eyes and if longer tied back.

Hair colors and styles should present a professional appearance in all patient facing areas

If wigs or toupees are worn these are to be secured to ensure they do not fall off. They need to be washed as frequently as natural hair.

Beards must be always kept neat and tidy. Long beards must be secured off the uniform/shirt in a manner to prevent it falling forward (e.g. by plaiting or via use of a beard net).

6.11 Fingernails
Should be kept clean, short and neat.

6.12 Fingernails for Staff working in Clinical Areas
Nail varnish, false fingernails, nail extensions (with a tip or sculpted) or nail overlays, including acrylic, gel coated, crystal, polygel, fiberglass or silk nails, nail art or nail jewelry/gems are not allowed to be worn as these substances compromise hand hygiene.

6.13. Make–up, perfumes and aftershave.
Make up should be discreet and not draw undue attention. Perfumes and aftershaves should be subtle as some patients and others may be nauseated by overpowering smells.

6.14 False eyelashes in clinical areas
Staff working in clinical areas should not wear any form of false eyelashes. This is inclusive of strip lashes, individual flare lashes and individual single lashes that are either glued on or applied via eyeliner and magnetic strip.

6.15 Tattoos
It is recognized that today many individuals now have tattoos. Tattoos in areas that remain exposed when wearing a uniform must not be offensive. It is for managers to discuss with individual staff members the appropriateness of their tattoo being on display where it is considered inappropriate or likely to cause upset to patients, carers, visitors, or other staff. The individual may be requested to cover the tattoo with an appropriate dressing.

Semi-permanent tattoos are permitted e.g. Henna tattoos. However, the paste/dye must have been washed off the skin completely this is to ensure compliance with IPC guidelines.

Temporary Tattoos e.g. Sticker or transfers are **not permitted** due to the risk of the transfer coming off during patient care.

6.16. Jewellery & Watches
For non-uniformed, non-clinical staff, jewellery and watches need to be in line with Health and Safety requirements and promote a professional image, and when entering a clinical area, they must adhere to the guidance for clinical staff as below.

For clinical staff (both uniformed and non-uniformed) jewellery is restricted to: -

- one pair of small stud-type earrings
- plain band with no engraving and nose studs.
- No hoop earrings or nose rings are permitted.
- No rings with stones permitted.

Staff entering a clinical area will be asked to remove rings with stones as, compromise effective hand hygiene.

Wristwatches and electronic fitness monitoring devices must not be worn by any staff in any clinical setting; however, they can be attached via a bicep band, around the ankle or as a fob watch. They harbor many organisms, compromise effective

hand hygiene and could in certain situations, such as delivering direct patient care, cause injury to patients, staff, or visitors.

Religious bracelets/medic-alert bracelets can be worn but must be loose enough to be pushed up and secured at the elbow to allow for hand washing and during clinical care. A mangal sutra (a sacred thread/marriage necklace) must be secured underneath clothing/uniform so that it is not visible or dangling.

No necklaces, chains, bracelets, ankle chains are to be worn in the clinical areas. This includes items in all metals or materials, including those worn for therapeutic purposes apart from those mentioned above.
No visible body jewellery is to be worn. This includes ear jewellery not worn in the ear lobe, tongue studs and other visible body piercing (DH, 2010)

The Trust will not be liable for any injury sustained by an employee caused by the wearing of any jewellery.
The security of an employee's jewellery remains the responsibility of the wearer even if they have been asked to remove it. The Trust is not liable for any loss.

6.17 Ties

Ties are to be removed prior to carrying out patient care in any clinical setting.

When entering a clinical area ties should either be removed or tucked securely into the wearer's shirt.

6.18 Fleeces and outer garments

Fleeces are only to be allocated and worn by staff if it is part of their designated uniform as per appendix 8&9

No outer garment should be worn when entering a clinical area-this includes fleeces, cardigans, and jackets. Coat hooks should be utilized at the entrance to every ward/department where available or placed in the designated area for staff belongings.

Plain navy-blue cardigans/sweatshirts must not be worn whilst attending patients, but may be worn outside the clinical area, for example, in staff rest areas and staff restaurants (DH, 2010)

7. PERSONAL PROTECTIVE EQUIPMENT FOR STAFF

Uniforms/workwear become contaminated with micro-organisms during clinical duties. It is, therefore, essential that the disposable protective clothing that is supplied for staff is used when providing direct patient care and/or when exposure to blood and body substances is anticipated.
Personal protective clothing must be changed between patients and tasks. See relevant infection prevention policies for additional guidance which can be accessed via WeShare.

The Personal Protective Equipment (PPE) at Work Regulations 2022 form part of health and safety regulations.

Items supplied by the Trust for this purpose include respiratory protective equipment, aprons, gowns, safety footwear, gloves, eye and ear protection, high visibility and waterproof clothing and should be worn when required.

8. TRAVELLING TO AND FROM WORK

Hospital based Staff are not permitted to wear their uniform outside of trust premises, and should change into uniform on arrival at work and change before leaving to go home, this includes staff who are travelling using personal modes of transport.

If changing on-site presents difficulties, permitting employees to commute in uniform can alleviate physical strain and improve workplace accessibility- therefore where employees with a disability require it, this adjustment will be provided to promote inclusivity and wellbeing in discussion with their line manager.

Members of staff are encouraged to seek advice from their line managers for identification of suitable changing facilities.

Trust staff must **not** go into any commercial premises (except those on the hospital campus) in uniform; this includes shops that are outside the designated campus area.

9. STAFF WORKING IN THE COMMUNITY

Staff may need to work in various settings in the community and therefore they may not be expected to always wear a uniform.

Community based staff when in a clinical setting as described in Section 4.1 wear the appropriate NHS uniform as per their role and a single uniform will be provided.

It is essential that at all times staff adhere to robust infection, prevention and control precautions whilst working in the community- i.e. bare below the elbows and the wearing of PPE whilst carrying out clinical tasks.

The type of dress code and when uniform should be worm should be discussed during the recruitment process.

If an individual is found to be wearing clothing that is felt inappropriate, it is the responsibility of their line manager to deal with this in the first instance.
Staff always present a professional image no matter what the setting.

10. NEWLY QUALIFIED STAFF

All newly qualified health care professionals and internationally recruited staff awaiting NMC PIN numbers at the time of employment must wear a health care support worker uniform until the Trust formally receives their PIN Number.

These staff should wear a name badge which clearly defines their role as a Health Care support worker.

11. WORKWEAR FOR HOT WEATHER

During periods of extreme heat, the following changes may be made to the uniform policy at the discretion of the Director of Nursing and/or Head of Service.

Uniformed staff who wear tights are exempt from wearing them if they wish.
All staff not in the scope of the NHS Uniform are allowed to wear smart knee length shorts should they wish to do so.

12. ORDERING PROCESS FOR CLINICAL UNIFORMS

Clinical Uniforms are to be ordered via Supply Chain Catalogue on Oracle by Ward, Unit or Department Manager.

This will then be signed off by the Associate Director for Nursing (AdoN) or equivalent for Service or Speciality only then will the allocated uniform be dispatched by the supplier. Prior to signing off Adon will check Healthroster to ensure that staff do not already have a correct allocated uniform.
The Ward, Unit or Department Manager will add the allocated uniform to the individuals Healthroster as a Uniform Skill- this is to ensure governance and the correct allocation of uniform as depicted **in Appendix 8**

13. MONITORING THE EFFECTIVENESS OF THIS POLICY

Issue being monitored	**Monitoring method**	**Responsibility**	**Frequency**	**Reviewed by and actions arising followed up by**
Management of the uniform and dress code policy in practice remains within the sphere of responsibility of the departmental manager and any breaches of the uniform/dress code policy must be addressed in the first instance at this level.	Annual audits of compliance. Monitored during senior nurse and senior leaders back to the floor clinical Fridays	The annual audit (appendix 12) will be led by the Hospital Director of Nursing and supported by infection control and nursing leadership teams and well as management teams	Annual as well as ad hoc by line managers	Directors of Nursing will review in their specific areas

APPENDIX 1: Policy Change Log

Change Log – Policy Name		
Substantive changes since previous version	**Reason for Change**	**Author & Group(s) approving change(s)**
Substantive changes since previous version	Reason for Change	Author & Group(s) approving change(s)
Inaugural Barts Health New Uniform Policy	Trust Merger	Associate Chief Nurse
Update	Bare below elbows wording	Chief Nurse / TPC
Update February 2018	Revision to bring in line with Trust Values and Behaviour and revised national guidance	Director of Nursing, Whipps Cross Hospital
Updated July 2018	Provision for changes to uniform in hot weather	NMAHP SLT, DIPC and Chief Nurse
Update June 2022	Routine update to wording and minor procedural changes pending comprehensive review with the advent of national uniform for specific staff groups	Director of Nursing, Workforce and Professional Standards; NMAHP
Update January 2025	Comprehensive Review in line with Trust adopting National Uniform for all clinically facing staff within scope. Adding of Trust policy regarding wearing of Political slogans, pins and badges Tightening of compliance with policy Removal of Lanyards for all Hospital site-based staff and guidance on appropriate badges	Clinical Operational Lead for NHS Uniform Project (Secondment)

APPENDIX 2: Impact assessments

Equalities impact checklist - must be completed for all new policies

EQUALITIES IMPACT CHECKLIST

Which groups of the population do you think will be affected by this proposal? **Other groups :**	
minority ethnic people (including gipsy/travellers, refugees & asylum seekers	people of low income
women and men	people with mental health problems
people in religious/faith groups	
disabled people	
older people, children & young people	staff
lesbian, gay, bisexual & transgender people	any other groups
N.B. The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed.	What positive & negative impacts do you think there might be? Cultural Garments are available, Gender Neutral sizing, clarity for patients on staff roles-supports patient safety
	Which groups will be affected by these impacts? Staff and patients
What impact will the proposal have on lifestyles? For example, will the changes affect:	
Diet and nutrition? Nil	
Exercise and physical activity? Nil	
Substance use: tobacco, alcohol or drugs? Nil	
Risk taking behaviour? No	
Education and learning or skills? No	
Will the proposal have any impact on the social environment? Things that might be affected include:	
Social status-no	
Employment (paid or unpaid)-No	
Social/family support-No	
Stress-No	
Income-No	
Will the proposal have any impact on:	
Discrimination? Yes but positive as gender neutral also greater sizing options	
Equality of opportunity?	
Relations between groups?	
Will the proposal have any impact on the physical environment? For example, will there be impacts on:	
Living conditions? No	
Working conditions? No	
Pollution or climate change? Yes the fabric is	
Accidental injuries or public safety? No	
Transmission of infectious disease? Positive yes	

Will the proposal affect access to and experience of services? For example:
Health care- NO
Transport-NO
Social Services-No
Housing services-No
Education

Equalities Impact Checklist: Summary Sheet

Positive Impacts (Note the groups affected)	Negative Impacts (Note the groups affected)
Incorporates peoples cultural and religious beliefs. Uniform Funded by trust. Reduces the risk of cross infection and supports good health and safety at work. Gender neutral sizing and wider range of sizing available as standard	No negatives detected
Race Equality Does the policy take account of race equality legislation and the Trust's Race Equality Scheme?	See: Race Equality Scheme, Equal Opportunities Policy
Disability discrimination Does the policy take account of DDA legislation? Age discrimination Does the policy take account of relevant legislation? Gender discrimination Does the policy take account of relevant legislation?	See: Equal Opportunities Policy, Employment of People with Disabilities Policy See: Equal Opportunities Policy, Working beyond Retirement Age Policy See: Equal Opportunities Policy

Additional Information and Evidence Required

N/A

Recommendations

Promote Compliance

From the outcome of the Equalities Impact Assessment, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?

Manager's Signature: **Date: 21/02/2025**

Organisational Impact Assessment

Name of policy	Uniform and Dress Code			
Date of impact assessment	21/02/2025	**Completed by:**	Polly Payne	**Clinical Operational Lead for NHS Uniform Project (Secondment)**

Area for consideration	**Description of issue**	**Trust contact**	**Policy author description of how issue has been taken into account in the policy/guideline**
Financial impact on Trust	Does the policy impose an additional direct or indirect financial cost on the Trust and how will this be managed?	TBC	Budget allocated to cost centre code for individual units Potential on going cost of providing Bank Staff Uniforms
Impact on PFI Service Providers	How will the policy impact on the volume/cost of services provided by the Trust's PFI partner and how has this been addressed?	TBC	N/A
Impact on other partner organisations	How will the policy impact on other partners?	TBC	Bank Staff required to wear allocated uniform

APPENDIX 3: REFERENCES

Department of Health (2010). *Uniforms and work wear: Guidance on uniform and work wear policies for NHS employers*
http://webarchive.nationalarchives.gov.uk/20130124054344/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114754.pdf

Equality Act (2010). *Chapter 15*
https://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

The Health and Safety at Work Act (1974) Section 2:
Covers risks to employees.
Section 3: Covers others affected by their work (e.g.) patients
http://www.legislation.gov.uk/ukpga/1974/37/pdfs/ukpga_19740037_en.pdf

The Control of Substances Hazardous to Health Regulations (COSHH 2002)
http://www.hse.gov.uk/coshh/index.htm

Further information about COSHH and its applicability to infection control can be found at
http://www.hse.gov.uk/biosafety/healthcare.htm

Further information regarding the NHS Uniforms can be found at NHS Healthcare Uniforms » NHS Supply Chain

APPENDIX 4: UNIFORM & DRESS CODE FOR UNIFORMED STAFF

POLICY	RATIONALE
Appearance: Wear the correct uniform. Dress in a professional manner which is likely to inspire public and colleague confidence in hospital standards and standard of care.	Dress and appearance are important factors in promoting the professional image of the Trust. This also promotes good health and safety, infection control and security for patients/clients, their families, other staff and visitors to the Trust.
Hair: Hair must be neat, off the face (including fringes) and collar. Hair coverings must be plain in colour and close in colour to the appropriate uniform. All headwear must be secured discretely and changed daily. Veils which cover the face are not practical in the clinical setting as they impose a communication barrier with patients and therefore must not be worn.	Hair carries a wide range of bacteria and professional standards and confidence in staff is retained when staff appear well groomed to patients. Loose veils and headwear possess an infection control risk. Veils and headscarves must not prevent effective communication with patients and families.
Fingernails: Must be clean and short. Nail varnish, acrylic and false nails of any kind are not permitted.	Prevention of infection transmission. Reducing the risk of injury to patients when involved in direct care.
Political Attire Wearing or displaying political symbols e.g. badges, lanyards, or clothing with political slogans, ideology or national flags.	This is not permitted in order to adopt a position of political neutrality and foster and environment of inclusivity We know, from feedback, that this could cause worry and even fear for some of our patients or colleagues
For clinical staff (both uniformed and non-uniformed) Jewellery is restricted to small earrings, Plain metal band with no engraving and nose studs. No hoop earrings or nose rings are permitted. Nor are rings with stones permitted. Wrist watches, including electronic fitness devices, must not be worn in the clinical area.	Jewellery harbours bacteria, which creates an infection control risk, particularly if worn on the hands/wrists, which will impede good hand hygiene. Jewellery may also be a hazard to patients when delivering care, particularly loose, hanging jewellery, which can also be harmful to staff if pulled upon by patients during the delivery of care.

POLICY	RATIONALE
Where for reasons of religion or to convey health information (e.g., Med-alert bracelets) members of staff wish to wear bracelets, they must be able to push the bracelets up to the elbow, covered and secured with tape for hand hygiene and direct patient care activity, or in direct contact with patient care activity, or in direct contact with patients' environment. Where, for reasons of religion or belief, or to convey health information, staff wish to wear a necklace, this will be considered in terms of the specified requirements of the particular religion or belief/or health concern.	**NOTE:** In reference to health issues, staff will be permitted to retain the necklace as long as it remains out of access to patients.
Tattoos: Permanent visible tattoos do not have to be routinely covered up unless they are deemed offensive and distracting. This will be discussed with your line manager on a case to case basis	Tattoos may be unsettling for some people.
Make-up: Uniformed clinical staff must make sure that make-up is discreet and maintains professionalism. Detachable false eyelashes are not permitted.	To maintain professionalism and public confidence Risk of dislodgement in the clinical area causing infection or safety risk
Footwear: Uniformed staff must wear low heeled, rubber soled, closed toe, black or white leather or leather look shoes in good condition. **Crocs™ and Crocs work shoes, open toed sandals, flip-flops and canvas or suede shoes are <u>not</u> permitted.** Trainers (leather or leather effect) are permitted only if they are all black, black with a white sole or white and plain without garish logo or design, with a sturdy surround. Anti-slip, impervious to fluids and protective against needle stick etc. clinical clogs must only be worn in designated areas i.e., Theatres.	To reduce noise levels for patients. To ensure that staff are able to respond rapidly in emergency situations. To ensure staff are protected from spillage or body fluids. To facilitate safe moving and handling and reduce staff risks of trips and falls

POLICY	RATIONALE
Belts: Uniform belts must have smooth edges and be positioned so as not to harm patients during clinical care/contact. Belts must be cleaned as a minimum standard at the beginning and end of every shift.	To reduce the risk of injury to patients during care interventions. To maintain good standards of infection control
Uniform and Clothing: Staff to wear the allocated NHS uniform for their Role. The uniform must be well fitting (not tight) clean, tidy and worn in the correct way without modification. All shirts/blouses must be buttoned with no more than one button opened at the neck. White coats must NOT be worn in clinical areas or when delivering patient care/treatment. **NOTE:** Barts Health provides uniforms for pregnant staff.	Uniforms help patients and relatives to identify staff. Uniforms worn in a poor state of repair or untidiness indicate a lack of professional pride and may imply poor standards of care to patients and relative. Cuffs can become contaminated when working in direct clinical contact with patients and therefore the need to maintain excellent standards of hand, wrist and forearm hygiene is essential to prevent cross contamination and spread of infection between patients during the course of care delivery. To portray a professional image at all times. To prevent spread of infection and cross contamination between patients
Cardigans: These additional outer garments may be worn; however, they must be plain and meet local guidance. They must never be worn when engaging in direct patient care and must never be worn around the waist.	To reduce the risk of cross infection. To promote a positive image to staff to patients
Washing/Laundry Guidance: For effective washing and decontamination of clothes work in a clinical setting, washed either via the Trust laundry service or at home. When washing uniforms or work wear at home, the clothes must be washed at the hottest temperature suitable for the fabric.	Washing uniforms or work wear at 60 degrees Celsius destroys most micro-organisms. To prevent cross contamination and enable uniform to be washed at highest possible temperature. In addition to the principles outlined in the above section, healthcare professionals, who do not wear uniform, have a responsibility to

POLICY	RATIONALE
Uniforms should be laundered separately from domestic laundry. Uniforms should be carried in a separate bag both when clean and when used.	minimise the spread of HCAIs by wearing appropriate clothing in the clinical setting. Microorganisms are frequently carried on clothes, and this represents a potential source of HCAI in the clinical setting. To prevent contamination of clothes and potential spread of infection between patients.

APPENDIX 5: DRESS CODE FOR NON-UNIFORMED STAFF

NB includes staff who come into general contact with patients or members of the public.
NB For staff directly involved in patient care see Appendix 6

POLICY	RATIONALE
Acceptable Clothing All staff must at all times maintain professionalism and adhere to infection control policies and practices. Work wear should promote trust and confidence in hospital staff by public **Unacceptable Clothing** For non-uniform wearing staff, examples of unacceptable clothing can be found listed at 6.1 in the policy Blatantly visible undergarments are also considered inappropriate clothing. Any clothing that is sufficiently long that it touches the ground when walking is not acceptable on safety and hygiene grounds. Clothing bearing any inappropriate slogans must not be worn including political slogans	To reduce the risk of infection being brought in and out of the hospital environment. Dress and appearance are important factors in promoting the professional image of the Trust and to good health and safety, infection control and security for patients/clients, their families, other staff and visitors to the Trust
Wearing or displaying political symbols e.g. badges, lanyards, or clothing with political slogans, ideology or national flags.	This is not permitted in order to adopt a position of political neutrality and foster and environment of inclusivity We know, from feedback, that this could cause worry and even fear for some of our patients or colleagues

APPENDIX 6: DRESS CODE FOR NON-UNIFORMED CLINICAL STAFF

NB covers includes all clinical and medical staff directly involved in patient care)

POLICY	RATIONALE
Cuffs become heavily contaminated and are likely to come into contact with the patient. Sleeves must be rolled up, or short-sleeved shirts and blouses must be worn in clinical areas at all times. All clinicians and students must observe the following guidance when working in clinical areas. The standards listed below are mandatory for all clinical areas Jackets must be removed. Bare below the elbows when in clinical areas, during all direct patient contact and during hand washing. Ties are not to be worn in clinical areas Long necklaces removed. Wristwatches removed, and any hand jewellery removed except one plain wedding band. Hand/wrist jewellery can harbour micro-organism and can reduce compliance with hand hygiene All bags, jackets and other personal belonging must be removed in ward areas. Wearing or displaying political symbols e.g. badges, lanyards, or clothing with political slogans, ideology or national flags.	In addition to the principles outlined in the above section, healthcare professionals, who do not wear uniform , have a responsibility to minimise the spread of HCAIs by wearing appropriate clothing in the clinical setting. Micro-organisms are frequently carried on clothes, and this represents a potential risk. This policy will be applied fairly and consistently to all staff employed at the Trust regardless of sex, race, religion, ethnic origin, marital status, disability, union membership, age, sexual orientation, status, staff group, profession, numbers of hours worked or any other irrelevant factor. It also applies to those working in the Trust as students, temporary staff, staff working through bank and agencies staff working on a consolatory basis and contractors. Consultants are asked to lead by example ensuring that juniors adhere to this dress code, as well as decontaminating hands in line with infection control policy. This is not permitted in order to foster an inclusive environment. We know, from feedback, that this could cause worry and even fear for some of our patients or colleagues

APPENDIX 7: PROTECTIVE ACTIONS & THE USE OF PROTECTIVE CLOTHING ALL STAFF GROUPS

POLICY	RATIONALE
Hand Hygiene: All staff must ensure that hands are thoroughly decontaminated using appropriate hand hygiene produc t when entering and leaving clinical areas. Hands must be washed between each patient contact and wash with hot, soapy water wherever possible. Supplement with alcohol hand rub. Alcohol gel can be used as an alternative to washing with soap and water in certain situations. Please refer to infection control policy.	**This part of the policy must be used in conjunction with Infection Control Policies** Hand hygiene is the single, most important factor in the prevention of cross-infection. Staff have a professional duty to protect patients from risk of infection and are expected to comply with Infection Control Policy. The use of hand disinfection gels containing synthetic alcohol does not fall within the Islamic prohibition against alcohol (from fermented fruit or grain). This point has been clarified by The DoH Muslim Spiritual Care Provision Group, which include Islamic Scholars and Chaplains
Disposable Aprons: All staff must wear a disposable apron when providing direct patient care or on contact when in direc t contact with bodily fluids. The apron must be for single use only and must be changed between patient contacts.	Aprons provide a barrier to protection. Refer to *Infection Control Policy* (Standard Precautions)
Gloves: Gloves, when worn, must be changed between each patient contact. • Hand hygiene must happen prior to being put on and once gloves have been removed. • Gloves are single use items and must not be washed.	Gloves provide a barrier to body fluids and bacteria.

POLICY	RATIONALE
Eye Protection: Protective eye wear (goggles) must be worn to protect the eyes from risk of blood and other body fluids, other particles, or when working with dangerous substances	
Masks: Masks must be worn to reduce the transfer of airborne particles and to help prevent blood and body fluids entering the oral cavity during clinical procedures and care.	The use of mouth protection masks has been shown to reduce the incidence of infection and ingestion of unwanted particles/fluid

APPENDIX 8: ALLOCATION OF NHS UNIFORM BY PROFESSION AND ROLE

Allocated Uniforms Nursing and Midwifery

Nursing Associate	Registered Nurse	Registered Midwife	Enhanced Practitioner	Team Leader	Matron	Advanced Nurse Practitioner
Sky blue with Sky Blue Trim	Hospital Blue, Navy Trim	Postman Blue with Navy Trim	Royal Blue with Navy Contrast Trim	Navy with Navy Trim	Purple with Navy Trim	Navy with Dark Red Contrast Trim
						

Nursing and Midwifery						
Nursing Associate	**Registered Nurse**	**Registered Midwife**	**Enhanced Practitioner(experienced nurse practicing beyond specific single environment, likely with a speciality focus)**	**Team Leader**	**Matron**	**Advanced Nurse Practitioner**
Registered Nursing Associates	Band 5&6 Ward Based Nurses	All Midwives	Clinical Nurse Speicalist (regardless of Band)	Ward Manager	All Matrons attached to a division	Advanced Nurse Practitioner
Dental Nurses	Band 5&6 OPD Nurses	Community Midwives	Bed Manager	Midwifery Unit Manager	Barts Health Senior Nurse Role	Advanced Neonatel Nurse Practitioner
Community Dental Nurse	Band 5&6 Critical Care Nurses	Registered Midwife	Palliative Care Team	Theatre Team Leader		Clinical Site Practioner
	Band 5&6 Emeregency Department Nurses	Specialist Midwives	CCOT/PCCOT	Team Lead for NICU		
	Mental Health Nurses		IPC Nurse	Team Lead for PCCU		
	Pediatrics or Neonatal Nurse		Discharge Coordinator	Team Lead for ITU		
			Emergency Nurse Practitioner			
			Practice Development Nurses			
			Practice Education Facilitators			
			Research Nurses			
			Patient Flow Practitioners			

Please note that the roles listed in the Allocated Uniforms for each profession are common roles at Barts Health but is not an exhaustive list further guidance can be found at

NHS Healthcare Uniforms » NHS Supply Chain

Navy or Black trousers will be allocated dependent on the Uniform Colour Way- however this has been set by the National Team and is allocated automatically and cannot be changed.

Advanced Clinical Practitioner	Head of Department	HCA or Support Worker	Students		Heathcare Science Practitioner	Heathcare Science Scientist
Dark Red with Navy Contrast Trim	Black/ Red Trim	Lilac with Navy Trim	Cloud Blue with Navy Contrast		Eau-De-Nil/ Navy Contrast Trim	Peacock with Navy Contrast Trim
						
Shared across all professions					**Healthcare Science**	
Advanced Clinical Practitioner	**Head of Department**	**HCA or Support Worker**	**Students**		**Heathcare Science Practitioner**	**Heathcare Science Scientist**
Advanced Clinical Practitioner in all specialities	Chief Nurse	Health Care Support Worker	Trainee Nursing Associate		Decontamination Unit Techinicians	Biomedical Scientists
Advanced Clincal Practice Physiotherapist	Deputy Chief Nurse	Clinical Support worker	NHS Apprentices		Ophthalmic Technician	Cardio-respiratorists
Advanced Clinical Practice for AHPs (all roles)	Director of Nursing/ Midwifery	Critical Care Health Care Assistant			Pathology Technician	Diabetic Eye Clinicians
Advanced Clinical Practice in Pharmacy	Deputy Director of Nursing,	Nursery Nurse			Phlebotomists	Clinical Scientists
Advanced Clinical Practice Paramedic	Director of AHPs	Therapy Assistants			Dental Technicians	Healthcare Scientist
Advanced Clinical Practice Radiographer		AHP support worker			Casting Technicians	Mammogram / Sonnographers
Advanced Critical Care Practitioner		Maternity Support Workers			Research Practioners Non Registered	Pathologist
					Non Registered Research Practioners	Photo Clinical Photography
						Reconstructive / Maxillofacial Scientists
						Audiologist
						Registered Research Practioners

Navy or Black trousers will be allocated according to the profession- this decision has been set by the national team and allocation is automatic and cannot be changed.

Physiotherapist	Occupational Therapist	Prosthetist Orthotist	Dietician	Speech & Language Therapist	Orthoptics
White with Navy Contrast	White with bottle Green Cntrast	White with Hospital Blue Contrast	Ruby with hospital blue Contrast	Ruby with Postman Blue contrast (light Grey)	Ruby with black contrast
					
Physiotherapist	Occupational Therapists	Orthotist	Dietician	Speech & Language Therapist	Orthoptist

Osteopathy	Operating Department Pratitioner	Music, Arts & Drama Therapists	Podiatry	Diagnostic Radiographer	Therapeutic Radiographer
Ruby with Cloud Blue contrast	Ruby with sky blue Contrast	Ruby with Sherwood Green Contrast	Ruby with Royal blue contrast	Ruby with Eau de nil	Ruby with white contrast
					
Osteopath	Operating Departement Practioner	Music, Art & Drama Therapist	Podiatrist	Diagnostic Radiographers	Therapeutic Radiographers

Navy or Black trousers will be allocated according to the profession- this decision has been set by the national team and allocation is automatic and cannot be changed.

Pharmacy Technician	Pharmacist
Sherwood Green with Navy Trim	Bottle Green with Navy Trim
	
Pharmacy	
Pharmacy Technician	**Pharmacist**
Pharmacy Technician	Pharmacist
Pharmacy Support Assistant	Advanced Practitioner in Pharmacy

APPENDIX 9: STAFF UNIFORMS not in National Scope

Profession	Uniform colour
Resuscitation Team	Teal Tops and Black Trousers
Trauma Team RLH	Red Scrub top with Navy trim and Navy Trousers
Ward Clerks	TBC
Transport Staff	Green Shirt and Trousers
House Keepers- Not in dual HCA Roles	Black Polo Shirt and Black Trousers- Adults Grey Scrub Top and Trousers- Paediatric RLH

	Soft FM Uniforms
Cleaning	Green (jade) polo shirt and black trousers Shoes in black colour
Catering	Blue (peacock) shirt or blouse and black trousers Shoes in black colour
Porters	Blue (pale) shirt or blouse and black trousers with Grey Gilet Shoes in black colour
Security	White shirt /blouse and black trousers with black fleece Shoes in black colour
Supervisors	White shirt or blouse and black trousers/skirt with Grey Gilet Shoes in black colour

APPENDIX 10: Operating Theatre Suite Dress Code

Introduction

- Trust staff have a responsibility to always portray a professional image

  The theatre suite means the entire theatre complex including operating theatres, storerooms, staff facilities and the office accommodation. The operating theatre is a single operating theatre and adjoining anaesthetic and preparation rooms

  The Uniform and Dress Code Policy applies to all staff who enter the operating theatre Suite

- Restricted areas are defined as the operating rooms and preparation rooms
- All personnel must be correctly dressed before entering the restricted areas of the operating department and off duty clothing will not be worn in these areas.
- Correct theatre attire includes trouser/scrub suits, hats covering head/facial hair masks and protective eyewear failure to comply with this will initially be managed
- informally via informal conversations and then a letter of expectation (an editable version of this letter is available in the related document column in Mexa) however continued failure to comply with the dress code could be managed formally in line with the Trust's Disciplinary Policy https://nhs.sharepoint.com/sites/R1H_Mexa/published/POL0056.pdf
- Plastic aprons should be worn as PPE whilst cleaning, for potential direct contact with blood or body fluids, for direct contact with an infectious patient and their environment when clothing is likely to become wet or soiled.
- They are single patient and single activity use only.
- All staff working in/visiting theatres and recovery must be bare below the elbow unless wearing a surgical gown
- Wrist watches must not be worn however smart watches can be worn using a bicep band or around the ankle
- For security, it is recommended that a minimum number of valuables be brought into the operating department.

Theatre attire

- All clinical staff within the operating suite should wear freshly laundered scrub suits at the start of each shift.
- Scrubs selected should be of an appropriate and comfortable fit
- Soiled scrubs must be changed as soon as possible; as a minimum this means before the start of the next patient procedure.
- Soiled scrubs MUST NOT be worn outside the theatre suite

- If clean, scrubs may be worn outside the theatre department. If visiting the canteen or other retail units then theatre footwear must not be worn and clean warming jackets. (provided) should be worn over scrubs and be fully fastened

- Unless stated otherwise below, theatre personnel must not leave the main hospital

building in theatre attire/shoes. This includes the hospital grounds during rest breaks, the car parks and public transport. The only exceptions to this are Staff attending medical emergencies in the Trust grounds.

• Neither used nor clean theatre attire should be stored in lockers for further use.

Headwear

- Surgical site infections have been traced to organisms isolated from the hair and scalp. (Association for Perioperative Practice, 2011).

  Headwear should be donned prior to donning the scrub suit, this reduces the possibility. of hair or dandruff being shed onto scrub clothing.

- Staff who are not working within restricted areas do not need to wear a hat in the theatre suite.

- Before entering a restricted area, all head and facial hair must be covered, using a single use disposable theatre cap/hood, that must be discarded after each use and **must not** be worn outside the operating theatre suite unless transferring a patient. from theatre direct to Critical Care or responding to an emergency

- Used headwear, including linen headscarves should be discarded into a clinical waste bin after each use or if soiled.

Failure to comply will initially be managed informally however continued failure to adhere to the policy could be managed in line with the trust's Disciplinary Policy. https://nhs.sharepoint.com/sites/R1H_Mexa/published/POL0056.pdf

Footwear

- Theatre footwear should provide adequate protection and be suitable for Decontamination

- The purpose of specific theatre footwear is to provide antistatic properties in accordance with BS EN ISO 20345 (BSI 2004)

- Footwear should be regularly cleaned/decontaminated using appropriate PPE

- Clean theatre footwear may be worn when leaving theatre while on theatre business e.g. visits to clinical areas to review/collect patients or to the surgical division. administration area or to attend an emergency. At all other times, change into outdoor footwear

- Soiled footwear MUST NOT be worn outside theatres

- Staff are responsible for ensuring their own clogs are cleaned at the end of each shift

- Theatre footwear should not be left in a contaminated state or on changing

room floors. Footwear should be left clean and ready for use

Face masks

The use of facemasks in a surgical setting is to contain the micro-organisms expelled. from the mouth and nose. They also protect the wearer from potential splashes of body. fluids and blood. Masks also offer some protection from inhalation of surgical smoke and laser plume.

The Association for Perioperative Practice (AfPP) also explains that the primary purpose of surgical masks is to prevent splashes and droplets contaminating the wearer's mouth and respiratory tract. In the case of the scrubbed surgical team masks may prevent large droplets from the mouth and nose entering the surgical site (AfPP 201622).

- Surgical masks or full-face visor must be worn when sterile items are being opened or are already open, when surgery is about to commence or is already underway, and during surgical intervention.

- Masks are single-use and disposable. They must not be worn outside of an operating theatre unless transferring a patient from theatre to recovery or directly to Critical Care without being changed.

- Some masks have additional features, such as fluid shields. Protective face shields should be worn whenever activities could place personnel at risk of splashes or aerosol contamination

- Masks should cover the mouth and nose, fit the contour of the face and be tied Securely

- The user should avoid touching the mask once it is applied. A used mask should be handled by the tapes only

- Used masks should be discarded into a clinical waste bin after each use or if soiled

- Masks should not hang around the neck or under the chin. They should not be put into pockets for future use. A fresh mask should be worn following a rest break.

- When required, for example, when caring for a patient who has a confirmed or suspected diagnosis of Mycobacterium Tuberculosis, a higher filtration and closer fitting FFP3 mask in line with the PPE policy. These conform to the required standard. Additional training is required in its correct application and is available via the Training Department Fit testing service

Eye protection

- Protective eyewear, mask or face shields should be worn whenever there is a risk of splash or spray contamination to face or eyes.

- Protective eyewear should be discarded or decontaminated when contaminated, observing standard precautions.

- Personal eyewear is not a substitute for PPE

Surgical gowns

- Surgical gowns are worn for surgical/aseptic clinical procedures.

- They should not be worn to counteract cool ambient temperatures. If staff are

cold in theatres they must address the problem by adding under layers e.g. short sleeved Tshirt/thermal garments under their scrubs.

- Jewellery/piercings/tattoos/false eyelashes/fingernails

- Jewellery/piercings ma increase surface bacterial counts when in situ and its removal eliminates the risk of it falling onto a sterile area or being lost in a wound.

Staff must comply with sections:-

6.12 Fingernails for Staff working in Clinical Areas
6.13 Make–up, perfumes and aftershave
6.14 False eyelashes in clinical areas
6.16 Jewellery & Watches

APPENDIX 11 UNIFORM & DRESS CODE COMPLIANCE AUDIT TOOL

The compliance with this policy needs to be audited annually per hospital site and Canary Wharf

The audit will look at staff members' compliance of the uniform dress code policy upon arrival or departure to/from their site of work and compliance with the policy in clinical areas.

For arrival and departure to and off the hospital premises criteria of measurements are:

- Staff should not be leaving or arriving to work in uniform.
- No Theatre scrubs should be worn outside the designated areas, therefore staff members should not be coming into work or going home wearing scrubs

For the second part of the audit, auditors will be stationed at nursing stations of all wards, ICU and theatre/recovery areas, in clinical areas to observe compliance with uniform and dress code policy for all members of the multidisciplinary team. The following criteria will be measured:

For clinical staff (both uniformed and non-uniformed) Jewellery is restricted to small earrings, wedding bands and nose studs. No hoop earrings or nose rings are permitted.

Nor are rings with stones permitted.

All staff must be bare below the elbow

Correct footwear (No crocs, black shoes for uniformed staff)
Hair tied back appropriately and appropriate make-up

Unacceptable clothing for non-uniformed staff:

Denim jeans or skirts (all colours and styles)
Track suits, leggings, casual sports T-shirts, leisure shorts, sweatshirts
Combat trousers, baseball caps/hats
Overly tight or revealing clothes, including mini-skirts,
tops with plunging necklines or which expose the midriff.
Any clothing that is sufficiently long that it touches the ground when walking is not acceptable on safety and hygiene grounds.
Clothing bearing any inappropriate slogan
Notes

Please record staff discipline as D = doctor, N= Nurse, AHP- allied health professional , StN= Student Nurse state which university

Discipline of staff					
Coming in/going home	**Audit criteria**	**y/n**	**y/n**	**y/n**	**y/n**
All staff have uniforms covered outside of the hospital (including smart scrubs)	Audit staff entering the hospital to assess if wearing uniform, this is covered by a coat (no visibility of the uniform dress or tunic)				
No staff should be wearing theatre scrubs outside of the hospital premises	Audit all staff entering the hospital to ensure they are not wearing hospital theatre scrubs. Please note smart scrubs are excluded				
Clinical areas	**Audit criteria**				
Appropriate uniform	Wear the correct uniform Dress in a professional manner which is likely to inspire public and colleague confidence in hospital standards and standard of care.				
If staff in uniform Jewellery is appropriate	For clinical staff (both uniformed and non-uniformed) Jewellery is restricted to small earrings, Plain band and nose studs. No hoop earrings or nose rings are permitted. Nor are rings with stones permitted				
Make-up in clinical area	Uniformed clinical staff must make sure that make is discreet and maintains professionalism Heavy long false eye lashes are not permitted.				
Correct footwear worn	no crocks, black shoes for uniformed staff				
Hair	Hair tied back appropriately				
All staff are bare below the elbow in clinical areas	Sleeves rolled up No watches, if staff have a fitness tracker it is worn above the elbow if visable Ties tucked in				

	Audit criteria				
Unacceptable Clothing For non-uniformed staff	Denim jeans or skirts (all colours and styles) Track suits, leggings, casual sports T-shirts, leisure shorts, sweatshirts Combat trousers, baseball caps/hats Overly tight or revealing clothes, including mini-skirts, tops with plunging necklines or which expose the midriff. Any clothing that is sufficiently long that it touches the ground when walking is not acceptable on safety and hygiene grounds. Clothing bearing any inappropriate slogan				

APPENDIX 12 LETTER OF EXPECTATION

Department of Author dept
Author dept address

Contact tel: Contact tel
Dept. fax. Author fax

Strictly Private & Confidential Date

Subject: Letter of Expectation – Upholding Professional Standards Dear [Recipient],

Thank you for taking the time to meet with me on [Day/Date]. I appreciate your engagement as we discussed key aspects of maintaining high standards of professionalism and care.

