

**ASSOCIATION OF
DENTAL
ANAESTHETISTS**



**PROCEEDINGS
OF
2007-2008
ANNUAL CONFERENCE**










THE OFFICERS AND COUNCIL MEMBERS:

President: Dr Ken Ruiz
Immediate past president: Dr Nigel Robb
Hon Secretary: Dr Diana Terry
Hon Treasurer: Dr Bill Hamlin
Hon Membership Secretary: Dr Christine Arnold
Proceedings Editor: Dr Harry Ashurst
SAAD Representative: Dr Barry Devonald

COUNCIL MEMBERS

Dr Ian Fletcher
Dr Yusuf Omar
Dr Ian Tring

Dr Fiona Wraith
Dr Barry Corkney

 Dr Ken Ruiz	 Dr Nigel Robb	 Dr Bill Hamlin	 Dr Christine Arnold
 Dr Ian Fletcher	 Dr Ian Tring	 Dr Harry Ashurst	 Dr Diana Terry
 Dr Barry Devonald			

Disclaimer

"Please note that the views expressed in these proceedings are those of the speakers and not necessarily those of the ADA and its Board."

MINUTES OF THE
ANNUAL GENERAL MEETING OF THE ASSOCIATION OF DENTAL ANAESTHETISTS
HELD AT THE UNIVERSITY OF MANCHESTER CONFERENCE CENTRE
10TH MAY 2008. 09.00AM

1. APOLOGIES FOR ABSENCE

Apologies were received from Dr Ian Fletcher.

2. MINUTES OF THE AGM JUNE 2007, SHEFFIELD

The minutes were displayed for the members. Some typing errors were identified. The Treasurer declared that the financial queries had been resolved and no financial error had occurred.

3. MATTERS ARISING FROM THE MINUTES

No issues were raised.

4. PRESIDENT'S REPORT

Dr Ruiz reported that his first year as President had been uneventful after the activity produced by legislative changes in 2007. In 2008, the National Institute for Clinical excellence, NICE, is proposing to investigate the use of sedation in paediatric practice. This controversial area is one where ADA might be expected to have input and Dr Ruiz has registered ADA as a stakeholder for the consultation. NICE is also seeking a chair for this committee.

The President thanked the Councils of ADD and DSTG for coming together to host a joint meeting.

5. TREASURER'S REPORT

Dr Hamlin reported that the year end for the Accounts was 30th April therefore the figures were lodged with the Accountants, Birch Littlemore for the preparation of the documentation. There are assets in both the deposit and current accounts.

ADA has third party insurance with AXA and questioned if this should be increased. As ADA is now hosting one meeting annually the current arrangements were accepted.

Direct debit payment of membership subscriptions is used by 50% of the membership, leaving many standing orders still active some of which still pay only £5.

Income tax was paid of £299.23p due to changes in legislation.

QUESTIONS FROM THE FLOOR:

"Why there is £50,000 held by the society and what is it used for?" The treasurer explained that the Society is costing more to run than it is receiving in subscriptions and income from meetings. The society has looked at changing direction and currently does not offer much to members. It was therefore decided to keep the membership fee at the current level. Current costs are £2,000 annually, but this is deemed a correct use of our capital, to manage the society from the AAGBI, produce the newsletters and website, organise the ADA archives and organise meetings.

Dr Cripps asked how the accounts would be approved. Dr Robb suggested that a copy of the accounts as a summary will be available to members with the Winter 2008 Newsletter along with a form asking for comments and approval. The accounts will be scrutinised and if the members assent, they will be examined for approval at ADA Council in January 2009. The members were asked to approve the re-appointment of Birch Littlemore as Accountants by the treasurer and this was passed unanimously.

6. HONORARY SECRETARY'S REPORT

Dr Terry informed the members that using the AAGBI as our base office greatly facilitated the running of the ADA. Professional Advice has been taken about preserving the historical papers relating to the ADA from the AAGBI Archivist. Dr Terry is gathering in documentation from previous Presidents currently held in their personal possession around the UK. The newsletter had been attractively produced by Busola at AAGBI, and Dr Ashurst has agreed to reinstate the Proceedings and act as Editor.

