

Association of Dental Anaesthetists



Proceedings

2008 -2009

www.dentalanaesthesia.org.uk

Proceedings of the Association of dental anaesthetists

The officers and Council Members

President:	Dr Diana Terry
Immediate past president:	Dr Ken Ruiz
Hon Secretary:	Dr Rachel Pollard
Hon Treasurer:	Dr Ian Fletcher
Hon Membership Secretary:	Dr Christine Arnold
Proceedings Editor:	Dr Harry Ashurst

Council Members

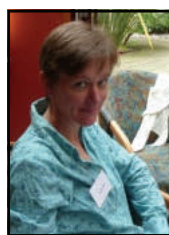
Dr George Hamlin
Dr Yusof Omar
Dr Nigel Robb



Dr Diana Terry



Dr Ken Ruiz



Dr Rachel Pollard



Dr Yusof Omar



Dr Ian Fletcher



Dr Christine Arnold



Dr Harry Ashurst

Minutes of the Annual General Meeting of the Association of Dental anaesthetists 2009

The meeting was held at Regents College London on Friday 9th October at 13.45.

The President Dr Ken Ruiz chaired the AGM

10 ordinary members attended in addition to the Officers of the Society.

1. Apologies for absence: Were received for Dr Bill Hamlin Honorary Treasurer, Dr Meg Skelly Life Member and Dr Penelope B Hewitt Life Member.

2. Minutes of the AGM 2008 in Manchester.; The minutes were displayed to the Members and questions and corrections invited.

Matters arising from the Minutes; there were none

3. President's Report. Dr Ken Ruiz presented the members with a summary of a report to be presented at the annual meeting of the Specialist Societies of the Association of Anaesthetists of Great Britain and Ireland.

4. Treasurers Report; Presented by Dr Ian Fletcher in place of Dr Bill Hamlin. The accounts were presented to the members and comments invited. The Society has expenditure in excess of income in the last 12 months of £2,000. The Society has funds to continue the activities of the Society and the meeting of 2009 is anticipated to reverse the reduction on funds. Council has instigated some expenditure reduction; only one meeting per annum is held, with 2 Council meetings and the number of Council members is now 9. The Proceedings and communication with the membership will be mainly via the ADA website to reduce printing and postage costs.

Honorary Secretaries Report Dr Diana Terry informed the membership that the Society had a string Council and had organised a popular Scientific Meeting for 2009 which had been over subscribed Council members have contributed to National Organisations concerned with standards and training and has sent representatives to the Royal College of Anaesthetists regarding revalidation requirements for specialist practice. We also attended the annual Specialist Societies meeting at the Association of Anaesthetists of Great Britain and Ireland. Dr Bill Hamlin has contributed to the Association of Paediatric Anaesthetists project concerning OPGA exodontia in children and a report is expected early in 2010.

6. Membership Secretaries Report Dr Christine Arnold reported the number of current members; the new membership in 2008-9 being similar to retirements and resignations. Members attending the meetings received a discount, and non-members received a free membership of 6 months. Direct debit forms for membership were included in the delegate pack.

Appointment to Council members and officers The Honorary Secretary had received two nominations for membership of Council but neither were deemed valid by the Board as the requirement to be an active member of ADA for a minimum of 12 months had not been met. Dr Ken Ruiz finished his term as President and becomes immediate Past President for 1 Year. Dr Diana Terry was proposed by Council to be President for the 2 year term 2009-2011 Dr Rachel Pollard is appointed Honorary Secretary Dr Ian Fletcher takes over from Dr Bill Hamlin as Honorary Treasurer Dr Harry Ashurst is Proceedings Editor Dr Christine Arnold is Membership Secretary

8. Any other Business. There were no items of business raised from the members.

Date and time of next Meeting The 2010 annual General Meeting of the Association of Dental Anaesthetists will be held in association with the Annual scientific meeting, in London, in November 2010. The venue and timing will be confirmed after analysis of feedback from the 2009 meeting, informing the likely number of delegates.