During our conversation, we reviewed the Trust's Uniform and Dress Code Policy, which supports compliance with Infection Prevention and Control (IPC) measures and promotes a positive, professional image. These guidelines are essential in safeguarding patient safety and delivering high-quality care.

We discussed the specific instance of [nail varnish/false nails/hair not tied up above the collar/not being bare below the elbow — delete as appropriate], and I invited you to share your perspective on this. You [agreed/disagreed] with some of the points raised, and I appreciate your openness.

I reiterated the importance of following the Dress Code Policy, which specifies that:

- False nails, nail varnish, and false eyelashes should not be worn in clinical environments.
- Staff must be bare below the elbow.
- Hair must be tied up securely above the collar, using plain, dark-coloured fasteners where necessary.

These expectations are in place not only to ensure patient safety but also to support the professional image we convey to patients, families, and colleagues.

As part of the Barts Health *WeCare* values, we are all called upon to lead by example and be role models for our teams and students. Adhering to these standards reinforces a culture of professionalism and safety that benefits everyone.

We also acknowledged previous conversations on [Dates/Notes – delete if not applicable] regarding similar matters. I appreciate your agreement to reflect on this and commit to making the necessary adjustments going forward.

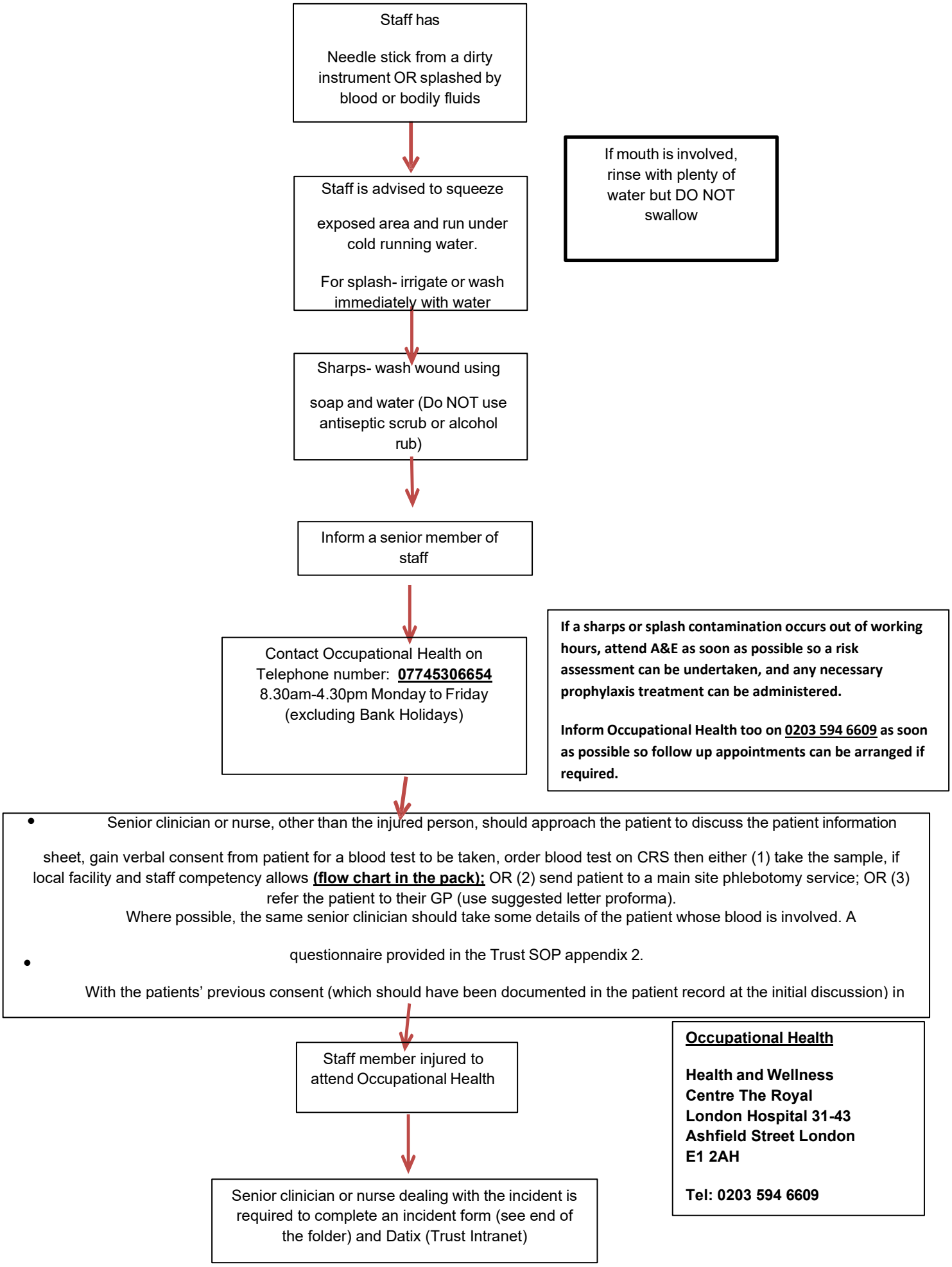
I am pleased that we can consider this matter resolved. However, I reminded you that consistency in adhering to the dress code is expected, and further instances of non-compliance may require more formal discussions.

Thank you for your attention to this matter and your dedication to delivering safe, high-quality care in line with our *WeCare* values.

Kind regards,

[Your Name] [Your Job Title]

Step by step guidance



Letter to General Medical Practitioner

Clinic detail (address and telephone number)	
Date	

Patient details	*General Medical Practitioner detail*

Dear Colleague

One of our staff has accidently been exposed to the blood of Mr/Mrs… There is no risk of contracting blood born viruses to the patient from this, but we would like your help in checking that Mr/Mrs_____is not carrying hepatitis C, hepatitis B or HIV in their blood which might be passed to the member of staff. To do this, we would be grateful if you could organise for blood tests for the below blood born viruses as a matter of urgency:

1. HIV 1 and 2 antibody.
2. HBV surface antigen (HBsAg).
3. HCV IgG.

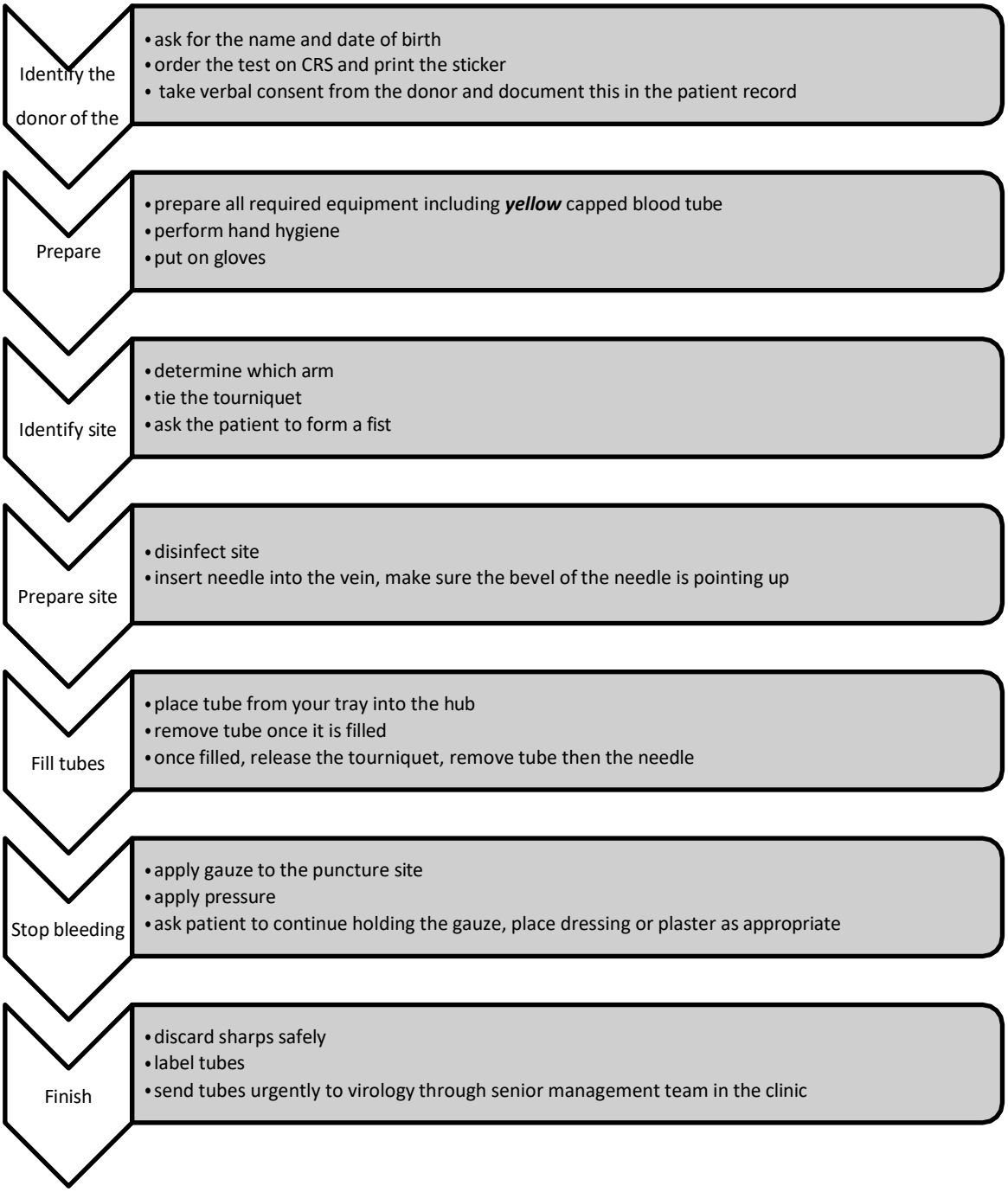
Once the results are available, we would be grateful if you could communicate it with us urgently by an email to_____@nhs.net.

Best Regards

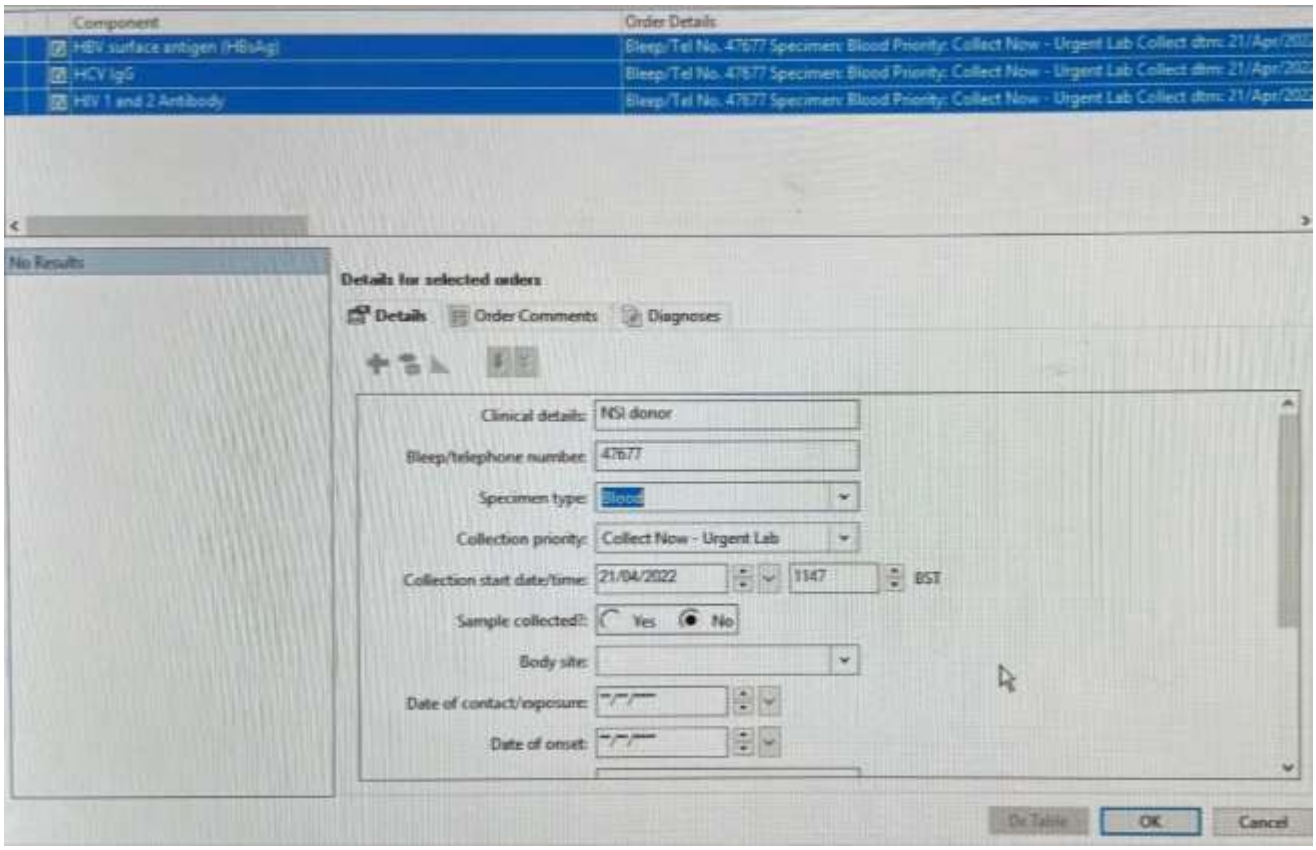
Clinician signature and detail

Blood taking flow chart

Blood taking for the donor of the NSI should be done by a competent nurse or clinician trained on phlebotomy. If no one available with this skill, the patient should be sent to phlebotomy after ordering the tests on the CRS. Alternatively, the GP should be asked to organise for the tests to be done in the community using the above-mentioned letter. Blood taking for the recipient of the NSI should be done in the occupational health or accident and emergency.



Request on the CRS for NSI donor blood tests



Needle stick injury or Splash injury contact information

Be sharp/ splash safe

Please contact Occupational health immediately

During working hours

(Monday to Friday 8:30am to 4:30pm)

Occupational health service **- 07745 306654** (Needle stick helpline)

Occupational Health:

Health and Wellness centre, the Royal London hospital, 31 - 43 Ashfield Street, London E1 2AH

If you are based at the Newham University Hospital site call the Occupational Health department on: 0207363 8677 (int. ext. 6377) (Monday-Friday 9.00am to 5.00pm)

First Aid

Procedure for sharps/needle-stick incidents

- Encourage bleeding by squeezing where skin is punctured
- Wash thoroughly with soap and warm water; do not use a scrubbing brush or alcohol

Procedure for splash by blood or body fluids

- If eyes or broken skin areas are involved, irrigate immediately with water
- If mouth is involved, rinse with plenty of water but *do not swallow*

Contact us immediately:
020 7377 7449 RLH
020 7363 8677 (int. ext. 6377 NUHT)

Make sure you complete an incident Datix form

- Please note: Your case will be dealt with CONFIDENTIALLY and your identity will only be known to Occupational Health, Clinical Virologist/A&E team and Datix staff*

Sharps Injury/ Splash Patients Information sheet

(From whom a blood test is to be requested following a contamination incident)

- *This sheet should be given to the patient prior to consenting for any possible blood test, they should be given time to read it and any questions they may have should be answered unambiguously.*
- One of our staff has accidently been exposed to your blood. There is no risk to you from this, but we would like your permission to check that you are not carrying any diseases in your blood which might be passed to the member of staff. In order to do this we would like to take a small sample of your blood to test.

What will my blood sample be tested for?

- If you agree to the test, we would like to test for Hepatitis B, C, and HIV, Hepatitis B and C are viruses that may cause liver diseases; HIV is the virus that causes AIDS.

- **Why are you asking me to do this?**
- If you did have any of these viruses in your blood, then these might pass to the staff as a result of the incident which has occurred. The test results will help us to determine the risk of such an infection occurring, or in most cases that there is no risk at all. If there is a risk, then the member of staff can get the correct advice and treatment as soon as possible. Some of the treatment that the staff might need has unpleasant side effects, so we don't want to have to do it unless it is really necessary.

- **How are the tests done?**
- After you have given verbal consent a simple blood sample would be taken.

- **What are the benefits of the test?**
- You will be helping the member of staff as we have already said- early diagnosis and possible treatment makes a big difference.

- **Can I be sure the test results are confidential?**
- Yes, your results will be dealt with confidentially. However, your GP and our health and Wellness department will need to know the results to act on it for your benefit and the involved health care worker benefit.

- **Will I be informed of the results myself?**
- Your GP would normally be the best person to talk to if you want to know your results. In case of positive results, they will contact your to initiate discussion and deliver the appropriate management.

- **What would happen if any of the results were found to be positive?**
- Your GP may carry out further tests and discuss with you what to do next with recommendations of referring you to another specialist.

- **Is it likely I will have one of these infections?**
- Certain people are more at risk than others, for example those who have had unprotected

sex with, or shared needles with someone from a community or country where these infections are widespread. If you think you may have been exposed to such infections recently (in the last 6 months) it may be recommended that you are re-tested in 3-6 months' time. This is because it takes time for your anti-bodies to be detected in your blood following an infection.

- **Will insurance companies turn me down because I have been tested for HIV?**
- New insurance applications should only be affected if the test result is positive. If you have specific concerns, you may wish to discuss these directly with your insurance provider.

- **How can I get further advice?**
- The person who has given you this form is usually able to answer questions and they can refer you to another advisor if you still require further information.

Incident Form

Date & Time: Details of Staff injured: Details of patient involved: Description of Incident: Action Taken: Bloods Taken: Yes/No (Please Circle) Circle)	Reported by: Datix completed: Yes/No (Please
Date & Time: Detail of Staff injured: Details of patient involved: Description of Incident: Action Taken: Bloods Taken: Yes/No (Please Circle) circle)	Reported by: Datix completed: Yes/No (Please
Date & Time: Detail of Staff injured: Details of patient involved: Description of Incident: Action Taken: Bloods Taken: Yes/No (Please Circle) Circle)	Reported by: Datix completed: Yes/No (Please
Date & Time: Detail of Staff injured: Details of patient involved: Description of Incident: Action Taken: Bloods Taken: Yes/No (Please Circle) Circle)	Reported by: Datix completed: Yes/No (Please

TRUST CLINICAL POLICY
HAND HYGIENE and PERSONAL PROTECTIVE EQUIPMENT POLICY

APPROVAL	Trust Policies Committee Trust Policies Committee Chair's Approval	Date approved: Date Approved:	03/03/2025 03/03/2025
EFFECTIVE FROM			
DISTRIBUTION	All wards and departments		
RELATED DOCUMENTS	Barts Health NHS Trust Policies - Blood Culture Policy - Control of Outbreaks of Communicable Diseases and Healthcare Associated Infections - Control of Transmissible Spongiform Encephalopathies (TSEs), including Creutzfeldt-Jacob Disease (CJD) - Environmental Cleaning and Decontamination of Medical and Non-Medical Devices - Infection Control Principles and Responsibilities - Infectious Diarrhoea, including Clostridium difficile and Norovirus Infection Control Policy - IPC Respiratory Virus Guideline - Isolation Notification and management of Infectious Diseases – Infection Control Policy - MRSA, Prevention, Treatment and Containment – Infection Control Policy - Prevention and Control of Multi Resistant Gram Negative Bacteria, including Carbapenem Resistant Organisms (CRO) - Prevention and Control of Tuberculosis – Infection Control Policy - Staff Immunisation and Health Screening Policy - Varicella Zoster Virus (Chickenpox & Shingles) – Infection Control Policy - Viral Haemorraghic Fevers, Management of - Water Safety Policy		
STANDARDS	National infection prevention and control manual (NIPCM) for England, 23 May 2024 WHO '5 Moments' for Hand Hygiene (May, 2009)		

	EPIC 3 (2013) National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England Department of Health (2013) Water Systems Health Technical Memorandum 04-01: Addendum. *Pseudomonas aeruginosa – advice for augmented care units*.
OWNER	Barts Health Infection Prevention & Control Team
AUTHOR/FURTHER INFORMATION	Barts Health Infection Prevention and Control Team
SUPERSEDED DOCUMENTS	Hand Hygiene Trust Policy 19 November 2021
REVIEW DUE	December 2027
KEYWORDS	Hand hygiene, alcohol rub, handwashing, PPE, protective personal equipment, gloves, aprons and masks.

CONSULTATION	*Barts Health*	Infection Prevention and Control Committee
	External Partner(s)	Capital Hospital Limited (CHL) Serco

APPLICATION	**Included in policy:** *For the groups listed below, compliance with this policy is a contractual requirement and failure to follow the policy may result in investigation and management action which may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees, and other action in relation to organisations contracted to the Trust, which may result in the termination of a contract, assignment, placement, secondment or honorary arrangement.*
	All Trust staff, working in whatever capacity
	Other staff, students and contractors working within the Trust
	Exempted from policy: *The following groups are exempt from this policy*
	No staff groups are exempt from this policy.

Table of Contents

Hand Hygiene and Personal Protective Equipment Policy 2024

1. INTRODUCTION AND AIMS OF POLICY

Standard infection control precautions

1.1 Standard infection control precautions (SICPs) are to be used by all staff, in all care settings, at all times, for all patients whether infection is known to be present or not, to ensure the safety of those being cared for, staff and visitors in the care environment.

1.2 SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection. Sources of (potential) infection include blood and other body fluids, secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated.

1.2 The application of SICPs during care delivery is determined by assessing risk to and from individuals. This includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids.

1.3. To protect effectively against infection risks, SICPs must be used consistently by all staff. SICPs implementation monitoring must also be ongoing to ensure compliance with safe practices and to demonstrate ongoing commitment to patient, staff and visitor safety.

1.4 There are 10 elements of SICPs:

- Patient placement/assessment for infection risk
- Hand hygiene
- Respiratory and cough hygiene
- Personal protective equipment (PPE)
- Safe management of care equipment
- Safe management of the care environment
- Safe management of linen
- Safe management of blood and body fluid
- Safe disposal of waste (including sharps)
- Occupational safety/managing prevention of exposure (including sharps).

1.5 This SICPs policy focuses on hand hygiene and PPE.

2. DEFINITIONS

Hand hygiene	Is a means of achieving a reduction in, or removal of visible soiling, transient or resident microbes and/or other hazardous or toxic substances?
Transient microbes	Microbes which are picked up during daily activities and may be shed on skin scales. They can be effectively removed, or substantially reduced to a low level, by hand washing or using alcohol rub/gel.
Resident microbes	Micro-organisms that are permanently resident on the skin forming part of the body's normal defence mechanisms and protecting skin from invasion by more harmful micro-organisms and can only be removed for a short time.
Clinical Areas	A clinical area is the entrance to a ward area and entrance to a clinic room
Clinical Care(for the purpose of hand hygiene)	Clinical care is performing duties that include: • Patient contact that involves patient examination resulting in contact. • Intact skin or carrying out any clinical procedure. • Patient environment contact. • Contact with equipment, charts at the end of a patient's bed such as would apply to pharmacists. • Outpatients: whilst performing duties that involve, but not exclusively, patient examination, wound dressing, collecting samples for laboratory tests. • Working in surgical minor procedures rooms. • Manipulation or adjustment of any piece of clinical equipment or device that is being used in the clinical environment including patient's charts or beds.
Aerosol Generating Procedures	**Aerosol Generating Procedures are defined as:** • Intubation, extubation and related procedures, e.g., manual ventilation/open suctioning • Cardiopulmonary resuscitation • Bronchoscopy • Surgery and postmortem procedures in which high-speed devices are used • Non-Invasive Ventilation (NIV) e.g. Bilevel Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP) • High Frequency Oscillatory Ventilation (HFOV) • Induction of sputum

Augmented Care Area	A Ward /Unit where: • The patients are severely immunosuppressed because of disease or treatment: this will include transplant patients and similar heavily immunosuppressed patients during high-risk periods in their therapy. • Organ support is necessary e.g., critical care (adult paediatric and neonatal), renal, respiratory (may include cystic fibrosis units) or other intensive care situations. • Patients have extensive breaches in their dermal integrity and require contact with water as part of their continuing care.

3. HAND HYGIENE

3.1 Hand hygiene is considered an important practice in reducing the transmission of infectious agents that cause healthcare associated infections (HCAIs).

3.2 Sinks for washing hands must be used solely for that purpose and not for disposing of liquids. Refer to Appendix 5 for Best practice advice relating to all clinical wash hand basins in healthcare facilities.

3.3 Before performing hand hygiene (following the WHO '5 Moments' as Appendix 6):

- Expose forearms (bare below the elbow). Note that staff are expected to be bare below the elbows in clinical areas and for clinical care.
- Remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene
- Ensure fingernails are clean and short, and do not wear artificial nailsor nail products
- Cover all cuts or abrasions with a waterproof dressing.

3.4 To perform hand hygiene:

- Alcohol-based handrubs (ABHRs) must be available for staff as near to the point of care as possible. Where this is not practical, personal ABHR dispensers should be used.

3.5 Perform hand hygiene:

1. Before touching a patient.
2. Before clean or aseptic procedures.
3. After body fluid exposure risk.
4. After touching a patient.
5. After touching a patient's immediate surroundings.

3.6 NB: perform hand hygiene before putting on and after removing gloves.

3.7 Wash hands with non-antimicrobial liquid soap and water if:

3.7.1 Hands are visibly soiled or dirty.

3.7.2 Caring for patients with vomiting or diarrhoeal illnesses.

3.7.3 Caring for a patient with a suspected or known gastrointestinal infection, e.g., norovirus or a spore-forming organism such as *Clostridium difficile*. In all other circumstances, use ABHRs for routinehand hygiene during care.

3.8 Where running water is unavailable, or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first opportunity.

3.9 Hand Hygiene in Augmented Care Settings

All healthcare workers in augmented care areas that have washed their hands using soap and water must follow this by the use of Alcohol-based hand rubs. This is to reflect the guidance issued in water systems –HealthTechnical Memorandum 04-01 – Pseudomonas aeruginosa – advice for augmented care units. Refer to Appendix 4 for a list of the augmented care areas.

3.9 For how to wash hands see this step-by-step guide.
http://www.nipcm.hps.scot.nhs.uk/appendices/appendix-1-best-practice- how-to-hand-wash/

3.10 For how to hand rub, see this step-by-step guide.

http://www.nipcm.hps.scot.nhs.uk/appendices/appendix-2-best-practice- how-to-hand-rub/

3.11 Link to video – Hand Hygiene Technique

3.12 Skin care

3.12.1 Dry hands thoroughly after hand washing, using disposable paper towels.

3.12.2 Use an emollient hand cream during work and when off duty.

3.12.3 Do not use or provide communal tubs of hand cream in the care setting.

3 12.4 Staff with skin problems should seek advice from occupational health.

4. SURGICAL HAND ANTISEPSIS

4.1 Surgical scrubbing/rubbing (this applies to those undertaking surgical and some invasive procedures):

4.1.1 perform surgical scrubbing/rubbing before donning sterile theatre garments or at other times, eg before inserting central vascular access devices remove all hand and wrist jewellery (including wedding band)
4.1.2 nail brushes should not be used for surgical hand antisepsis
4.1.3 nail picks (single-use) can be used if nails are visibly dirty
4.1.4. soft, non-abrasive, sterile (single-use) sponges may be used to apply antimicrobial liquid soap to the skin if licensed for this purpose
4.1.5 5use an antimicrobial liquid soap licensed for surgical scrubbing or an ABHR licensed for surgical rubbing (as specified on the product label)
4.1.6 ABHR can be used between surgical procedures if licensed for this use or between glove changes if hands are not visibly soiled.

4.2. Follow the technique in this step-by-step guide for surgical scrubbing.
http://www.nipcm.hps.scot.nhs.uk/appendices/appendix-3-best-practice-surgical-scrubbing/

4.3 Follow the technique in this step-by-step guide for surgical rubbing.
http://www.nipcm.hps.scot.nhs.uk/appendices/appendix-4-best-practice- surgical-rubbing/

4.4 Further information can be found in the hand hygiene literature reviews:

4.4.1 Hand hygiene products http://www.nipcm.hps.scot.nhs.uk/documents/sicp-hand-hygiene-hand- hygiene-products-in-hospital-settings/
4.4.2 Hand washing in healthcare settings https://www.nhs.uk/live-well/best-way-to-wash-your-hands/
4.4.3 Indications for hand hygiene in the hospital setting https://www.nhs.uk/live-well/best-way-to-wash-your-hands/
4.4.4 Skin care http://www.nipcm.hps.scot.nhs.uk/documents/sicp-hand- hygiene-skin-care/
4.4.5 Surgical hand scrubbing/rubbing in the hospital setting http://www.nipcm.hps.scot.nhs.uk/documents/sicp-hand-hygiene- surgical-hand-antisepsis-in-the-clinical-setting/
4.4.6 Use of alcohol-based hand rub in the hospital setting https://www.england.nhs.uk/wp-content/uploads/2022/09/national- infection-prevention-and-control-manual-appendix-4.pdf

5. **PERSONAL PROTECTIVE EQUIPMENT**

5.1 Before undertaking any procedure, staff should assess any likely exposure to blood and/or other body fluids, non-intact skin or mucous membranes and wear personal protective equipment (PPE) that protects adequately against the risks associated with the procedure.

5.2 All PPE should be:
Located close to the point of use.
Stored to prevent contamination in a clean, dry area until required for use (expiry dates must be kept to).
Single-use only items unless specified by the manufacturer.
Changed immediately after each patient and/or after completing a procedure or task.
Disposed of after use into the correct waste stream, i.e., healthcare waste or domestic waste.
Reusable PPE items – e.g., non-disposable goggles, face shields, visors – must be decontaminated after each use.

5.3 Gloves must be:
5.3.1 Worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely.
5.3.2 Changed immediately after each patient and/or after completing a procedure or task.
5.3.3 Changed if a perforation or puncture is suspected.
5.3.4. Appropriate for use, fit for purpose and well-fitting.
5.4.5 **Double gloving** is recommended during some exposure prone procedures, eg orthopaedic and gynaecological operations or when attending major trauma incidents.

5.4 For appropriate glove use and selection, see this flowchart.
https://www.nipcm.scot.nhs.uk/appendices/appendix-5-gloves-use- and-selection/

5.5 Further information can be found in the gloves literature review
http://www.nipcm.hps.scot.nhs.uk/documents/sicp-ppe-gloves/

5.6 Aprons must be:
5.6.1 Worn to protect uniform or clothes when contamination is anticipated orlikely, e.g., when in direct care contact with a patient.
5.6.2 Changed between patients and/or after completing a procedure or task.

5.7 Full body gowns and fluid-repellent coveralls must be:
5.7.1 Worn when there is a risk of extensive splashing of blood and/or otherbody fluids, e.g., in the operating theatre.
5.7.2 Worn when a disposable apron provides inadequate cover for the procedure or task being performed.
5.7.3 Changed between patients and immediately after completing a procedure or task.

5.8 Further information can be found in the aprons/gowns literature review
http://www.nipcm.hps.scot.nhs.uk/documents/sicp-ppe-apronsgowns/

5.9. Eye and face protection (including full-face visors) must:
5.9.1 Be worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely – e.g., by members of the surgical theatre team – and always during aerosol generating procedures; regular corrective spectacles are not considered eye protection.

5.9.2 Not be impeded by accessories such as piercings or false eyelashes.
5.9.3 Not be touched when being worn.

5.10 Further information can be found in the eye/face protection literature review. https://www.nipcm.hps.scot.nhs.uk/media/1689/2020-08-sicp-tbp-lr- eyeface-protection-v1.pdf#:~:text=1)%20A%20face%20shield%20that,%2Fface%2C%20out%20with%20AGPs.

5.11 Fluid-resistant surgical face masks must be:
5.11.1 Worn with eye protection if splashing or spraying of blood, body fluids, secretions, or excretions onto the respiratory mucosa (nose and mouth) is anticipated or likely.
5.11.2 Worn to protect patients from the operator as a source of infection, e.g., when performing surgical procedures or epidurals or inserting acentral vascular catheter (CVC).
5.11.3 Well-fitting and fit for purpose, fully covering the mouth and nose (manufacturers' instructions must be followed to ensure effective fit and protection).
5.11.4. Valved FFP3 respirators/Powered Air Purifying Respirators (PAPRs) MUST NOT be worn when undertaking a sterile procedure or directly over the surgical field. In exceptional circumstances where a patient is suspected or known to have an infectious agent/disease spread whollyor partly by the airborne or droplet route and delay to surgery or procedure would harm the patient this must be risk assessed on a case-by-case basis. (In these instances, this must be documented and the wearer should place a surgical mask over the nose and mouth underneath the PAPRs).

5.12. Removed or changed:
5.12.1 At the end of a procedure/task.
5.12.2 If the mask's integrity is breached, e.g., from moisture build-up after extended use or from gross contamination with blood or body fluids.
5.12.3 In accordance with manufacturers' specific instructions.

5.13 Further information can be found in the surgical face masks literature review. https://www.nipcm.hps.scot.nhs.uk/media/2229/2023-11-16-surgical-masks- sicps-and-tbps-v20.pdf

5.14 Footwear must be:
5.14.1 Visibly clean, non-slip and well-maintained, and support and cover theentire foot to avoid contamination with blood or other body fluids or potential injury from sharps.
5.14.2 Removed before leaving a care area where dedicated footwear is used, e.g., theatre; these areas must have a decontamination schedulewith responsibility assigned.

5.15 Further information can be found in the footwear literature review. http://www.nipcm.hps.scot.nhs.uk/documents/sicp-ppe-footwear/

5.16 Headwear must be:
5.16.1 Worn in theatre settings and clean rooms, eg central decontamination unit.
5.16.3 Well-fitting and completely cover the hair. Changed or disposed of between clinical procedures or tasks or if contaminated with bloodand/or body fluids.
5.16.4 Removed before leaving the theatre or clean room.

5.17 For the recommended method of putting on and removing PPE, see this guide. http://www.nipcm.hps.scot.nhs.uk/appendices/appendix-6-best-practice- putting-on-and-removing-ppe/

5.18 Further information can be found in the headwear literature http://www.nipcm.hps.scot.nhs.uk/documents/sicp-ppe-headwear/

6. AUDIT AND MONITORING COMPLIANCE

6.1. Clinical areas are required to audit hand hygiene monthly.

A minimum of 10 observations per week must be entered on the Trust's 'Synbiotix System'.

6.3 The results of these audits should be displayed in a designated area within each ward/department.

6.4 If wards/departments have consistently scored below 90% in their hand hygiene audits or they fail to submit data an action plan must be implemented.

7. TRAINING

7.1.1 All staff joining the Trust will have an Infection Prevention and Control (IP&C) induction, which will include hand hygiene.

7.1.2 Staff working in clinical areas must have an annual update which includes hand hygiene. As Infection Prevention and Control training is a mandatory requirement any non-compliance should be noted at staff apparaisal and rectified.

7.1.3 The Infection Prevention and Control Team will provide additional training where required for staff working in non-clinical areas.

8. DUTIES AND RESPONSIBILITIES.

All staff working in the Trust	All healthcare staff will adhere to the Trust's Hand Hygiene policy which can be found on the Trust intranet site. Staff are also required to support and encourage visitors and patients to comply with the standard.
Managers	**Managers of all services must ensure that staff:** • Are aware of and have access to this policy • Have had instruction/education on infection prevention and control by attending events and/or completing training • Have adequate support and resources to implement, monitor and take corrective action to comply with this policy; if not, a risk assessment must be undertaken and approved through local governance procedures • With health concerns (including pregnancy) or who have had an occupational exposure are referred promptly to the relevant agency, e.g., GP, occupational health or accident and emergency • Have had the required health checks and clearance (including those undertaking exposure prone procedures (EPPs) • Include infection prevention and control as an objective in their personal development plans (or equivalent) • Refer to infection prevention and control in all job descriptions.

Staff providing care	**Staff providing care must:** • Show their understanding by applying the infection prevention and control principles in this policy. • Maintain competence, skills and knowledge in infection prevention and control by attending education events and/or completing training. • Communicate the infection prevention and control practices to be carried out by colleagues, those being cared for, relatives and visitors, without breaching confidentiality. • Have up-to-date occupational immunisations, health checks and clearance requirements as appropriate
	• Report to line managers and document any deficits in knowledge, resources, equipment and facilities or incidents that may result in transmitting infection including near misses, e.g., PPE failures. • Not provide care while at risk of transmitting infectious agents to others; if in doubt, they must consult their line manager, occupational health department, infection prevention and control team (IPCT) or health protection team (HPT). • Contact their HPT/IPCT if there is a suspected or actual HAI incident/outbreak.
Infection Prevention and Control Team	• Engage with staff to develop systems and processes that lead to sustainable and reliable improvements in applying infection prevention and control practices. • Provide expert advice on applying infection prevention and control in all care settings and on individual risk assessments, ensuring action is taken as required. • Have epidemiological/surveillance systems capable of distinguishing patient case(s) requiring investigation and control.
Other posts	The Chief Executive is responsible for ensuring that there are effective infection prevention and control arrangements within the Trust.
Committees	The Infection Prevention and Control Committee is responsible for ensuring appropriate policies and procedures are in place to support hand hygiene practice.
Failure to comply with the requirements of this policy may result in investigation and management action being taken as considered appropriate, this may include formal action in line with the Trust's disciplinary procedures for employees	

MONITORING THE EFFECTIVENESS OF THIS POLICY

Issue being monitored	Monitoring method	Responsibility	Frequency	Reviewed by and actions arising followed up by
Process for ensuring all staff groups complete hand hygiene training as per training needs analysis and ensure follow up of non attenders	Recorded on WIRED	All staff. Managers to ensure training is up to date.	Infection Control training is a yearly requirement.	Division/Site Lead.
All staff will follow the hand hygiene	Hand hygiene audit.	Audits carried out by Link	Audits are carried out in	Division/Site Lead.
practice as laid out in the policy		Practitioners and compliance reported back to managers.	clinical areas on a weekly basis.	
Hand hygiene facilities are in line with policy	Environmental audit.	Infection Prevention and Control Team.	Annual	Infection Prevention and Control Team/ Ward Managers/ Facilities/Estates
Hand hygiene compliance scores	IPC Committee Meeting per site	Infection Prevention and Control Team / DIPC.	Monthly	Members of the IPC Committee

Appendix 1: Change Log

Change Log – Hand Hygiene Policy		
Substantive changes since previous version	**Reason for change**	**Author / Group(s) approving change(s)**
Minimal change to wording content remains the same for the hand hygiene and now also includes use of Personal Protective Equipment. December 2024: Update to NICPM May 2024 Added WHO '5 Moments for Hand Hygiene November 2021: Inserted lines in section 5.4 to reflect the NPSA about wearing valved masks or respirators in theatres	Introduction of national hand hygiene policy. To reflect latest guidance on surgical hand antisepsis Opportunities when to undertake hand hygiene To reflect the requirements of the NPSA about wearing valved masks or respirators in theatres	Trust Infection Prevention and Control Committee.

Appendix 2: Impact assessments

Equalities impact checklist - must be completed for all new policies

equalities

Organisational impact checklist - must be completed for all new policies

Organisational impact assessment

Appendix 3:

References

Department of Health (2013) Water Systems Health Technical Memorandum 04-01: Addendum. *Pseudomonas aeruginosa – advice for augmented care units*.