7. MEMBERSHIP SECRETARY'S REPORT

Dr Arnold reported there are currently 281 members; In 2008 3 retired 4 resigned and Council approved 4 new members. At Sheffield non-members were given a year's free membership by virtue of a £10 excess on the registration fee. As 2008 was a joint meeting with DSTG, delegates attending 2 days paid £20 but were given 1 year membership of both societies, delegates attending 1 day chose one society membership, with DSTG members being given an invitation to join ADA with Direct debit form in their delegate packs.

8. ELECTION OF OFFICERS

Council members; there are no current vacancies for ordinary Council members. In 2009 3 posts will be available.

President-Elect. One nomination had been received by Council correctly nominated and seconded, and Dr Terry confirmed her willingness to stand as president –elect. The nomination was approved unanimously by a show of hands.

9. ANY OTHER BUSINESS

Dr Tring highlighted the change of proposed venue of the summer 2009 meeting from York on grounds of expense and remote location. Council will inform the membership in the website and newsletter as to the arrangements for 2009.

The Proceedings Editor has obtained abstracts from the 2007 and 2008 meetings and retrieved data from other meetings since the last proceedings were produced. Proceedings will be sent to members.

Council will require an Honorary Secretary and Treasurer to stand in 2009 and members were asked to consider standing for these posts.

Dr Ruiz reported that a questionnaire had been sent to members after the Sheffield meeting regarding attendance, and requirements to revitalise ADA activity. A summary of responses was offered and permission asked to destroy the individual responses- this was approved by the meeting.

10. NEXT MEETING

The next Council meeting will be held in January 2009 in London where the venue and timing of the next AGM will be confirmed.

The meeting was closed by the President at 09.43

ASSOCIATION OF DENTAL ANAESTHETISTS

&

DENTAL SEDATION TEACHERS GROUP

ANNUAL SYMPOSIUM

9&10TH MAY 2008

Speakers

Mr Andrew Bridgman,

Barrister, St Johns Buildings Chambers, Manchester

Professor Paul Coulthard

Chairman DSTG, Professor of OMFS & Director of Graduate Education & Research, The University of Manchester

Dr David Craig

Head of Sedation and Special Care Dentistry, KCL Dental Institute, London

Mr Jonathan Green

Endoscopy Vice-President, British Society of Gastroenterology

Dr Tony Jenner

Deputy Chief Dental Officer for England

Mr Neal Jones

Manager, Cheshire and Merseyside Simulation Centre

Professor James Roelofse

Professor and Head of Anaesthesia & Sedation, University of Western Cape, South Africa, Visiting Professor of Anaesthesiology UCL, London

Professor Phil Rood

Dental Clinical Director, King's College Hospital, London

Dr Jan Shaw

Consultant Anaesthetist & Course Director for Patient Safety Training, Central Manchester NHS Trust

Professor Martin Tickle

Professor of Dental Public Health & Primary Care & Honorary Consultant in Dental Public Health, North West Strategic Health Authority

Session Chairs

Dr Christine Arnold, Senior Clinician Special Care Dentistry, Halton and St Helens PCT

Dr Chris Dickinson, DSTG Treasurer & Membership Secretary, Sedation & Special Care Dentistry, KCL

Dr Lesley Longman, DSTG Hon Secretary, Consultant and Senior Lecturer in Restorative Dentistry, Liverpool Dental Hospital

Dr Ken Ruiz, ADA President, Consultant Anaesthetist, Rotherham

Dr Diana Terry, ADA Hon Secretary, Consultant Anaesthetist, Bristol

PROGRAMME

FRIDAY 9th May

Conference Centre

- 10.00 Scientific Session
Politics and Postgraduate Education
Chair, Dr Ken Ruiz & Prof Paul Coulthard
DOH Policy
Dr Tony Jenner
Commissioning Anaesthesia and Sedation Services
Professor Martin Tickle
Dentists with a Special Interest in Sedation
Dr David Craig
'The Standard Sedation Certificate'
Professor Paul Coulthard
- 12.00 **DSTG Annual General Meeting**
- 13.45 Scientific Session
Clinical Teaching
Chair, Dr Lesley Longman
Simulation in Sedation and Anaesthesia Teaching
Dr Jan Shaw & Mr Neal Jones
- 15.30 Scientific Session
Free Papers
Chair, Dr Chris Dickinson