The President closed the meeting at 14.05

Association of Dental Anaesthetists
Annual Symposium
9th October 2009
Regents College

Speakers

Julie Cliff,

Community Nurse Specialist Acute liason/Learning

Difficulties

Rachael Pollard

Consultant Anaesthetist, Oxford Radcliffe Hospital

Debbie Townsend

Physical Intervention Training Manager,

Ridgeway Partnership, Oxfordshire Learning Disability NHS

Trust

Konrad Jacobs

Consultant Clinical Psychologist,

Oxford Children's Hospital

Chris Hayward

Associate Specialist in Oral Surgery

Newcastle Dental Hospital, Newcastle Upon Tyne

Ken Ruiz

Consultant Anaesthetist, Rotherham Hospital

Harry Ashurst

Consultant Anaesthetist,

Bradford Teaching Hospitals NHS Foundation Trust

Joe Omar

Dental Sedationist, Private Medical Practitioner.

Hon. Lecturer, Eastman Dental Institute CPD, UCL

Diana Terry

Consultant Anaesthetist & Course Director for Patient Safety

Training, Bristol Hospitals

Programme

9.00 Registration

09.35 Session One: **The Patient with Special Needs**

Chair, Dr Harry Ashurst

The Dental patient and Mental health Capacity

Julie Cliff

After Consent - treating uncooperative adults.

Case Presentations

Rachel Pollard

Physical restraint for special needs adults

Debbie Townsend

11.00 **Coffee/Tea break**

11.15 **Session Two: Children**

Chair, Dr Rachael Pollard

Treating difficult children – interactive case presentations

Rachel Pollard

Procedural distress in children – How to avoid it and how to treat

Konrad Jacobs

Dental Caries: An index of Child Neglect

Chris Hayward

13.00 Lunch

13.45 AGM - Association of Dental Anaesthetists

14.15 **Session Three: Safety in Dental Anaesthesia and Sedation**

Chair, Dr Diana Terry

Safety in dental anaesthesia, WHO Checklist,

AAGBI Guidelines

Harry Ashurst

NPSA Throat Pack Policy

Rachel Pollard

Safety in Dental Sedation

Who takes responsibility?

Joe Omar

15.30 **Coffee/Tea Break**

Is Blind Nasal and AFOBI a core skill of the Dental Anaesthetist and Sedationist?

Diana Terry

16.25 Close of Day

The Mental Capacity Act 2005. People with learning disabilities and consent to dental treatment

Name Julie Clift

Position Specialist Nurse Learning Disabilities

Contact details (Optional) Julie.clift@eastlancspct.nhs.uk



In 1995, the Law commission was given the task of investigating the adequacy of procedures for decision making on behalf of mentally incapacitated adults. The Law Commission concluded that there needed to be a single statute to govern 'best interest' decision making and after a 15 year consultation resulted in the Mental Capacity Act 2005.

This presentation looks at the five statutory principles outlined in the Mental Capacity Act 2005 code of practice and how it impacts on the treatment of people who we believe are unable to make their own decision about treatment. The main focus of this presentation is to highlight the requirements under the act for dental practitioners with regard to capacity assessment, accessible communication with the patient, consultation with those caring for the patient and the need for dentists to ensure that capacity assessment, 'best interest' decision making and care planning are comprehensively documented in the patients notes.

Mental capacity Act 2005.London; The Stationary Office.

www.opsi.gov.uk/acts/acts2005/20050009.htm

Emmett,C. The Mental Capacity Act 2005 and its impact on dental practice. *British Dental Journal*. Vol. 203 no.9 Nov 10 2007

The Use of Restrictive Physical Interventions in Dental Healthcare

Ruth Barber

R.N.L.D

Community Nurse – Learning Disability Team

General Services Tutor

Ridgeway Partnership (Oxfordshire Learning Disability NHS Trust)

Debbie Townsend

R.N.L.D

Physical Intervention Training Manager

General Services Senior Tutor

Ridgeway Partnership (Oxfordshire Learning Disability NHS Trust)