World Health Organisation '5 Moments' for Hand Hygiene, 9 May 2009: https://www.who.int/teams/integrated-health-services/infection-prevention-control/hand-hygiene/training-tools

National infection prevention and control manual (NIPCM) for England (2024): https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/

Appendix 4
Augmented care areas

Augmented Care Areas

- All Intensive Care Units and High Dependency
- All Paediatric Intensive Care Units
- All Neonatal Units

Additional Areas at Royal London Site

- 9E and 9F Renal Wards
- 13C, 13E, 13F
- 12C
- 7E, 7F, 7CB, 7D

Additional Areas at Barts Site

- 4E, 4D
- 5A, 5B, 5C, 5D

Appendix 5

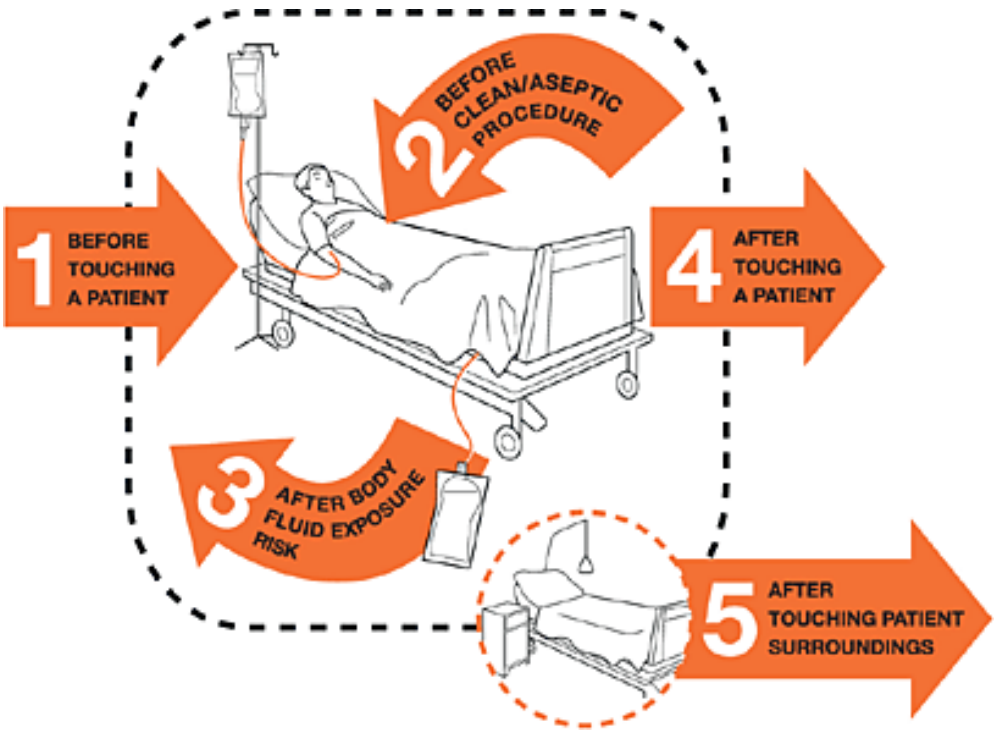
Best practice – clinical wash hand basins

Best practice advice relating to all clinical wash hand basins in healthcare facilities

- Use the clinical wash hand basin only for hand washing.
- Do not dispose of body fluids at the clinical wash hand basin – use the slophopper or sluice in the dirty utility area.
- Do not dispose of tea/coffee or other beverages in the hand wash basin – dispose in the kitchen sink.
- Do not wash any patient equipment in clinical wash hand basins.
- Do not use clinical wash hand basins for storing used equipment awaiting decontamination.
- Do not touch the spout outlet when washing hands.
- Clean taps before the rest of the clinical wash hand basin. Do not transfer contamination from wash hand basin to wash hand basin.
- Do not dispose of used environmental cleaning agents at clinical wash hand basins.
- Use non-fillable single-use bottles for antimicrobial hand rub and soap.
- Consider the appropriate positioning of soap and antimicrobial hand rub dispensers. The compounds in the products can be a source of nutrients to some micro- organisms. Therefore, it is advisable to prevent soiling of the tap by drips from the dispensers or during the movement of hands from the dispensers to the basin when beginning handwashing.
- Identify and report any problems or concerns relating to safety, maintenance, and cleanliness of wash hand basins to the Water Safety Group. Escalate unresolved issues to higher management and/or the IPC Team as appropriate.

Appendix 6

WHO '5 Moments' for Hand Hygiene (May, 2009)



4. LiftUpp Calibration for Staff & Students

4.1 Introduction:

LiftUpp is a platform used to assess clinical skills in multiple areas and allows the continuous assessment of non-technical skills such as communication and professionalism. The data input creates a personal portfolio with the ability to provide feedback enabling students and assessors to monitor, reflect and further develop their skill set to become safe beginners.

This section is designed to help assessors and students understand and apply the LiftUpp descriptor outcomes and is an adjunct to the LiftUpp protocol and progression E-Handbook. LiftUpp is a contemporaneous record of clinical experience, attainment and progress collected from all Restorative, Child Oral Health and Oral Surgery clinics at Whitechapel, Barkentine, Sir Ludwig Guttman and Kenworthy Road clinics. The data is assessed at regular intervals and students who receive poor feedback or have low clinical attainment will be required to discuss this with the subject area lead and, if appropriate, the Directors of Undergraduate Dental Education.

LiftUpp is designed to help supervisors longitudinally assess and record performance at all patient clinical sessions using a 6-point developmental indicator scale:

Score 1 UNABLE to do this	Has **caused harm** to the patient, or **Does not seek essential guidance**
Score 2 UNABLE to do this independently	**Not able** to complete to the required quality, or **Largely demonstrated by tutor**
Score 3 UNABLE to do this independently	**Able** to complete to the required quality **with significant help** (procedural and / or by instruction)
Score 4 ABLE to do this PARTIALLY independently	Requires **minor help** (procedural and / or discussion)
Score 5 ABLE to do this independently	Requires **confirmatory advice / assurance**
Score 6 ABLE to do this independently	No assistance / advice / assurance required

This calibration handbook is designed to:

1. Help ensure consistency of scoring when supervisors are assessing students.
2. Help supervisors justify to the students the reasons for their scores.
3. Help students understand their scores and gain valuable feedback which can be used to enhance their development, competency and confidence.

How to use this handbook:

1. Please review the developmental indicator scoring descriptors above. These should be used to help determine the score of each assessment criteria for a given procedure.
2. Examples of scenarios linked to various procedures and reflective LiftUpp scores have been given to help supervisors and students interpret the developmental indicator definitions to some clinical situations.

Limitations of this calibration handbook:

1. This handbook does not provide examples of all scores for all marking criteria within LiftUpp.

2. It is impossible to try and account for every possible scenario that may warrant a score of 1-6 and therefore the development indicator definitions should be used with the examples given as guidance.

Please ensure that students' scores are discussed with the student at the end of the session to promote further feedback.

Please ensure that **written comments** (where necessary) are provided in LiftUpp to help justify scores of 1-3 and enable student learning. When students demonstrate particularly good levels of knowledge or skill, for example in a very difficult case, it is also good for them to receive written positive feedback as well. Students can use these comments for reflective practice in order to help their development.

Please note that you do not need to provide written feedback for all assessed stages, but key important points you feel the student should take away with them is beneficial.

4.2 Clinical Alerts

Clinical alerts will be raised if a student causes **"actual or potential harm to the patient, themselves, or others in the dental team".**

Any **developmental indicator scores of 1** should also be summarised in the clinical alert. Clinical alerts may also be used by supervisors where they may not be one specific serious concern, but a **multitude of more minor concerns that is globally more concerning**. This may relate to professionalism, knowledge and / or clinical concerns. These should be summarised within the clinical alert.

The outcome of clinical alerts is discussed in the LiftUpp protocol and progression handbook. Clinical alerts do **NOT** need to be used to document a single absence episode from a student. However, if a student is regularly late or absent or acts unprofessionally, this justifies a clinical alert.

4.3 Minimum data entry

The minimum data entry for LiftUpp should include:

1. Professionalism
2. Cross infection control
3. Time management and organisation

4.4 Professionalism:

Appropriate	• Student is respectful and courteous and behaves in a way that is in-line with the GDC standards for Dental Professionals.
Inappropriate (non-exhaustive examples)	• Serial lateness. • Calling a patient into the dental chair without asking/presenting to a supervisor. • Letting a patient leave the clinic without asking a supervisor. • Inappropriate behaviour in the clinical environment including: language used, mobile phone use, inappropriately accessing patient notes, putting your own interests above the patients.

4.5 Cross Infection Control:

Appropriate	• Conforms with the Bart's Health SOP's for Infection Prevention Control and Uniform Policies.
Inappropriate	• Does not adhere to the Bart's Health SOP's for Infection Prevention Control and Uniform Policies.

4.6 Time management and organisation:

Time keeping should be recorded on LiftUpp. This may include students who attend late, students who are unable to work within the time boundaries of the clinic e.g. running excessively late, or students who keep to time well, and those who struggle with organisation which may also impact on time keeping.

Students should not automatically be penalised for running late on a clinic – many factors may affect this and justify it. However, this is at the tutor's discretion as to whether this was avoidable or not. The LiftUpp score should reflect this.

Lateness should be recorded on LiftUpp under time management and organisation, **documenting how late the student attended for clinic in the comments**. A single episode of lateness does not demonstrate a professionalism concern, however a recurrent theme does. If a student attends late on multiple timetabled sessions, this can also be documented as a professionalism concern and potentially a clinical alert. Comments must be provided for these data entries.

Lateness at the start of a clinical session should be given a LiftUpp score of 1-3. The score provided should consider and reflect:

1. How late was the student?
2. Was there a justifiable reason or could it have been avoided?
3. Did they inform staff members before the clinic start time?
4. Was patient care affected?

Non-exhaustive examples:

Score	Time management and organisation
1	• A student attends 35 minutes late because they overslept. They did not inform any other students / staff members that they would be running late. A patient was left waiting for their appointment as a result. • A students working environment was untidy and hazardous causing injury to themselves, a team member, or the patient.
3	• A student attends 15 minutes late because of a public transport issue. They informed the students and staff about this before the start of the session. This had a minor impact on the start time for the patient's appointment but did not impact on the overall treatment or appointment timing.
6	• A student who attends on time for the start of the clinic, sets up their bay, collects all necessary instruments for the given procedure, is ready to call the patient in on time, keeps the working environment organised and safe throughout and completes the treatment and note keeping by the end of the timetabled session.

4.7 Assisting

When students are assisting, their attendance needs to be documented along with the minimum data entry (above).

Further feedback scores may be added as appropriate e.g. diagnosis, treatment planning.

Please do **NOT** add the procedure marking it as 'Assist only' on LiftUpp. This confuses the data for subject leads when it is analysed.

4.8 Examples of LiftUpp scores

The below are examples of LiftUpp scores for numerous stages of various procedures.

Please note that not all stages have been documented below, and you will be inputting more data into LiftUpp for these procedures than is documented in these examples.

4.8.1 Prevention for all patients

Score	Oral hygiene provision
1	• **Knowledge:** Demonstrates little to no understanding of basic oral hygiene principles and is not aware of evidence-based guidelines • **Skills:** Does not tailor advice to the patients specific needs; unable to provide explanations re the importance of oral hygiene or provide an evidence-based approach • **Communication:** is unclear, disorganized, and lacks engagement; body language and eye contact are poor, technical language is used, there is minimal empathy or listening skills • **Professionalism and self-reflection**: Lacks professionalism and shows little confidence in delivery of the advice; does not self-reflect
2	• **Knowledge:** Shows limited understanding of oral hygiene practices. Struggles to explain key concepts and their relevance to oral health; does not follow evidence-based guidelines such as DBOH • **Skills:** Advice is partially correct, and essential elements may be missing or not explained well; Advice is generic with limited effort to customise it to the patient's specific needs or lifestyle • **Communication:** is inconsistent, unclear with technical language used, with minimally engagement, with poor body language, limited eye contact, and a lack of empathy or listening skills • **Professionalism and self-reflectio**n: some professionalism is present, but confidence is low, leading to hesitancy in delivering advice; does not self-reflect
3	• **Knowledge:** Demonstrates a satisfactory understanding of oral hygiene principles. Can explain key practices but lacks depth in the rationale behind them according to the evidence-base • **Skills:** provides the basic components of oral hygiene advice, including brushing and ID cleaning, but may omit or underemphasise some elements; makes some effort to tailor advice to the patient, patients parent/guardian but lacks depth in personalisation • **Communication:** communicates reasonably clearly but may need improvement in ensuring the patient fully understands; engagement with the patient is present but could be stronger; some listening skills shown and demonstrates some empathy • **Professionalism and self-reflection:** exhibits professionalism and adequate confidence but may appear unsure at times; generally, maintains appropriate behaviour.
4	• **Knowledge:** displays a good understanding of oral hygiene practices and follows some of the evidence-based guidelines • **Skills:** can explain them clearly and link them to oral health outcomes; provides comprehensive oral hygiene advice covering all key areas; builds some rapport with the patient; avoids using jargon or technical language; tailors advice to the patient's specific needs, considering their lifestyle, habits, and potential barriers to compliance • **Communication:** communicates effectively and at a level appropriate for the patient, engaging them in the discussion and checking for understanding; clear, appropriate body language and tone are used • **Professionalism and self-reflection** demonstrates professionalism and confidence in delivering advice.

Score	Oral hygiene provision
5	• **Knowledge:** Shows a thorough understanding of oral hygiene principles according to evidence-based guidelines. • **Skills:** provides detailed explanations with evidence-based rationales; delivers thorough, accurate, and evidence-based oral hygiene advice that includes all essential components and provides additional tips for optimal care • **Communication:** effectively tailors advice to the patient's specific needs and demonstrates an understanding of the patient's barriers and motivations, offering practical solutions; communicates clearly and effectively; patient engagement is strong, and the student actively listens and responds to patient questions or concerns; sets realistic goals with the patient • **Professionalism and self-reflection:** exhibits a high level of professionalism and confidence throughout the interaction. Approachable and composed, with appropriate non-verbal communication.
6	• **Knowledge:** Demonstrates an exceptional understanding of oral hygiene principles, including the latest research and guidelines. • **Skills:** can explain complex concepts in a simple, patient-friendly manner;; provides comprehensive, well-structured, and personalised oral hygiene advice, covering all areas in depth and suggesting advanced techniques or preventive measures where appropriate; highly individualised advice based on an in-depth understanding of the patient's needs, concerns, and barriers; empowers the patient with actionable steps that are realistic and sustainable. • **Communication:** is exemplary—clear, concise, empathetic, and fully adapted to the patient's level of understanding; excels in patient engagement and ensures full comprehension through active listening and feedback. Uses Motivational Interviewing Principles. Communication is excellent (body language, eye to eye contact) and established rapport with the patient. Demonstrates exemplary empathy and listening skills. • **Professionalism and self-reflection**: displays a high level of professionalism, confidence, and compassion. Body language, tone, and demeanour are exemplary and enhance patient trust and compliance

Score	Diet Analysis Advice
1	• **Knowledge:** Demonstrates little to no understanding of the relationship between diet and oral health and is not aware of evidence-based guidelines • **Skills:** No analysis of the patients dietary habits; provides little to no dietary advice or provides advice that is irrelevant or incorrect; no effort to personalise advice to the patient's specific dietary habits or oral health concerns; unable to provide explanations re the importance of diet or provide an evidence-based approach • **Communication:** is unclear, disorganised, and lacks engagement; body language and eye contact are poor, technical language is used, does not demonstrate empathy or listening skills • **Professionalism and self-reflection**: Lacks professionalism and shows little confidence in delivery of the advice; does not self-reflect
2	• **Knowledge:** Shows limited understanding of how diet affects oral health; missing key concepts (e.g. sugar intake; acid erosion); does not follow evidence-based guidelines such as DBOH • **Skills:** Analysis of the patient's diet is superficial or overly simplistic, missing key dietary risk factors; provides some basic dietary advice, but it is vague, incomplete, or lacking in relevance. Advice is partially correct, and essential elements may be missing or not explained well; advice is generic with limited effort to customise it to the patient's specific needs or lifestyle; struggles to convey information clearly; may use overly technical language or miss patient concerns; lacks confidence and clarity when delivering advice and may seem uncertain • **Communication:** is inconsistent, sometimes unclear and only partially adapted to the patients level of understanding, minimal engagement with the patient; poor communication (body language, eye-to-eye contact) and does not establish a rapport with the patient; a lack of empathy or listening skills not demonstrated • **Professionalism and self-reflectio**n: some professionalism is present, but confidence is low, leading to hesitancy in delivering advice; does not self-reflect
3	• **Knowledge:** Shows a basic understanding of the relationship between diet and oral health, though some details may be lacking; can explain key practices but lacks depth in the rationale behind them according to the evidence-base • **Skills:** provides a limited analysis of the patient's dietary habits, identifying some risks but not thoroughly exploring their impact; provides relevant dietary advice, covering key aspects such as sugar reduction and general oral health; makes an effort to customise advice to the patient's dietary habits but lacks depth in personalisation • **Communication:** communicates adequately but may lack depth or engagement; uses appropriate language; shows some confidence but may still appear hesitant in certain areas; some listening skills shown and demonstrates some empathy • **Professionalism and self-reflection:** exhibits professionalism and adequate confidence but may appear unsure at times; generally, maintains appropriate behaviour.
4	• **Knowledge:** displays a good understanding of the impact of diet on oral health, addressing key risk factors; • **Skills:** analyses the patient's dietary habits effectively, identifying risk factors; provides clear and relevant dietary advice, including important details on sugar, acids, and frequency of intake. Tailors advice to the patient's specific dietary habits, making it practical and actionable • **Communication:** communicates effectively and at a level appropriate for the patient, engaging them in the discussion and checking for understanding; clear, appropriate body language and tone are used • **Professionalism and self-reflection:** demonstrates confidence and professionalism; advice is delivered clearly and concisely.

Score	Diet Analysis Advice
5	• **Knowledge:** Shows a good understanding of the complex relationship between diet and oral health according to evidence-based guidelines. • **Skills:** Conducts a detailed analysis of the patient's diet, recognising risk factors and providing well-considered recommendations; provides comprehensive and accurate dietary advice, covering both preventive and corrective aspects in detail; provides well-thought-out, personalised advice based on the patient's dietary habits and health history; builds some rapport with the patient • **Communication:** effectively tailors advice to the patient's specific needs and demonstrates an understanding of the patient's barriers and motivations, offering practical solutions; communicates clearly and effectively; encourages patient involvement and checks for understanding; avoids using technical language • **Professionalism and self-reflection:** exhibits a high level of professionalism and confidence throughout the interaction. Approachable and composed, with appropriate non-verbal communication.
6	• **Knowledge:** Demonstrates an exceptional understanding of the relationship between diet and oral health, incorporating evidence based principles. • **Skills:** can explain complex concepts in a simple, patient-friendly manner;; provides comprehensive, well-structured, and personalised oral hygiene advice, covering all areas in depth and suggesting advanced techniques or preventive measures where appropriate; highly individualised advice based on an in-depth understanding of the patient's needs, concerns, and barriers; empowers the patient with actionable steps that are realistic and sustainable. • **Communication:** is exemplary—clear, concise, empathetic, and fully adapted to the patient's level of understanding; excels in patient engagement and has an open dialogue with the patient. Uses Motivational Interviewing Principles. Communication is excellent (body language, eye to eye contact) and established rapport with the patient. Demonstrates exemplary empathy and listening skills. • **Professionalism and self-reflection**: displays a high level of professionalism, confidence, and compassion. Body language, tone, and demeanour are exemplary and enhance patient trust and compliance

Score	Fluoride varnish application technique
1	• **Knowledge:** Demonstrates little to no understanding of fluoride varnish risks, benefits and usage and is not aware of evidence based guidelines • **Skills:** Unable to select appropriate amount of fluoride for the dentition to be treated without significant help from others. Poor moisture control or no attempt to gain optimum moisture control. Able to apply appropriate amount of fluoride agent to relevant areas with significant support, but not confident in this • **Communication:** is unclear, disorganised, and lacks engagement; body language and eye contact are poor, technical language is used, there is minimal empathy or listening skills. Unable to explain fluoride and its use to patient and/or carer using appropriate language. Unable to provide adequate post-operative instructions to patient and/or carer using appropriate language • **Professionalism and self-reflection**: Lacks professionalism and shows little confidence in delivery of the advice; does not self-reflect
2	• **Knowledge:** Is unable to explain fluoride varnish risks, benefits and usage to patient and/or carer using appropriate language; does not demonstrate awareness of evidence based guidelines • **Skills:** Has difficulty selecting appropriate amount of fluoride for the dentition to be treated without support from others. Is unable to gain adequate moisture control without support from others. Able to apply appropriate amount of fluoride agent to affected areas with significant support, but not confident in this • **Communication:** is inconsistent, unclear with technical language used, with minimally engagement, with poor body language, limited eye contact, and a lack of empathy or listening skills. Unable to provide adequate post-operative instructions to patient and/or carer using appropriate language • **Professionalism and self-reflectio**n: some professionalism is present, but confidence is low, leading to hesitancy in delivering advice; does not self-reflect
3	• **Knowledge:** Demonstrates a satisfactory explanation regarding fluoride benefits, risks and usage to patient and/or parent without assistance. Can explain key practices but lacks depth in the rationale behind them • **Skills:** Has difficulty selecting appropriate amount of fluoride for the dentition to be treated. Is unable to gain adequate moisture control without support. Able to apply appropriate amount of fluoride agent to affected areas with support. Able to provide post-operative instructions but poorly undertaken • **Communication:** communicates reasonably clearly but may need improvement in ensuring the patient and/or carer fully understands; engagement with the patient and/or carer is present but could be stronger; some listening skills shown and demonstrates some empathy. • **Professionalism and self-reflection:** exhibits professionalism and adequate confidence but may appear unsure at times; generally, maintains appropriate behaviour.
4	• **Knowledge:** Adequately explains the benefits, risks and use of fluoride to the patient and/or parent • **Skills:** With minimal support, selects appropriate amount of fluoride for the dentition to be treated. Adequate moisture control is obtained throughout whole procedure. With minimal assistance, applies appropriate amount of fluoride agent to affected areas • **Communication:** communicates effectively and at a level appropriate for the patient and/or carer, engaging them in the discussion and checking for understanding; clear, appropriate body language and tone are used. Able to provide appropriate post-operative instructions with minor support • **Professionalism and self-reflection:** demonstrates professionalism and confidence in delivering advice.

Score	Fluoride varnish application technique
5	• **Knowledge:** Explains fluoride application and the risks, benefits and its use in the prevention of dental disease well • **Skills:** Selects appropriate amount of fluoride for the dentition to be treated independently. Maintains good moisture control throughout whole procedure. Appropriately applies fluoride to dry isolated areas independently • **Communication:** effectively tailors advice to the patient's and/or carers specific needs and demonstrates an understanding of the patient's barriers and motivations, offering practical solutions; communicates clearly and effectively; patient engagement is strong, and the student actively listens and responds to patient questions or concerns; sets realistic goals with the patient. Post-operative instructions given and understood by patient and/or carer to a high standard • **Professionalism and self-reflection:** exhibits a high level of professionalism and confidence throughout the interaction. Approachable and composed, with appropriate non-verbal communication.
6	• **Knowledge:** Demonstrates an exceptional understanding of the risks, benefits and use of fluoride application, including the latest research and guidelines. • **Skills:** Independently selects appropriate amount of fluoride for the dentition to be treated. Maintains very good moisture control throughout whole procedure. Independently appropriately applies fluoride agent to dry isolated areas • **Communication:** is exemplary—clear, concise, empathetic, and fully adapted to the patient's level of understanding; excels in patient engagement and ensures full comprehension through active listening and feedback. Communication is excellent (body language, eye to eye contact) and established rapport with the patient. Demonstrates exemplary empathy and listening skills. Post-operative instructions given and understood by patient/ and/or carer to an exceptional standard • **Professionalism and self-reflection**: displays a high level of professionalism, confidence, and compassion. Body language, tone, and demeanour are exemplary and enhance patient trust and compliance

Score	Tobacco Cessation Advice
1	• Demonstrates little to no understanding of the health risks associated with tobacco use or cessation methods or evidence-based cessation methods. Inaccurate or missing key information • Struggles to engage with the patient. Uses unclear or inappropriate language. Fails to encourage open dialogue • Fails to offer any practical cessation strategies or assess patient's readiness for change. Lacks knowledge of NHS and local cessation services • Lacks empathy or sensitivity toward the patient's circumstances. Fails to maintain a respectful, non-judgmental attitude
2	• Demonstrates limited understanding of tobacco-related health risks and cessation strategies. Provides some incorrect information • Engages minimally with the patient, and the advice is poorly structured. Limited ability to encourage the patient to discuss their tobacco use. • Offers minimal cessation strategies and displays limited knowledge of referral to cessation services • Displays some empathy but often lacks consistency. Shows some effort in maintaining a professional manner but may struggle with being non-judgmental.
3	• Demonstrates basic understanding of the oral health risks associated with smoking. Provides mostly accurate advice • Adequate communication with the patient, though at times lacks clarity or confidence. Engages in basic dialogue but may not fully explore the patient's concerns or motivations. • Offers general cessation strategies and discusses referral to local services. Links cessation to improved oral health but lacks personalised advice • Shows empathy and respect. Maintains a generally non-judgmental approach but may show some hesitancy in discussing sensitive topics
4	• Demonstrates solid understanding of tobacco-related health risks and cessation methods. Provides accurate and relevant information • Demonstrates actively listening and engaging in meaningful dialogue. Uses appropriate language, showing good patient interaction • Provides tailored cessation strategies based on the patient's needs and stage of readiness. Discusses NHS/local cessation services and is to undertake a referral with help. Demonstrates competence in helping the patient set realistic goals • Displays empathy, respect, and a non-judgmental approach throughout the interaction.
5	• Demonstrates a strong understanding of the health risks of tobacco use and the various cessation methods. Provides comprehensive, accurate, and relevant advice and follows guidelines thoroughly • Communicates effectively and confidently. Engages the patient in meaningful discussions, using clear and patient-centred language. Encourages patient reflection and participation • Suggests well-tailored and specific cessation strategies. Effectively assesses the patient's readiness to quit and offers personalised support. Effectively refers to local/NHS cessation services • Shows high levels of empathy, sensitivity, and respect. Maintains a consistently professional and non-judgmental approach, making the patient feel supported and understood

Score	Tobacco Cessation Advice
6	• Demonstrates exceptional and thorough understanding of tobacco cessation. Provides detailed, accurate, and comprehensive information and follows guidelines thoroughly • Communicates fluently and confidently. Engages the patient in a highly interactive, motivating dialogue. Encourages open communication, ensuring that the patient feels heard and supported throughout • Provides highly individualized and effective cessation strategies. Accurately assesses the patient's readiness to quit and tailors advice to their specific situation, addressing any challenges the patient may face. Accurately refers to cessation services • Demonstrates outstanding empathy, sensitivity, and respect. Maintains a deeply supportive, non-judgmental, and professional manner throughout the interaction, fostering a strong rapport with the patient

Score	Alcohol Misuse Advice
1	• **Knowledge:** Demonstrates little to no understanding of using the AUDIT-C screening tool and there is no attempt to assess the patients drinking habits. Is not aware of evidence based guidelines • **Skills:** Does not tailor advice to the patients specific needs; unable to provide explanations re the importance of alcohol cessation or provide an evidence based approach • **Communication:** is unclear, disorganised, and lacks engagement; body language and eye contact are poor, technical language is used, there is minimal empathy or listening skills. Fails to use Motivational Interviewing principles. • **Professionalism and self-reflection**: Lacks professionalism and shows little confidence in delivery of the advice; does not self-reflect
2	• **Knowledge:** Introduces Audit-C but lacks confidence in administering or interpreting the results correctly; does not follow evidence-based guidelines • **Skills:** Analysis of the Audit-C is superficial or overly simplistic, missing key risk factors; provides some basic advice, but it is vague, incomplete, or lacking in relevance. Advice is partially correct and essential elements may be missing or not explained well; advice is generic with limited effort to customise it to the patient's specific needs or lifestyle; struggles to convey information clearly; may use overly technical language or miss patient concerns; lacks confidence and clarity when delivering advice and may seem uncertain • **Communication:** is inconsistent, sometimes unclear and only partially adapted to the patients level of understanding, minimal engagement with the patient; poor communication (body language, eye-to-eye contact) and does not establish a rapport with the patient; a lack of empathy or listening skills not demonstrated • **Professionalism and self-reflectio**n: some professionalism is present, but confidence is low, leading to hesitancy in delivering advice; does not self-reflect
3	• **Knowledge:** Demonstrates a satisfactory understanding and usage of audit-C, but may lack full confidence in interpreting the results. • **Skills:** provides the basic components of alcohol cessation advice, , but may omit or underemphasise some elements; makes some effort to tailor advice to the patient, patients parent/guardian but lacks depth in personalisation • **Communication:** communicates reasonably clearly but may need improvement in ensuring the patient fully understands; engagement with the patient is present but could be stronger; attempts to use some Motivational Interviewing principles; some listening skills shown and demonstrates some empathy • **Professionalism and self-reflection:** exhibits professionalism and adequate confidence but may appear unsure at times; generally, maintains appropriate behaviour.
4	• **Knowledge:** displays a good understanding of the AUDIT-C screening tool effectively • **Skills:** interprets the results correctly and can explain the links with alcohol to oral health outcomes; provides comprehensive advice covering all key areas; builds some rapport with the patient; avoids using jargon or technical language; tailors advice to the patient's specific needs, considering their lifestyle, habits, and potential barriers to compliance. Applies Motivational Interviewing principles with reasonable effectiveness • **Communication:** communicates effectively and at a level appropriate for the patient, engaging them in the discussion and checking for understanding; clear, appropriate body language and tone are used • **Professionalism and self-reflection:** demonstrates professionalism and confidence in delivering advice.

Score	Alcohol Misuse Advice
5	• **Knowledge:** Shows a thorough understanding of alcohol cessation principles according to evidence-based guidelines. • **Skills:** provides detailed explanations with evidence-based rationales; delivers thorough, accurate, and evidence-based advice that includes all essential components and provides additional tips for optimal care. • **Communication:** effectively tailors advice to the patient's specific needs and demonstrates an understanding of the patient's barriers and motivations, offering practical solutions; communicates clearly and effectively; patient engagement is strong, and the student actively listens and responds to patient questions or concerns; sets realistic goals with the patient. Demonstrates strong use of motivational interviewing principles • **Professionalism and self-reflection:** exhibits a high level of professionalism and confidence throughout the interaction. Approachable and composed, with appropriate non-verbal communication.
6	• **Knowledge:** Demonstrates an exceptional understanding of alcohol cessation principles, including the latest research and guidelines. • **Skills:** can explain complex concepts in a simple, patient-friendly manner; provides comprehensive, well-structured, and personalised advice, covering all areas in depth and suggesting advanced techniques or preventive measures where appropriate; highly individualised advice based on an in-depth understanding of the patient's needs, concerns, and barriers; empowers the patient with actionable steps that are realistic and sustainable. • **Communication:** is exemplary—clear, concise, empathetic, and fully adapted to the patient's level of understanding; excels in patient engagement and ensures full comprehension through active listening and feedback. Uses Motivational Interviewing Principles. Communication is excellent (body language, eye to eye contact) and established rapport with the patient. Demonstrates exemplary empathy and listening skills. • **Professionalism and self-reflection**: displays a high level of professionalism, confidence, and compassion. Body language, tone, and demeanour are exemplary and enhance patient trust and compliance

Score	Fissure sealant
1	• **Knowledge:** Little to no understanding of the procedure or its purpose • **Skills:** incorrect material selection and flawed technique; patient and tooth preparation is severely inadequate, with serious breaches in infection control and complete failure of moisture control. Sealant is almost entirely ineffective, with major portions of the tooth left uncovered or excessive material creating further issues. High levels of trauma and discomfort caused to the patient due to extremely poor handling and lack of skill. Light curing is either not performed or entirely incorrect. Occlusion is not checked and patient leaves with unresolved issues • **Communication:** Patient management is very poor, with little to no regard for patient comfort or understanding
2	• **Knowledge:** Weak understanding of the procedure, with major gaps in rationale, technique, and material properties • **Skills:** Inadequate patient or tooth preparation, with clear lapses in infection control and moisture control that compromise the procedure. Sealant is poorly placed, with large areas of pits and fissures left uncovered or significant excess of material. Significant trauma to the patient, with improper handling or poor technique throughout the procedure. Light curing is incomplete or poorly executed. Occlusion is not checked or adjusted. • **Communication:** There are noticeable difficulties in managing the patient appropriately
3	• **Knowledge:** Basic understanding of the procedure but lacks confidence and depth in rationale or material selection; requires significant verbal help from tutor • **Skills:** Adequate patient and tooth preparation but there are several areas of concern in infection control or moisture control that could impact the procedure. Sealant placement is somewhat uneven, with significant areas of over or under-application that might compromise effectiveness. Moderate trauma to the patient, with clear discomfort or errors in positioning or handling. Light curing performed but with obvious errors in timing or focus. Occlusion checked but not properly adjusted • **Communication:** Communication and patient management are adequate but lacking in clarity, confidence, or professionalism
4	• **Knowledge:** Reasonable understanding of the procedure with noticeable gaps that requires minor verbal help from tutor • **Skills:** Adequate patient and tooth preparation, but some noticeable lapses in infection control or moisture control that could have been improved. Sealant is generally well-placed, with some minor areas of over or under-application that may require correction. Minor trauma to the patient due to issues with positioning or handling, though generally acceptable. Light curing completed but with small errors in timing or technique. Occlusion checked but slightly under-adjusted. • **Communication:** Professional communication and appropriate patient management most of the time but with a few minor lapses in focus, confidence, or clarity.
5	• **Knowledge:** Solid understanding of the procedure and only requires verbal confirmation from tutor • **Skills:** Patient and tooth preparation completed efficiently with only minor imperfections in infection control or isolation. Sealant covers most pits and fissures well, with slight over or under-application that does not compromise the outcome. Generally atraumatic, with minimal discomfort to the patient Adequate light curing with slight variations in timing or technique. Occlusion checked and mostly adjusted as necessary. • **Communication:** professional communication and good patient management, with minor lapses in focus or demeanour

Score	Fissure sealant
6	• **Knowledge:** Demonstrates a deep understanding of the rationale for fissure sealants, material properties, and the role in preventive care • **Skills:** Demonstrates flawless patient and tooth preparation, following all infection control protocols without errors. Isolation and moisture control are impeccable. Material is placed with precision, ensuring full coverage of all pits and fissures without excess. Margins are smooth and seamless. Atraumatic technique used, with no discomfort to the patient. Proper light curing is performed with the correct duration and intensity. Occlusion checked and adjusted if necessary. • **Communication:** Communication is clear and professional throughout the procedure. Shows excellent patient management skills

4.8.2 Administration of Local Anaesthetic (infiltration and block)

Score	Administration of Local Anaesthetic (infiltration and block)
1	• **Knowledge:** Has limited awareness of the correct nerve(s) to be anaesthetised and required significant prompting • **Skills:** Unable to correctly assemble the LA syringe and cartridge without significant assistance. Unable to identify appropriate landmarks or use a safe, correct technique and is likely to cause harm to the patient/ others
2	• **Knowledge:** Has some awareness of the correct nerve(s) to be anaesthetised but required prompting • **Skills:** Correctly assembles the LA syringe and cartridge with significant assistance. With significant assistance, manages to identify appropriate landmarks, uses a correct technique and safe administration is undertaken
3	• **Knowledge:** with prompting, is able to states the correct nerve(s) to be anaesthetised • **Skills:** With assistance, correctly assembles the LA syringe and cartridge, correctly identifies all appropriate landmarks, uses a correct technique, and safe administration undertaken
4	• **Knowledge:** with minimal assistance, is able to state the correct nerve(s) to be anaesthetised • **Skills:** With minimal assistance, correctly assembles the LA syringe and cartridge and correctly identifies all appropriate landmarks and using a correct technique, and safe administration undertaken
5	• **Knowledge:** states the correct nerve(s) which are to be anaesthetised. • **Skills:** correctly assembles the LA syringe and cartridge independently. Correctly identifies all appropriate landmarks Uses the correct technique, and safe administration is undertaken independently with no assistance required
6	• **Knowledge:** confidently states the correct nerve(s) to be anaesthetised • **Skills:** correctly assembles the LA syringe and cartridge independently. Uses the correct technique, and safe administration is undertaken to an exceptional standard for the stage of the programme

4.8.3 Periodontology:

Oral Hygiene Instruction (refer to 2.8.1 Oral Hygiene Provision under Prevention)

Score	**Complete Periodontal Assessment (6PPC):**
1	• Lack knowledge and understanding of how to complete a full periodontal assessment. Leaving core components out and not seeking support to complete properly. Unaware of reasons to obtain a 6PPC.
2	• Missing components and needing support from the tutor to complete the chart completely and adequately. Mobility or furcation not recorded, pocket measures recorded far from true measures. • Need significant help to understand and interpret data, and support to use data for diagnosis and prognosis. • Tutor largely demonstrating how to communicate, educate and engage patients using the data obtained.
3	• Able to complete a full periodontal assessment including all its components with some support and reassurance needed on complex areas to measure (i.e. deep pockets, mobility, furcation). • Need significant help to understand and interpret data, and support to use data for diagnosis and prognosis. • Help needed to communicate, educate and engage their patients using the data obtained, as well as integrating with other components (radiographs, risk assessment).
4	• Able to complete a full periodontal assessment including all its components with some correction needed on complex areas to measure (i.e. mobility, furcation). • Need some prompting to interpret data, lead to diagnosis and risk assessment and to communicate, educate and engage their patients.
5	• Able to complete a full periodontal assessment including all its components. Requires confirmatory advice, reassurance and confirmation that is appropriately completed. • Able to understand, interpret but need prompting to use charts to communicate, educate and engage their patients.
6	• Able to complete a full periodontal assessment including all its components with no need for assistance and prompting. • Able to understand, interpret and use the completed charts to communicate, educate and engage their patients.

Score	**Plaque and Bleeding scores:**
1	• Does not understand when to complete plaque and bleeding scores and how to use the data to guide patient's discussion and provide targeted oral hygiene advice.
2	• Requires prompting from tutor to perform both plaque and bleeding scores when they are indicated. • Not able to perform the technique for plaque and/or bleeding scores or missing important components, for example not disclosing teeth or walking the probe instead of swiping the probe at marginal level. • Requires tutor to demonstrate using the charts to guide patient's discussion and provide target advice.
3	• Able to complete plaque and bleeding scores to the adequate standard. However, requires prompting to complete both charts and use them to guide patient's discussion and provide target advice.
4	• Able to complete plaque and bleeding scores as part of monitoring patient's oral hygiene. Requires some prompting from tutor to use charts to guide patient's discussion and provide target advice.

Score	**Plaque and Bleeding scores:**
5	• Understand the reasons for completing plaque and bleeding scores as part of monitoring patient's oral hygiene. Both charts are completed and used to guide patient's discussion and provide target advice. Although require confirmation and reassurance from the tutor.
6	• Fully understand the reasons for completing plaque and bleeding scores as part of monitoring patient's oral hygiene and providing target advice. • Both charts are completed accurately and used to guide patient's discussion. No assistance or reassurance from tutor needed.

Score	**Supragingival PMPR (Hand, Ultrasonic or Combination):** NOTE: Supragingival instrumentation to be recorded in LiftUpp according to the instrument used: Hand, Ultrasonic or both.
1	• Iatrogenic damage of the soft tissues due to improper instrumentation technique and/or wrong instrument selection.
2	• Could not identify obvious calculus with leaves gross amounts remaining. • Most of the instrumentation was completed by the tutor. • Incorrect instruments chosen for area. • Unable to use instruments with correct technique and in a safe manner (i.e. finger rest not used). • Required largely the tutor to demonstrate the technique.
3	• Able to use instruments correctly and with minimal tissue damage. • However, not all calculus identified and removed, requiring tutor to demonstrate or remind of the correct technique.
4	• Able to use instruments correctly and in a safe manner. • Most calculus identified and removed but required minimal verbal or debridement assistance from the tutor to remove some strenuous calculus.
5	• Able to use instruments correctly and in a safe manner with minimal damage to tissues. • All calculus removed supragingivally but required some verbal reassurance to achieve this.
6	• Able to use instruments correctly and in a safe manner. • All calculus removed independently from supragingival surfaces without any assistance or reassurance required.