SATURDAY 10th May

Conference Centre

- 9.00 **ADA Annual General Meeting**
- 9.30 Scientific Session
The Law
Chair, Dr Christine Arnold
The Mental Capacity Act
Mr Andrew M Bridgman
Are lawyers a threat?
Professor Phil Rood
- 11.30 Scientific Session
Clinical Practice Sedation Techniques
Chair, Dr Diana Terry
Sedation for Endoscopy
Mr Jonathan Green
Safety and Efficacy in Paediatric Sedation
Professor James Roelofse
- 14.00 End of Meeting

COMMISSIONING DENTAL SEDATION AND GA SERVICES

PROFESSOR MARTIN TICKLE

Professor of public health & Primary Care
& Honorary Consultant in Dental Public Health
North West Strategic Health Authority
University of Manchester



The only constant in the NHS is change. A number of factors will have an impact on dental sedation and general anaesthetic services over the next 3-5 years. These include the requirements of PCTs to improve the dental health of their populations, to deliver 18 weeks waits in a sustainable way and the growing agenda to move specialist services out of hospitals and into primary care.

Due to the changes in legislation set out in the 2003 Water Act water fluoridation is now a realistic option for areas of the country with high levels of dental disease. New water fluoridation schemes plus a new focus on commissioning primary care services to provide evidence-based preventive care has the potential to dramatically reduce dental disease in young children and patients with special needs; two groups who are major users of GA and sedation services.

The same principles for 18 weeks will be applied to primary care based specialist services as to consultant led services. To deliver 18 weeks and to move care outside of hospitals, many PCTs are considering radical service redesign and moving the assessment and triage of patients into primary care locations. This reduces inappropriate referrals to specialist services and provides the opportunity to refer patients to the clinician whose skills are best matched to the needs of the patient. This could be a GDP, a dentist with a special interest, a specialist or a consultant. To deliver this approach requires clinicians; both independent practitioners and salaried dentists employed by different Trusts, to work in clinical networks, with agreed clinical pathways for patient referrals and agreed firm management and clinical governance arrangements.

Another major influence on services over the next five years will be the growing competition amongst providers for NHS contracts. The NHS sees this as a means of increasing value for money as providers will compete for contracts on the price and quality of the services they provide. Providers will be much more business-like in their approach to providing care in this more competitive environment. As hospital trusts move to foundation trust status, the provider arms of PCTs become stand alone organisations, the private sector and entrepreneurial GDPs seek NHS contracts, there will be more choice of providers for PCTs to buy services from and more competition amongst providers for NHS contracts.

To survive and prosper in this environment clinicians need to be involved in the management of their services and engage with commissioners to understand and participate in service redesign. To do this, clinicians have to understand how commissioning works and understand their business; the population their service is provided for and the population who use their service, plus the opportunities for growth and development.

World class commissioning requires long term engagement between commissioners and clinicians to guide the implementation of local oral health strategies. Successful providers will be proactive in this process and a first stage would involve discussion with the consultant in dental public health to understand the local landscape of the NHS. If clinicians adopt a head in the sand approach to the management of services they will run the risk of having change done to them rather than helping to shape and manage change.

DENTISTS WITH A SPECIAL INTEREST (DwSI) IN CONSCIOUS SEDATION



Dr David Craig

Head of Sedation and Special Care Dentistry
KCL Dental Institute, London

Over the past two years, the Faculty of General Dental Practice (UK) and the Department of Health (DH) have worked together to develop a series of competency frameworks for 'Dentists with Special Interests' (DwSIs). The frameworks are intended for use by dentists and Primary Care Trusts, and set out competencies for the scope of treatment that can be undertaken by dentists who have developed special interests in addition to their generalist role.