Restrictive Physical Interventions may be required before a procedure e.g. to enable someone who lacks capacity to have a general anaesthetic or after an anaesthetic e.g. if a patient becomes disorientated or aggressive. Restrictive physical interventions can be categorised into 2 groups, emergency / unplanned interventions and planned interventions. In both cases, restrictive physical interventions should be considered as a last resort and should only be used when necessary. It is important that professionals are working within the legal framework (Duty of Care, Mental Capacity Act 2005, Health and Safety at Work Act 1974). Any use of force must be reasonable in the circumstances and proportionate to the harm that may occur. The least restrictive hold should be used for the shortest possible time. Staff who are in situations that may require them to use restrictive physical interventions should have training by appropriately qualified tutors and annual refreshers. All incidences should be carefully recorded.

People who have a learning disability may have particular difficulty accessing healthcare for a number of different reasons. More work is needed to explore how people who have a learning disability can be supported to access healthcare. Examples from practice and research include:

De-sensitisation programmes

Person centred adjustments

Solution based therapy

Non-aversive person centred support

Psychotherapeutic interventions

Cognitive, psychodynamic and creative therapies

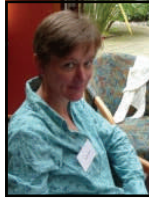
Health Action Plans

Collaborative working

If a person lacks capacity, if it is agreed that a procedure is in their best interests and if it is foreseen that restrictive physical interventions may be required, a number of strategies may be used to ensure this process is carried out as safely as possible with minimum distress to the person. Good practice guidelines were outlined.

Paediatric Problems

Dr Rachel Pollard



Treating the uncooperative child is the subject of much discussion and variety in practice. The references below deal comprehensively with the variety of issues regarding the underlying legal and ethical issues.

Preoperative play, preparation and discussion with the child and parents is essential to help with cooperation for the procedure.

Managing the uncooperative child at the time depends on the developmental age of the child, the parent child relationship, and the procedure.

Treatment of the resistant child must be thoroughly discussed, documented, and a debrief performed after the procedure.

Guidelines are available to provide a framework of appropriate holding with a resistant child. (see below)

References

- Pro-Con debate: The place of premedication in paediatric practice A Rosenbaum Z Kain *Paediatric anaesthesia* 2009 19:817-828
- Editorial: Brute Force or gentle persuasion J Thomas *Paediatric anaesthesia* 2005 15:355-357
- Mask fear in children presenting for anaesthesia: aversion, phobia, or both? HJ Przybylo SE Tarbell GW Stevenson *Paediatric anaesthesia* 2005 15:366-370
- The Runaway Child : managing anticipatory fear, resistance and distress in children undergoing surgery. Review article. D Hearst *Paediatric Anaesthesia* 2009 19:1014-1016
- The child who refuses to undergo anaesthesia and surgery-a case scenario-based discussion of the legal and ethical issues. H Walker, *Paediatric anaesthesia* 2009 19:1017-1021