Score	**RSD or Subgingival PMPR (Hand, Ultrasonic or Combination):** **IMPORTANT:** RSD to be recorded in LiftUpp in **quadrants** or according to amount of work (may need to merge quadrants). Do not add data for both anterior and posterior. Instead, enter it for **posterior only.**
1	• Significant avoidable iatrogenic damage: trauma to tooth or soft tissues as a result of debridement technique
2	• Could not identify obvious calculus with gross amounts remaining. • Most of the debridement was completed by the tutor. • Incorrect instruments chosen for site. • Unable to use instruments with correct technique and in a safe manner (i.e. finger rest not used). • Required largely the tutor to demonstrate the technique.
3	• Able to use instruments correctly and with minimal tissue damage.

Score	**RSD or Subgingival PMPR (Hand, Ultrasonic or Combination):** **IMPORTANT:** RSD to be recorded in LiftUpp in **quadrants** or according to amount of work (may need to merge quadrants). Do not add data for both anterior and posterior. Instead, enter it for **posterior only.**
	• However, not all calculus identified and removed, particularly from the subgingival area, requiring tutor to demonstrate or remind of the correct technique.
4	• Able to use instruments correctly and in a safe manner. • Most calculus identified and removed but required minimal verbal or debridement assistance from the tutor to remove some strenuous subgingival calculus.
5	• Able to use instruments correctly and in a safe manner with minimal damage to tissues. • All calculus removed subgingivally but required some verbal reassurance to achieve this.
6	• Able to use instruments correctly and in a safe manner. • All calculus removed independently from subgingival surfaces without any assistance or reassurance required.

4.8.4 Direct Restorations:

Score	**Appropriate moisture control**
1	• Failure to floss the clamp and rubber dam fails causing inhalation / swallowing of any objects/debris/unwanted fluids. • Treatment carried out without RD, ignoring tutor's instruction that RD is required. • **Endodontics:** Poor isolation technique, failing to obtain a seal resulting in irrigant escaping into the oral cavity.
2	• Understands the process but unable to perform this. • Tutor required to carry this stage out.
3	• Student able to demonstrate technique, but unable to complete it to an acceptable standard on the patient. • Tutor required to assist in fitting the clamp on the tooth.
4	• Student able to place rubber dam in the patient's mouth, but tutor required to make small amendments to it to ensure it is satisfactory.
5	• Student able to place rubber dam independently to the required quality with some verbal advice form the tutor.
6	• Student able to place rubber dam independently to the required quality without any verbal or practical assistance.

Score	**Appropriate management of caries**
1	• Extensive inappropriate cavity prepared causing significant iatrogenic damage to the tooth which could include pulpal involvement. • Incorrect cavity prepared e.g. DO instead of MO. • Incorrect tooth treated
2	• After multiple reviews/advice from tutor extensive caries still remained. The supervisor had to remove significant caries to continue. • Tooth overprepared in relation to the pulp, but no exposure.
3	• After multiple reviews/advice from tutor, some caries still remained. The supervisor had to remove small remaining caries.
4	• Student managed to remove most caries independently. • Tutor required for minimal advice +/- removal of small remaining caries.
5	• Student managed to remove all caries independently with some verbal confirmation / reassurance.

Score	Appropriate management of caries
6	• Student managed to remove all caries independently to the required quality without any verbal or practical assistance.

Score	Appropriate restoration of tooth contour and anatomy
1	• Restoration not functional – requiring immediate replacement before patient leaves the clinic.
2	• Restoration not functional – requiring immediate repair or re-booking for replacement e.g. poor marginal adaption and seal / addition by the tutor.
3	• Restoration required significant help from tutor to ensure it is functional e.g. addition of material, removal of overhangs, gross polishing.
4	• Required a little verbal advice or practical assistance from tutor to correct any minor issues to ensure restoration is ideal.
5	• Restoration completed to satisfactory standard, independently, with minimal confirmatory advice.
6	• Restoration completed to satisfactory standard, independently without need for any tutor intervention or advice.

4.8.5 Endodontics:

Appropriate moisture control: *See direct restorations.*

Score	Ability to gain appropriate access
1	• Extensive iatrogenic inappropriate access cavity +/- perforation resulting in a significant reduction in prognosis of endodontic treatment or extraction
2	• After multiple reviews/advice from tutor, student was still unable to gain access to the pulp chamber. Significant tutor demonstration required. • Inappropriate access cavity shape and form with iatrogenic damage weakening the coronal tooth structure.
3	• Student able to partially gain access to pulp chamber but required tutor intervention in order to refine the access and find all of the canals.
4	• Student able to gain access to pulp chamber and find canals but required verbal / demonstration assistance to gain ideal access into the canals.
5	• Student able to gain access to pulp chamber, locate canals and have appropriate access to them but with some confirmatory reassurance.
6	• Student able to demonstrate independently an ideal access cavity preparation, locating the canals with straight line access, without any assistance required.

Score	Ability to determine working length with apex locator
1	• No knowledge at all of apex locator. • Inappropriate use of the apex locator with student obtaining measurements greatly excessive of tutor indicating file is being placed traumatically into the periapical tissues.
2	• Poor knowledge of apex locator. • Able to briefly describe it's use but unable to demonstrate it.
3	• Technique for using apex locator correct but unable to obtain accurate measurements requiring the tutor to complete all canal measurements.
4	• Technique for using apex locator correct. • Able to determine some (but not all) root canal lengths, requiring some help from the supervisor.
5	• Technique for using apex locator correct. • Able to determine accurate lengths for all canals with some reassurance from the supervisor.
6	• Technique for using apex locator correct. • Able to determine accurate lengths for all canals independently.

Score	Ability to negotiate canals and / or biomechanical preparation
1	• Inappropriate instrumentation which may include technique or instruments causing iatrogenic damage and reduced prognosis e.g. over instrumentation of the canal, perforation. (This may / may not include file separation depending on the case complexity, risk of this occurring, techniques used).
2	• Unable to negotiate / instrument the canal to the desired working length. This may be due to inappropriate technique causing ledges/blockages which cannot be negotiated reducing the prognosis of the tooth.
3	• Unable to negotiate / instrument the canal to the desired working length. Required significant help from the tutor to achieve this.
4	• Able to negotiate / instrument to the desired working length to achieve a satisfactory preparation with some verbal / demonstration assistance from the supervisor.
5	• Able to negotiate / instrument to the desired working length independently, achieving a satisfactory preparation with only confirmatory reassurance required.
6	• Able to negotiate / instrument to the desired working length independently, achieving an ideal preparation without any assistance required.

Score	Obturation
1	• Poor technique causing harm to a patient e.g. excessive pressure breaking an instrument / iatrogenic damage. • Poor control of heated instruments causing trauma to the patient.
2	• Obturation past the radiographic apex into the apical tissues, or obturation short of the desired working length, or numerous voids affecting the quality of the RCT. Re-treatment may need to be considered.
3	• Required some help with obturation to achieve an acceptable quality e.g. addition of accessory cones and cold lateral compaction.
4	• Obturation completed mostly independently and to an acceptable standard, with some verbal and demonstration assistance required e.g. removal of excess coronal GP.
5	• Obturation completed independently and to an acceptable standard, with some verbal reassurance / confirmation provided.
6	• Obturation completed independently to an acceptable standard without any assistance required.

4.8.6 Fixed prosthodontics:

Score	Appropriate tooth reduction
1	• Excessive inappropriate tooth preparation significantly impacting the (reduced) prognosis of the tooth due to reduced structural strength / retention / risk of pulp necrosis. • Inappropriate post preparation significantly weakening or perforating the root of the tooth significantly reducing the prognosis of the tooth / requiring extraction.
2	• Tooth preparation not completed to the required standard. This could involve over preparation or preparation significantly reducing retention and resistance form and / or required supervisor to demonstrate most of this procedure (due to either preparation outcome or time constraints). • Unable to carry out post preparation satisfactorily to an acceptable quality without significant hands-on help from the tutor.
3	• Significant help required from supervisor to ensure the preparation met the required standard. • E.g. Preparation not completed by student: student ran out of time, but the preparation completed up to that point was either under-prepared or acceptable allowing for adjustments to be made by tutor (or student in a future appointment) to ensure it met the required quality. • E.g. Most of preparation completed by student, but they were unable to complete approximal reduction without significant tutor assistance. • Student attempted post preparation but required significant tutor assistance to ensure quality was acceptable.
4	• Student able to complete the preparation to an acceptable standard with a little help from the tutor e.g. refining margins, removing minor undercuts, refining difficult approximal sub gingival margins. • Student completed the majority of the post preparation to an acceptable standard but required a little assistance from the tutor to ensure this was ideal.
5	• Student completed tooth preparation to the desired quality with some verbal reassurance / advice from the tutor.
6	• Student completed tooth preparation to the desired quality independently and without any verbal/practical help from the tutor.

Score	Removal of indirect restoration
1	• Failure to protect the airway so upon removal, the patient inhaled/ingested (part of) the indirect restoration. • Severe iatrogenic damage to the underlying tooth tissue due to overcutting through the crown and then tooth thus reducing the prognosis of the tooth due to structural strength, retention or pulp necrosis risk.
2	• Unable to remove the indirect restoration after advice from the supervisor. Supervisor required to complete the majority of this stage. • Some moderate iatrogenic damage to the underlying tooth tissue due to overcutting through the crown. This will require preparation modification or restoration but does not affect the prognosis of the tooth.
3	• Able to complete most of the crown sectioning for this stage, however tutor was required still required to remove part / all of the restoration. • Some minor iatrogenic damage to the underlying tooth tissue due to overcutting through the crown which could be polished / minimally modified to ensure no detrimental effect on the outcome.
4	• Able to complete the crown removal to the desired quality themselves with a little verbal / technical assistance from the tutor.
5	• Able to complete the crown removal to the desired quality themselves with verbal reassurance from the tutor.
6	• Able to complete the crown removal to the desired quality independently without supervisor reassurance or intervention.

Score	Impression taking:
1	• Inappropriate impression technique e.g. taking a silicone impression with a special tray on a patient with undercuts causing the tray to have to be sectioned out of the patient's mouth or avoidable harm to teeth/soft tissues.
2	• Poor impression knowledge and/or technique. Unable to capture multiple areas / teeth in the arch and unable to obtain an accurate impression of the preparation. After multiple attempts, patient had to be rebooked, or tutor had to complete this stage.
3	• Overall impression captures details of the arch but was unable to obtain an accurate impression of the preparation. Tutor had to complete this stage or patient had to be rebooked to try again.
4	• Able to obtain a satisfactory impression with some verbal / practical help from the tutor.
5	• Able to obtain a satisfactory impression with some reassurance from the tutor.
6	• Able to obtain an ideal impression independently without help / reassurance from the tutor.

Score	Fit of indirect restoration
1	• Inappropriate airway protection with ingestion/inhalation of the indirect restoration.
2	• Inappropriate cementation/bonding of the restoration. • E.g. Failure of the cementation/bonding requiring the tutor to recement/bond at the same appointment. • E.g. Not cemented/bonded in the correct position requiring removal and recementation/bonding.
3	• Fitted the indirect restoration with significant procedural help form the tutor. • E.g. Advice on cementation stages to complete this phase. • E.g. Tutor advice/modification of the preparation / indirect restoration to ensure restoration fully seating. • E.g. Tutor advice/modification of the restoration to ensure occlusion satisfactory. • E.g. Excess cement not removed adequately
4	• Fitted the indirect restoration to an acceptable standard with a little advice / practical assistance from a supervisor. • E.g. Student identified areas affecting the seating of the crown and made most modifications themselves but required a little help. • E.g. Student completed majority / all of the occlusal adjustments but required verbal help in doing so or minor practical assistance to ensure it met the required standard. • E.g. Minor excess cement which was able to be removed easily.
5	• Fitted the indirect restoration to an acceptable standard, only requiring reassurance from the tutor.
6	• Fitted the indirect restoration to an acceptable standard working independently without any reassurance or assistance required from tutor.

4.8.7 Removable prosthodontics:

Score	Impression taking
1	• Inappropriate impression technique e.g. taking a silicone impression with a special tray on a patient with undercuts causing the tray to have to be sectioned out of the patient's mouth or avoidable harm to teeth/soft tissues.
2	• Poor impression knowledge and/or technique. Unable to capture multiple areas required. After multiple attempts, patient had to be rebooked, or supervisor had to complete this stage.
3	• Student able to capture an acceptable impression but required significant help from the tutor, without which they would not have obtained an impression with the desired quality e.g. adequate border moulding, sufficient detail of surfaces to be covered by denture, as well as occlusal surfaces of remaining natural teeth.
4	• Student able to capture an acceptable impression but required some advice and / or minimal practical help to achieve this.
5	• Student able to capture an acceptable impression independently with some verbal reassurance only.
6	• Student able to capture an acceptable impression independently without requiring any supervisor assistance or reassurance.

Score	Rest seat preparation on natural teeth
1	• Little or no knowledge about how denture design relates to tooth preparation(s) required. • Student unable to carry out tooth preparation(s), patient either had to be re-booked, or tutor stepped in to carry out / complete the task. • Over preparation of rest seat, such that natural tooth now needs repairing with a direct restoration.
2	• Some explanation needed from tutor about how denture design relates to tooth preparations required. • Significant tutor assistance needed throughout whole procedure. • Rest seat preparation inappropriate but does not require a direct restoration to repair tooth. Adjustment may be needed next visit.
3	• Rest seats prepared to an acceptable standard but required significant advice and/or modification from the tutor to ensure they met the required quality.
4	• Rest seats prepared to an acceptable standard, requiring some advice and/or slight modification from the tutor to ensure they met the required quality.
5	• Rest seats prepared to an acceptable standard with some verbal reassurance only.
6	• Rest seats independently prepared to an acceptable standard without requiring any supervisor assistance or reassurance.

4.8.8 Oral surgery:

Score	Appropriate tooth movement
1	• Inappropriate technique causing trauma to soft / hard tissues e.g. elevating incorrect tooth, damaging a 'low risk' adjacent tooth.
2	• Unable to elevate / extract the tooth or gain significant mobility. The supervisor was required to complete the majority of the extraction.
3	• Extracted the tooth but required significant help from the supervisor, without which, this would not have been successful.
4	• Student demonstrated appropriate elevation and forceps technique and managed to extract the tooth but required some verbal / demonstration assistance from the tutor.
5	• Student demonstrated appropriate elevation and forceps technique and managed to extract the tooth with verbal reassurance from the supervisor.
6	• Student demonstrated appropriate elevation and forceps technique and extracted the tooth independently.

Score	Routine bleeding management
1	• Failure to identify a socket where haemostasis had not been achieved and the patient was higher risk e.g. due to anti-coagulant medication, causing risk to the patient.
2	• The student was unable to demonstrate routine bleeding management to the requires standard, and so had to be performed by the supervisor.
3	• The student managed to demonstrate bleeding management but required significant help from the tutor.
4	• The student managed to demonstrate bleeding management but required some verbal / demonstration assistance from the tutor.
5	• The student demonstrated bleeding management with verbal reassurance from the supervisor.
6	• The student demonstrated ideal bleeding management independently.

Score	Socket management
1	• Inappropriate irrigation solution used
2	• Unable to demonstrate appropriate socket management so had to be performed by the supervisor.
3	• The student managed to demonstrate socket management but required significant help from the tutor.
4	• The student managed to demonstrate socket management but required some verbal / demonstration assistance from the tutor.
5	• The student demonstrated socket management with verbal reassurance from the supervisor.
6	• The student demonstrated ideal socket management independently.

4.8.9 Paediatric dentistry:

Paediatric dentistry includes several of the same subjects as adult restorative dentistry and therefore similar examples discussed above can be applied to paediatric dentistry.

Descriptor for UG Stainless Steel Crown Placement on LiftUpp

Score	Crown Fit

1	• **Knowledge**: Lacks understanding of the principles of stainless-steel crown fit, including marginal adaptation, retention, and occlusal fit.
	• **Skills**:
	  ○ Crown is grossly misfitting, with visible gaps at the margins or improper seating, leading to a loose or excessively tight fit.
	  ○ Poor marginal fit, resulting in overhangs or incomplete seating, risking caries or irritation.
	  ○ Occlusion is severely misaligned, causing patient discomfort or bite interference.
	  ○ Crown fails to cover the entire tooth or overextends to the gingiva, causing significant trauma.

2	• **Knowledge**: Limited understanding of SSC fit principles, with noticeable gaps in addressing marginal adaptation, retention, and occlusal considerations.
	• **Skills**:
	  ○ Crown fit is inadequate, requiring extensive adjustment or compromising retention.
	  ○ Margins are uneven, leading to visible gaps or overextension.
	  ○ Occlusion is poor with significant interference in the bite.
	  ○ Patient experiences moderate discomfort due to repeated fitting attempts or improper handling.

3	• **Knowledge**: Basic understanding of SSC fit principles, but with difficulty achieving optimal marginal adaptation or occlusal fit.
	• **Skills**:
	  ○ Crown fit is generally acceptable but may require significant adjustment to ensure retention and sealing.
	  ○ Margins are mostly acceptable, with minor gaps or overhangs that do not significantly compromise the restoration.
	  ○ Occlusion is checked, but minor bite interference persists.
	  ○ Patient experiences slight discomfort due to minor errors in handling or fitting technique.

4	• **Knowledge**: Demonstrates a solid understanding of SSC fit principles, including marginal fit, retention, and occlusion.
	• **Skills**:
	  ○ Crown fit is appropriate, requiring only minor adjustments.
	  ○ Marginal fit is good.
	  ○ Occlusion is checked and minimal interference.
	  ○ Patient experiences minimal discomfort due to effective technique and patient management.

5	• **Knowledge**: Thorough understanding of SSC fit principles, with the ability to address patient-specific anatomical or functional challenges.
	• **Skills**:
	  ○ Crown fit is highly accurate, with smooth, well-adapted margins that ensure a secure seal and retention.
	  ○ Crown is perfectly seated, covering the tooth completely without overextension or gaps.
	  ○ Occlusion fit is good, ensuring minimal disruption with opposing dentition.
	  ○ Patient experiences minimal discomfort due to atraumatic technique and efficient handling.

6	• **Knowledge**: Expert-level understanding of SSC fit principles, with the ability to address patient-specific anatomical or functional challenges, and long-term restoration outcomes.
	• **Skills**:
	  ○ Crown fit is flawless, with good marginal fit and retention, and seamless integration with the tooth and gingiva.
	  ○ Occlusion fit is excellent, ensuring minimal disruption with opposing dentition.
	  ○ Patient experiences minimal discomfort due to meticulous handling and expert technique.

Descriptor for UG Trauma exercise on LiftUpp

Score	**Ability to Assess Trauma and Decide on Appropriate Action**

1	• **Knowledge:** Little to no understanding of trauma principles or rationale for assessment and management.
	• **Skills:**
	  ○ Fails to properly assess the extent of trauma (e.g., ignores radiographic imaging, clinical examination).
	  ○ No clear decision-making regarding the management of the trauma (e.g., fails to stabilise, reposition, or re-implant as necessary).
	  ○ No consideration for potential long-term outcomes or complications.

2	• **Knowledge:** Weak understanding of trauma principles, with major gaps in rationale, assessment or management.
	• **Skills:**
	  ○ Limited assessment of trauma, with inadequate examination or failure to take necessary radiographs.
	  ○ Does not make the correct decision regarding the management of the trauma (e.g., neglects the need for stabilisation or proper re-implantation).
	  ○ Some attempt is made to consider long-term outcomes, but important factors are overlooked.

3	• **Knowledge:** Basic understanding of trauma principles but lacks confidence and depth in rationale; requires significant verbal help from tutor.
	• **Skills:**
	  ○ Basic assessment of trauma, with some clinical and radiographic evaluations; however, important aspects may be missed.
	  ○ Makes a reasonable decision regarding the management of the trauma, though the approach may not be fully optimal.
	  ○ Considers long-term outcomes and potential complications, but the action taken may not fully reflect these considerations.

4	• **Knowledge:** Reasonable understanding of trauma principles with noticeable gaps; requires minor verbal help from tutor.
	• **Skills:**
	  ○ Thorough assessment of trauma, including clinical examination and appropriate radiographic evaluation.
	  ○ Makes a correct decision on the management of trauma, with steps taken to stabilise the tooth if needed and prevent further complications.
	  ○ Takes into account long-term outcomes and potential risks, including pulp vitality and restoration.

5	• **Knowledge:** Solid understanding of trauma principles; only requires verbal confirmation from tutor. • **Skills:**

- Comprehensive and accurate assessment of trauma, with clinical and radiographic evaluation leading to a clear diagnosis.
- Correct decision-making based on the trauma assessment, ensuring proper treatment, stabilisation, and/or re-implantation.
- Thoughtful consideration of long-term consequences, and appropriate management is initiated to mitigate future complications.

6

- **Knowledge:** Demonstrates exceptional understanding of trauma principles and rationale for assessment and management.
- **Skills:**
  - Highly thorough and accurate assessment of trauma, with a well-executed clinical examination and radiographs taken at the appropriate angles.
  - Optimal decision-making, with immediate and appropriate action to manage the trauma and minimize the risk of long-term issues.
  - Anticipates and plans for potential complications, ensuring the best possible outcome for both short- and long-term care

4.8.10 Yearly LiftUpp Targets / Requirements

BDS LiftUpp Protocol and Progression Handbook 2025-26

The tables below outline the engagement expectations and minimum clinical requirements for BDS Years 3, 4 and 5. Targets for Year 1 and 2 have not yet been set.

BDS	Attendance	Periodontics	Direct Restorations	Endodontics	Fixed Prosthodontics	Removable Prosthodontics	Paediatric Dentistry	Oral Surgery	Local Anaesthesia
Year 3 BDS	Attending scheduled timetabled operating and assisting clinics. Attendance during these sessions is recorded on LiftUpp. Failure to attend will affect overall attendance data which may prevent sign-up to finals and progression to Year 4, as per the Clinical, Academic and Professionalism Concerns policy.	Patient Care: 7 **Oral hygiene instructions** 7 **Plaque and bleeding scores** 7 **Comprehensive periodontal assessments** 7 **Supra-gingival PMPR** using hand and ultrasonic instrumentation 7 **RSD** (quadrants) using hand and ultrasonic instrumentation under LA	Patient Care: 4 **Direct restorations** to include occlusal, anterior approximal, posterior approximal and smooth surface restorations using a range of materials i.e. GIC/ Composite/ Amalgam.	Simulation: Satisfactorily attended and engaged with the Year 3 Endodontics **clinical skills lab course.** Passed the **gateway assessment.** Patient Care: Attendance on clinics will be monitored, and any clinical activity will be counted on LiftUpp towards requirements going forwards.	Simulation: Satisfactorily attended and engaged with the Year 3 Fixed Prosthodontics **clinical skills lab course.** Passed the **gateway assessment.**	Simulation: Satisfactorily attended and engaged with the Year 3 Removable Prosthodontics **clinical skills lab course.** Patient Care: Clinical targets: Should start to gain some experience in denture construction.	Simulation: Skilling in summer term. Patient Care: Attendance on clinics will be monitored, and any clinical activity will be counted on LiftUpp towards requirements going forwards.	Passed the Oral Surgery **gateway assessment.** Patient Care: Attendance on clinics will be monitored, and any clinical activity will be counted on LiftUpp towards requirements going forwards.	Patient Care: 5 LA technique - **Inferior Alveolar Nerve Block** (including oral surgery and restorative dentistry clinics) 10 LA technique - **Infiltration** (including oral surgery and restorative dentistry clinics)
Year 4 BDS	Attending scheduled timetabled operating and assisting clinics. Attendance during these sessions is recorded on LiftUpp.	Patient Care: 12 **Oral hygiene instructions** 12 **Plaque and bleeding scores** 12 **Comprehensive periodontal assessments**	Patient Care: 10 **Direct restorations** to include occlusal, anterior approximal, posterior approximal and smooth surface restorations using a range of materials	Simulation: Completed clinical skills lab **revalidation assessment** and achieve a pass grade	Simulation: Satisfactorily attended and engaged with the Year 4 Fixed Prosthodontics **clinical skills lab course.**	Simulation: Satisfactorily attended and engaged with the Year 4 Removable Prosthodontics **clinical skills lab course.**	Patient Care: 10 **Preventive treatment** (OHI/ Diet advice/ Plaque score) 10 **Fissure sealants**	Completed **OMFS rotation.** Simulation: Completed **Pig's head Minor Oral Surgery (MOS) gateway** and achieve a pass grade.	Patient Care: 10 LA technique - **Inferior Alveolar Nerve Block** (including oral surgery and restorative dentistry clinics)

BDS	Attendance	Periodontics	Direct Restorations	Endodontics	Fixed Prosthodontics	Removable Prosthodontics	Paediatric Dentistry	Oral Surgery	Local Anaesthesia
	Failure to attend will affect overall attendance data which may prevent sign-up to finals and progression to Year 5, as per the Clinical, Academic and Professionalism concerns policy	12 **Supra-gingival PMPR** using hand and ultrasonic instrumentation 12 **RSD** (quadrants) using hand and ultrasonic instrumentation under LA One start-to-finish **case** on the same patient: Management of generalised periodontitis, including OHI, Plaque and bleeding scores, Comprehensive periodontal assessment, Supra- and sub-gingival PMPR, RSD and Reassessment	i.e. GIC/ Composite/ Amalgam. 3 **Caries removal**	Patient Care: One start-to-finish root canal treatment **case** on the same patient: Access opening, Canal preparation and Obturation on a single-rooted or molar tooth.	Completed clinical skills lab **revalidation assessment** and achieve a pass grade. Patient Care: 1 **Indirect restoration:** Using a Conventional impression or Digital scan for impression taking. For Crown/ Onlay/ Veneer/ Conventional Bridge Retainer ***1 unit includes:*** • Tooth preparation (0.25 unit) • Provisional restoration (0.25 unit) • Impression (0.25 unit) • Fit (0.25 unit) For Resin bonded bridge or Cast Post ***0.5 unit includes:*** • Impression (0.25 unit)	Patient Care: 1 **Primary impression** 1 **Secondary impression** 1 **Jaw registration** 1 **Tooth try-in** 1 **Fit** 1 **Denture review**	1 **Direct restoration** on a primary tooth 2 **Pre-formed metal crowns** on primary tooth 2 **Extractions** of primary teeth (under LA or GA)	Patient Care: 10 **Extractions** (difficulty 3 and above)	20 LA technique - **Infiltration** (including oral surgery and restorative dentistry clinics)

BDS	Attendance	Periodontics	Direct Restorations	Endodontics	Fixed Prosthodontics	Removable Prosthodontics	Paediatric Dentistry	Oral Surgery	Local Anaesthesia
					• Fit (0.25 unit)				
Year 5 BDS	Attending scheduled timetabled operating and assisting clinics. Attendance during these sessions is recorded on LiftUpp. Failure to attend will affect overall attendance data which may prevent sign-up to finals and progression to graduation, as per the Clinical, Academic and Professionalism concerns policy.	Patient Care: 15 **Oral hygiene instructions** 15 **Plaque and bleeding scores** 15 **Comprehensive periodontal assessments** 15 **Supra-gingival PMPR** using hand and ultrasonic instrumentation 15 **RSD** (quadrants) using hand and ultrasonic instrumentation under LA One start-to-finish **case** on the same patient: Management of generalised periodontitis, including: OHI, Plaque and bleeding scores, Comprehensive periodontal assessment, Supra- and sub-gingival PMPR, RSD and Reassessment	Patient Care: 30 **Direct restorations** to include occlusal, anterior approximal, posterior approximal and smooth surface restorations using a range of materials i.e. GIC/ Composite/ Amalgam. 10 **Caries removal**	Simulation: Completed clinical skills lab **reskilling**. Patient Care: 4 start-to-finish root canal treatment **cases** on the same patient: Access opening, Canal preparation and Obturation on a single-rooted (minimum 1) or molar (minimum 1) tooth.	Patient Care: 4 **Indirect restorations:** Of the 4 indirect restorations, at least 2 must be completed on the same patient from start to finish. Using a Conventional impression or Digital scan for impression taking. For Crown/ Onlay/ Veneer/ Conventional Bridge Retainer **1 unit** includes: • Tooth preparation (0.25 unit) • Provisional restoration (0.25 unit) • Impression (0.25 unit) • Fit (0.25 unit) For Resin bonded bridge or Cast Post **0.5 unit** includes:	Patient Care: 3 **Primary impression** 3 **Secondary impression** 3 **Jaw registration** 3 **Tooth try-in** 3 **Fit** 3 **Denture review** One start-to-finish denture **case** on the same patient at Whitechapel: All stages i.e. primary impression (optional), secondary impression, jaw registration, tooth try-in, fit and denture review; including lab work. The start-to-finish case may contribute toward the overall requirement for	Simulation: 1 **Dressing** of an immature tooth. 1 **Pulpotomy** 1 **Crown build-up** of permanent upper central incisor Patient Care: 10 **Preventive treatments** (OHI/ Diet advice/ Plaque score) 10 **Fissure sealants** 6 **Restorations** on primary teeth including direct restorations and stainless-steel crowns 2 **Extractions** of primary teeth (under LA or GA)	Completed **OMFS rotation following** by a **presentation** Simulation: 2 **Surgical procedures** on the pig's head course and achieve a pass grade. Patient Care: 30 **Extractions** (difficulty 3 and above)	Patient Care: 20 LA technique - **Inferior Alveolar Nerve Block** (including oral surgery and restorative dentistry clinics) 40 LA technique - **Infiltration** (including oral surgery and restorative dentistry clinics)

BDS	Attendance	Periodontics	Direct Restorations	Endodontics	Fixed Prosthodontics	Removable Prosthodontics	Paediatric Dentistry	Oral Surgery	Local Anaesthesia
					• Impression (0.25 unit) • Fit (0.25 unit)	three of each stage.			

Minimum Clinical Requirements – Year 5 BDS 2025/26

Procedure	Minimum Clinical Requirement
Periodontics	
Oral Hygiene Instructions (OHI)	15
Plaque and Bleeding Scores	15
Comprehensive periodontal assessment	15
Supra-gingival PMPR (hand and ultrasonic instrumentation)	15
RSD (quadrants)	15
One start-to-finish case on the same patient: Management of generalised periodontitis, including: OHI, Plaque and bleeding scores, Comprehensive periodontal assessment, Supra- and sub-gingival PMPR, RSD and Reassessment	1
Endodontics	
Reskilling (Simulation)	Completed
Total number of cases on the same patient: Access opening, Canal preparation and Obturation • RCT single rooted - Minimum 1 • RCT Molar - Minimum 1	4
Direct Restorations	
Caries removal	10
Restoration (a range of direct restorative materials i.e. GIC/ Composite/ Amalgam; and tooth surfaces)	30
Fixed Prosthodontics	
Indirect Restorations ▪ ***Of the 4 indirect restorations, at least 2 must be completed on the same patient from start to finish.** ▪ **Either a conventional impression or a digital scan (intra-oral scanner, IOS) for impression taking.** **Crown/ Onlay/ Veneer/ Conventional Bridge Retainer:** • Tooth preparation (0.25 unit) + Provisional restoration (0.25 unit) + Impression (0.25 unit) + Fit (0.25 unit) = 1 unit **Resin bonded bridge or Cast Post:** • Impression (0.25 unit) + Fit (0.25 unit) = 0.5 unit	*4
Removable Prosthodontics	
Primary impression	3
Secondary impression	3
Jaw registration	3
Tooth try-in	3
Fit	3
Denture review	3
Denture completed from start to finish on the same patient at Whitechapel: All stages i.e. primary impression (optional), secondary impression, jaw registration, tooth try-in, fit and denture review; including lab work. **Start-to-finish case may contribute toward the overall requirement for three of each stage.**	1
Oral Surgery	
OMFS rotation, followed by a presentation	Completed
Surgical procedures on the pig's head course (Simulation; Pass grade)	2
Extractions (difficulty 3 and above)	30
LA Inferior Alveolar Nerve Block (not as a separate assessment; including oral surgery and restorative dentistry clinics)	20
LA Infiltration (not as a separate assessment; including oral surgery and restorative dentistry clinics)	40
Paediatric Dentistry	
Simulation	
Dressing of an immature tooth	1
Pulpotomy	1
Crown build-up of permanent upper central incisor	1
Patients	
Preventative treatment (OHI/ Diet advice/ Plaque score)	10
Fissure sealant	10
Restoring primary teeth (including restorations and Stainless-Steel Crowns)	6
Extraction of a primary tooth (under LA or GA)	2

Minimum Clinical Requirements – Year 4 BDS 2025/26	
Procedure	**Minimum Clinical Requirement**
Periodontics	
Oral Hygiene Instructions (OHI)	12
Plaque and Bleeding Scores	12
Comprehensive periodontal assessment	12
Supra-gingival PMPR (hand and ultrasonic instrumentation)	12
RSD (quadrants)	12
One start-to-finish case on the same patient: Management of generalised periodontitis, including: OHI, Plaque and bleeding scores, Comprehensive periodontal assessment, Supra- and sub-gingival PMPR, RSD and Reassessment	1
Endodontics	
Revalidation Assessment (Simulation; Pass grade)	Completed
Total number of cases on the same patient: Access opening, Canal preparation and Obturation (RCT Single-rooted or Molar)	1
Direct Restorations	
Caries removal	3
Restoration (a range of direct restorative materials i.e. GIC/ Composite/ Amalgam; and tooth surfaces)	10
Fixed Prosthodontics	
Satisfactorily attended and engaged with the Year 4 Fixed Prosthodontics clinical skills lab course.	Completed
Revalidation Assessment (Simulation; Pass grade)	Completed
Indirect Restorations	1
Either a conventional impression or a digital scan (intra-oral scanner, IOS) for impression taking. **Crown/ Onlay/ Veneer/ Conventional Bridge Retainer:** • Tooth preparation (0.25 unit) + Provisional restoration (0.25 unit) + Impressions (0.25 unit) + Fit (0.25 unit) = 1 unit **Resin bonded bridge or Cast Post:** • Impressions (0.25 unit) + Fit (0.25 unit) = 0.5 unit	
Removable Prosthodontics	
Satisfactorily attended and engaged with the Year 4 Removable Prosthodontics clinical skills lab course.	Completed
Primary impression	2
Secondary impression	2
Jaw registration	2
Tooth try-in	2
Fit	2
Denture review	2
Oral Surgery	
OMFS rotation	Completed
Pig's head Minor Oral Surgery (MOS) gateway (Simulation; Pass grade)	Completed
Extractions (difficulty 3 and above)	10
LA Inferior Alveolar Nerve Block (not as a separate assessment; including oral surgery and restorative dentistry clinics)	10
LA Infiltration (not as a separate assessment; including oral surgery and restorative dentistry clinics)	20
Paediatric Dentistry	
Preventative treatment (OHI/ Diet advice/ Plaque score)	10
Fissure sealant	10
Direct restoration on primary tooth	1
Pre-formed metal crown on primary tooth	2
Extraction of a primary tooth (under LA or GA)	2

Minimum Clinical Requirements – Year 3 BDS 2025/26	
Procedure	**Minimum Clinical Requirement**
Periodontics (Patients)	
Oral hygiene instructions	7
Plaque and bleeding scores	7
Comprehensive periodontal assessment	7
Supra-gingival PMPR (ultrasonic and hand instrumentation)	7
RSD (in quadrants, using ultrasonic and hand instrumentation) under LA	7
Direct Restorations (Patients)	
Restoration (GIC/Composite/Amalgam)	4
Local Anaesthesia (LA) (Patients)	
LA technique - Inferior Alveolar Nerve Block	5
LA technique - Infiltration	10
Endodontics (Simulation and Patients)	
• Satisfactorily attended and engaged with the Year 3 Endodontics clinical skills lab course. • Passed the gateway assessment. • Attendance on clinics will be monitored, and any clinical activity will be counted on LiftUpp towards requirements going forwards.	
Fixed Prosthodontics (Simulation)	
• Satisfactorily attended and engaged with the Year 3 Fixed Prosthodontics clinical skills lab course. • Passed the gateway assessment.	
Removable Prosthodontics (Simulation and Patients)	
• Satisfactorily attended and engaged with the Year 3 Removable Prosthodontics clinical skills lab course. • Clinical targets: Should start to gain some experience in denture construction.	
Paediatric Dentistry (Simulation and Patients)	
• Skilling in summer term – Dates to be confirmed • Attendance on clinics will be monitored, and any clinical activity will be counted on LiftUpp towards requirements going forwards.	
Oral Surgery (Simulation and Patients)	
• Passed the Oral Surgery gateway assessment. • Attendance on clinics will be monitored, and any clinical activity will be counted on LiftUpp towards requirements going forwards.	

BScOH LiftUpp Protocol and Progression Handbook 2025-26

The tables below outline the engagement expectations and minimum clinical requirements for BSc Oral Health Year 2 and Year 3. Targets for Year 1 have not yet been set.

BScOH Year 2

Procedure	Simulation	Patient Care
Periodontology	-	• 25 Oral hygiene instructions • 20 Plaque and bleeding scores • 15 Comprehensive periodontal assessments • 20 Supra-gingival PMPR utilising hand and ultrasonic instrumentation • 15 RSD (quadrants) utilising hand and ultrasonic instrumentation under LA
Direct Restorations	-	• 12 Direct restorations to include occlusal, anterior approximal, posterior approximal and smooth surface restorations using a range of materials i.e. GIG/Composite/Amalgam. • 7 Caries removal
Impression Taking	-	• 3 Maxillary and/or mandibular impressions with Alginate
Local Anaesthesia (LA)	-	• 3 LA technique - Inferior Alveolar Nerve Block • 10 LA technique – Infiltration
Paediatric Dentistry	Pulpotomy	• 5 Prevention • 5 Fissure Sealants • 2 Restoring primary teeth (including direct restorations and Stainless-Steel Crowns) • 0-2 Extractions of primary teeth (under LA or GA)
Attendance	-	• Attending scheduled timetabled operating and assisting clinics. • Attendance during these sessions is recorded on LiftUpp. • Failure to attend will affect overall attendance data which may prevent sign-up to finals and progression to Year 3, as per the Clinical, Academic and Professionalism concerns policy.

BScOH Year 3

Procedure	Simulation	Patient Care
Periodontology	-	• 50 Oral hygiene instructions • 40 Plaque and bleeding scores • 30 Comprehensive periodontal assessments • 40 Supra-gingival PMPR utilising hand and ultrasonic instrumentation • 30 RSD (quadrants) utilising hand and ultrasonic instrumentation under LA
Direct Restorations	-	• 22 Direct restorations to include occlusal, anterior approximal, posterior approximal and smooth surface restorations using a range of materials i.e. GIG/Composite/Amalgam. • 12 Caries removal
Impression Taking	-	• 5 Maxillary and/or mandibular impressions with Alginate
Local Anaesthesia (LA)	-	• 10 LA technique - Inferior Alveolar Nerve Block • 20 LA technique - Infiltration
Paediatric Dentistry	Pulpotomy	• 10 Prevention • 10 Fissure Sealants • 6 Restoration primary teeth (including direct restorations and Stainless-Steel Crowns) • 2 Extraction of a primary tooth (under LA or GA)
Attendance	-	• Attending scheduled timetabled operating and assisting clinics. • Attendance during these sessions is recorded on LiftUpp. • Failure to attend will affect overall attendance data which may prevent sign-up to finals and progression to graduation, as per the Clinical, Academic and Professionalism concerns policy.

