Staff Confidence In Oral Care-Related Topics			
Immediately before Training	Immediately after Training	Four Months after Training	
		Staff that Attended Training	Staff that did not Attend Training
66%	98%	93%	75%

Table 1. Summary of results of study.

healthcare in care homes across England. The report found that there was an extensive lack of awareness of NICE guidelines amongst care home staff and that too many residents were not being supported to maintain and improve their oral health.

NICE have three quality statements that pertain to oral health in care homes:
1. Adults who move into a care home have their mouth care needs assessed on admission;
2. Adults living in care homes have their mouth care needs recorded in their personal care plan;
3. Adults living in care homes are supported to clean their teeth twice a day and to carry out daily care for their dentures.

The recommended assessment tool requires staff to be able to identify caries, retained roots, plaque and calculus. Given that patient management may be extremely difficult and that care homes lack the facilities of a dental practice, this is often a challenging task for a dental professional, let alone a healthcare assistant. Whilst there is some provision for dentists working in the Community Dental Service to carry out domiciliary visits, at present such provision is finite.

In light of this, the Oral Health Promotion team, based at Chippenham Community Hospital, have been visiting care homes to provide training.

We assessed the confidence of care staff in matters pertaining to oral care at three time points:
1. Before training;
2. Immediately after the training; and
3. Again 4 months later.

A summary of the results of the study are presented in Table 1.

I think the key finding from this study is that, whilst the training was very effective for those who received it, the confidence of staff that did not attend the training also improved compared to the baseline. This suggests that the training builds institutional knowledge that then cascades on to other members of the care team.

I hope this project highlights how important it is that members of the dental team work with and support care staff in helping to deliver improved outcomes to care home residents.

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Guest Editorial – 50 lashes by the GDC

The guest editorial in the first *Dental Update* of 2020 by Conor O'Malley recounting his experience is an appalling example of the actions of the DCS and GDC.

I've read the article three times with increasing incredulity at every reading. We have, as a profession, 'allowed' the authorities to take over the GDC from the profession from the time when we could elect peers to sit in judgement on us. The patients are not being served as well as when dentists were much more involved in the procedures of the GDC; one wonders what the point of the DCS is when it puts cases like this straight to the GDC with no attempt at resolution, which I understood was to be their prime objective. As Dr O'Malley correctly points out, the patient could have had all her fees refunded at the very beginning of her 'complaint' if she so wished and, consequently, lost that option by the actions of the DCS and GDC.

This case should never have got past the DCS seeing as the patient was wrong and that the dentist was not at fault. I find it unbelievable that they did not ask Dr O'Malley for his comments at any stage and this just adds to the presumption that the dentist is immediately considered to be guilty. It is noted that the clinical assessment found all Dr O'Malley's work to be satisfactory.

One can only feel great sadness for Dr O'Malley having gone through all of this and can appreciate the enormous strain it places on him, his colleagues and his family.

I feel very great sadness for the young dentists who 'look forward' to a career under this awful regimen and sorrow for patients, the majority of whom will not be getting the necessary appropriate treatment as dentists practice increasingly defensively and/or leave the profession.

Dr O'Malley is to be applauded for being so open about his treatment and bringing it to the attention of all his dental colleagues, for ALL of us could very easily have been in exactly the same position as he was placed.

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Guest Editorial – 50 lashes by the GDC

I read with interest your recent editorial article *50 lashes by the GDC*. As someone who has experience of being referred to the GDC, I can empathize with the author, but I am unsure if the solution lies solely with

the Regulator. While concurring with the well-considered argument about the GDC approach, I would like to ask if we, the dental profession, are also exacerbating the problem by adopting a blame culture? I believe that the fault does not entirely lie with the GDC, but with a failure to educate dentists about the different perspectives we can use to acquire knowledge, specifically in terms of diagnosis and treatment planning. If we wish to safeguard ourselves, as dentists, it is important that we fully review the background to our own learning.