New guidelines for the appointment of DwSI in conscious sedation were published in January 2008 and are available on the FGDP website (www.fgdp.org.uk). The 'standard' conscious sedation techniques (intravenous midazolam for adults and nitrous oxide/oxygen for patients of all ages) are acknowledged as suitable for use by all appropriately trained and experienced primary care dentists whereas a DwSI in conscious sedation may, additionally, be able to:

- offer more advanced or 'alternative' conscious sedation techniques
- provide conscious sedation for patients with more complex medical histories and/or treatment needs
- provide conscious sedation for patients under 12 years of age using techniques other than inhaled nitrous oxide/oxygen
- accept referrals from other practices, clinics and hospitals.

THE STANDARD SEDATION CERTIFICATE



Paul Coulthard

Chairman DSTG
Professor of OMFS & Director of Graduate Education & Research
The University of Manchester

There has always been a regulatory body requirement for UK dentists to have appropriate postgraduate education to fit them for the practice of conscious sedation techniques for their patients. This further education has never been clearly described. DSTG set up a Working Group in 2007 to develop a standard for postgraduate training in conscious sedation. The Group wrote a programme specification, including assessment, appropriate to standard conscious sedation practice. These techniques were defined as: intravenous sedation using midazolam alone, inhalational sedation using nitrous oxide and oxygen, and oral/transmucosal sedation using benzodiazepines. The Group proposed that practitioners who satisfy the assessment examiners and become holders of the 'Standard Sedation Certificate' will have demonstrated that they have achieved a standard and that this, whilst not essential for practice, might be of use in demonstrating experience and competence or simply provide the satisfaction of achieving a recognised level. The programme requirements are likely to be delivered by a number of courses already in existence.

With the support of the DSTG Committee, the draft publication, 'Postgraduate Conscious Sedation Education in Dentistry' was circulated to the whole DSTG membership for consultation. The membership was strongly supportive of publishing a Postgraduate Standard, and also of introducing a core assessment, the Standard Sedation Certificate. The membership was also strongly supportive of DSTG being involved in delivery of the assessment model.

SIMULATION IN SEDATION AND ANAESTHESIA TEACHING



Dr Jan Shaw
Consultant Anaesthetist
& Course Director for Patient Safety
Training
Central Manchester NHS Trust



Mr Neal Jones
Manager
Cheshire & Merseyside Simulation
Centre

To err is human...

Everyone makes mistakes. Early training programmes had a clear and simple goal. The goal was to **eliminate** error. The message was **be careful**. These initiatives were bound to fail because the goal was impossible: **you cannot stop people making mistakes**. Error is a central part of the human experience and cannot be 'deleted'. People working in the NHS are dedicated and conscientious and have worked hard to acquire clinical skills and knowledge. They are motivated by a genuine desire to reduce suffering and illness; yet up to 10% of hospital inpatients suffer an avoidable, 'adverse event'. (National Audit Office report 2001). More than 2000 patients died in 2004 in English hospitals alone due to lapses in patient safety.

As well as the costs in terms of human suffering, the total direct annual cost to the NHS of outstanding litigation for adverse patient incidents is estimated to be higher than £5 billion. There are also other indirect costs such as a mean adverse incident related delay to discharge of 8.5 extra bed-days. These indirect costs total at least a further £2 billion per annum.



Audience enjoying
Simulation Session

Adverse events are rarely the result of a single mistake by one individual. Often a chain of events will lead eventually to the major adverse event. Some of the root causes of the incident lie within the system: "an accident waiting to happen" and these are common in healthcare. The experiences of industries which have succeeded in reducing their accident rate (High Reliability Organisations) show that the solution to human error problems lies in learning to 'manage error' effectively. These

industries now accept that error is 'normal'. High Reliability Organisations (HROs) work hard to risk manage the workplace and eliminate system errors, but they also focus on training all of their employees in error management techniques.