Minimum Clinical Requirements – BScOH Year 3 2025/26	
Procedure	**Minimum Clinical Requirement**
Periodontics	
Oral hygiene instructions	50
Plaque and bleeding scores	40
Comprehensive periodontal assessment	30
Supra-gingival PMPR (ultrasonic and hand instrumentation)	40
RSD (quadrants)	30
Direct Restorations, Impression Taking and Local Anaesthesia (LA)	
Caries removal	12
Restoration (GIC/Composite/Amalgam)	22
Impression taking (Alginate)	5
LA technique - Inferior Alveolar Nerve Block	10
LA technique - Infiltration	20
Paediatric Dentistry	
Simulation	
Pulpotomy	1
Patients	
Prevention	10
Fissure sealant	10
Restoring primary teeth (including direct restorations and Stainless-Steel Crowns)	6
Extraction of a primary tooth (under LA or GA)	2

Minimum Clinical Requirements – BScOH Year 2 2025/26	
Procedure	**Minimum Clinical Requirement**
Periodontics	
Oral hygiene instructions	25
Plaque and bleeding scores	20
Comprehensive periodontal assessment	15
Supra-gingival PMPR (ultrasonic and hand instrumentation)	20
RSD (quadrants)	15
Direct Restorations, Impression Taking and Local Anaesthesia (LA)	
Caries removal	7
Restoration (GIC/Composite/Amalgam)	12
Impression taking (Alginate)	3
LA technique - Inferior Alveolar Nerve Block	3
LA technique - Infiltration	10
Paediatric Dentistry	
Simulation	
Pulpotomy	1
Patients	
Prevention	5
Fissure sealant	5
Restoring primary teeth (including direct restorations and Stainless-Steel Crowns)	2
Extraction of a primary tooth (under LA or GA)	0-2

4.8.11 Course Unit Assessments Handbook- Gateway tests

YEAR	COURSE UNIT No	TITLE	1st SIT	2nd SIT
Year 2 BDS and Year 1 BSc	2.1	Introduction to Clinical Skills- Cariology	Autumn/Spring	
	2.2	Introduction to Clinical Skills- Periodontology Presentation	Spring	
	2.3	Introduction to Clinical Skills- Periodontology Gateway Viva	Spring	
	2.5	Introduction to Clinical Practice- Phantom Head Clinic	Spring	
	2.8	Radiology Gateway	Summer	
	2.9	Articulated Study Casts Gateway	Summer	
Year 3 BDS	3.1	Materials for Removable Appliance	Autumn	
	3.2	Materials for Fixed Appliance	Spring	
	3.3	Endodontics Written Assessment	Autumn	
	3.4	Clinical Endodontics Gateway Test	Autumn	
	3.5	Dental Manikin Extraction and OS Standard Operating Practice Test	Autumn	
	3.8	Crown Gateway Test	Spring	
Year 4 BDS	4.1	PHEBD Gateway	Spring	
	4.3	Advanced Dental Materials	Summer	
	4.7	Simple Forceps Exodontia under GA	Summer	
	4.8	Anterior Crown Revalidation	Spring	
	4.9	Decontamination Assessment	Spring	
	4.10	Special Care Report	Spring	
	4.11	Crown Revalidation	Spring	
	4.12	Premolar Metal Ceramic Preparation	Summer	
	4.13	Anterior All Ceramic Preparation	Summer	
Year 5 BDS	5.6	Unseen Patient	Spring/summer	
	5.7	Paediatric Dentistry- Placement of Stainless Steel Crown	During year	
	5.8	Practical Radiography	Spring/summer	
	5.9	Minor Oral Surgery	During year	
	5.11	Crowns Skills Test / Revalidation	Spring	
	5.13	Endodontics Skills Test / Revalidation	Autumn/spring	

4.8.12 Authorisation to carry out irreversible procedures

If a student wishes to carry out an irreversible clinical procedure for a patient, it will be necessary to demonstrate successful completion of the relevant clinical competency to their Clinical Supervisor. Successful completion of competencies will be uploaded to the electronic system as soon as possible.

Carrying out a procedure for a patient on clinic for which students have not passed the relevant competency or have been restricted from carrying out is a very serious matter. Students are responsible to the dental school to ensure this does not occur. They will regularly meet new supervisors who may not be aware of the procedures they are allowed to do at a particular time, it is the student's responsibility to inform the supervisor and, if necessary, decline to proceed. If a student were to proceed, an unprofessional mark would be awarded and escalated to the Director of Education (UG) to decide on next steps; this could include a referral to the Fitness to Practice (FTP) or Professional Capability Committee (PCC) committee.

4.8.13 Oral Surgery – Surgical Safety Check List

Use of the surgical safety checklist for tooth removal is taught in term 7 of BDS3 and term 4 of BSc2. This is taught in oral surgery at the same time as use of forceps, chair position, operator position and appropriate tooth movement. Before being involved in any stage of tooth removal a student will have to have passed their 'OS gateway' (CUA 3.5) which assesses the student's ability to use the surgical safety checklist as well as demonstrating the necessary knowledge and skills for tooth removal.

4.8.14 Guidance on taking images of students in clinical or simulated clinical facilities

Images and video - Social media, Facebook and blogging

Images, still or video, of other students or members of staff must not be recorded within the Institute of Dentistry clinical or simulated clinical facilities without the written permission of an appropriate lead.

If permission to take an image or video recording is granted, guidance will be provided which must be followed. Barts Trust is currently working on a policy regarding Videos and Pictures capturing by staff or patients.

Students are not permitted to put any images taken in the clinical environment on social media platforms.

Please remain aware that wearing clinical clothing outside clinical facilities or off-site is not allowed. Students should not appear in images on social media outside the Institute of Dentistry clinical facilities or off-site wearing clinical clothing.

Taking images of patients, or patient's records (e.g., radiographs), with personal devices is strictly forbidden. This includes taking images of recordings of patients (i.e., copying images depicting patients from presentations or videos).

Mobile phones are not permitted in the clinical environment and should be stored in lockers. If a student needs to keep their mobile phone on them due to an urgent personal matter permission should be gained from the supervising tutor.

4.8.15 Patient requests for radiographs or clinical records

Students and Clinical Supervisors are not permitted to issue copies of clinical records, radiographs or images to patients. All requests must be made by the patient, in writing and can be done online.
https://portal.privacyengine.io/nhs/4A3CCF80-94DC-468C-B882-487E67627706/9992673F-088C-44AA-8CC0-6EE451011FEF

4.8.16 Reporting incidents on clinic

All students should ensure that they are familiar with (Incident reporting system) DATIX within the CRS Millenium and now how to use it.

4.8.17 Prescriptions for Dental Therapy Students from Dentists

The new dental exemptions framework allows qualified dental hygienists and dental therapists to supply and administer certain medications without a dentist's prescription, enhancing patient access to timely care. The Human Medicines (Amendments relating to Registered Dental Hygienists, Registered Dental Therapists and Registered Pharmacy Technicians) Regulations 2024

However, students in training are not covered by these exemptions and must still follow existing prescribing protocols. This means that dentists must continue to provide prescriptions for students when required, ensuring that all medication use aligns with legal and educational requirements. This maintains patient safety while supporting students in developing their clinical competence under supervision.

For a legally valid prescription for students in training, the prescription must include:

1. **Name of staff member who is prescribing**
2. **Drug Name** – The exact name of the medication being prescribed.
3. **Site of Administration** – If applicable, the specific location where the drug should be applied or administered (e.g., infiltration for local anaesthetic).
4. **Maximum Dose** – The highest allowable dose to be administered to the patient within a given timeframe.

5. The Dental Skills Laboratory

5.1 Professionalism in the dental skills laboratory

The dental lab facilities are a safer environment than clinic with regard to infection control; however, there are risks involved working with sharp instruments and rotary instruments. Students will be advised with regard to health and safety and wearing protective equipment. It is part of their duty of professionalism to follow guidance and care for themselves and others.

Staff and fellow students will be afforded courtesy and respect.

5.2 Lateness

It is expected that students act in a professional manner with regard to punctuality and arrive on time to start sessions.

If students are late then they should report their lateness via the absence reporting system, copying in the relevant tutor, no later than 15 minutes before the session commences. If they are late by 10 minutes or more, they must make reasonable efforts not to disturb the teaching session unnecessarily, in addition to apologising to the staff leading the session.

Students may be awarded a clinical alert on LiftUpp for lateness or inappropriate reporting of absence.

5.3 Student's Uniform policy

Barts Health have high expectations with regard to both students and staff appearance and behaviour, and it is expected that exemplary conduct and presentation is essential for the reputation of the Institute of Dentistry and NHS Trust.

- Smart, professional dress (no jeans)
- Students should wear a clean, ironed, scrub top and trousers
- Students must be bare below the elbow. For those students where exposure of forearms is not acceptable due to their faith, the IoD follows the advice from the Muslim Spiritual Care Provision, where disposable over-sleeves, elasticated at the elbow and wrist will be provided and must be put on and discarded in exactly the same way as disposable gloves.
- Footwear with toes and most of top of foot covered (no trainers or sandals or high heels)
- Jewellery / watches should not be worn
- Plain wedding bands may be worn
- PPE should not be worn outside the Clinical Skills area
- Scrub tops must not be worn outside the building.
- Nails should be kept short and clean. No nail varnish or acrylic nails at all, as they harbour bacteria.
- Hair should be tied back and secured off the collar.

5.4 The Educational Philosophy for the Dental Skills Laboratory

Students are expected to watch the pre-recorded theoretical PowerPoint presentation prior to each relevant session. These are available on QMPlus. If students have not done this, they may be directed to leave the session to catch up on the concepts during their lab-based session.

Lab based sessions cannot be swopped and students who miss teaching sessions are not permitted to swop into other identical sessions, as this may affect the numbers of students present at any one time.

Enthusiastic and conscientious students are the most important resource in sessions. Students will be encouraged to identify their own learning needs. Problem posing, peer

learning and the involvement of students in dialogue will be encouraged. Every question is a good question, identifies a learning need and represents an opportunity to acknowledge students' engagement with learning.

The physical and emotional well-being of students, while undergraduates and in the future, is as important as the well-being of patients. This is an educational concern of the staff and is included in the curriculum.

The values, dignity and individuality of each student will be respected in all lab-based activities.

Students are in transition into a profession with caring, decent and honest members who strive to gain the trust and respect of their patients.

We aim to facilitate professional development and personal growth in reflectiveness, integrity, ethical awareness and sensitivity to the needs of patients. Educational activities will be primarily learner centred (helping students become more effective learners) and acknowledge individual preferred learning styles

Students will be supported towards a future of autonomous, self-directed, independent learning.

Emotions and feelings are sources of learning and should be acknowledged.

Staff and students are professional colleagues and should be extended consideration with regard to punctuality and courtesy.

5.5 Clinical competencies (Gateway assessments)

Clinical competencies (Gateways) are assessments of a student's ability to carry out specific dental procedures. These are designed to be checkpoints within the curriculum to ensure patient safety before students carry out these procedures on clinic. These are predominantly assessed in lab based sessions but may be on a non-patient clinic.

Clinical staff are randomly pre-allocated prior to each assessment, and this is subject to change on the day, due to staff availability. Any student receiving a Not Competent grade will have had their work assessed, signed off and agreed by the more than one assessor.

There is no set limit to the number of attempts available for students to achieve a Pass grade for the Gateway assessments. However, should a student consistently not pass a specific assessment, a discussion with the students and relevant staff members will take place to agree a way forwards.

5.6 I cannot attend my competency assessment. What does this mean?

Extenuating Circumstances

If you do not attend, and an assessment is missed, the University of Plymouth Extenuating Circumstances procedures must be followed. You are strongly advised to contact Faculty Office at the earliest opportunity. Details of extenuating circumstances rules and procedures can be found on Moodle.

If extenuating circumstances are approved, another opportunity at the assessment will be scheduled for you. If extenuating circumstances procedures are not followed, or are not approved, the assessment attempt will be graded 'Not competent' (SDLE, Clinic and Clinical Skills Competencies) or 'Unsatisfactory' Clinical Capability Assessment (CCapA).

5.7 Consolidation

Within Year 1 and Year 3 most consolidation will take place during your normal curriculum SDLE sessions. Year 2 have voluntary consolidation sessions as well as consolidation within their normal curriculum SDLE sessions.

Students will also have the opportunity to practice techniques on the portable phantom head manikins in the clinics in the event of patient non-attendance. These may be made available at the discretion of the DEF clinic staff.

5.8 Remediation

Students who are unsuccessful at the summative attempt of a Clinical Competency Assessments (simulated) Assessment will have remediation sessions, which may be as part of a group, prior to the resit attempt.

5.9 Remediation for re-sit opportunities

If a student is unsuccessful at the second attempt of a Clinical Skills Competency Assessment, he or she may be offered a re-sit by the Award Assessment Board. This decision is at the discretion of the Award Assessment Board. Prior to a re-sit students will be offered at least one hour of remediation and two hours of supervised consolidation, which may be as part of a group. This will be organised on an individual basis as necessary.

5.10 Reintegration table

Students who are repeating or returning after an interruption to their studies will have additional support. See table below:

<table>
<tr><td>Module</td><td colspan="5">Re-integration Year</td></tr>
<tr><td rowspan="2"></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td colspan="5">Academic support * - Programme Lead meeting at start of year (All students)**
Remediation – (Repeating IDS/ADK students only) – Level 2 remediation meeting at the start of term.</td></tr>
<tr><td>Clinical Dentistry</td><td rowspan="2">Starting Course from beginning</td><td colspan="4">12 hours Supervised Simulated Dental Learning Environment (SDLE) reintegration on practical tasks.</td></tr>
<tr><td>MCQ / ADK</td><td colspan="4">Formative assessment offered</td></tr>
</table>

* All students meet with their Academic Tutor once per term during the RPA process. If any concerns are raised at SCPRG, additional meetings will be arranged on a more personalised process.

** Programme Leads can recommend additional meetings for repeating and reintegrating students as deemed appropriate with module leads etc. at the beginning of the year.

6. Local and national guidance and associated links

Internal and National Guidance documents

-
- The Challacombe Scale for Clinical Oral Dryness
  Challacombe-Scale-ENG.pdf

Examination and Assessment

The Examination and Assessment is the foundation of dental care, but is very challenging because proficiency can really only be acquired by experience. In addition, students in the earlier stages of training will have limited skills and knowledge.

Students should familiarise themselves with the marking criteria for Form S, from which it will be clear that they should not expect to consistently achieve a Satisfactory grade until they have reached the later years in the course.

More than one visit may be necessary to complete a full examination and assessment.

***Stage 1* Meeting the patient**

- Confirm patient details – name, age. Paeds: age in years **and** months, and ask name and relationship of accompanying adult.
- Find out briefly whether there are any urgent problems that need to be addressed during this appointment.
- Explain what will happen today, and check whether patient has to leave by a particular time.
- Consent: first part of form. Additionally for Paeds, if the accompanying adult is not a parent, establish whether they can give consent.
- Find out how the patient is feeling today (we need to establish as soon as possible if they cannot be treated e.g. cold sore, D&V, other infectious disease or recent contact). Consult with CS **at this stage**, if their current health status is in doubt.
- Take a full Medical History.

CS to check Medical History, consent and any other relevant findings

(If you are waiting, take the Social History, Family History and Dental History)

- Social History
- Family History (including siblings for Paeds)
- Dental History
  - Past: Broadly, what types of dental problems and treatment have they experienced in the past? Any problems with having dental treatment?
  - Current: Any concerns at present? Oral hygiene: what do they use, how often?
  - Future: Try to find out what they are hoping for from us. Why have they come to the dental school? Do they have a deadline for completion of treatment e.g. wedding, moving abroad?

***Stage 4* Diagnosis**

- Your diagnosis of conditions found.
- Place in order of priority.

Stage 2 Examination (**must not** be started until CS has checked Medical History)

- Extra-Oral: before starting, fully explain to patient what you are going to do and why. Nurse **must** be present. (Emily Edwards week 2: Extra- and Intra-Oral examination 2012-13.ppt and video).
- Intra-Oral soft tissues.
- Hard tissues – chart the dentition. (See NEBDN Charting in Published Guidelines and Standards/Miscellaneous)
    - You may find it helpful before you begin, to count the teeth in each quadrant and decide which teeth are present in the mouth. In the adult dentition the third permanent molars are frequently not visible because they are either unerupted or have been removed. Unless or until you have radiographic evidence that they are not present, you should chart them as unerupted.
    - Where primary teeth are present, you also need to chart the unerupted secondary dentition.
    - Start the charting with the UR8, work around the upper arch to the UL8 entering all details for each tooth so that a single pass around the arches will suffice, drop down to LL8, and then around the lower arch to LR8

- Orthodontic assessment: this should be quite brief, looking at for example
    - Skeletal pattern
    - Incisor relationship, first molar relationship
    - Centreline
    - Anterior and posterior crossbites or displacements
- BPE (see Clinical Pathways for Periodontal Protocols)
- Prostheses and related tissues and structures

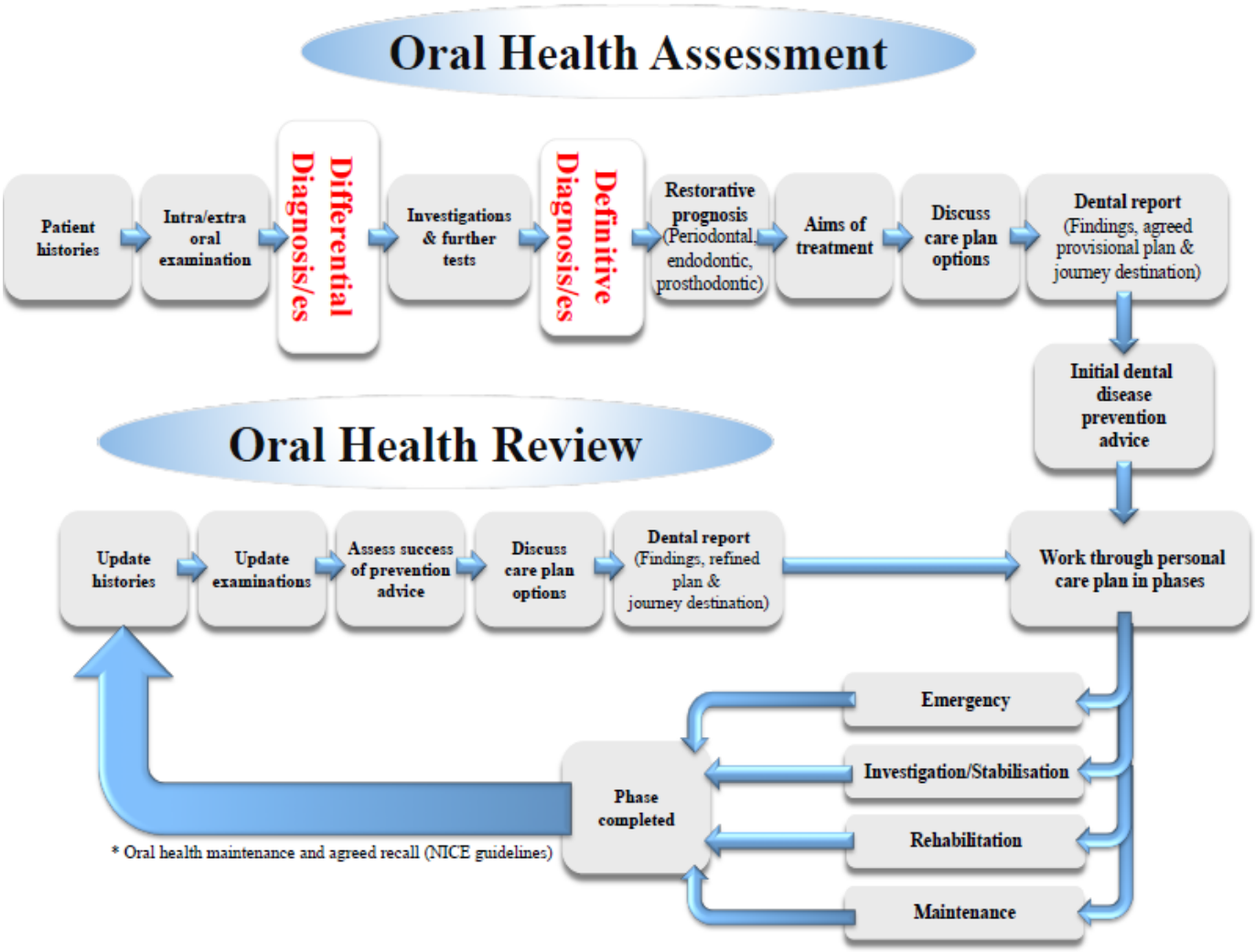
CS for presentation of findings and suggestions for further investigations

Stage 3 Further Investigations for example:

- Radiography
- Vitality tests
- Periodontal indices
- Diet sheet
- Full orthodontic assessment
- Study models

CS for presentation of interpretation of findings, and student to suggest the following:

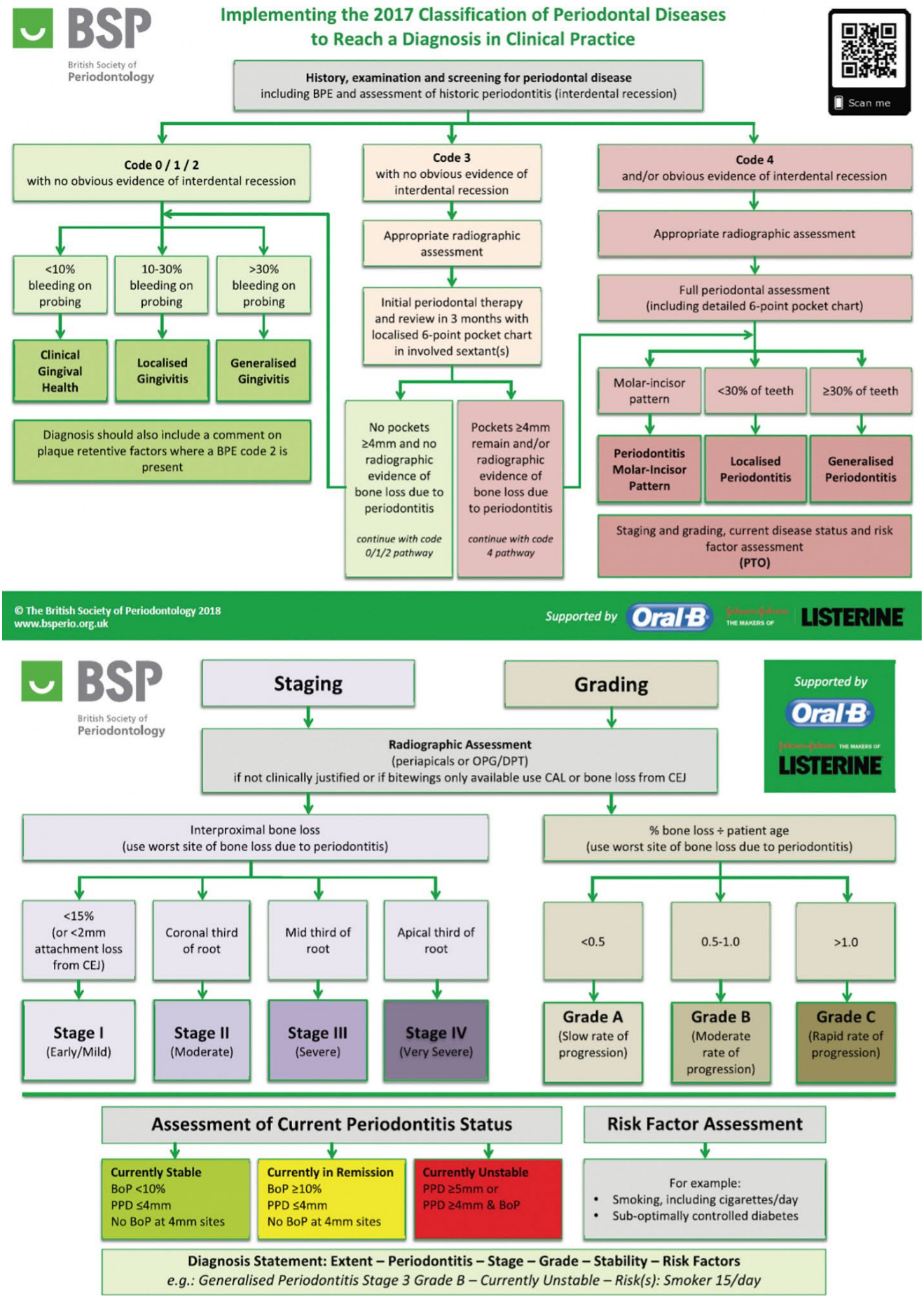
Treatment Planning Overview



Periodontology

Links to useful literature/guidance

- BPE Guidelines BSP BPE Guidelines 2019.pdf
- BSP Flowchart Implementing the 2018 Classification of Periodontal Diseases to reach a diagnosis in clinical practice BSP Flowchart Implementing the 2018 Classification



- BSP UK Clinical Practice Guidelines for the Treatment of Periodontal Diseases and Conditions BSP UK Clinical Practice Treatment Flow Chart - Haleon
- BSP Patient Information Leaflet: Periodontal Health for a Better Life Gum Health for a Better Life.pdf
- BSP Periodontitis and General Health- videos BSP Videos: Periodontitis and General Health

Case Definitions for Periodontal Health, Gingivitis and Periodontitis

As outlined on the Proceedings of the World Workshop on the Classification of Periodontal and Peri-implant Diseases and Conditions, 2018, a patient is assigned the following case definition if the below characteristics are observed:

Periodontal Health

- In Intact periodontium or a reduced periodontium in no periodontitis patient
- <10% sites with bleeding on probing
- PPD <= 3mm

Localised Gingivitis

- In Intact periodontium or a reduced periodontium in no periodontitis patient
- 10 – 30% bleeding on probing sites
- PPD <= 3mm

Generalised Gingivitis

- In Intact periodontium or a reduced periodontium in no periodontitis patient
- > 30% bleeding on probing sites
- PPD <= 3mm

Periodontitis

- Patients with a history of periodontitis or reduced periodontium due to periodontitis
- Interdental clinical attachment loss of 1 mm or more at 2 or more non-adjacent teeth
- Buccal clinical attachment loss of 3mm or over with associated 4mm or more of PPD detectable in at least two teeth
- As long as, CAL due to non-periodontitis reasons has first been excluded.

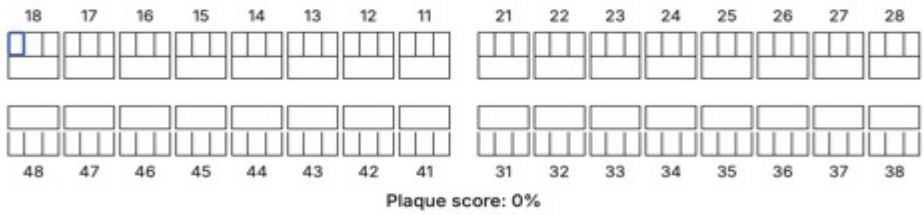
Every patient seen in clinic should be assigned a periodontal diagnosis according to the case definitions

Periodontal Investigations

PLAQUE AND BLEEDING SCORES

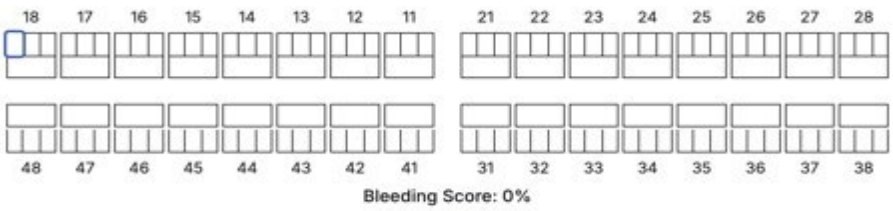
PLAQUE SCORE

Complete plaque scores using https://app.dentascribe.uk/plaque
Use *4 surfaces chart*



MARGINAL BLEEDING

Complete plaque scores using https://app.dentascribe.uk/bleeding
Use *4 surfaces chart*



PATIENT ENGAGEMENT

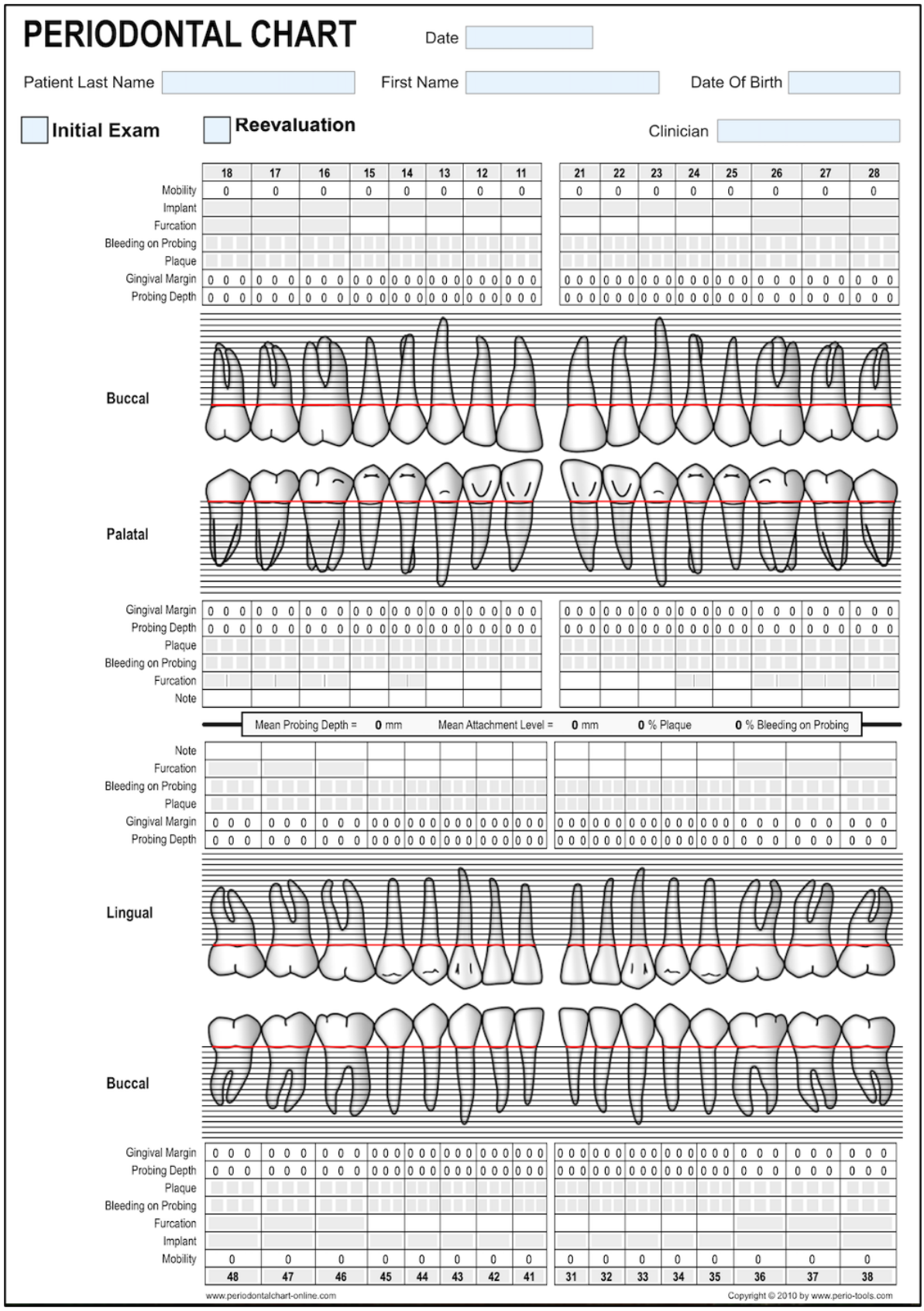
Using past and current plaque and bleeding scores, complete:

Date	Plaque score	Marginal Bleeding

Is patient engaging? yes/no
Explain:

FULL MOUTH PERIODONTAL CHART

Complete https://www.periodontalchart-online.com



Periodontal Assessment- Useful information

Mobility (Miller et al., 1950)

To check mobility, use the back of one instrument and a finger or two instruments.

Score 0:	Physiological mobility of up to 0.2mm – "normal" mobility of the tooth within the periodontium, imperceptible.
Score 1:	Mobility in a horizontal direction between 0.2mm – 1mm
Score 2:	Mobility in a horizontal direction by more than 1mm
Score 3:	Mobility in both a horizontal and a vertical direction

Furcation Grading - Recorded with Nabers/Furcation Probe

Grade 1:	Furcation entrance can be felt with tip of probe. Horizontal probing depth into furcation of no more than 3 mm ("superficial")
Grade 2:	Horizontal probing depth into furcation of more than 3mm but does not pass completely (cul-de-sac). Involve only one entrance or combined with grade I
Grade 3:	Horizontal probing depth into furcation of more than 3mm from 2 or more entrances, representing a "through-and-through"

Radiographic Selection in Periodontal Assessment

Modified from: *Selection Criteria for Dental Radiography. Edited by K Horner & KA Eaton. Faculty of General Dental Practice (UK). 3rd Edition (Updated 2018). Chapter 5: Radiographs in Periodontal Assessment (p.65-69*)

https://cgdent.uk/wp-content/uploads/securepdfs/FGDP-SCDR-ALL-Web.pdf

There is insufficient evidence from research into radiographic selection criteria for periodontology to allow for robust, evidence-based recommendations. However, the following are proposed as good practice:

- It is essential that selection of dental radiographs is **based on the individual patient's history and a clinical examination**.
- The use of radiography is used t**o supplement (not replace) the clinical examination and full mouth periodontal assessment**. To help inform/confirm diagnosis, and may provide additional information that change patient management and prognosis.
- Where possible, **use existing radiographs** to determine alveolar bone levels, avoiding duplication. For example, if you have already obtained for caries or other assessment.
- When determining which radiographic technique to use, **consideration** should be given to the **clinical presentation**, the required **image quality** and the **relative dose-benefit** based on the equipment available.
- As a general rule, radiographs to assess alveolar bone levels should be obtained for teeth or sextants where **BPE codes 3, 4,*** are identified.
- If a patient has generalised pocketing of 4-5mm (**BPE= 3** in any sextant) and little or no recession, **horizontal bitewings** are recommended. These may be supplemented by **intraoral periapicals for selected anterior teeth**, but only if this is likely to change management of the patient.
- If a patient has pocketing of 6 mm or more (**BPE= 4**), **vertical bitewing** radiographs are recommended, **supplemented by anterior periapicals.**
- Assessment of all teeth and their periodontal support can also be achieved by an **optimal-quality panoramic radiograph** with supplementary periapical radiographs, as needed, or a full mouth series.
- A **full mouth series** should only be taken when clinically indicated and likely to impact on diagnosis, prognosis, and treatment to be carried out. For example, reduced number of teeth; if a patient has generalised pocketing of 4-5 mm (BPE=3) with additional recession of ≥2mm; if a patient has generalised pocketing of 6mm+ (BPE=4 in all/most sextants).

- **Before taking any radiograph** you must ask how will the information from the radiograph impact on diagnosis, determination of prognosis, and treatment to be carried out. If it will not impact on this then a radiograph may not be necessary.

Periodontal protocol – Examination, Diagnosis and Treatment

History, examination and screening for periodontal disease including BPE and assessment of historic periodontal disease (interdental recession, past diagnosis or treatment)

Further Investigations (based on BPE)

Full Periodontal Examination: 6 point pr**obing depths and bleeding on pr**obing, gingival recession, furcation grading, mobility & suppuration **– recorded at baseline and reassessed at healing after 8-12 weeks.**

Radiographs: check existing radiographs and request according to clinical need.

Indices: Plaque and marginal bleeding scores – carried out at initial appointment and subsequent appointments. If the patient's plaque score is above 20% you should look for some improvement before commencing sub-gingival PMPR.

Diagnosis:
Following the BSP Implementation flowchart for the 2018 Classification of Periodontal Diseases to reach a diagnosis in clinical practice BSP implementation flowchart for periodontal diagnosis
Assign each patient a periodontal diagnosis: Periodontal Health, Gingivitis or Periodontitis
If Periodontitis: provide a diagnostic statement including:
Extent + Periodontitis + Stage + Grade + Stability + Risk factors
Eg.: Generalised Periodontitis Stage 2 Grade B – Currently Unstable – Risk(s): Smoker 10/day

Treatment - Periodontitis:
Following the S3 Clinical Practice Guidelines for the Treatment of Periodontal Diseases and Conditions BSP UK S3 Treatment Guidelines Flowchart

Emergency phase: Consider extraction of teeth with hopeless prognosis or unsalvable.

Step 1:
- Provide diagnosis, explain the disease and treatment alternatives
- Tailored Oral Hygiene Advice
- Discuss Risk Factor control including removal of plaque retentive factors
- Supragingival PMPR (supra- and sub-gingival on clinical crown)
- Determine if patient is engaging

Step 2:
- If engaging, start Step 2 (if not, reinforce or move to palliative care)
- It is possible to move into Step 2 with your not engaging patients, but make sure to consider this when evaluating treatment outcomes(e.g this could explain non or minimal improvement)
- Reinforce OH, risk factor control
- Systemic antibiotics only provided under tutor support, by specialist or accredited level 2
- RSD or Subgingival PMPR (consent patients verbally inform possible secondary effects; plan your instrumentation: by quadrant, two quadrants, or all mouth; use hand or ultrasonic or combination of both)
- Re-evaluate after 8-12 weeks

Step 3:
- Reassessment with a Full Periodontal Assessment and plaque and marginal bleeding scores.
- If endpoints were met (pocket closure & stability) move to Step 4.
- If endpoint not met, reflect on possible reasons: engagement, risk factors, operator experience, state of instrument/equipment, local anaesthetics avoided. Plan re-intervention with a modified approach (Draft a new treatment plan for remaining care plan)

- If presence of pockets of 5mm+ or 4mm with BoP, management of non-responding sites by instrumentation localised to residual pockets.
- If long gap since last appointment, supragingival and subgingival (RSD) instrumentation may be needed – i.e. restart Step 1&2.
- Consider referral for pocket management or regenerative surgery.