Parental Survey-Holding children

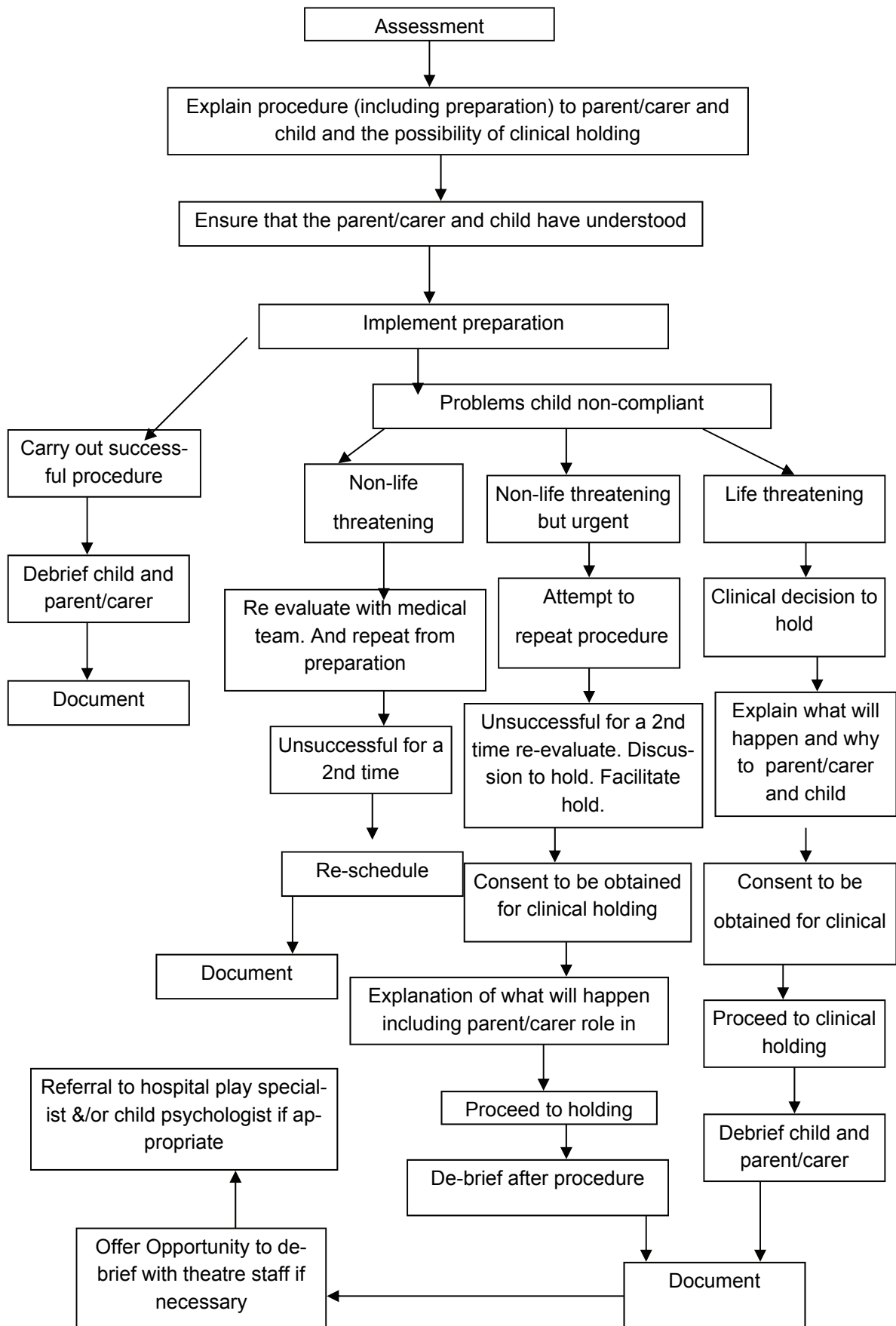
Dr Raj Sethuraman

82 parents responded to a voluntary questionnaire about holding if their child was uncooperative during anaesthetic induction.

The results are summarised below:

- Parents would prefer to hold the child themselves if necessary.
- Premedication and holding by staff are also viable options if parents agree.
- Postponing or cancelling should be the last option.
- Premedication should be discussed more during anaesthetic assessment.

Flow Chart (adapted from Liverpool 2005)



Safety in Dental Anaesthesia

Human factors and the WHO surgical check list

Dr Harry Ashurst,

Associate Medical Director and Consultant Anaesthetist,

Bradford Teaching Hospitals Foundation Trust



The provision of safe high quality anaesthesia in any setting is the responsibility of all. As we know anaesthesia for dental surgery has special considerations which present unique problems and challenges.

We know that 1 in 10 patients admitted to hospital suffer some adverse event, some of which lead to harm and fortunately very few lead to serious harm or death. We know that chair dental anaesthesia is associated with a very few deaths comparative to other surgical specialities but it is difficult to know the rate now chair dental anaesthesia is now no longer allowed in the community setting.

What is certain is that there is still harm occurring to dental patients as a result of what we all do and no matter what we do harm will continue. 'To err is human.' Our job is to reduce that harm to its minimum. What can we do?