Medical education has traditionally focused on the technical skills required to do the job but it is apparent that often the mistakes people make in the run-up to an adverse event are due to a lack of non-technical skills such as communication failures, loss of situation awareness, poor teamwork and

many more. Human Factors Training teaches the understanding of these non-technical skills required to improve safety for both staff and patients in the healthcare setting. Human factors training is mandatory in UK commercial aviation and many other organisations have similar programmes including astronautics, military & maritime organisations, nuclear power and petrochemical industries. All 'Safety Critical' industries teach human factors theory to improve safety, ***apart from healthcare!*** The introduction of the basic principles of 'human factors' science to the healthcare environment is long overdue.

Simulation training lends itself very well to teaching these non-technical skills. It allows the presentation at will, of rare but critical events in a non-threatening safe learning environment. The modern simulation centre is a high fidelity environment that effectively mimics real clinical environments in the hope of increasing the transference of knowledge, skills and behaviours from the classroom to the clinical area. It is through the use of simulation that we can rehearse power failures, anaphylaxis and drug errors, seeking identifiable curative measures both with clinical training and culture changes as a result of embracing and acknowledging the effect of human factors and the role they play in errors.

In this presentation we hope to convey the general principles of human factors training and demonstrate the enormous contribution simulation training can make to medical education and promoting safer practice.

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HYPNOSIS AND IHS – DO THEY WORK TOGETHER?

Cath Potter

Senior Clinical Teaching Fellow in Behavioural Sciences
University of Leeds Dental Institute
PhD student University of Manchester



There is a general acceptance that suggestion, hypnotic or semi-hypnotic is important in the success of inhalation sedation techniques using nitrous oxide/oxygen mixtures for dental treatment. However, little systematic investigation of the relationship between hypnosis and Inhalation Sedation has been reported in the literature and evidence for the importance of hypnotic techniques is limited to case reports and case series.

An early paper which investigated the effect of nitrous oxide on the acceptance of hypnotic suggestions in volunteers concluded that nitrous oxide/ oxygen mixtures increased the likelihood of suggestions being responded to.

Work has been carried out showing that the effects of nitrous oxide/oxygen mixtures on pain perception can be altered by giving information designed to increase expectations about its effects. Expectancy of this sort has also been shown to be important in hypnotic responding.

This paper will present the background, results of pilot studies and the protocol of an experiment to investigate the effects of presenting a hypnotic induction procedure and post-hypnotic suggestions for anxiety reduction with inhalation sedation on anxiety produced by a film aimed to induce dental anxiety.

RESTRAINT DURING INDUCTION OF DENTAL CHAIR ANAESTHESIA: WHAT DO PARENTS THINK?



A Jhamatt

Specialty Registrar in Psychiatry
Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust

BACKGROUND

Any medical professional treating children, needs a spectrum of behavioural techniques from the simplest, tell and show, all the way through to a general anaesthetic. Within this spectrum lies restraint. The misconception of restraint is embedded so deep in the minds of many parents, that although much evidence may be brought to justify its use, they often still object.

Weighing the balance between the child's best interests against the will of the child when deciding on management, has both professional and legal implications. Hence, clear guidelines should be available on the use of restraint.

AIM

The aim of this audit was to determine parental opinions towards the use of restraint during induction of paediatric dental chair anaesthesia within the Community Dental Unit at the Countess of Chester Hospital.

The data can be used to produce a departmental restraint policy, acceptable to both parents and staff. Such a policy is currently unavailable.

METHOD

A questionnaire-based audit approved by the Trust Learning Disability Subgroup, the Patient Participation Involvement Group and Halton PCT was conducted.

No ethical approval was required.

The sample population consisted of 40 parents.

RESULTS

34 out of 40 (85%) of parents said they should be allowed to restrain their child for urgent treatment.
23 out of 40 (57.5%) of parents said they should be allowed to restrain their child for non-urgent treatment.

33 out of 40 (82.5%) of parents said staff should be allowed to restrain their child for urgent treatment.
22 out of 40 (55%) of parents said staff should be allowed to restrain their child for non-urgent treatment.

CONCLUSIONS

The majority of parents believe that restraint is a valid management technique for both urgent and non-urgent dental treatment. Most parents would prefer to restrain their own children rather than allow staff to do so, regardless of urgency of treatment.

These findings are consistent with those of a similar audit conducted within the Chair Dental Anaesthesia Unit of the Royal Liverpool Dental Hospital (n = 3218).