Step 4:

- Provide advice or recall visits according to periodontal & other risk assessment
- Supportive Periodontal Care is not normally carried out in hospital.
- Refer patient back to GDP to reinforce OH, risk factor control, regular targeted PMPR as required

Periodontal Definitions in Personalised Patient Care

Patient engagement

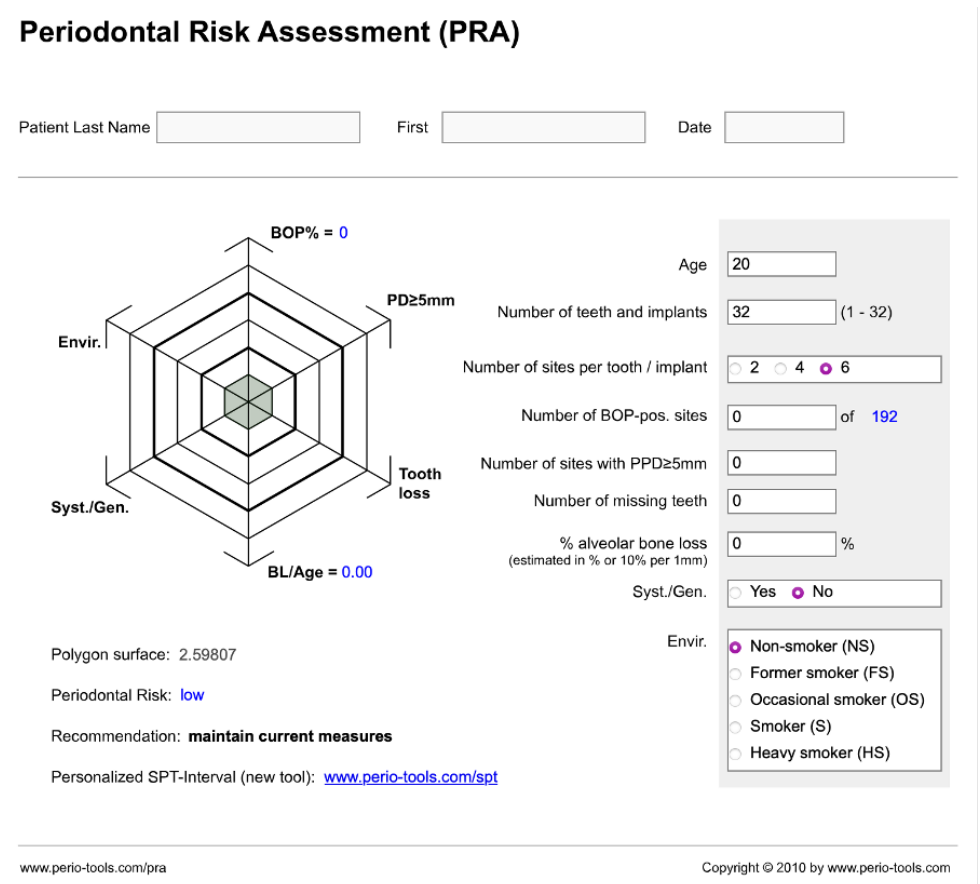
The British Society of Periodontology have defined patients as being engaging or non-engaging depending on their compliance or ability to comply with recommended oral hygiene regimens. https://www.bsperio.org.uk/assets/downloads/Delivering_phased_Care_Final_6th_May_2021_1.pdf

Engaging patient: Demonstrates a favourable response to self-care advice and sufficient improvement in oral hygiene as indicated by:

- a 50% or greater improvement in plaque and marginal bleeding scores,
- Indicative Bleeding Levels <30% and Plaque Levels <20%
- A stated preference to achieving periodontal health

Periodontal Risk Assessment

Complete *PRA* https://www.perio-tools.com/pra/en/



Further analysis of risk factors:

Site specific factors: (Assess disease activity/ indicate active inflammation)		
BoP (negative predictive factor)	%BoP	
PPD and CAL		
Suppuration		
Tooth level factors: (Evaluate prognosis and function of teeth and need for specific therapeutic measures)		
Position (crowding)		
Furcation involvement		
Iatrogenic factors (overhangs)		
Residual periodontal support (CAL)		
Mobility		
Flaring and other		
Patient level factors: Affect onset, severity and progression of periodontitis		
NON-MODIFIABLE:		
Age (correlation)		
Sex (men, increased inflammatory response)		
Ethnicity (linked to inequality and SE)		
Genetics (altered immune response)		
MODIFIABLE/ ACQUIRED/ENVIRONMENTAL:		
Smoking		
Uncontrolled diabetes		
Other: medications, stress and psychological factors, malnutrition, SE status, compliance with recall)		
Other		

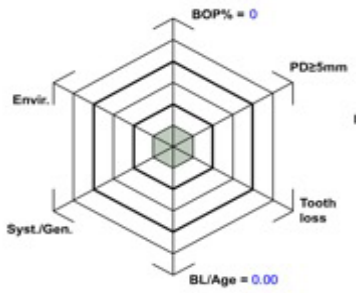
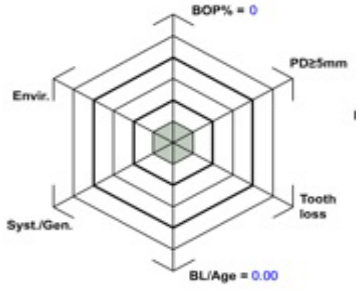
REFLECTION AND OUTCOME INTERPRETATION

END POINTS	Before	Intervention	After	Reflection
Smoking control	*10/day*	*Smoking cessation advice*	*Quit smoking*	*Major risk factor eliminated*
Diabetes control	*Unaware of diabetic status*	*Advised to see GMP*	*Diagnosed with NIDDM – now having blood tests and controlling diabetes through diet and medication*	*Identified periodontal risk factor and patient having GMP and diabetic nurse to help manage*
Plaque Score (%)- <20%	*80%*	*OHI*	*30%*	*Patient has reduced plaque score by 50% although the patient still remains "uncompliant"*
Bleeding Score (%)- <30%	*90%*	*OHI*	*20%*	*Improvement in bleeding score reflecting less inflammation associated with deep pocketing.*
Number of unstable pockets (4mm with BoP or more)	*150*	*OHI and Supra and subgingival instrumentation*	*100*	*Reduction in number of unstable pockets although there remains a number of unstable sites in the mouth.*
Number of residual pockets of 6mm+ or more				
Furcation II or III				
Mobility and Suppuration				

OUTCOME OF THERAPY REPORT

	Yes / No	Explain
Is Patient Engaging?	Yes	E.g. *Patient has reduced plaques score by 50% and although technically "compliant" still has plaque score >20%*
Has patient reached end point of periodontal care	**BoP<10%:** No	E.g. BoP <10%
	Pocket closure: No	E.g. *100 sites >4mm still remain* *Bleeding although has dramatically reduced*
Does patient require further care?	Yes	E.g. *A further round of NS treatment is advised to try to reduce pocketing further and to also work on the patients oral hygiene*
What further care would you suggest?	Further round of NS or	E.g. *In order to reduce pocketing further a further round of NS therapy could be attempted.*

PERIO RISK PROFILE UPDATE

RISK PROFILE	INITIAL	REASSESSMENT
DATE		
Periodontal Risk	High / Moderate / Low	High / Moderate / Low
Recall time	3mo / 6 mo / 12 mo	3mo / 6 mo / 12 mo
	Insert previous Periodontal Risk Assessment here 	*Insert new PRA* https://www.perio-tools.com/pra/en/ 
OUTLINE CHANGES TO PERIODONTAL RISK (|MODIFIABLE FACTORS]		
No Teeth		*Indicate any XLA*
Plaque Score		
Marginal Bleeding		
%BoP		
PPD ≥4mm wBoP or PPD>4		
PPD≥5mm		
PPD≥6mm		
Furcation II, III		
Mobility		
Suppuration		
Smoking		
Diabetes		
Other		

Restorative

Direct Posterior Composite Protocol

Policy compared to amalgam	**Phase down amalgam**
Contraindications	**History of adverse reaction to resin composite materials**
Size	**No restriction**
Cavity design	**Remove caries and all existing restorative materials, remove unsupported enamel, no further cavity enlargement except to provide1.5 – 2mm minimal thickness of composite in areas of occlusal load**
Bevels	**No**
Protection of operatively exposed dentine	**Setting Calcium Hydroxide in deep areas when managing caries.** **Setting calcium hydroxide or Biodentine for direct pulp cap**
Bonding technique	**Etch and rinse (etch / primer / adhesive) (Never self-etch)**
Curing	**Light cure**
Isolation / moisture control	**Rubber dam mandatory**
Placement technique	**Modified incremental layering**
Matrices	**Triodent (Palodent Plus) sectional matrix system**
Unfilled composite (flowable)	**Intermediate layer**
Margins	**Use only when enamel margins present around entire cavity**
Treatment of primary carious Lesions	**Yes**
Replacement of existing defective direct restorations	**Yes**
Replacement of existing defective indirect restorations (e.g., inlays)	**Yes**
Restoration of fractured and cracked teeth	**Yes**
Restoration of teeth affected by tooth wear and erosion	**Yes**
Margin below gingival margin	**Use composite providing moisture control is effective / consider crown lengthening**
Margin below cement enamel Junction	**Use amalgam or a metal alloy indirect restoration**
Presence of altered or abnormal enamel and dentine	**May be used to address aesthetic issues**

The Basic Erosive Wear Examination

- version 3 Guideline_Recomendations_and guidelines BEWE

Diagnosis, prevention and management of dental erosion RCS

- https://www.rcseng.ac.uk/-/media/files/rcs/fds/guidelines/erosion-guidelines_2021_v4_mj.pdf

British Endodontic Society- publications

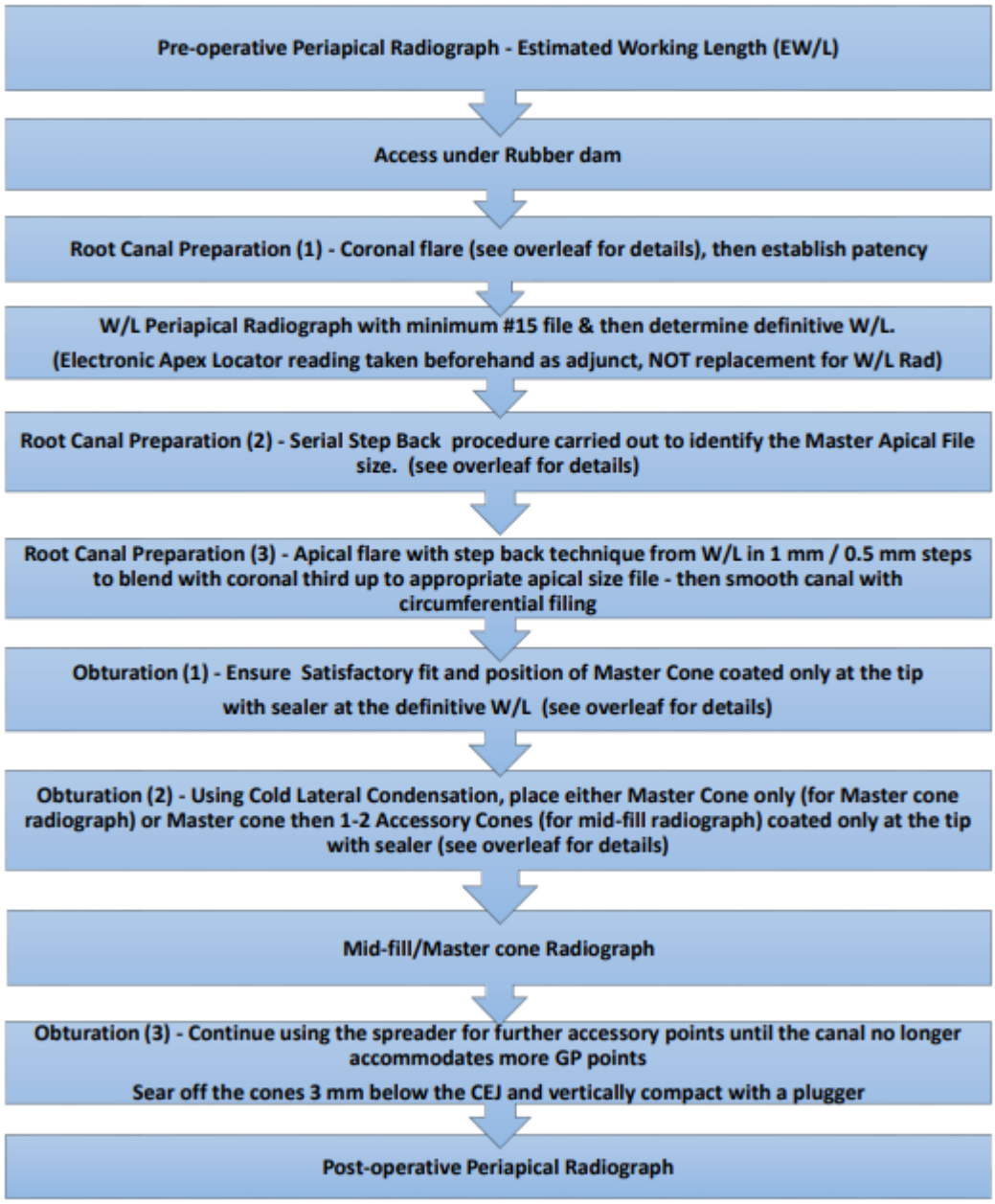
- [Endodontic publications | British Endodontic Society]

Updated version of Clinical Guidelines in Endodontics

ROOT CANAL TREATMENT GUIDELINES* for UG CLINICAL TEACHING

**** It is expected that any deviation from these guidelines should only be in exceptional circumstances and clinically justified in an individual case.***

THE USE OF RUBBER DAM DURING ENDODONTIC TREATMENT IS ESSENTIAL AT ALL TIMES



ESSENTIAL Periapical Radiographs during root canal treatment•

1. Pre-operative radiograph [Estimated working length (W/L)]
2. Working length radiograph with at least file size 15 in place
3. Mid-fill radiograph
4. Post-operative radiograph to assess the quality of obturation

- *All periapical views should include at least 3 mm of the area around the root apex/apices of the tooth being treated*
- *All radiographs, should be of good quality, undistorted, taken with a beam-aiming device and using the paralleling technique*

Root canal preparation

- Estimate W/L from **the pre-operative radiograph;**
- Access under rubber dam;
- **Coronal Prep**:
  - Explore canal with size 10 file;
  - Use of SX Protaper for the coronal preparation if the canal is already capable of accommodating a minimum size 10 file.
- **Canal patency** with size 10 file;
- Hand file to size 15 file
- **Check with the Electronic Apex Locator, at the zero reading, beforehand; estimated W/L should be the length at zero reading minus 1 mm.**
- **Then, Definitive W/L Radiograph with a size 15 file**
- Establish the Definitive W/L
- **Serial step back procedure** carried out to identify the Master Apical File size. This is a procedure that where size 15, 20, 25 or 30 files incrementally advance within the root canal system at the Definitive W/L to apically gauge with a specific file size prior to the Step back procedure.
- **Step Back procedure** for apical flare with step back technique from W/L in 1 mm / 0.5 mm steps to blend with coronal third up to appropriate apical size file - then smooth canal with circumferential filing
- Following step back procedure, apically gauge to determine master apical file size at W/L; (at least size 25 file for **Cold Lateral Condensation obturation technique**)
- Ensure spreader goes to within at least 1 mm of WL without binding
- Not too loose, IF not to length then further preparation of canal required
- Smooth canal with circumferential motion
- **In between all file usage** irrigate with sodium hypochlorite**and maintain canal patency
- Consider use of EDTA pastes/solutions as a lubricant especially with fine and/or curved canals
- **Safe irrigation:**
  - ✓ Use side venting needle
  - ✓ Never bind irrigation needle in canal
  - ✓ Never use **excessive force** to 'inject' solution
  - ✓ Irrigate slowly
  - ✓ Use high volume suction until the solution is clear in the access cavity
  - ✓ A total of 2-3 ml irrigation is advisable at the 1st stage of root canal treatment

  ** *With fine and/or curved canals also consider use of EDTA pastes/solutions as a lubricant*

- **Objectives of the use of intracanal medicament in between visits**
  - ✓ To eliminate any remaining bacteria after canal instrumentation and irrigation
  - ✓ Evidence suggests that, in infected cases, bacteria surviving completion of preparation could increase in number between appointments if intracanal medicament is not used

  Non-setting calcium hydroxide is currently considered the most effective medicament for reducing the presence of intra-canal bacteria and is the medication of choice.

- **The use of Odontopaste.** ODONTOPASTE (Feb, 2008) is a newer therapeutic endodontic dressing which is an alternative to Ledermix, ODONTOPASTE is a zinc oxide-based paste, used as an intra-canal medicament.

  ODONTOPASTE is claimed to have anti-inflammatory characteristics of its ingredients, 5.6% clindamycin hydrochloride, a broad-spectrum antibiotic, and triamcinolone acetonide – a steroid-based anti-inflammatory agent. The majority of these active components are released within the first few days following application.

  The main difference between Odontopaste and Ledermix paste is that clindamycin hydrochloride in Odontopaste replaces demeclocycline hydrochloride in Ledermix paste. Clindamycin hydrochloride has an equivalent spectrum of antibacterial activity and exhibits minimal staining of teeth.

  The use of Odontopaste is not routine. Case selection is necessary when, for example, there is
  - ✓ Pain relief needed if associated with acute pulpitis
  - ✓ Interim pulpotomy dressing material for permanent teeth in cases of acute pulpitis where root canal treatment will follow
  - ✓ Following dental trauma, in prepared canals, to reduce the incidence of inflammatory root resorption
  - ✓ Reduction of existing inflammatory root resorption

Conditions necessary prior to insertion of root canal filling

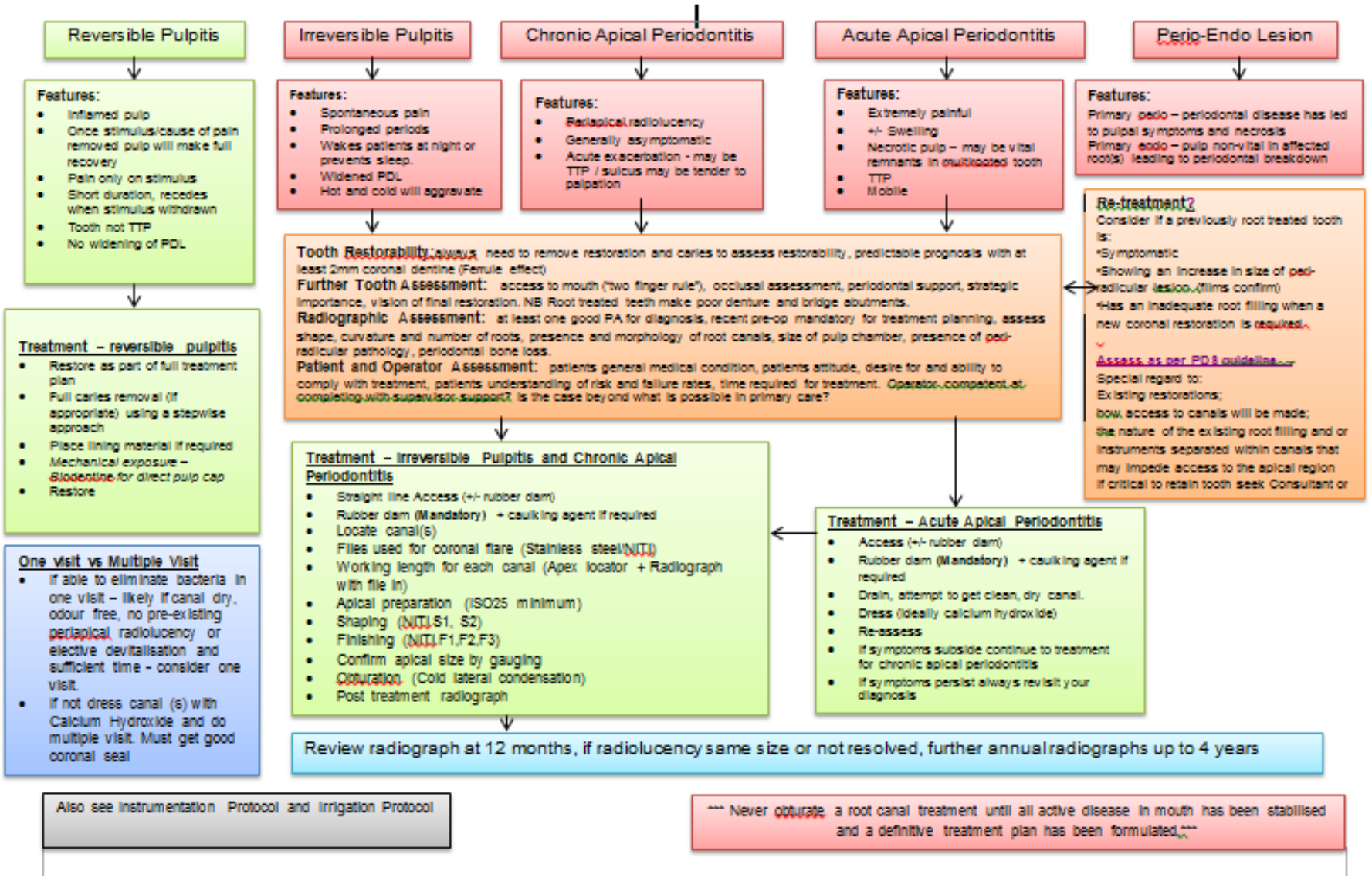
- Canal must be dry or capable of being dried
- Canal preparation must be complete
- Tooth should be symptom-free
- Soft tissues related to the tooth should not show signs of infection; e.g., a sinus tract should show signs of resolution

Cold lateral Condensation technique

- Spreader Selection
  - Ensure spreader goes to within at least 1 mm of WL without binding
  - Not too loose, IF not to length then further preparation of canal required
  - At appropriate length, mark this on spreader with a rubber stop
- Master gutta percha (GP) point selection – Ensure 'tug-back' is obtained at, or within, 1 mm of the definitive W/L within canal
- Master cone placement
  - Dry the canal with paper points;
  - Ensure the master GP point goes to definitive W/L, **take a Master GP radiograph**
  - Coat the inside of the canal lightly with sealer
  - Coat the tip of the master cone with sealer and place into the canal
  - Ideally ,the spreader should be able to go to within 1 mm of the definitive W/L with the master GP point
  - Laterally condense the master GP point coated only at the tip with sealer (ideally 2-3 mm at the tip of the GP)
  - Adjust rubber stop on spreader to the reference point
  - Clean the spreader with a gauze
  - Place accessory cones coated only at the tip with sealer (ideally 2-3 mm at the tip of the GP)
- Accessory cone placement –
  - Measure and mark accessory cone to marked spreader length
  - Lightly coat the accessory cone with sealer only at the tip
  - Ensure accessory cone goes to its marked length and laterally condense
  - Adjust rubber stop on spreader to the reference point
  - Clean the spreader
  - Repeat the above four steps

- After placing 2-3 accessory points **take a mid-fill radiograph**
- Assess whether the root filling is satisfactorily placed within the root canal and to the desired depth
- If too long or short of desired depth, then consider replacing the root filling to a more appropriate size/length
- Continue using the spreader to aid the introduction of further accessory points until the canal no longer accommodates more GP points
- Once the obturation is complete sear the cones off about 3 mm below the CEJ
- Vertically compact with an appropriately sized plugger
- Once the root canal treatment is completed, take **a post-operative radiograph**

Dr A Baysan and Prof BS Chong

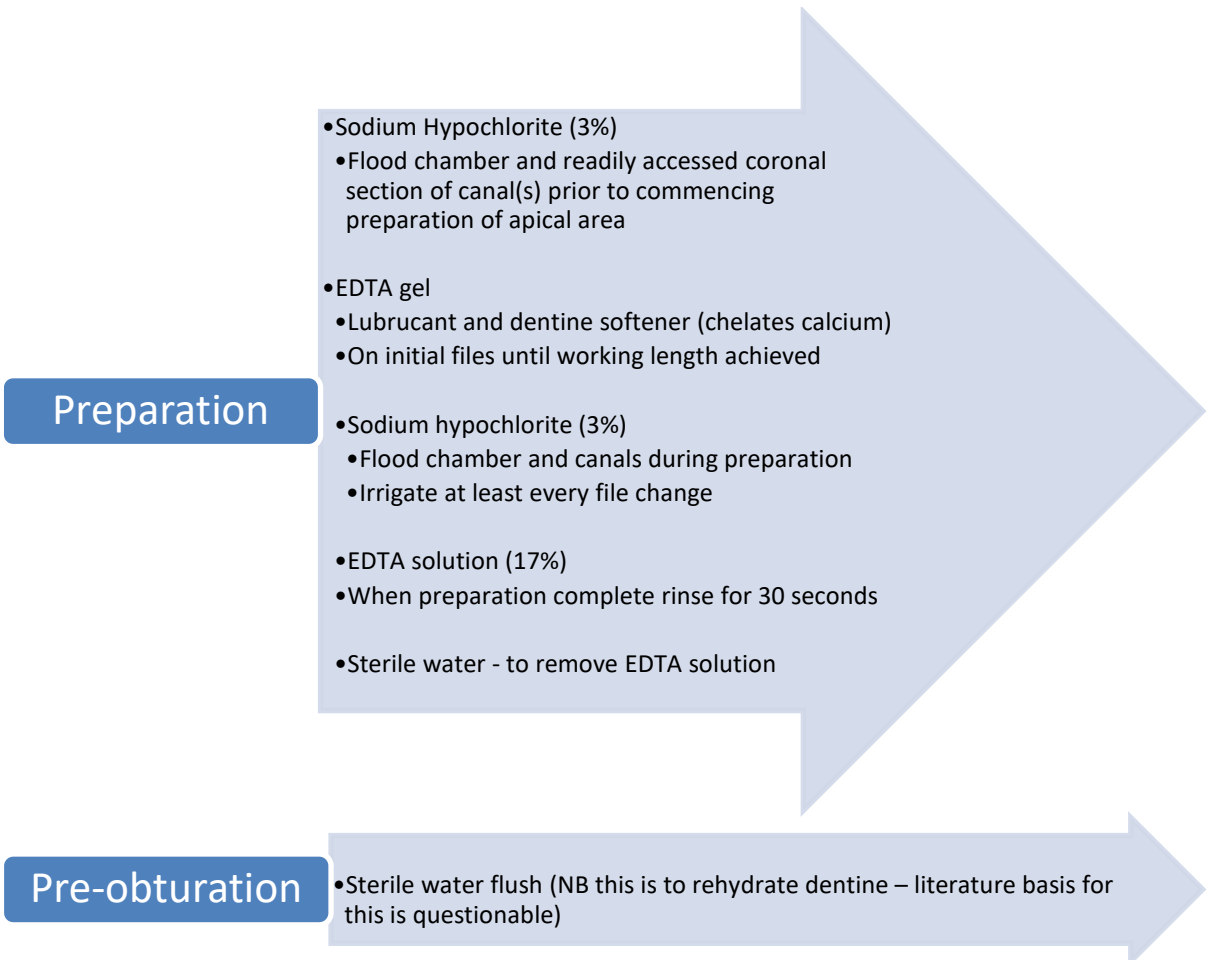

Reversible Pulpitis
Irreversible Pulpitis
Chronic Apical Periodontitis
Acute Apical Periodontitis
Perio-Endo Lesion
Features:
Inflamed pulp
Once stimulus/cause of pain removed pulp will make full recovery
Pain only on stimulus
Short duration, recedes when stimulus withdrawn
Tooth not TTP
No widening of PDL
Features:
Spontaneous pain
Prolonged periods
Wakes patients at night or prevents sleep.
Widened PDL
Hot and cold will aggravate
Features:
Periapical radiolucency
Generally asymptomatic
Acute exacerbation - may be TTP / sulcus may be tender to palpation
Features:
Extremely painful
+/- Swelling
Necrotic pulp – may be vital remnants in multirooted tooth
TTP
Mobile
Features:
Primary perio – periodontal disease has led to pulpal symptoms and necrosis
Primary endo – pulp non-vital in affected root(s) leading to periodontal breakdown
Tooth Restorability: always need to remove restoration and caries to assess restorability, predictable prognosis with at least 2mm coronal dentine (Ferrule effect)
Further Tooth Assessment: access to mouth ("two finger rule"), occlusal assessment, periodontal support, strategic importance, vision of final restoration. NB Root treated teeth make poor denture and bridge abutments.
Radiographic Assessment: at least one good PA for diagnosis, recent pre-op mandatory for treatment planning, assess shape, curvature and number of roots, presence and morphology of root canals, size of pulp chamber, presence of peri-radicular pathology, periodontal bone loss.
Patient and Operator Assessment: patients general medical condition, patients attitude, desire for and ability to comply with treatment, patients understanding of risk and failure rates, time required for treatment. Operator competent at completing with supervisor support? Is the case beyond what is possible in primary care?
Re-treatment?
Consider if a previously root treated tooth is:
•Symptomatic
•Showing an increase in size of peri-radicular lesion (films confirm)
•Has an inadequate root filling when a new coronal restoration is required.
Assess as per PDS guideline or
Special regard to:
Existing restorations;
how access to canals will be made;
the nature of the existing root filling and or instruments separated within canals that may impede access to the apical region
If critical to retain tooth seek Consultant or
Treatment – reversible pulpitis
Restore as part of full treatment plan
Full caries removal (if appropriate) using a stepwise approach
Place lining material if required
Mechanical exposure – Biodentine for direct pulp cap
Restore
One visit vs Multiple Visit
If able to eliminate bacteria in one visit – likely if canal dry, odour free, no pre-existing periapical radiolucency or elective devitalisation and sufficient time - consider one visit.
If not dress canal (s) with Calcium Hydroxide and do multiple visit. Must get good coronal seal
Treatment – Irreversible Pulpitis and Chronic Apical Periodontitis
Straight line Access (+/- rubber dam)
Rubber dam (Mandatory) + caulking agent if required
Locate canal(s)
Files used for coronal flare (Stainless steel/NiTi)
Working length for each canal (Apex locator + Radiograph with file in)
Apical preparation (ISO25 minimum)
Shaping (NiTi S1, S2)
Finishing (NiTi F1,F2,F3)
Confirm apical size by gauging
Obturation (Cold lateral condensation)
Post treatment radiograph
Treatment – Acute Apical Periodontitis
Access (+/- rubber dam)
Rubber dam (Mandatory) + caulking agent if required
Drain, attempt to get clean, dry canal.
Dress (ideally calcium hydroxide)
Re-assess
If symptoms subside continue to treatment for chronic apical periodontitis
If symptoms persist always revisit your diagnosis
Review radiograph at 12 months, if radiolucency same size or not resolved, further annual radiographs up to 4 years
Also see Instrumentation Protocol and Irrigation Protocol
*** Never obturate a root canal treatment until all active disease in mouth has been stabilised and a definitive treatment plan has been formulated ***

Endodontic Protocols

Diagnosis and Treatment

QMUL Endodontic Irrigation Clinical Pathway

QMUL Endodontic Irrigation Protocol



Care – Sodium Hypochlorite

(1) Always make sure that your rubber dam is sealed around the teeth – using caulking agent if necessary.
(2) Always use side vent needles. This ensures that the irrigant is injected laterally from the needle under minimum pressure rather than forced apically.
(3) The needle should be fine enough to be placed into the apical one third (27-29G) and should always be loose in the canal as the solution is placed.
(4) Sodium hypochlorite should NEVER be injected into the root canal with significant pressure

Firmly postgraduate only – not permitted in undergraduate clinic:

Root canal retreatments with potentially persistent infections use of higher concentration of sodium hypochlorite (5%).

Paediatric Dentistry

Key References & Guidelines:

- SDCEP Prevention and Management of Dental Caries in Children (2025)
- SDCEP Oral Health Assessments and Review (2011)
- BSPD Guidelines for Periodontal Screening and Management of Children and Adolescents Under 18 Years of Age (2021)
- SIGN Dental Intervention to Prevent Caries in Children (2014)
- Gov UK Delivering better oral health: an evidence-based toolkit for prevention (2021)
- NICE Dental checks: intervals between oral health reviews – Appendix G (2004)
- FGDP Selection Criteria for Dental Radiography. 3rd Edition (2018)
- The Hall Technique – User Manual (University of Dundee, V4)

Paediatric Caries Risk Assessment

Several factors are known to be associated with development of caries and, therefore, knowledge of them can inform a prediction of the risk of a child developing caries in the future. These factors include:

- Clinical evidence of previous disease
- Dietary habits, especially frequency of sugary food and drink consumption
- Social history, especially socioeconomic status
- Use of fluoride
- Plaque control
- Saliva
- Medical history

Amongst the risk factors listed above, SDCEP (2025) advises previous caries experience (decayed, missing due to caries or filled teeth) and socioeconomic status are the more reliable predictors of caries risk.

Although several tools for caries risk assessment exist, there is no consensus on which is most effective and comparisons have proved difficult to conduct because of the low quality of the studies relating to different tools. Examples from the American Academy of Pediatric Dentistry are shown below.

- **From Caries-Risk Assessment and Management for Infants, Children, and Adolescents (AAPD, 2022)**

Table 1. Caries-risk Assessment Form for 0-5 Years Old

Use of this tool will help the health care provider assess the child's risk for developing caries lesions. In addition, reviewing specific factors will help the practitioner and parent understand the variable influences that contribute to or protect from dental caries.

Factors	High risk	Moderate risk	Low risk
Risk factors, social/behavioral/medical			
Mother/primary caregiver has active dental caries	Yes		
Parent/caregiver has life-time of poverty, low health literacy	Yes		
Child has frequent exposure (>3 times/day) between-meal sugar-containing snacks or beverages per day	Yes		
Child uses bottle or nonspill cup containing natural or added sugar frequently, between meals and/or at bedtime	Yes		
Child is a recent immigrant		Yes	
Child has special health care needs[α]		Yes	
Risk factors, clinical			
Child has visible plaque on teeth	Yes		
Child presents with dental enamel defects	Yes		
Protective factors			
Child receives optimally-fluoridated drinking water or fluoride supplements			Yes
Child has teeth brushed daily with fluoridated toothpaste			Yes
Child receives topical fluoride from health professional			Yes
Child has dental home/regular dental care			Yes
Disease indicators [ƒ]			
Child has noncavitated (incipient/white spot) caries lesions	Yes		
Child has visible caries lesions	Yes		
Child has recent restorations or missing teeth due to caries	Yes		

[α] Practitioners may choose a different risk level based on specific medical diagnosis and unique circumstances, especially conditions that affect motor coordination or cooperation.

[ƒ] While these do not cause caries directly or indirectly, they indicate presence of factors that do.

Instructions: *Circle "Yes" that corresponds with those conditions applying to a specific patient. Use the circled responses to visualize the balance among risk factors, protective factors, and disease indicators. Use this balance or imbalance, together with clinical judgment, to assign a caries risk level of low, moderate, or high based on the preponderance of factors for the individual. Clinical judgment may justify the weighting of one factor (e.g., heavy plaque on the teeth) more than others.*

Overall assessment of the child's dental caries risk: High ☐ Moderate ☐ Low ☐

Adapted with permission from the California Dental Association, (Ramos-Gomez et al.)[38] Copyright © October 2007.

Table 2. Caries-risk Assessment Form for ≥6 Years Old[25]

(For Dental Providers)

Use of this tool will help the health care provider assess the child's risk for developing caries lesions. In addition, reviewing specific factors will help the practitioner and patient/parent understand the variable influences that contribute to or protect from dental caries.

Factors	High risk	Moderate risk	Low risk
Risk factors, social/behavioral/medical			
Patient has life-time of poverty, low health literacy	Yes		
Patient has frequent exposure (>3 times/day) between-meal sugar-containing snacks or beverages per day	Yes		
Child is a recent immigrant		Yes	
Patient uses hyposalivatory medication(s)		Yes	
Patient has special health care needs[α]		Yes	
Risk factors, clinical			
Patient has low salivary flow	Yes		
Patient has visible plaque on teeth	Yes		
Patient presents with dental enamel defects	Yes		
Patient wears an intraoral appliance		Yes	
Patient has defective restorations		Yes	
Protective factors			
Patient receives optimally-fluoridated drinking water			Yes
Patient has teeth brushed daily with fluoridated toothpaste			Yes
Patient receives topical fluoride from health professional			Yes
Patient has dental home/regular dental care			Yes
Disease indicators [ƒ]			
Patient has interproximal caries lesion(s)	Yes		
Patient has new noncavitated (white spot) caries lesions	Yes		
Patient has new cavitated caries lesions or lesions into dentin radiographically	Yes		
Patient has restorations that were placed in the last 3 years (new patient) or in the last 12 months (patient of record)	Yes		

[α] Practitioners may choose a different risk level based on specific medical diagnosis and unique circumstances, especially conditions that affect motor coordination or cooperation.

[ƒ] While these do not cause caries directly or indirectly, they indicate presence of factors that do.

Instructions: *Circle "Yes" that corresponds with those conditions that apply to a specific patient. Use the circled responses to visualize the balance among risk factors, protective factors, and disease indicators. Use this balance or imbalance, together with clinical judgment, to assign a caries risk level of low, moderate, or high based on the preponderance of factors for the individual. Clinical judgment may justify the weighting of one factor (e.g., heavy plaque on the teeth) more than others.*

Overall assessment of the dental caries risk: High ☐ Moderate ☐ Low ☐

Adapted with permission from the California Dental Association, (Featherstone et al.)[14] Copyright © October 2007.

Caries Prevention Advice for Children:

- **From** Gov UK Delivering better oral health: an evidence-based toolkit for prevention (2021)

	Standard risk	Increased risk / giving concern
0 - 3 yrs	• Breast/bottle feeding advice • Introduce free-flow cup form 6 months and discourage bottle from 1 year • Review diet • Reinforce oral hygiene instruction from eruption • Toothpaste containing at least 1000ppmF (smear) • Avoid sugar-containing medication • May not receive additional benefit from professional topical fluoride • Recall 3-12 months	• Diet analysis and advice as per Eatwell Guide • Reinforce oral hygiene instruction • Toothpaste containing 1350 - 1500ppmF • 2.2% NaF varnish **2 or more/yr** • Avoid sugar-containing medication • Reduce recall interval
3 - 6 yrs	• Review diet • Reinforce oral hygiene instruction • Toothpaste containing at least 1000ppmF (pea-sized) • Avoid sugar-containing medication • 2.2% NaF varnish **twice/yr** • Recall 3-12 months	• Diet analysis and advice as per Eatwell Guide • Reinforce oral hygiene instruction • Toothpaste containing 1350 - 1500ppmF • 2.2% NaF varnish **2 or more/yr** • Avoid sugar-containing medication • Reduce recall interval
7+ yrs	• Review diet • Reinforce oral hygiene instruction • Toothpaste containing 1350 - 1500ppmF • 2.2% NaF varnish **twice/yr** • Recall 3-12 months	• Diet analysis and advice as per Eatwell Guide • Reinforce oral hygiene instruction • Consider prescription Fluorides: o 2800ppm for ≥10 year olds o 2800 or 5000ppm for ≥16 year olds o Those ≥8 yrs old with active caries prescribe daily 0.05% F^- mouthrinse • 2.2% NaF varnish **2 or more/yr** • Fissure seal permanent molars • Avoid sugar-containing medication • Reduce recall interval

Setting a Recall Interval based on Caries Risk Assessment

- **From** NICE Dental checks: intervals between oral health reviews – Appendix G (2004)

The check list below, from *NICE Dental Recall* appendix G can be used to inform a caries risk assessment for a child, and for an adult for caries, periodontal and other oral health risk considerations.

Overview of how the interval between oral health reviews is set

		If the patient is **younger than 18 years**	*If the patient is* **18 years or older**
Step 1	> Consider the patient's age; this sets the range of recall intervals	3 months ⟷ 12 months	3 months ⟷ 24 months
Step 2	> Consider modifying factors (see checklist on page 2) in light of the patient's medical, social and dental histories and findings of the clinical examination	3 months ⟷ 12 months	3 months ⟷ 24 months
Step 3	> Integrate all diagnostic and prognostic information, considering advice from other members of the dental team where appropriate > Use clinical judgement to recommend interval to the next oral health review	3 months ⟷ 12 months	3 months ⟷ 24 months
Step 4	> Discuss recommended interval with the patient > Record agreed interval or any reason for disagreement	discussion	discussion
Step 5	> At next oral health review, consider whether the interval was appropriate > Adjust the interval depending on the patient's ability to maintain oral health between reviews	reassessment	reassessment

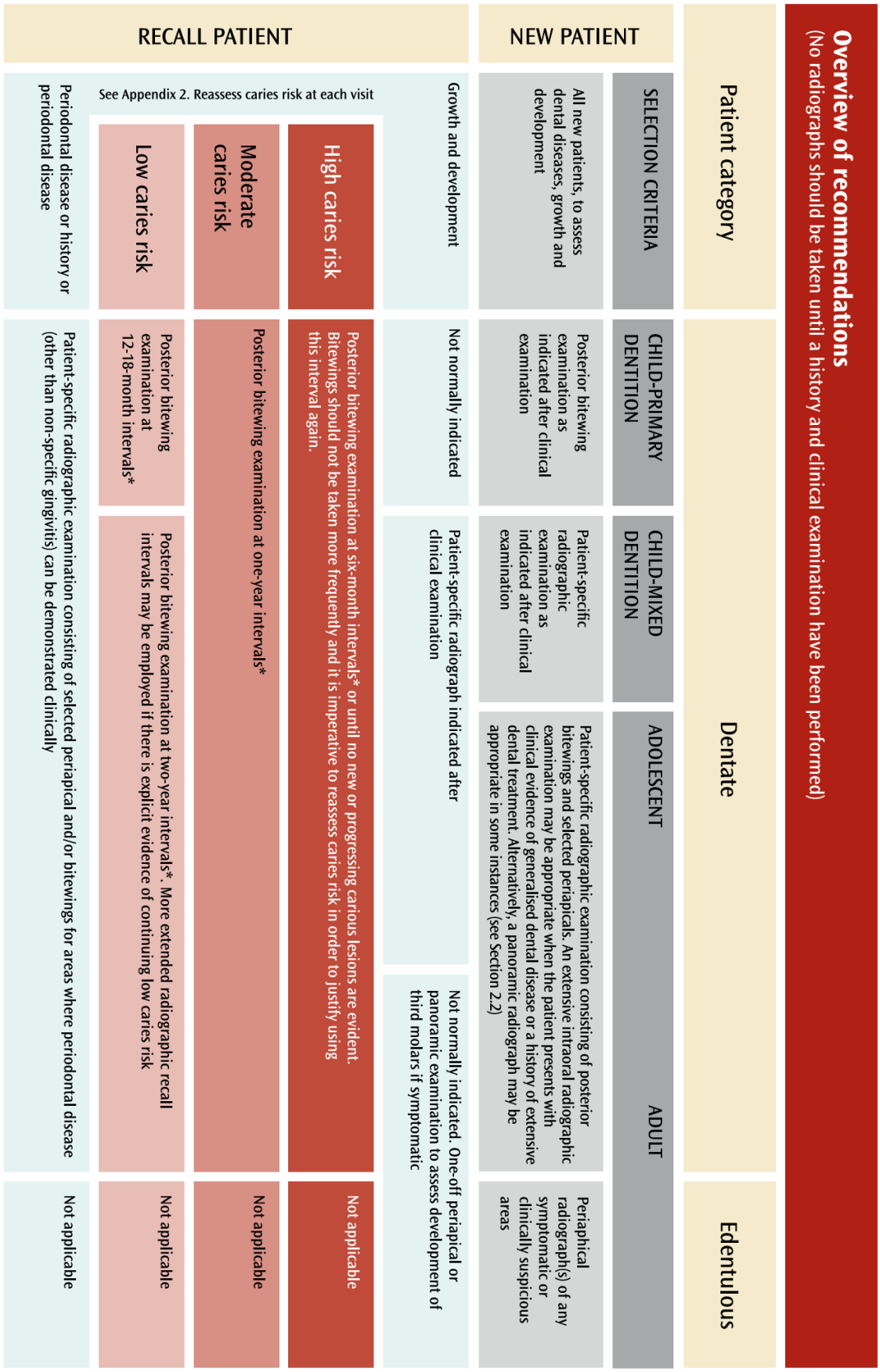
Checklist of modifying factors

Name: **Date of birth:** . . . . . / . . . . . / . . . . .