The acquiring of knowledge, which is needed to inform a diagnosis and gain consent, involves using established theoretical perspectives, but if these are used in isolation the knowledge acquired will have at least one fundamental flaw.[1] To complicate things further, most practitioners probably have a preferred perspective, which could easily conflict with a patient's perspective. This is the fundamental background to many litigation cases.

These fundamental flaws are surmountable and one way to do this is by liaising with colleagues with different lenses, or perspectives, to our own. This type of peer-review learning leads to self-determined learning, referred to as heutagogy.[2] Another way to learn about these lenses is through formal educational training. Advanced professionals, those who make a diagnose and acquire consent, must be familiar with each perspective and the associated flaws, not only for their personal safety but also for the patient. This type of training is starting to filter through, as theoretical perspectives are being taught to GDPs and educational supervisors in foundation training. However, as far as I am aware, it is not being made available to the wider dental community.

My GDC referral, four months after I completed my foundation training, was the making of me and I believe it safeguarded me and my last seven foundation trainees. Back in 2008 it made me reflect, upgrade my thinking and influenced the style of GDP I am today. Learning about theoretical perspectives is called epistemology and it takes the ideas discussed here into our individual daily practices. I would also encourage the GDC to update its own thinking around educational theory and learn how to safeguard registrants, rather than deliver punitive measures.

References

1. Creswell JW, Ivankova NV, Plano Clark VL. Foundations and approaches to mixed methods research. In: *First Steps in Research*. Pretoria: Van Schaik, 2007: pp253–282.
2. Hase S, Kenyon C. From andragogy to heutagogy. Ulti-BASE In-Site. Jupp V, 2006. *The Sage Dictionary of Social Research Methods*. Sage, 2000.

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Response to oral haemangiomas

I write in response to the recent Letter to the Editor entitled 'oral haemangiomas' (February 2020). I wish to draw attention to the incorrect, and unfortunately very common, use of the term 'haemangioma' to describe what is actually usually a vascular malformation. A *true* haemangioma is a benign vascular tumour (of which there are many types), most commonly an infantile haemangioma – a vascular tumour that develops in the first few months of life, which then rapidly grows before plateauing, usually resolving before the age of 10 years.

Historically, the term 'haemangioma' has been used to describe both vascular tumours and vascular malformations, hence the confusion in the literature, texts and amongst clinicians.

When the term 'oral haemangioma' is used, what the clinician is referring to is not a tumour, but usually a vascular malformation. I urge readers to view the easy-to-understand *International Society for the Study of Vascular Anomalies Classification*[1] for clarification on nomenclature; this guidance explains that *all* vascular lesions should be referred to as vascular anomalies. Vascular anomalies can then be divided into vascular tumours or vascular malformations. Vascular tumours are subdivided into malignant, locally aggressive and benign – where the reader will find haemangiomas. Vascular malformations may be divided into subcategories, depending on which vessel type is predominant (eg capillary, venous, arterio-venous, etc).

As well as blanching beneath a glass slide (emptying sign), clinically important features in assessing vascular anomalies include colour (red or blue/purple), if the lesion has a palpable pulse and if there is dependency (increase in size of the lesion with gravity). This can help the clinician determine if the lesion may be venous or arterial in nature, and therefore ultimately can affect treatment options.

Unfortunately, the term 'haemangioma' is commonly mis-used by dentists and those less familiar with vascular lesions. I encourage undergraduates and fully qualified dentists instead to refer to these lesions simply as vascular anomalies or vascular malformations, as when these lesions are referred on to a specialist (particularly OMFS or plastics) the term 'haemangioma' means an entirely different thing.

With thanks to Mr Nick Wilson-Jones (Consultant Paediatric Plastic Surgeon, Morriston Hospital, Swansea) for introducing me to the ISSVA classification.

Reference

1. *International Society for the Study of Vascular Anomalies (ISSVA) Classification*. 2018. Available at: **https://www.issva.org/classification** (Accessed 21 February 2020).

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