The use of physical restraint has been described as an example of a behavioural management strategy which facilitates the child's ability to ultimately accept care and enhance the work quality and efficiency of the dental team. Nevertheless, the appropriateness of physical restraint remains a contentious subject amongst parents & medical professionals alike and recently has been equated with denial of freedom. However, when avoidance of restraint is likely to result in more harm to the child, such avoidance is irresponsible.

The audit data should be used to construct explicit management guidelines with regard to the use of restraint within the Community Dental Unit. Such management guidelines should form part of a formal restraint policy which abides by the General Dental Council's guidance on professional and personal conduct as well as reflect both parental and staff opinion on paediatric behavioural management strategies.

The audit findings and any resulting policy should be made available on the hospital intranet in order to allow parents to see what other parents think, in other words, what is acceptable within society. This practice was adopted by the Royal Liverpool Dental Hospital. Their restraint policy for Dental Chair Anaesthesia, together with ongoing audit results, was available for public viewing on the hospital website.

REFERENCES

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- Manley MCG. A UK perspective. *Br Dent J 2004*; **196**(3): 138-9.
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- Nathan JE. Managing behaviour of preoperative children. *Dent Clin North Am 1995*; **39**(4): 789-816.
- Klein A. Behavior management. Issues for pediatric patients. *J Am Dent Assoc 1991*; **122**(12): 70-2.
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ACKNOWLEDGEMENTS

Dr C Arnold, Senior Dental Officer; Countess of Chester Hospital
Dr A Troy, Consultant Anaesthetist; Countess of Chester Hospital

MIDAZOLAM SEDATION - A DISJOINTED APPROACH

David Tait

SDO Warwickshire Special care Dental service
Postgraduate Certificate in Conscious Sedation
The University of Liverpool



This case report describes the dental management of a 40 year old female, with a rare connective tissue disease, under conscious sedation with intravenous midazolam. The indications for sedation will be discussed and also the complications encountered. The clinical governance aspects of this ladies management will also be highlighted.

IS THERE ANY RELATIONSHIP BETWEEN ETHNICITY AND THE LEVEL OF DENTAL ANXIETY IN AN ADULT POPULATION?

Christine Battison



AIM

To investigate if there is any relationship between an adult patients' ethnicity and their level of dental anxiety expressed in an emergency dental setting.

METHODOLOGY

This is a cross-sectional survey of demographic characteristics of adult patients attending for their first visit of emergency dental treatment at a Dental Access Centre. This is a questionnaire based study using the five questions from the Modified Dental Anxiety Scale combined with five extra questions about age, sex, socio-economic status (by means of occupation), ethnic origin and dental attendance which are relevant to this study.

PARTICIPANTS

These will be all adult patients attending Bury Dental Access Centre for their first visit for emergency dental treatment.

RESULTS

Only the questionnaires which have been completed 100% shall be included in the analysis. Ethnicity will be classified as it is described in the 2001 Census. Age will be grouped as it is in the Adult Dental Health Survey 1998 (Kelly et al.)¹ Socio-economic status will be classified according to the Registrar Generals classification of occupation.

NATIONAL SURVEY ON GENERAL ANAESTHESIA FOR EXODONTIA IN CHILDREN



L. Adewale

Consultant Paediatric Anaesthetist
Birmingham Children's Hospital



I. Barker

Consultant Paediatric Anaesthetist
Sheffield Children's Hospital

We report the interim results of a survey on general anaesthesia for exodontia in children, performed in the United Kingdom during the year 2007 – 2008.

AIMS

The safety of general anaesthesia for dental extractions in children has been a subject of concern for many years. This concern has led to the publication of several reports from expert groups and professional bodies, perhaps most notably "*A Conscious Decision*"¹. The aims of this survey were to establish current U.K. practice for this specialty and to identify whether or not there is a need for national guidelines.

DESIGN

The survey took the form of a postal questionnaire. Questions related to the provision of general anaesthesia for a healthy 5-year-old child undergoing extraction of deciduous molar teeth.