ORAL HEALTH REVIEW DATE:	...../...../.....		...../...../.....		...../...../.....	
Medical history	YES	NO	YES	NO	YES	NO
Conditions where dental disease could put the patient's general health at increased risk (such as cardiovascular disease, bleeding disorders, immunosuppression)	☐	☐	☐	☐	☐	☐
Conditions that increase the patient's risk of developing dental disease (such as diabetes, xerostomia)	☐	☐	☐	☐	☐	☐
Conditions that may complicate dental treatment or the patient's ability to maintain their oral health (such as special needs, anxious/nervous/phobic conditions)	☐	☐	☐	☐	☐	☐
Social history						
High caries in mother and siblings	☐	☐	☐	☐	☐	☐
Tobacco use	☐	☐	☐	☐	☐	☐
Excessive alcohol use	☐	☐	☐	☐	☐	☐
Family history of chronic or aggressive (early onset/juvenile) periodontitis	☐	☐	☐	☐	☐	☐
Dietary habits						
High and/or frequent sugar intake	☐	☐	☐	☐	☐	☐
High and/or frequent dietary acid intake	☐	☐	☐	☐	☐	☐
Exposure to fluoride						
Use of fluoride toothpaste	☐	☐	☐	☐	☐	☐
Other sources of fluoride (for example, lives in a water-fluoridated area)	☐	☐	☐	☐	☐	☐
Recent and previous caries experience						
New lesions since last check-up	☐	☐	☐	☐	☐	☐
Anterior caries or restorations	☐	☐	☐	☐	☐	☐
Premature extractions due to caries	☐	☐	☐	☐	☐	☐
Past root caries or large number of exposed roots	☐	☐	☐	☐	☐	☐
Heavily restored dentition	☐	☐	☐	☐	☐	☐
Recent and previous periodontal disease experience						
Previous history of periodontal disease	☐	☐	☐	☐	☐	☐
Evidence of gingivitis	☐	☐	☐	☐	☐	☐
Presence of periodontal pockets (BPE code 3 or 4) and/or bleeding on probing	☐	☐	☐	☐	☐	☐
Presence of furcation involvements or advanced attachment loss (BPE code *. BPE code * indicates furcation involvement) (Updated to reflect the 2016 BPE guidelines from The British Society for Periodontology)	☐	☐	☐	☐	☐	☐
Mucosal lesions						
Mucosal lesion	☐	☐	☐	☐	☐	☐
Plaque						
Poor level of oral hygiene	☐	☐	☐	☐	☐	☐
Plaque-retaining factors (such as orthodontic appliances)	☐	☐	☐	☐	☐	☐
Saliva						
Low saliva flow rate	☐	☐	☐	☐	☐	☐
Erosion and tooth surface loss						
Clinical evidence of tooth wear	☐	☐	☐	☐	☐	☐
Recommended recall interval for next oral health review:	months.		months.		months.	
Does the patient agree with recommended interval?	YES	NO	YES	NO	YES	NO
If 'No' record reason for disagreement in notes	☐	☐	☐	☐	☐	☐

Selection criteria for bitewing radiography in caries diagnosis for patients with posterior interproximal contacts

- **From: [FGDP Selection Criteria for Dental Radiography. 3rd Edition (2018)]**



Summary Treatment Options in the Primary Dentition

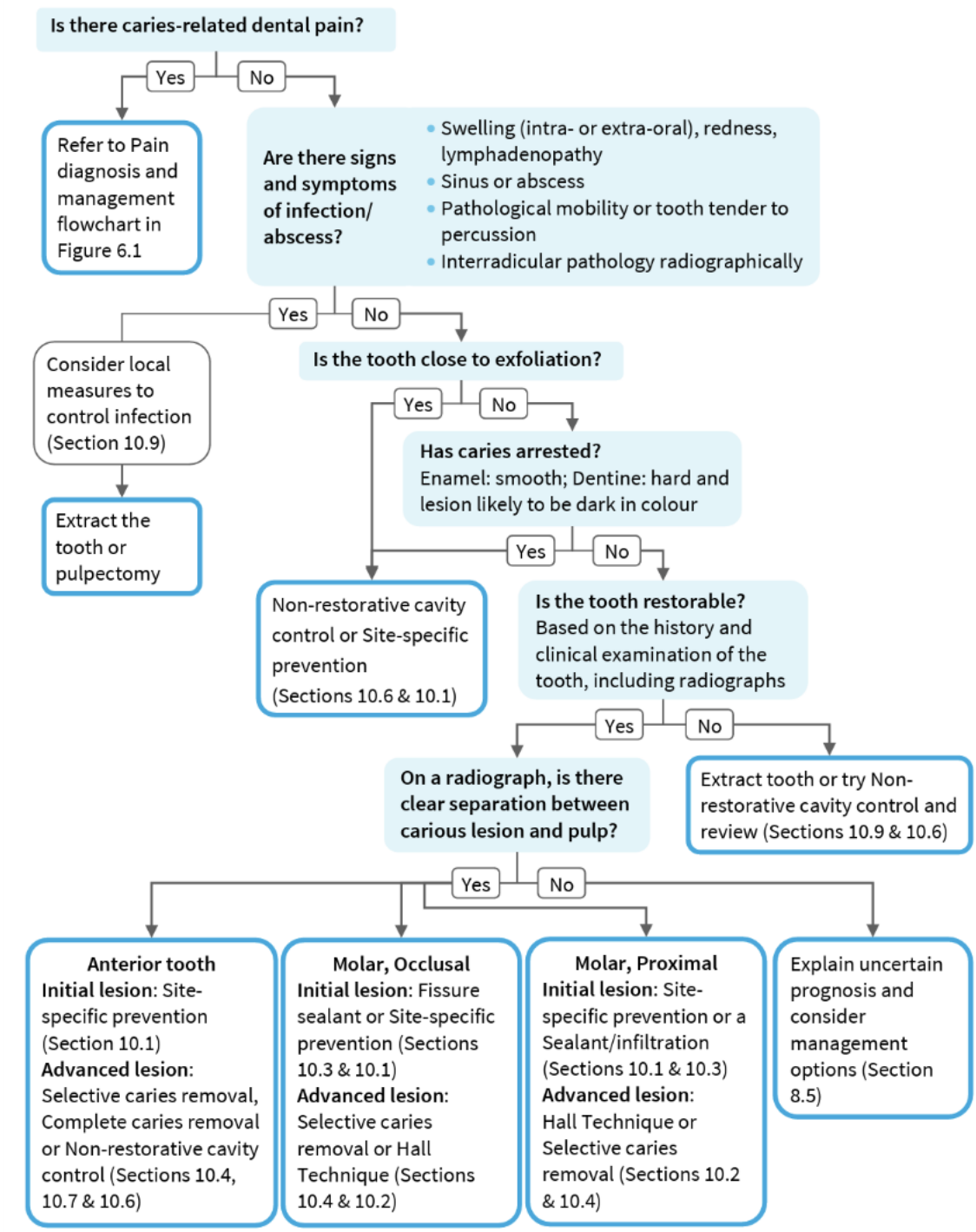
- **From** SDCEP Prevention and Management of Dental Caries in Children (2025)

PRIMARY TEETH	Enamel Lesion (Initial)	Dentine Lesion (Advanced)
Occlusal (class I)	• Site-specific prevention **e.g. OHI, DA, TFV** • **If not cavitated:** Fissure Sealant • **If cavitated:** sealant restoration (formerly PRR)	• **Restore: Composite/RMGIC/GIC** all are suitable depending on moisture control. • **Restore: SSC** if large lesion or child cannot cope with handpieces
Proximal (class II)	• **Site-specific prevention**	• **Restore: SSC*** *SSC is gold standard for proximal lesions. If the parents refuse or there are contraindications for SSC, select the next best material considering moisture control (e.g. resin-based like composite or RMGIC). Conventional GIC has poorer compressive + tensile strength so not recommended.
Anterior (class III/IV)	• **Site-specific prevention**	• **Restore: Composite/RMGIC** • Non-restorative cavity control to make the lesion a cleansable shape/self-cleansing so it can arrest. For patients who are engaging with DA/OHI (in other words, the lesion is expected to arrest) but cannot cope with restorations. • Silver diamine fluoride is often used as holding measure for young children awaiting extractions.
Tooth close to exfoliation	• **Site-specific prevention** • **Non-restorative cavity control** • **Silver diamine fluoride** • *Extract if painful* Note: first primary molars exfoliate ~9-11 yrs, second primary molars, ~10-12 yrs.	
Arrested caries	• **Site-specific prevention** • **Non-restorative cavity control** • *Extract if painful*	
Unrestorable tooth (pain/ symptoms free)	• **Non-restorative cavity control** if no signs or symptoms and close to exfoliation • **Extraction*** if there are signs or symptoms of pain/infection *This may be under LA, inhalation sedation or GA. If under LA, we try to avoid extractions at the first visit. It is better to establish a good rapport, gain trust and build the child's confidence with less invasive treatments first.	

Paediatric Restorative Pathway

Decision making for managing the carious primary tooth in a child with no medical complications

- **From** SDCEP Prevention and Management of Dental Caries in Children (2025) see SDCEP guidance for description.



Removable Prosthodontics Guidance

Denture patient treatment planning guidance (issued Feb 2025)

Order of treatment for denture patients	Other information	P/P acrylic	P/P CoCr	C/C acrylic or CoCr	C/C copy dentures
History, examination & treatment plan. Manage soft-tissue pathology in denture bearing area.	Resolve denture stomatitis, ulcers and denture granulomas before master impression(s).	✓	✓	✓	✓
Plaque control & periodontal disease stabilisation	• Before starting dentures. • Ideally reduce plaque score to 20% (or less).	✓	✓		
Direct restorations	Before master impressions.	✓	✓		
Primary impressions	Request occlusal rims if primary casts need articulating (see below).	✓	✓	✓	✓
Jaw registration to articulate primary casts (for treatment planning & denture design) (facebow only possible at WH)	• Applies to most CoCr and some acrylic dentures (but not if edentulous in one/both arches). • At WH, students mount casts themselves in 3rd floor pros lab. • For Outreach patients, contract laboratory request needed.	✓	✓		
Survey primary cast & confirm denture design (surveyor available at all sites)	• At WH, do this in pros lab between visits and bring design to clinic for approval. • For Outreach patients, allow time during an appointment to do this.	✓	✓		
Upper anterior denture tooth try-in (on primary cast)	Recommended for P/- CoCr denture that replaces upper anterior teeth.		✓		
Indirect restorations (crowns, bridges & onlays etc)	• Articulated primary casts useful before tooth preparation (to help indirect restoration design). • Include denture design when requesting indirect restorations (to show rest seat, guide plane, milled ledge or clasp location).	✓	✓		
Natural tooth modifications (guide planes, rest seats).	• Denture design must be approved prior to this visit. • Artificial guide planes & rest seats not used for acrylic partial dentures.		✓		
Master impression	Special trays used for all cases except C/C copy dentures.	✓	✓	✓	✓
Cobalt chrome framework try-in	Easier to adjust these without occlusal rims attached (can add rims later).		✓	✓ (CoCr only)	
Jaw registration to articulate master casts (facebow only possible at WH)	• Needs NEW occlusal rims made on master casts. • Hand articulation (without rims) sometimes possible.	✓	✓	✓	✓
Denture tooth-try in	A re-try visit may be needed.	✓	✓	✓	✓
Denture fit	Instruct patient on maintenance.	✓	✓	✓	✓
Denture review	Half a session may be sufficient.	✓	✓	✓	✓

LABORATORY WORK FOR DENTURE PATIENTS (Nov 2024)

Routine procedures for BDS denture patients at Whitechapel site (only)		
Stage	BDS student (in 3rd floor pros lab)	Outside laboratory (via model stores)
Impression casting (*latest time to start casting alginate impressions in 3rd floor pros lab is 4pm)	✓	
Cast articulation	✓	
Draft denture designs (*prior to approval on clinic by clinician **and** master impressions)	✓	
Occlusal rims		✓
Special trays		✓
Cobalt chrome frameworks		✓
Denture tooth set-ups	✓	
Denture flask, pack and finish		✓
Denture relines		✓
Occlusal splints		✓
• For all the above, clear and adequate laboratory instructions are required, **and** clinical tutor **must** sign (and print name) on laboratory card before student leaves clinic.		

In-house (urgent) denture procedures need **prior discussion** with 3rd floor Prosthetics Teaching Laboratory Manager (Tel: 0207 882 6317, Email: a.houmani@qmul.ac.uk)		
Procedure	Planning ahead	Notes
NEW immediate denture	• Discuss feasibility/ timeline in lab **before** confirming extraction(s) date with patient.	• May need several visits to construct denture prior to extraction(s). • The less natural teeth remaining, the more appointments needed usually.
Same-day immediate tooth addition (*mainly anterior teeth on existing partial dentures)	• Show disinfected denture to lab staff **and** discuss feasibility/ timeline for tooth addition **before** confirming extraction date with patient. • Warn patient that tooth addition takes several hours.	On day of extraction please provide: • Alginate over-impression of denture in situ **prior** to extraction • Opposing cast (or alginate impression) • Interocclusal record (if needed) • Denture tooth shade • Lab card specifying teeth to be added
Denture repairs (*only dentures made here are accepted)	• Show disinfected denture fragments to lab staff **and** discuss feasibility/ timeline **before** arrangements confirmed with patient.	• Warn patient that repairs **not** always same day. May need a second visit to fit denture.
• For all the above, clear and adequate laboratory instructions are required, **and** clinical tutor **must** sign (and print name) on laboratory card before student leaves clinic. • Also, patient **must** be made aware (and accept) that laboratory errors occasionally occur.		

The following guidance on appliances was circulated to staff on 12 July 2024:

Re: Labwork for appliances

This email concerns dental laboratory prescriptions/requests for **tooth bleaching trays, occlusal splints** and **Essix retainers** at any dental undergraduate clinic site.

Splints and Essix retainers can **only** be provided for **registered patients** if they are **part of an approved treatment plan** that has been properly recorded and approved by a staff member in patients' notes. Splints must have the type and material specified and laboratory prescriptions signed for by a restorative staff member who has seen the patient and confirmed it is part of the treatment plan.

Bleaching trays are not routinely used at any site, and in the event that a patient is treatment planned to have internal/external tooth bleaching using this method, again it needs to be confirmed as part of an approved treatment plan and signed for by a staff clinician who has seen the patient.

All appliances should be fitted on clinic and checked for quality, accuracy of fit and occlusal coverage. Splints should not be given to patients without directly trying in first.

Additional guidance on treating UG denture patients

Laboratory work for denture patients:

- Some types of laboratory work (in between patient appointments) are carried out by BDS students in the 3rd floor prosthetics laboratory at Whitechapel (assisted by lab tutor technicians), and some are sent out to an external laboratory.
- Currently, it is only BDS5 students who will carry out some items of laboratory work for their one start-to-finish denture patient at Whitechapel.
- All other laboratory work for Whitechapel patients is sent out via model stores on 1st floor.

Infection control for denture related laboratory work:

- All laboratory work must be disinfected on arrival to clinic, and again before leaving clinic. Please ensure casts are also disinfected before and after use on clinic, to prevent cross-infection.

Primary impressions for denture patients:

- Alginate is used for patients with natural teeth.
- Silicone putty (or impressions compound) with alginate wash, is preferred for edentulous patients.

Master impressions for denture patients:

- To reduce the risk of an **impression getting stuck** in a patient's mouth, ensure the supervising tutor checks the custom-made special tray is fit for purpose. If the tray is too tight-fitting or it extends into hard tissue undercuts (ie. teeth or bone) without sufficient spacing, the impression can be difficult to remove.
- For **partially dentate** patients, always use an **alginate** material. A more elastic, tear-resistant alginate is available on clinic specifically for master impressions. 'Kromogel Advance' is the one currently in use.
- For **edentulous** patients, **medium-body silicone** impression material is preferred. This makes it easier to produce a good quality working cast in the laboratory. Dry the area well before taking the impression.
- NEVER use **silicone** impression material for **partially dentate** patients (using silicone increases the risk of an impression getting stuck).
- Also, NEVER use **light-bodied silicone** for **any** denture patient (it is runny and may be swallowed).

Impression storage:

- **Alginate impressions** – once disinfected, cover in damp gauze (plus two layers of damp hand towel to prevent drying out). Wrap in a sealed bag and label with student and patient details. At Whitechapel, temporarily store in the 3rd floor pros lab fridge if needed.
- **Silicone impressions** – once disinfected, store dry in a sealed and labelled bag.

Articulators and facebows:

- All BDS students are provided with their own Bio-Art articulator and facebow to use at **Whitechapel** for laboratory teaching exercises and when they treat their start-to-finish denture case in Year 5.
- At **Outreach** sites, all laboratory work is carried out by an external laboratory that does not use the same type of articulator, however requests to articulate study casts for treatment planning and denture design can still be made (please liaise with the relevant clinical lead at that site for more details).

Diagnostic wax-ups:

These are often carried out for tooth wear cases. At Whitechapel a student can use their own articulator to prepare these. At Outreach diagnostic wax-ups can be provided by an external laboratory.

Partial denture designs:

- At **Whitechapel**, students can prepare a provisional denture design in the 3rd floor prosthetics lab. At **Outreach** sites, this may need to be done at the chairside with one of the available surveyors.
- It is the responsibility of the supervising **clinical tutor** to ensure that a denture design is appropriate and has been agreed with the patient (even if someone else has suggested a provisional design).

Laboratory prescription cards:

- All sites use the same Queen Mary approved laboratory card on undergraduate clinics.
- Please ensure clinical tutors check and sign laboratory card instructions at the end of clinic.
- At Whitechapel, and for quality assurance purposes, a second signature is needed from a 3rd floor laboratory tutor technician before the work is taken to the 1st floor model stores to be sent out.
- Check the lab work return date & ensure it is at least one day before the patient's next appointment.
- If a BDS5 student needs to carry out lab work, they must book a timeslot to do this with the 3rd floor lab.

USEFUL CONTACT DETAILS:

- **Dr Judi Rogers** (UG Lead for Removable Prosthodontics) j.a.rogers@qmul.ac.uk , **Mr Adel Houmani** (Lead Technical Skills Manager) a.houmani@qmul.ac.uk Tel: 0207 882 6317 , **Ms Sandy Rajapaksha** (Laboratory Tutor Technician) s.rajapaksha@qmul.ac.uk , **1st Floor Model Stores (Whitechapel)** Tel: 0203 594 6851

BDS5 instructions for START-TO-FINISH denture cases seen at Whitechapel:

1. Each student must complete **ONE** start-to-finish case at **Whitechapel** to be signed up for BDS Finals 2026.
2. Make this your **first** Whitechapel denture case in Year 5. Outreach patients and most immediate dentures are **not** suitable, but conventional and copy complete dentures **are**.
3. **Clinical stages** carried out by **you** must include; master impression, jaw registration, denture try-in, denture fit, and one review as a minimum.
4. **Laboratory stages** carried out by **you** must include; casting all impressions, articulating casts on your own articulator, partial denture designs (if relevant) and setting teeth. (Please **show** your work to a tutor technician to get it **logged** in your denture case progress file). All other lab work is sent out.
5. When ready to **set denture teeth**, please **book a session** in the pros lab diary, so that you receive all the tutor technician guidance you need. Not booking in will likely cause delays leading to patient cancellations.
6. All **other** lab work is carried out by an outside lab (ie. special trays, occlusal rims, heat-cured bases, CoCr frameworks, and denture FPFs). *[Please see below for guidance on sending work out].*
7. Please look out for an **email from Dr Rogers** asking for information about your denture cases (denture activity is being monitored throughout year 5 to help manage your caseload and to avoid students falling behind). Information needed will be patient's **MRN**, **initials**, and **denture type(s)**.
8. If you acquire **more** than one denture case at Whitechapel, please tell Dr Rogers as soon as possible to discuss how to manage this.

BDS5 instructions for OTHER (non start-to-finish) denture cases PLUS crown/bridge cases seen at Whitechapel:

1. From now on, **all** laboratory work requests for these cases (including casting of alginate impressions) will be sent to an **outside** laboratory via 1st floor model stores. This will **reduce** the time you spend in the pros lab in Year 5.
2. All you need to do first is to get disinfected items **pre-checked** and **counter-signed** by a 3rd floor tutor technician before they go out. (**Model stores** only accepts outgoing work that has been **countersigned** by a tutor technician).
3. Disinfected denture or crown and bridge **impressions** may be brought to the 3rd floor laboratory for checking whilst the patient is in the chair.
4. You will still need to **survey** primary casts and **design** partial dentures in the pros lab for these cases (with help from your tutor technicians as required).

How to get in touch when you need help and advice with prosthodontic cases:
Would all BDS5 students please add the following **phone numbers** to your contact lists for advice during working hours: 3rd floor pros lab **0207 882 6317** and 1st floor model stores **0203 594 6851**.
Email addresses for your **removable** pros teachers are:

- Mr Adel Houmani (Lead Technical Skills Manager) **a.houmani@qmul.ac.uk**,
- Ms Sandy Rajapaksha (Dental Tutor Technician) **s.rajapaksha@qmul.ac.uk**, and
- Dr Judi Rogers (Senior Clinical Lecturer) **j.a.rogers@qmul.ac.uk**.

FOR ANY ALGINATE IMPRESSIONS THAT NEED CASTING SAME DAY AT WHITECHAPEL

Please encourage BDS students to bring alginate impressions to the 3rd floor pros lab for casting by

4.00 pm

on the day of the patient's appointment.

It takes students 10 - 15 mins to cast impressions, so they'll still have time for notes and LiftUpp afterwards.

THANKYOU FOR YOUR HELP!!

Fixed restorations

National guidance

Tooth wear

GOV.UK Guidelines: Tooth wear
https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-7-tooth-wear

RCS Eng Guidelines: Clinical Guidelines for erosion
https://www.rcseng.ac.uk/-/media/files/rcs/fds/guidelines/erosion-guidelines_2021_v4_mj.pdf

BSRD Guidelines: Tooth wear Guidelines
https://www.bsrd.org.uk/File.ashx?id=15192

Fixed Prosthodontics

BSSPD Guidelines: Guidelines for Resin Bonded Bridges
https://www.bsspd.org/File.ashx?id=16308

BSSPD Guidelines: Prosthetic Dentistry Glossary
https://www.bsspd.org/File.ashx?id=16312

BSRD Guidelines: Crowns, Fixed Bridges and Dental Implants Guidelines
BSRD Guidance crownandbridge.pdf

Local guidance

Patient assessment, diagnosis and treatment plan

Patient assessment:
In addition to patient's examination and assessment mentioned in (4. Local and national guidance and associated links), student should consider the following:

- The motivation and aspirations of the patient.
- Analysis of the benefits, disadvantages and long-term consequences of providing a crown or fixed prosthesis.
- Complications which limit the likelihood of clinical success.
- The skill and competency of the student.
- The clinical advantages and long-term benefits of crowns or fixed bridges should justify such treatment and outweigh their disadvantages.
- In general, avoid replacement of failed crowns and bridges unless approved by your tutor.

The clinical examination should be supported by special tests, which may include:

- Clinical examinations: mobility, TTP, TTPal, presence of gingival swelling, fistula or sinus tract.
- Sensibility testing of teeth; EPT and cold test.
- Restorability assessment; Structure, pulpal, Periodontal and context
- Radiographic examinations; PA x-ray; to assess bone support, PA status, quality of RCT if present, or any other pathology.
- Occlusal assessment; in static and dynamic.
- Study casts mounted in a semi-adjustable articulator in an appropriate jaw relationship with wax-up, especially in bridge cases

Diagnosis
The diagnosis should be comprehensive covering all clinical findings
A specific diagnosis of the tooth to be restored with indirect restoration should include:

- Presence and extension of caries
- Presence and extension of current restoration.
- Pulpal diagnosis according to: American Association of Endodontists (AAE) Consensus Conference Recommended Diagnostic Terminology. J Endod 2009;35:1634
- Apical diagnosis according to: AAE Consensus Conference Recommended Diagnostic Terminology. J Endod 2009;35:1634

Table 1: Pulpal diagnosis. AAE Consensus Conference Recommended Diagnostic Terminology. J Endod 2009;35:1634

Pulpal	
Normal pulp	A clinical diagnostic category in which the pulp is symptom-free and normally responsive to pulp testing.
Reversible pulpitis	A clinical diagnosis based on subjective and objective findings indicating that the inflammation should resolve and the pulp return to normal.
Symptomatic irreversible pulpitis	A clinical diagnosis based on subjective and objective findings indicating that the vital-inflamed pulp is incapable of healing. Additional descriptors: lingering thermal pain, spontaneous pain, referred pain.
Asymptomatic irreversible pulpitis	A clinical diagnosis based on subjective and objective findings indicating that the vital inflamed pulp is incapable of healing. Additional descriptors: no clinical symptoms but inflammation produced by caries, caries excavation, trauma.
Pulp necrosis	A clinical diagnostic category indicating death of the dental pulp. The pulp is usually nonresponsive to pulp testing.
Previously treated	A clinical diagnostic category indicating that the tooth has been endodontically treated and the canals are obturated with various filling materials other than intracanal medicaments.
Previously initiated therapy	A clinical diagnostic category indicating that the tooth has been previously treated by partial endodontic therapy (eg, pulpotomy, pulpectomy).

Table 2: Apical diagnosis. AAE Consensus Conference Recommended Diagnostic Terminology. J Endod 2009;35:1634

Apical	
Normal apical tissues	Teeth with normal periradicular tissues that are not sensitive to percussion or palpation testing. The lamina dura surrounding the root is intact, and the periodontal ligament space is uniform.
Symptomatic apical periodontitis	Inflammation, usually of the apical periodontium, producing clinical symptoms including a painful response to biting and/or percussion or palpation. It might or might not be associated with an apical radiolucent area.
Asymptomatic apical periodontitis	Inflammation and destruction of apical periodontium that is of pulpal origin, appears as an apical radiolucent area, and does not produce clinical symptoms.
Acute apical abscess	An inflammatory reaction to pulpal infection and necrosis characterized by rapid onset,spontaneous pain, tenderness of the tooth to pressure, pus formation, and swelling of associated tissues.
Chronic apical abscess	An inflammatory reaction to pulpal infection and necrosis characterized by gradual onset, little or no discomfort, and the intermittent discharge of pus through an associated sinus tract.
Condensing osteitis	Diffuse radiopaque lesion representing a localized bony reaction to a low-grade inflammatory stimulus, usually seen at apex of tooth.

Case selection for indirect restorations:

I. Cuspal coverage restoration; Onlay or Crown
- Restoring badly broken down, worn or fractured tooth to the extent that simpler forms of restorations are contraindicated or have been found to fail in clinical service.
- To reduce the risk of fractures occurring in extensively restored teeth including endodontically treated posterior teeth.

II. Anterior crown
- Extensive decay or fracture; tooth too damaged for fillings or veneers
- Post-root canal restoration when tooth is week and needs reinforcement
- Replacement of large/failing restoration which is weakening the tooth
- To improve the form and appearance of unsightly teeth which cannot be managed by more conservative cosmetic procedures.

III. Resin bonded bridge
- An anterior or posterior edentulous span of short length (ideally a single missing tooth)
- A larger space may be restored using two adjacent cantilever RBBs, but with each pontic no bigger than a single unit (premolar size).
- More rarely, to prevent tooth movement and improve occlusal stability.
- An adjacent unrestored or minimally restored abutment tooth.
- The abutment tooth is caries free, and sound endodontically and periodontally, ideally with a vital pulp and no history of periodontal disease.
- Careful planning must be carried out with the use of study casts mounted on a semi adjustable articulator and a wax up of the proposed restoration
- If the abutment is restored, new composite restoration is recommended for better prognosis.

IV. Conventional bridge
- To replace one or more teeth of functional or cosmetic importance to the patient.
- Bridges require the availability of sufficient abutments of appropriate quality and prognosis.

Treatment Plan:

In addition to treatment planning covered in Treatment Planning Overview mentioned in (4. Local and national guidance and associated links), student should consider the following:
- Schedule the Restorative Phase after emergency, Investigations/stabilization of oral health.
- Reassess restorative plans after the stabilization phase, making adjustments as required based on updated clinical findings.
- Pre-select the type, design, and material for the core or post & core to match the specific case and available resources.
- Determine the type, design, and material for any indirect restoration (e.g., crowns, onlays) during treatment planning, with active input from both patient and supervising tutor.
- Prioritize a minimally invasive approach by opting for partial coverage restorations whenever clinically appropriate, rather than full coverage crowns.
- For bridgework, finalize and document the design and material for both retainers and pontics, after detailed discussion with the patient and tutor.
- In cases of resin-bonded bridges (RBB), Discuss the choice between preparation and non-preparation (following Dahl concept) with the patient and tutor beforehand.

Incorporate articulated study models and diagnostic wax-ups early to support planning, patient communication, and comprehensive, informed consent.

Crown preparation

Spaced perforated tray – alginate/putty for provisional restoration

Tooth preparation:

Fitting provisional

Using impression
Mix Pro-temp and fit into patient's mouth

Check marginal fit, contact points and occlusion

Fit with Temp-bond

In exceptional circumstances a laboratory made temporary

Preparation and working impression

Remove temporary (with LA if tooth vital)

Clean preparation, check margins
Clean temp for re-use
Take shade using Vita linear guide
When necessary use retraction cord +/- haemostatic agent
2 stage impression using rigid tray – Impregum Pentasoft into tray.
Light bodies Garant L-Duo syringed intra-orally around prep
Opposing alginate
Re-fit temporary
Lab instructions to include: type of crown, shade, marginal configuration, shoulder chamfer, size, lustre, texture, metal to be used. Plus guide any setup information and characteristics useful for lab.

Working impression

- Remove temporary (with LA if tooth vital)
- Clean preparation, check margins
- Clean temp for re-use
- Take shade using Vita linear guide
- When necessary, use retraction cord +/- haemostatic agent
- 2 stage impression using rigid tray – Impregum Pentasoft into tray. Light bodies Garant L-Duo syringed intra-orally around prep
- Opposing alginate
- Re-fit temporary

Disinfect impressions, wrap and store

- Rinse off debris (beware splash back).
- Carry in kidney dish to disinfectant.
- Immerse impression fully for recommended time (inside surface facing upwards for full contact).
- Rinse again before wrapping in damp gauze and paper towel.
- Store in sealed plastic bag (separate from lab card).
- Label bag with date and patient details (and your name and group).

Fill out Laboratory Card:

I. Conventional impression:

The following information MUST be filled:

<u>FRONT page:</u>

- Patient details: Surname, Forename, MRN no in Hospital no., Age & Sex
- Student name
- Staff Clinician name
- In summary of work section:
  - Type and material of the indirect restoration; for example: all-ceramic Zirconia crown
  - Tooth to be restored using the Palmer Notation System located in the section
- In Shade/Other details section:
  - Shade of the indirect restoration, if it is tooth coloured.
  - It is highly recommended to draw a shade map diagram with characterization.
- At the top, as UG student, you have to select the contract laboratory option

<u>BACK page:</u>

<u>Clear detailed instruction on what lab work is needed:</u>

- Date and time of recording impressions.
- Date and time for latest return of completed laboratory work.
- Specify the contents included in the package, for example: upper silicone impression, lower alginate impression and silicone bite registration.
- Unambiguous statement of type of material(s) to be used; for example: Monolithic Zirconia, layered Zirconia, e.max (Lithium Disilicate), OR PFM (base-metal alloy)
- Provide a detailed account of the form of the restoration, including considerations for pontics in bridges.
- Specify the materials used for margins and occlusal contacts.
- For anterior teeth with translucent ceramic systems, record the natural die shade (ND shade) to guide aesthetic layering.

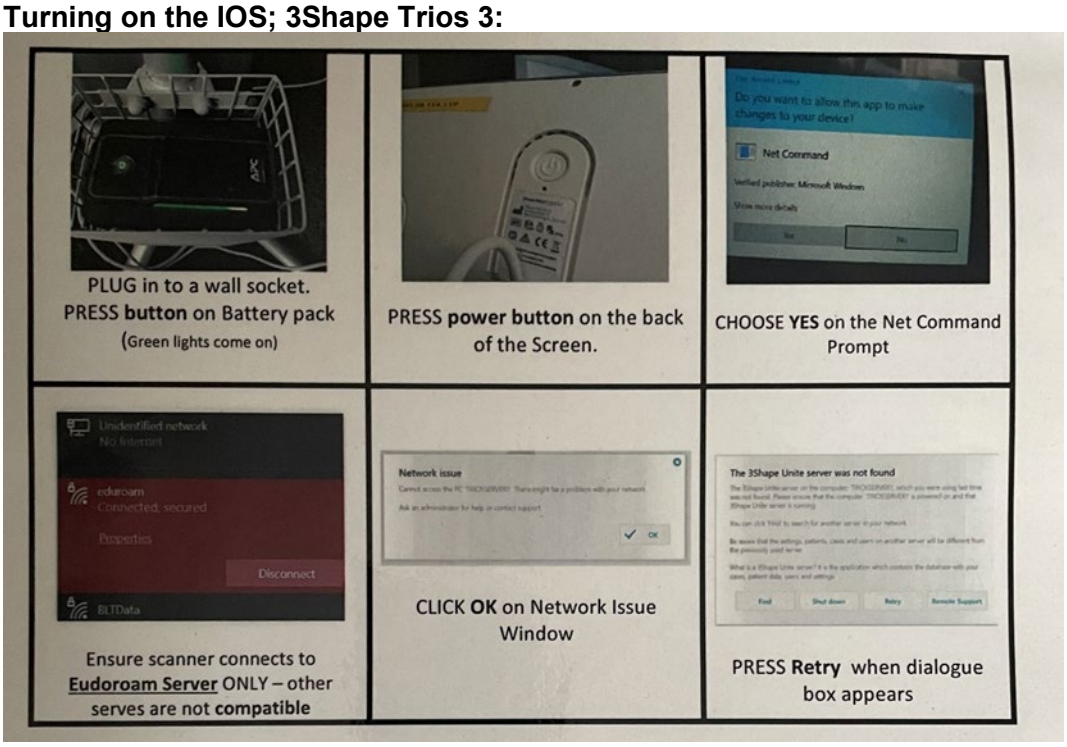
- Describe the surface features and finish of the restoration (e.g., polished, glazed, bisque stage).
- Include a description of the occlusal registration(s) provided for accurate bite alignment.
- Specify the required occlusal relationship, describing both static contacts and dynamic contacts, if applicable.
- Note any clinical observations and specific patient requests relevant to the restoration.
- Clearly state the required surface treatment of the inner restoration surface, such as sandblasting or acid etching.
- State clearly if any putty indices, study models, or diagnostic wax-ups are included to guide the laboratory work.
- Supervising clinical tutor MUST check and sign all instructions

II. Digital impression:

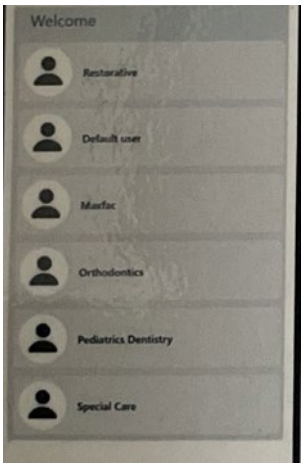
Intra-oral scanner (IOS) could be used for final impression in case of:

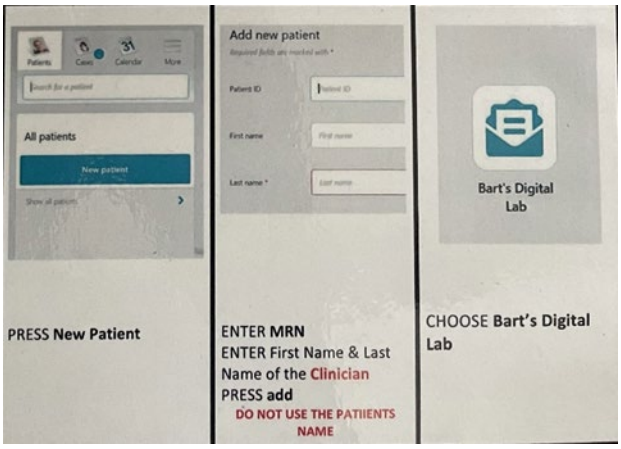
- After performing 3 conventional impressions
- Single units with supra-gingival margins
- Study Models & Diagnostic Wax-Ups; should be approved by your tutor and lab technician.
- Your tutor and nurses should approve using the IOS at the beginning of the session to confirm suitability and readiness

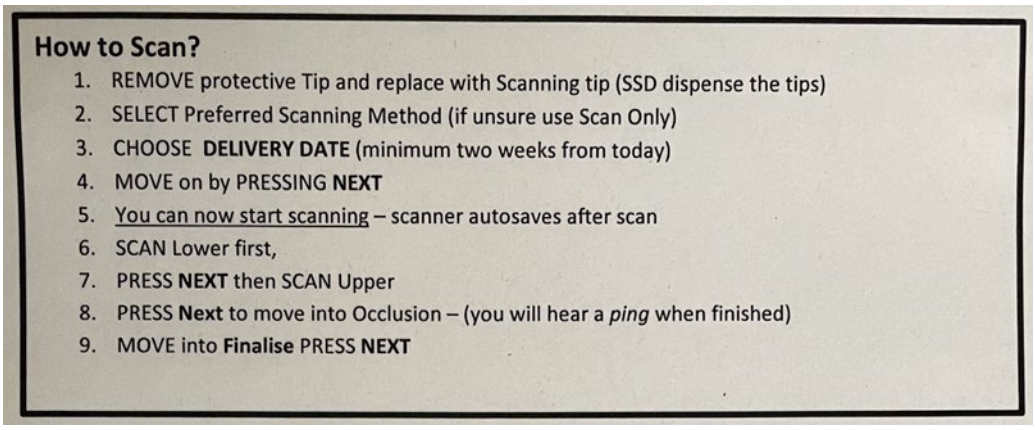
Turning on the IOS; 3Shape Trios 3:

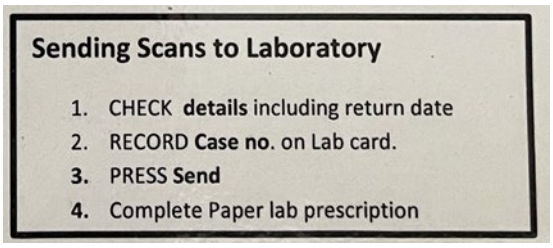


- The scanner is connected to Server and ready to scan.
- When connected to the server, you will see the picture below. Choose “Restorative” option for UG Fixed Prosthodontic cases. (It will take minutes to load the programme)





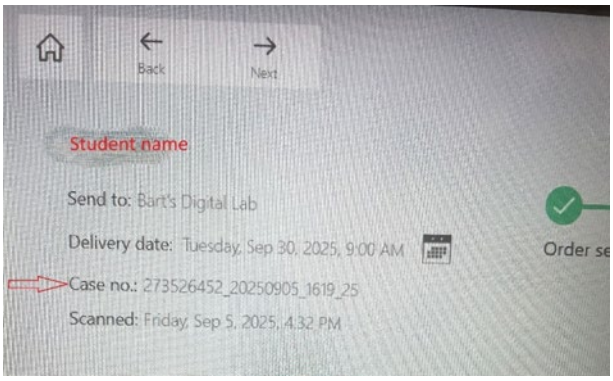




The laboratory card should be filled the same way as in the conventional impression except the following points:

- At the top of the front page, rather than selecting the contract laboratory, RLH laboratory option should be selected.
- Record the case no. at the top of the back side of the card. Case number is found when the case is sent as shown in the following photo.