PARTICIPANTS

The questionnaire was sent to the departments of anaesthesia in all U.K. hospitals with a department of dental surgery.

RESULTS

Interim results of the survey are shown in the tables below. 260 questionnaires were sent in total. 157 replies have so far been received. Not all questions were answered by every centre and some questions permitted more than one choice of answer.

CONCLUSIONS

This survey indicates that the provision of general anaesthesia for dental extractions in children varies considerably throughout the United Kingdom, suggesting that national guidelines may be useful for this specialty.

REFERENCES

1. "*A Conscious Decision*" – A Review of the Use of General Anaesthesia and Conscious Sedation in Primary Dental Care. Department of Health, 2000

Table 1

Number of General Anaesthetics Performed

Number of Cases per Annum	Number of Centres
0	19
< 499	62
500 – 999	43
1000 – 1499	19
1500 – 1999	5
> 2000	3
Don't Know	5
Total	156

Table 2

Premedication Administered (multiple responses permitted)

Agent	Number of Centres
Local Anaesthetic Cream	87
Oral Analgesia	41
Oral Midazolam	21
None	38

Table 3

Induction Agent (multiple responses permitted)

Agent	Number of Centres
Sevoflurane	105
Propofol	83
Thiopentone	2

Table 4

Insertion of Intravenous Cannula

Frequency of Insertion	Number of Centres
Always	97
Usually	18
Rarely	13
Never	7
Total	135

Table 5

Maintenance of Anaesthesia (multiple responses permitted)

Agent	Number of Centres
Nitrous Oxide	109
Sevoflurane	112
Isoflurane	23
Halothane	1
Desflurane	1
Propofol	8
Alfentanil	4
Remifentanil	1
None	1

Table 6

Number of Centres using Intraoperative Monitoring (question not completely answered by all centres)

Frequency	SaO2	ECG	NIBP	CO2	Agent
Always	132	105	73	118	110
Usually	1	9	21	3	7
Rarely	1	14	21	4	3
Never	0	3	14	7	9
Total	134	131	129	132	129

Table 7

Intraoperative Airway Management (multiple responses permitted)

Airway Device	Number of Centres
Facemask	31
Nasal Mask	43
Laryngeal Mask Airway	108
Oral Endotracheal Tube	19
Nasal Endotracheal Tube	9
Nasopharyngeal Airway	3
Oropharyngeal Airway	1
None	1

Table 8

Patient Position during Dental Extractions (multiple responses permitted)

Patient Position	Number of Centres
Sitting up in Dental Chair	8
Reclining in Dental Chair	2
Supine in Dental Chair	5
Sitting up on Trolley	4
Reclining on Trolley	14
Supine on Trolley	81
Supine on Operating Table	31

Table 9

Administration of Perioperative Paracetamol (multiple responses permitted)

Use of Paracetamol	Number of Centres
Pre-operative Oral	45
Pre-operative Rectal	18
Intra-operative Intravenous	24
Intra-operative Rectal	3
Post-operative Oral	61
Post-operative Rectal	1

RESTRAINT DURING INDUCTION OF DENTAL CHAIR ANAESTHESIA: *WHAT DO PARENTS THINK?*



Anita Jhamatt

AIM

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The data can be used to produce a departmental restraint policy, acceptable to both parents and staff. Such a policy is currently unavailable.

DESIGN

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PARTICIPANTS

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CONCLUSIONS

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DENTISTRY AND THE MENTAL CAPACITY ACT 2005



Andrew Bridgman

Barrister, St Johns Buildings Chambers, Manchester

In respect of providing medical care to patients lacking the capacity to consent to, or to refuse, treatment the Mental Capacity Act 2005 places on a statutory footing those principles of common law that have evolved since 1983. In addition, the Act provides the authority for a proxy consent through a Lasting Power of Attorney.

This paper explores the piecemeal development of those common law principles, their incorporation into Statute and what effect the Act is likely to have on the routine delivery of healthcare.

ARE LAWYERS A THREAT?