Treatment Planning Overview



Crown fit

Remove temporary

Clean preparation

Try-in restoration

Cement using a luting cement

Check occlusion

Check marginal fit

NEVER ADJUST AN UNCEMENTED CROWN IN THE MOUTH

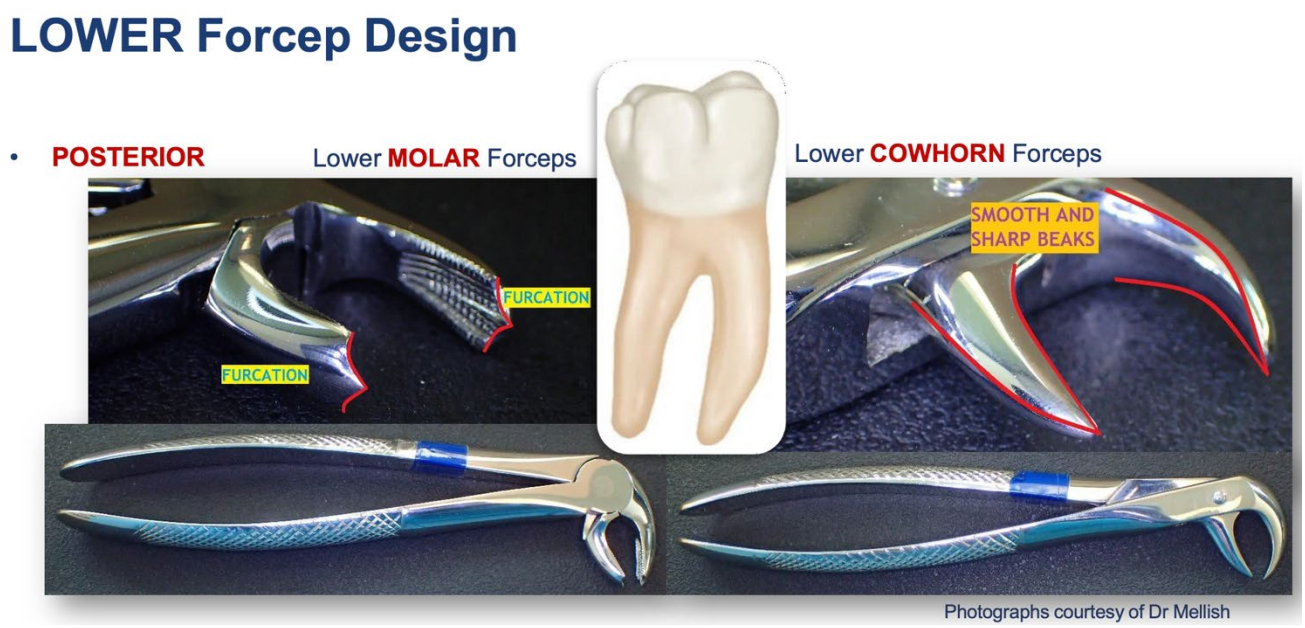
Review and discharge

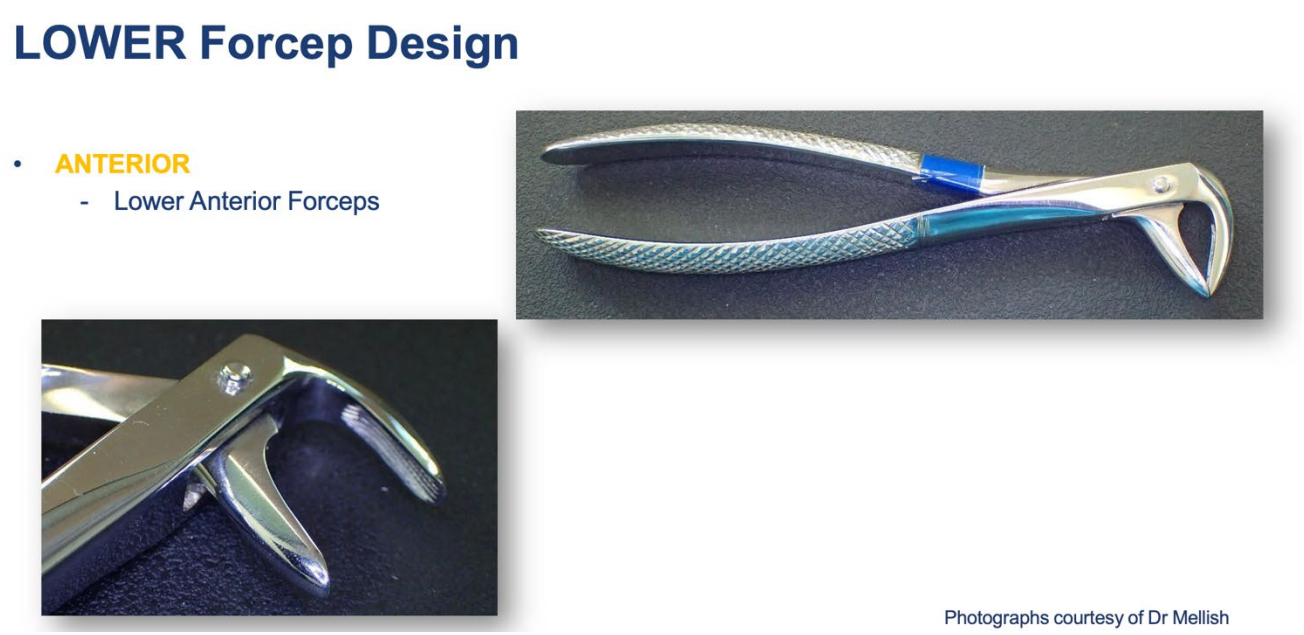
Oral Surgery Guidance

- **https://www.rcseng.ac.uk/-/media/FDS/Comprehensive-guideline-Management-of-painful-Temporomandibular-disorder-in-adults-March-2024.pdf**
- Guidance on the extraction of wisdom teeth
- **https://www.rcseng.ac.uk/-/media/Files/RCS/FDS/Guidelines/3rd-molar-guidelines--April-2021-v4.pdf**
- **https://www.sdcep.org.uk/published-guidance/anticoagulants-and-antiplatelets/**
- Antibiotic prophylaxis | Scottish Dental Clinical Effectiveness

Extractions

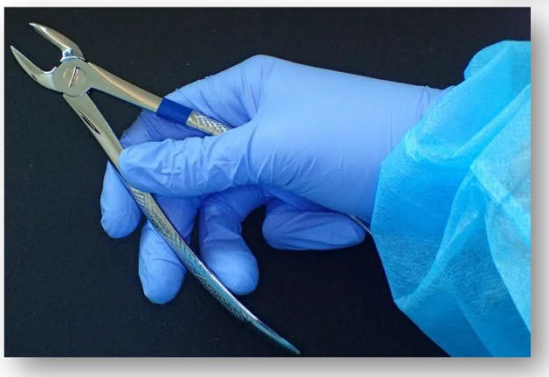
Forceps

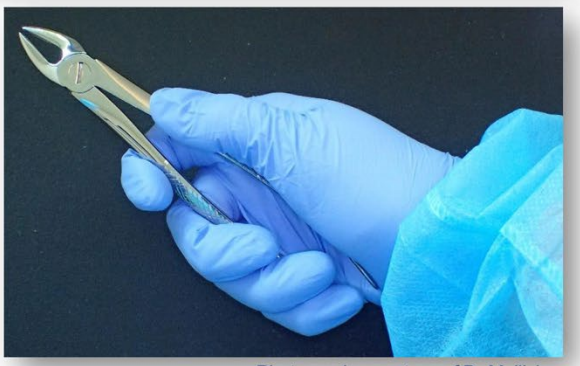




UPPER Forcep Design

- **ANTERIOR**
  - Upper Straight Forceps





Photographs courtesy of Dr Mellish

Forcep Design

LOWER

UPPER

DECIDUOUS

PERMANENT

Photographs courtesy of Dr Mellish

Forceps

2 blades and handles joined at a hinge.
Handles: contoured to facilitate a good grip.
Blades: concave on inner surface to fit the root; sharp edges to sever the PDL. Applied bucco-lingually along the long axis of a tooth; Wedge shaped to dilate the socket.

Maxillary forceps:

Anteriors: straight, 12-14cm long, beaks 2-3cm long. Applied labially and palatally along the long axis of the tooth.

Premolars: blades have curvature to clear the lower lip when along the long axis of the tooth.

Molars: designed with beaks on blades to allow them to be adapted closely to the roots (forces are distributed evenly to lower the risk of tooth fracture). Different upper molar forceps for the right and left side. Buccal beak fits into the bifurcation; Broad concave palatal blades.

Mandibular forceps:

Anteriors and premolars: blades follow a bend at right angle to allow positioning along the long axis of the tooth.

Molars: Buccal and lingual beaks on blades designed to closely fit into the bifurcation; concavities on either side to fit around the mesial and distal roots.

How to hold forceps:

Need to push the forceps firmly towards the apex of the tooth.

Handle must rest firmly in the palm of the hand with the wrist held straight.
First 3 fingers placed around the handle.

Little finger is used to open the forceps initially, should then be removed and placed around the handle.

Thumb: *Uppers* - rests on the handle and is pretty much passive. *Lowers*: thumb may be used to provide apical pressure

Position & Posture

Maxillary extractions:

- Both feet close to the chair and pointing forwards.
- Feet flat, back straight as possible.
- Patient should be tipped back about 30-60° to allow good vision.
- Chair should be positioned so that the occlusal plane is at the elbow level of the operator.
- Arm as straight as possible.

Right-handed Operators:

- Left leg forward and slightly bent.
- Right leg behind and straight.
- Stand in front of the patient and to the right.

Left-handed Operators:

- Right leg forward and slightly bent.
- Left leg behind and straight.
- Stand in front of the patient and to the left.

Mandibular extractions:

- Stand straight with legs slightly apart
- Feet flat, back straight as possible.
- Patient slightly reclined and occlusal plane slightly lower than the elbow level

Right-handed Operators:

- Stand in front of the patient and to the right for all extractions except for lower right posterior quadrant – stand behind the patient; slightly to the left.

Left-handed Operators:

- Stand in front of the patient and to the left for all extractions except for lower left posterior teeth - stand behind the patient; slightly to the right.

Technique Issues

1. The forceps are applied along the long axis of the tooth with apical pressure; the blades are then closed whilst maintaining apical pressure; the second movement loosens and displaces the tooth (specific for individual teeth).
2. Do not pull on the tooth until loose.
3. Ensure the forceps do not impinge on the lips or opposing teeth
4. Use the supporting (non-dominant) hand appropriately throughout the extraction(s): Reflect soft

tissues and support the alveolus and appreciate tactile sensations related to tooth movements during extraction(s).

Permanent Tooth Extraction Techniques

		1	2	3	4	5	6	7	8
MAXILLARY	ROOT	Straight, conical root. Circular in cross section.	Straight, slender root. Has a palatal inclination.	Long, sturdy root. Triangular in cross section.	Approximately 50% have 2 roots that are easily fractured.	Stout, single root. Oval in cross section.	Usually, 1 palatal and 2 buccal roots. May diverge widely.		TECHNIQUE SIMILAR FOR ERUPTED THIRD MOLARS; USUALLY IMPACTED MAXILLARY 8s ARE REFERRED.
	DOs	1) Apical pressure. 2) Twist in both directions. 3) Delivery in labial direction.	1) Apical pressure. 2) Careful labial displacement. 3) Delivery in labial direction.	1) Slight labial force. 2) Rotation. 3) Delivery in labial direction.	1) Progressive bucco-palatal displacement with no great movement in either direction. 2) Delivery down through the socket, in occlusal direction.	1) Apical pressure. 2) Bucco-palatal rocking. 3) Delivery in buccal direction.	1) Progressive bucco-palatal rocking. 2) Buccal displacement for delivery.		
	DON'Ts / CAUTIONS		The tooth may resist rotation (due to palatal inclination of root).	The longest root in the maxillary arch.	Do not rotate (likely to lead to fracturing of the roots).	Evaluate the relationship of the roots to the antral floor	Rotation less helpful. 'Beaks to the cheeks' – make sure there is close adaptation to the tooth surface.		
	SUPPORTING HAND	Support and stabilise the jaw with a firm grip and retract soft tissues: *Right-handed Operators:* Forefinger on labial side of alveolus; thumb on the palate, except upper right posterior quadrant - Forefinger on palate; thumb on the buccal alveolus *Left-handed Operators:* Forefinger on labial side of alveolus; thumb on the palate, except upper left posterior quadrant - Forefinger on palate; thumb on the buccal alveolus							

		1	2	3	4	5	6	7	8
MANDIBULAR	ROOT	Fine roots that are flattened mesial-distally.		Longer, thicker root.	Straight, single root. Round in cross section.		Two roots – mesial and distal.		
	Dos	1) Apical pressure. 2) Small amount of buccal-lingual displacement (more buccal than lingual because the buccal plate is thinner in the anterior region). 3) Delivery in labial direction.		Heavier bladed forceps required. 1) Apical pressure. 2) Slight rotation or bucco-lingual rocking. 3) Delivery in labial direction.	1) Apical pressure. 2) Rotation or bucco-lingual rocking. 3) Delivery in buccal direction.		1. Apical pressure. 2. Slow displacement in buccal direction and/or a figure of 8 movement. 3. Delivery in either buccal direction or lingual direction – (lingual cortex may be thinner in the 2nd molar region).		TECHNIQUE SIMILAR FOR ERUPTED 8s: IMPACTED 8s ARE REFERRED
	DON'Ts / CAUTIONS	Beware: lower incisors are very close together. Use fine forceps.			Do not use sudden buccal displacement – the tooth will fracture because the mandible is thicker in this region.				
	SUPPORTING HAND	Middle finger lingually. Fore finger labially (to retract the lower lip). Thumb supporting the mandible.			*Right-handed Operators*: For the right: thumb on lingual side; forefinger on buccal alveolus, retracting soft tissues; other fingers supporting the mandible. For the left: Forefinger on buccal alveolus, middle finger lingually retracting the soft tissues and thumb supporting the mandible. *Left-handed Operators*: For the right: Forefinger on buccal alveolus, middle finger lingually retracting the soft tissues and thumb supporting the mandible. For the left: thumb on lingual side; forefinger on buccal alveolus, retracting soft tissues; other fingers supporting the mandible.				

Primary Tooth Extraction Techniques

		A	B	C	D	E
M	ROOT	Straight, conical root. Circular in cross section.		Long, sturdy root. Triangular in cross section.	Usually, 1 palatal and 2 buccal roots. May diverge widely.	
	DOs	4) Apical pressure. 5) Twist in both directions. 6) Delivery in labial direction.		4) Slight labial force. 5) Rotation. 6) Delivery in labial direction.	3) Progressive bucco-palatal rocking. 4) Buccal displacement for delivery.	
	DON'Ts / CAUTIONS			The longest root in the maxillary arch.	Rotation less helpful. 'Beaks to the cheeks' – make sure there is close adaptation to the tooth surface.	
	SUPPORTING HAND	Support and stabilise the jaw with a firm grip and retract soft tissues: *Right-handed Operators:* Forefinger on labial side of alveolus; thumb on the palate, except upper right posterior quadrant - Forefinger on palate; thumb on the buccal alveolus *Left-handed Operators:* Forefinger on labial side of alveolus; thumb on the palate, except upper left posterior quadrant - Forefinger on palate; thumb on the buccal alveolus				

		A	B	C	D	E
MANDIBULAR	ROOT	Fine roots that are flattened mesial-distally.		Longer, thicker root.	Two roots – mesial and distal.	
	Dos	4) Apical pressure. 5) Small amount of buccal-lingual displacement (more buccal than lingual because the buccal plate is thinner in the anterior region). 6) Delivery in labial direction.		Heavier bladed forceps required. Apical pressure. Slight rotation or bucco-lingual rocking. Delivery in labial direction.	4. Apical pressure. 5. Slow displacement in buccal direction and/or a figure of 8 movement. 6. Delivery in buccal direction	
	DON'Ts / CAUTIONS	Beware: lower incisors are very close together. Use fine forceps.				
	SUPPORTING HAND	Middle finger lingually. Fore finger labially (to retract the lower lip). Thumb supporting the mandible.			*Right-handed Operators*: For the right: thumb on lingual side; forefinger on buccal alveolus, retracting soft tissues; other fingers supporting the mandible. For the left: Forefinger on buccal alveolus, middle finger lingually retracting the soft tissues and thumb supporting the mandible. *Left-handed Operators*: For the right: Forefinger on buccal alveolus, middle finger lingually retracting the soft tissues and thumb supporting the mandible. For the left: thumb on lingual side; forefinger on buccal alveolus, retracting soft tissues; other fingers supporting the mandible.	

Post Extraction Procedure

1. Check the apices – make sure the entire root has been extracted.
2. Put the tooth and forceps on gauze.
3. Squeeze the socket firmly to facilitate healing.
4. Place piece of rolled up gauze at the extraction site and ask patient to close their mouth. Leave in place for 10-15 minutes to achieve haemostasis. Ask the patient to open their mouth and check there is no active bleeding.
5. Give the written and verbal patient post-operative instructions.
6. Consider a follow up appointment especially for complicated / difficult extractions.

Post-Operative Instructions – Written and Verbal

1. **Pain and analgesia**: "You will be numb in the area of the extraction for the next 3-4 hours. Be careful not to bite or burn yourself with hot food or drink during this time." "You will experience some discomfort after the extraction. You will be recommended appropriate painkillers before you leave the clinic. Please follow the instructions on the bottle/packet, especially if you buy them over the counter. It may be sensible to take the painkillers regularly for the first 24 hours to avoid excessive soreness during this period." "If the pain increases over the next 3 days, it may be that your socket is not healing properly and you should contact your dentist on the numbers given below."
2. **Post-op bleeding**: "Please rest as much as possible over the next 2-3 hours whilst the clot forms in the socket." "Do not disturb the socket with your tongue or foreign body." "If bleeding restarts, apply pressure to the socket by biting down on one of the bite packs provided. If these are not available, roll up a clean handkerchief, place it over the socket and bite down for at least 20 minutes. If the bleeding continues, you should contact your dentist on the number below."
3. **Diet:** "Avoid chewing on the affected side for the next 24 hours." "Avoid hot liquids and hard foods for the next 24 hours. After each meal ensure there is no debris left in the extraction socket."
4. **Smoking:** "If you smoke, please try and avoid for at least the next 3 days."
5. **Exercise and alcohol:** "Avoid exercise or alcohol over the next 24 hours as this may result in the socket re-bleeding."
6. **Warm saline rinses:** "Avoid rinsing immediately after the extraction. After 24 hours we suggest you swish out your mouth with regularly warm saltwater mouth wash (1tsp in a cup of warm water)."
7. **Oral hygiene:** "You should be able to clean the adjacent teeth the day after the extraction with a soft toothbrush and toothpaste as usual but take care around the site of extraction."
8. **Emergency contact:** – give the number of the practice and also any out-of-hours service; and "If you are still having difficulties, attend your local accident and emergency department."

Clinical Notes

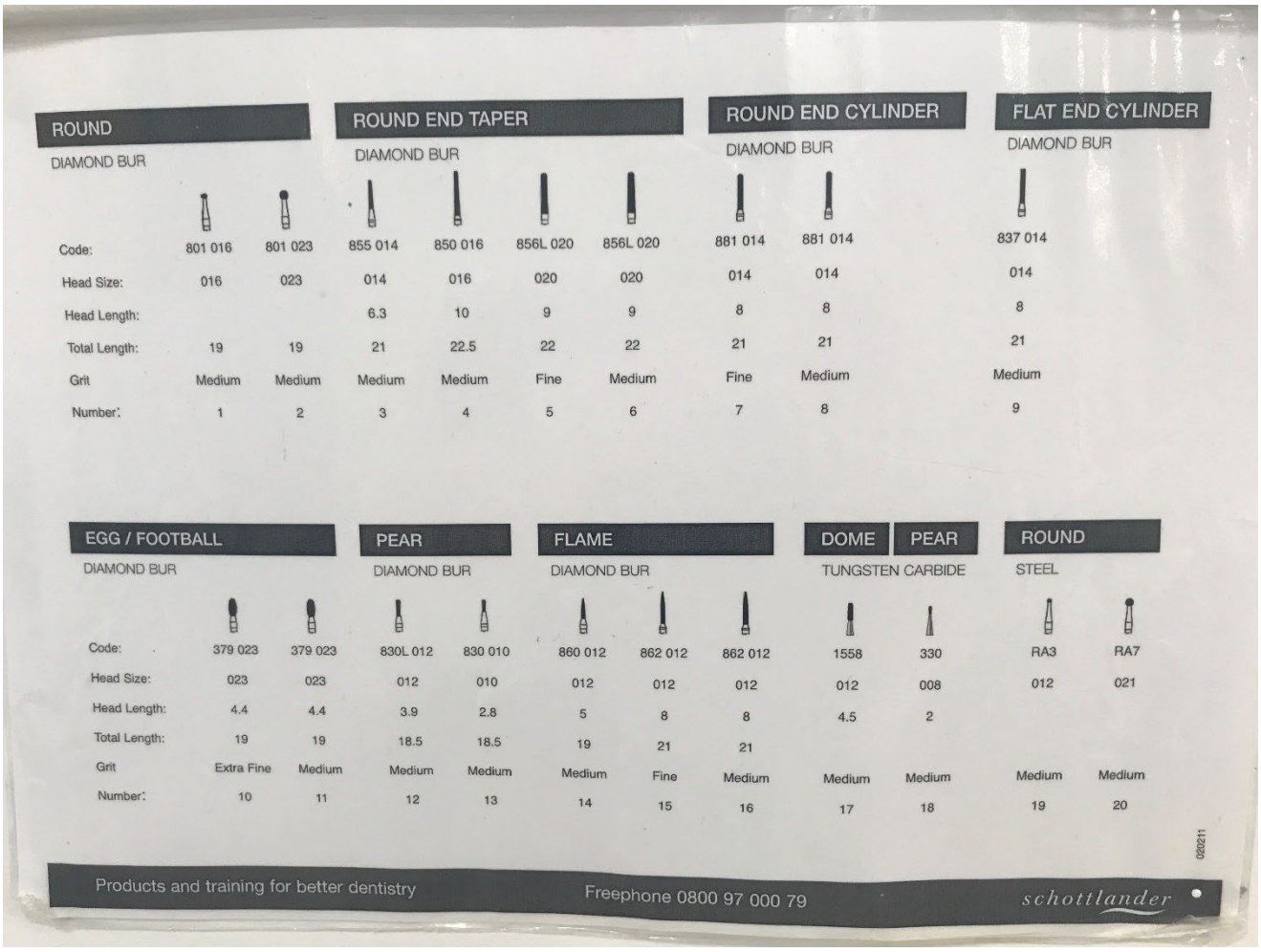
1) Informed consent obtained for extraction(s) – mention the teeth you plan to extract
2) LA used: site, drug, dose, expiry date, batch number.
3) Tooth/teeth extracted. (Mention the teeth and instruments used)
4) Haemostasis achieved with a bite pack before the patient left the clinic.
5) Did you experience any complications?
6) Did you experience any unusual findings and the action taken?
7) Post-Operative Instructions Given (POIG).
8) Have you made any follow up arrangements?
9) Ensure safe surgery checklist is completed

NB:

1) Every extraction is different.
2) Good pre-op assessment is essential.
3) Always feel what the tooth wants to do!

7. IoD Resources

Available burs at the IoD



ROUND — DIAMOND BUR

Code:	801 016	801 023
Head Size:	016	023
Head Length:		
Total Length:	19	19
Grit	Medium	Medium
Number:	1	2

ROUND END TAPER — DIAMOND BUR

Code:	855 014	850 016	856L 020	856L 020
Head Size:	014	016	020	020
Head Length:	6.3	10	9	9
Total Length:	21	22.5	22	22
Grit	Medium	Medium	Fine	Medium
Number:	3	4	5	6

ROUND END CYLINDER — DIAMOND BUR

Code:	881 014	881 014
Head Size:	014	014
Head Length:	8	8
Total Length:	21	21
Grit	Fine	Medium
Number:	7	8

FLAT END CYLINDER — DIAMOND BUR

Code:	837 014
Head Size:	014
Head Length:	8
Total Length:	21
Grit	Medium
Number:	9

EGG / FOOTBALL — DIAMOND BUR

Code:	379 023	379 023
Head Size:	023	023
Head Length:	4.4	4.4
Total Length:	19	19
Grit	Extra Fine	Medium
Number:	10	11

PEAR — DIAMOND BUR

Code:	830L 012	830 010
Head Size:	012	010
Head Length:	3.9	2.8
Total Length:	18.5	18.5
Grit	Medium	Medium
Number:	12	13

FLAME — DIAMOND BUR

Code:	860 012	862 012	862 012
Head Size:	012	012	012
Head Length:	5	8	8
Total Length:	19	21	21
Grit	Medium	Fine	Medium
Number:	14	15	16

DOME / PEAR — TUNGSTEN CARBIDE

Code:	1558	330
Head Size:	012	008
Head Length:	4.5	2
Total Length:		
Grit	Medium	Medium
Number:	17	18

ROUND — STEEL

Code:	RA3	RA7
Head Size:	012	021
Head Length:		
Total Length:		
Grit	Medium	Medium
Number:	19	20

020211

Products and training for better dentistry — Freephone 0800 97 000 79 — schottlander

Queen Mary IoD Video Library

INFECTION CONTROL AND CLINIC/LAB MANAGEMENT				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
ICP L36 Decontamination and disinfection			Nov-21	https://youtu.be/gUnMjwdyVI0
IOD Clinical Skills Lab - How to set up your bays	CSL	Sally McFadyen	Sep-21	https://youtu.be/wU6fqUnLPdA
CSL Manikin video	CSL	Sally McFadyen	Aug-21	https://youtu.be/pWM2x8vFUpA
How to strap a mobile manikin head to a dental chair			Sep-20	https://youtu.be/t8_zCW3DUTs
Operating the dental manikins	Skills lab	Sally McFadyen	Jul-19	https://youtu.be/c9H3vkUxM_g
Alcohol rub	Fundent	Swati Nehete	Oct-20	https://youtu.be/ortFz0HfmMU
Handwashing	Fundent	Melanie Alexandrou	Oct-20	https://youtu.be/17wJIrubRHA
Setting up the bay	Fundent	Melanie Alexandrou	Oct-20	https://youtu.be/75j6pvwN7rU
Dental assistant procedures- setting up a bay			Feb-12	https://youtu.be/ePd414wYkew
Cleaning the bay	Fundent	Melanie Alexandrou	Oct-20	https://youtu.be/mzRUmgmaFQY
PPE	Fundent	Melanie Alexandrou	Oct-20	https://youtu.be/K64Jj6tUUeo
The exam kit	Fundent	Melanie Alexandrou	Oct-20	https://youtu.be/k_QFS7yuBD0
Using Radiography Equipment at SLG		Mark Viner	May-20	https://youtu.be/tv2byR-l3Rw

MEDICAL EMERGENCIES MANAGEMENT				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
BLS - Choking	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/3hWYIHU7PSI
BLS - Recovery Position	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/RtMj45Ik3B8
BLS - Emergency Equipment - Oxygen Cylinders	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/CXKjpw1Wi9s
BLS - Emergency Equipment - Adrenaline	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/1u0A4mQXoUU
BLS - Emergency Equipment - Midazolam	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/0IFJaBE784U
BLS - Emergency Equipment - Glucagon	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/2eNC1x1keM0
BLS - Emergency Equipment - Aspirin GTN spray	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/Rnqi5DD_tLg
BLS - Emergency Equipment - Inhalers	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/NzSDRkgHjSw

MEDICAL EMERGENCIES MANAGEMENT				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
BLS - Automated External Defibrillator	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/6CC8nxr9mBU
BLS - Paediatric Defibrillation	BLS	Swati Nehete / John Bucanan	Oct-21	https://youtu.be/0iPlh6qXiTM

LOCAL ANALGESIA				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Intrapapillary infiltration	LA	Dominic Hurst	Jul-11	https://youtu.be/Twxi-q8Z6UU
Labial infiltration	LA	Dominic Hurst	Jul-11	https://youtu.be/T-5wK7b-9i4
ID Block	LA	Dominic Hurst	Jun-11	https://youtu.be/7NJpymVfNcM

PAIN MANAGEMENT				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Rocabado 6 by 6 - jaw exercises	Pain Management	Selina Sufraz	Jun-20	https://youtu.be/K7l6i55dutk
Tooth Slooth	Pain Management	Selina Sufraz	Jun-20	https://youtu.be/r3bVqTRp7XI
Transillumination technique	Pain Management	Selina Sufraz	Jun-20	https://youtu.be/hrWEuIOn1wU
Sensibility testing	Pain Management	Selina Sufraz, Ruth Baidoo	Jun-20	https://youtu.be/9ytj82GycFI

PERIODONTOLOGY				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Cavitron demonstration on interproximal bone loss cases (on model)		Dominic Hurst	Jun-11	https://youtu.be/EfZnZdzyNrg
BPE probing in posterior areas (on patient)		Dominic Hurst	Jun-11	https://youtu.be/q-WX9vpEZyY
BPE positioning video		Dominic Hurst	Jun-11	https://youtu.be/F9HZM7fAnaY
6 point pocket chart (6ppc) probing in posterior area [In patient]		Dominic Hurst Cecilia Gonzales-Marin	Jun-11	https://youtu.be/tz_AGhIgYh0

ADULT RESTORATIVE PROCEDURES				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Rubber dam placement		Dominic Hurst	Jun-11	https://youtu.be/P_1lpMqTDug
Approximal posterior restoration part 2	Restorative	Mark Payne, Sami Bissasu	Apr-21	https://youtu.be/Eo3eaaVgEqc
Approximal posterior restoration part 1	Restorative	Mark Payne, Sami Bissasu	Apr-21	https://youtu.be/6O14OSgngxc
Occlusal Composite Restoration	Restorative	Mark Payne, Sami Bissasu	Apr-21	https://youtu.be/CTi8DrFY25o
Preparing and Restoring Maxillary Canine with Cervical Composite Restoration	Restorative	Mark Payne, Sami Bissasu	Apr-21	https://youtu.be/M0ZGDjIXlRU
Preparing and Restoring Mandibular Premolar with Cervical GIC Restoration	Restorative	Mark Payne, Sami Bissasu	Apr-21	https://youtu.be/ELA-ibU74CI
Incisal edge			Feb-12	https://youtu.be/0dKdWy6tUZg
Approximal Anterior			Feb-12	https://youtu.be/usxFbXK5qzE
Approximal Posterior - amalgam			Feb-12	https://youtu.be/aHP1lKzAmaE
Approximal Posterior - composite			Feb-12	https://youtu.be/bsekuO-nhiE
Occlusal			Feb-12	https://youtu.be/afFotgv_2lY
Cervical			Feb-12	https://youtu.be/oTwCJ5D9Z5E
PRD complex amalgam part 1 of 3			Aug-11	https://youtu.be/PyrM7gnmbw8
PRD complex amalgam part 2 of 3			Aug-11	https://youtu.be/9fhc_TU5NCg
PRD complex amalgam part 3 of 3			Aug-11	https://youtu.be/ERXJ27IDxYY
PRD approximal posterior amalgam part 1 of 2			Aug-11	https://youtu.be/SXftluM-57k
PRD approximal posterior amalgam part 2 of 2			Aug-11	https://youtu.be/VYzyyHJ1IqU
PRD cervical composite			Jun-11	https://youtu.be/eQASca0hKiM
PRD approximal posterior composite			Jun-11	https://youtu.be/z74fO_vbm40
PRD anterior approximal			Jun-11	https://youtu.be/Ww1xgNsDH9Q
PRD amalgam occlusal			Jun-11	https://youtu.be/AecAmR6TxjY

ENDODONTICS				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Approximal Anterior Restorations	Endodontics	A Baysan	Jun-21	https://youtu.be/LMPmE5COj5I
Access Cavity with Mechanical Preparation of a simulated mandibular first molar	Endodontics	Aylin Baysan	May-21	https://youtu.be/LMPmE5COj5I
Access cavity mechanical preparation - simulated upper maxillary first premolar	Endodontics	Aylin Baysan	Apr-21	https://youtu.be/FJdP_sx9GEo
Rotary endodontics	Endodontics	Aylin Baysan	Sep-20	https://youtu.be/St1yW_yY1dI
Preparation of a simulated canal and obturation using CLC technique	Endodontics	Aylin Baysan	Dec-20	https://youtu.be/hlE6hfPCZFo
Access cavity	Endodontics	Aylin Baysan	Dec-19	https://youtu.be/jXD7PWXvfVY
Endo canal prep	Endodontics		May-12	https://youtu.be/PI1FpafSDOw

FOUNDATION RESTORATIONS				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Fiber Post and Composite Core on Anterior Tooth	Foundation Restorations	Maria Piana, David Kramer	Jan-21	https://youtu.be/XPF_yOUsQdo
Nayyar Core Technique	Foundation Restorations	Maria Piana, David Kramer	Jan-21	https://youtu.be/mWtikbiUKr4
Duralay Post and Core Technique	Foundation Restorations	Maria Piana, David Kramer	Jan-21	https://youtu.be/yI3_0OW-3YQ
Metal Ceramic Crown - Upper Right Premolar		Tim Friel	Dec-12	https://youtu.be/y7cwUNteHhg
Full metal crown		Tim Friel	Feb-12	https://youtu.be/UtjkG4zuqno
Metal Ceramic Crown - Upper Right Premolar		Tim Friel	Feb-12	https://youtu.be/R21Q4BbU8kw
Metal Ceramic Crown Upper Right First Molar		Tim Friel	Feb-12	https://youtu.be/K9B_IxPqDwc
All ceramic crown		Tim Friel	Feb-12	https://youtu.be/36evjnuW_RY
Laminate veneer		Tim Friel	Feb-12	https://youtu.be/rxuE4GrH-ag

ORAL SURGERY				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Medical history	Oral Surgery	Somit Prasad, Victoria Mellish	Sep-20	https://youtu.be/0QzeYxGmhxs
Consent	Oral Surgery	Somit Prasad, Victoria Mellish	Sep-20	https://youtu.be/0BPyY3UoD0I
Post op instructions	Oral Surgery	Somit Prasad, Judith Jones	Sep-20	https://youtu.be/Hb2PIs047iE
Forceps positioning	Oral Surgery	Judith Jones	Sep-20	https://youtu.be/yqLL-bRod4c
Chair positioning	Oral Surgery	Somit Prasad	Sep-20	https://youtu.be/cvwaj2ycm5A
Post extraction socket check	Oral Surgery	Somit Prasad	Sep-20	https://youtu.be/cPvWWBfGo1Y
Forceps extraction	Oral Surgery	Victoria Mellish	Sep-20	https://youtu.be/4nLUOf29qXw
Oral Surgery - Pigs Head Teaching	Oral Surgery		Jun-21	https://youtu.be/2Ls3-QeeAMk
Surgical Extraction - treatment options	Oral Surgery	Fleur Mumford, Ed Bailey	Nov-20	https://youtu.be/Lc4UCgYjDj8
Surgical Extraction - patient history	Oral Surgery	Fleur Mumford, Ed Bailey	Nov-20	https://youtu.be/EAXb8WCpiPA
Pulse oximetry, blood pressure and heart rate	Oral Surgery	Fleur Mumford, Ed Bailey	Nov-20	https://youtu.be/QQEZbPapraw
Correct site surgery		Ed Bailey	Jul-19	https://youtu.be/BgKI07fJ-eM

PAEDIATRIC DENTISTRY				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Testing Local Anaesthesia for Paediatric Dental Extraction - Lower Right D	Paeds LA	Sarah Redwood, Casandra Lewis	Sep-21	https://youtu.be/fkY95DuQ4wo
Pulpotomy of deciduous molar	Paeds	Cassie Lewis, Khaled Almukhtar	Nov-19	https://youtu.be/GN20ifL4UBs
Conventional crown preparation for PMC	Paeds	Cassie Lewis, Leon Bassi	Oct-19	https://youtu.be/qpJSCF_2hEs
Paediatric Extraction Forceps	Paeds	Sarah Redwood, Cassie Lewis	Sep-21	https://youtu.be/LXwEONKBtro
Removal of fractured root of Lower Left D with Warwick James elevator	Paeds	Sarah Redwood, Casandra Lewis	Sep-21	https://youtu.be/Wf0_VElYkNw
Forceps Extraction of Primary Teeth - Paediatric Dentistry	Paeds	Sarah Redwood, Cassie Lewis	Sep-21	https://youtu.be/Q71BgYYUd8w
Calcium hydroxide management of the immature permanent incisor tooth	Paeds Endo	Ferranti Wong	May-20	https://youtu.be/SP27sc8Bn8Y

PROSTHODONTICS				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Primary impressions for a partially dentate mouth		Tim Friel	Mar-13	https://youtu.be/dsc4DMRdrSE
Putting Facebow Together		Tim Friel	Jun-11	https://youtu.be/msYTc4mbTTM
Recording Arch on Bitefork		Tim Friel	Jun-11	https://youtu.be/xRyJbgjNv0Q
Assembling a facebow		Tim Friel	Jun-11	https://youtu.be/bIT6VnqXHmk
Disassembling facebow		Tim Friel	Jun-11	https://youtu.be/cr__XRCNRq4
Jaw registration		Tim Friel	Dec-12	https://youtu.be/-czB29thQ-g
Special Tray for Partially Dentate and Edentate Casts	Pros lab	Adel Houmani	Sep-21	https://youtu.be/V730iaXEP5A
Putty matrix		Tim Friel	Feb-12	https://youtu.be/kr6GpFO8iZE

MISCELLANEOUS				
Video title	**Subject (if known)**	**Academic/s**	**Date recorded**	**Video link**
Sleep Apnoea and treatment		Ama Johal	Jan-20	https://youtu.be/nJs6BLxmymc
Introduction to Clinical Photography		Tim Friel	Apr-12	https://youtu.be/bXVJVxuUW0E
Interspace brush		Dominic Hurst	Jun-11	https://youtu.be/L3n9enmRw_U
Flossing	Fundent	Sarah Murray	Oct-20	https://youtu.be/D7qsQdpMm6I
Oral hygiene aids	Fundent	Sarah Murray	Oct-20	https://youtu.be/1AW1MdEM-pg
Dentist and patient position		Tim Friel	Feb-12	https://youtu.be/DWwl-0YOn5A

Clinical, Academic and Professionalism Concerns Policy

BDS: BDS - Clinical, Academic and Professionalism Concerns Policy

BSc Oral Health: BScOH - Clinical, Academic and Professionalism Concerns Policy