Phil Rood

Dental Clinical Director
King's College Hospital
London

Contact with the legal profession often causes anxiety. When alleged failures of care are being investigated, the responsibility of lawyers is to represent the patients – or the dental surgeons concerned. The adversarial nature of the legal process can generate resentment. There should be no concerns if appropriate standards of conduct have been followed.

Standards of clinical care are set by the profession, not by lawyers. It is obviously important to comply with guidelines and to adhere to regulations.

The practice of sedation is not an area where legal enquiries are particularly frequent. There have been criminal and civil challenges in every aspect of pain and anxiety management – examples will help to illustrate how problems can arise.

An examination of our practise by an intelligent investigator often provokes unease. Scrutiny by the legal profession has undoubtedly raised clinical standards.

SEDATION FOR GASTROINTESTINAL (GI) ENDOSCOPY

Dr Jonathan RB Green

Consultant Gastroenterologist
University Hospital of North Staffordshire;

Recent Endoscopy Vice President
British Society of Gastroenterology



There are approximately 1 million GI endoscopies performed each year in the UK. Where sedation has been used, this has traditionally involved benzodiazepine agents (with or without opioids/opiates) used under the sole direction of the endoscopist with no formal anaesthetic involvement. This has been generally satisfactory in the past for all concerned but this is now longer the case. The growth of specialist therapeutic endoscopy has in the last few years highlighted the need to have the option of deeper sedation for some patients, many of whom are increasingly sick, frail and elderly. This requirement for deeper sedation challenges some of the longest standing medical interprofessional barriers. However, as the needs of patients require this development, it is imperative to move GI endoscopy sedation into the modern era and a strategy to achieve this will be discussed.

SAFETY AND EFFICACY IN PAEDIATRIC SEDATION

James Roelofse

Professor and Head of Anaesthesia and Sedation
University of the Western Cape
Cape Town;

Visiting Professor in Anaesthesiology
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Children undergoing diagnostic or therapeutic procedures are often frightened and uncooperative. This fear may be exacerbated by strange environments, parental anxiety, separation from parents, and pain, or the anticipation of pain, from the procedure itself.

The need to provide some form of distraction, analgesia, sedation, and/or pain control to allay fear has resulted in the proliferation of sedative, hypnotic agents, opioids, and “general anaesthetic agents” - alone or in combination - in various settings. Polypharmacy have become commonplace.

The question is can polypharmacy be safely done in children - of all patients receiving sedation children represent the highest risk, lowest error tolerance subgroup.

Significance advances in paediatric sedation have made the use of combinations of drugs safer, however, drugs are almost always being implicated as the reason for adverse events with polypharmacy, which may not always be the case.

Appropriate application of the local anaesthetic may allow pure sedative use for an otherwise painful procedure because it may constitute the analgesic component of the sedation plan. However, is this argument valid for longer and more complex operations, the possibility of significant postoperative pain, where the local anaesthetic is not always effective, or cannot be used, and for patient comfort.

Paediatric sedation is also provided for procedures where a local anaesthetic cannot be used – we need to rely on drugs to produce sedation and analgesia, in fact polypharmacy.

The argument for polypharmacy needs to be addressed taking into account the definition, benefits, availability of safe drugs, evidence-based studies, and a possible scientific reason for using polypharmacy.

Multimodal analgesia or balanced sedation and analgesia represent an approach in preventing intra- and postoperative pain/anxiety (patient comfort) that involves administration of a combination of sedatives, opioid and/or non-opioid analgesics.

Anaesthetists are increasingly turning to the use of a combination of non-opioid analgesic medications as the “first line” of therapy for the prevention of pain/anxiety - polypharmacy or balanced sedation and analgesia.

In addition to local anaesthetics, traditional non-steroidal inflammatory agents, COX - inhibitors, ketamine, alpha-2 agonists, paracetamol, gabapentin, pregabalin can all provide beneficial effects when administered in appropriate doses as part of a multimodal/balanced sedation/analgesia - polypharmacy - model in the perioperative setting in dentistry and medicine - polypharmacy without the opiates.

The question remains, do we have the drugs that we can use in combinations for polypharmacy, and are there evidence-based studies available that can guide us in accepting the use of polypharmacy as a safe and effective technique for paediatric sedation.