The first is to understand why harm occurs despite our best efforts. These are multitude and the solutions are even more prolific. But as individuals the first thing to appreciate is human error is often the most common cause. Human factors contribute to many errors. Situational awareness, personalities, authority gradients and motivational issues to name a few. The aviation and nuclear industries have long appreciated the consequences of adverse events and have made huge systematic changes that are now so imbedded that they have proved exceptionally safe.

Healthcare is different though, or is it? There are now many organisations striving to improve patient safety and quality of care. The recent government white paper outlines where it feels we can make changes to make improvements.

Recently the New England Journal of Medicine published a paper outlining the changes made to perioperative mortality and morbidity as a result of the introduction of the World Health Organisation (WHO) Surgical checklist. The results were impressive especially for those centres in more developing areas. The checklist is born from the aviation industry and fits well with previous initiatives to use pre-operative briefings.

The National patient Safety Association (NPSA) took up this challenge and have, unusually, issued and obligatory order that all patients receiving surgical treatment must have a checklist completed by January 2010. Many would say that we are doing this already unfortunately the evidence for this is lacking, local examination of root cause analysis of adverse events often highlights elements that could have been prevented by correct implementation of the checklist.

Is this possible and appropriate to perform the checklist in dental surgery and anaesthesia? How can this be done and what are the benefits for all?

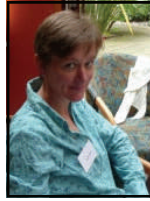
The pre-operative briefing remains the main key to the checklist in patient safety. A well performed briefing will address many of the human factors which lead to adverse events. Communication, situational awareness, motivation and control. We should embrace this tool as just one of the ways to make the work place a safer and better place for us and our patients.

How we introduce and embed this tool into dental practice is as important as the tool itself. It will no doubt be difficult and many will see it as an intrusion to normal safe practice but the tool can and

should be modified locally, maintaining the core principles, to help the champions and engage the laggards.

Throat Packs

Dr Rachel Pollard



Safety in practise

NPSA throat pack alert

In April this year the NPSA published the results of its multidisciplinary investigation into problems with throat packs. (RCoA 19, CODP17, AfPP 6, RCN 3).

1. The size of the RTP problem:
 - a. 24 month NPSA data: 24 RTP, 5 with airway obstruction (<1:10⁶)
 - b. 10year NHSLA data: 2 claims against NHS related to RTP
2. Many reasons for RTP:
 - a. 'Surgeon said it had been removed'
 - b. Additional packs placed during surgery
 - c. Unexpectedly rapid awakening
 - d. Change of anaesthetist
 - e. Fatigue, distraction
 - f. Whole team forgot

Summary recommendations

- *At least two* of listed procedures listed below should be used because no single method is risk free.
- Other procedures that are already in use locally should be subjected to risk assessment. If the method is found to be safe, it may be selected as one of the chosen local procedures.
- The working party does not endorse labelling of the anaesthetic machine, because it is not specific to individual patients, and the label remains in the operating theatre after the patient has left the theatre with or without the throat pack *in situ*.

Procedures involving visual checks:

- Label or mark patient:
 - either on the head;
 - or, exceptionally, on another visible part of the body with an adherent sticker or marker.
- Label artificial airway (for example, tracheal tube or supraglottic mask airway).
- Attach pack securely to the artificial airway.
- Leave part of pack protruding.

Procedures involving documentary checks:

- Formalised and recorded 'two-person' check of insertion and removal of pack.
- Record insertion and removal on swab board.

Use WHO Surgical Safety Checklist (adapted for England and Wales):

Consider local adaptation of Checklist to include throat packs if appropriate

Dental Sedation- Who is responsible?

Dr Yusof (Joe) Omar

MBBCh, DA, MRCA

Hon Lecturer in Sedation, Eastman Dent Inst, UCL



This presentation looks at the responsibilities of the Dentist, the Sedationist and the Nurse in looking after the sedated patient.

Studies show that up to fifty per cent of the population are anxious, nervous or phobic about dental treatment and would rather stay away. The GDC demands that we "Respect patients' dignity and choice" and in the presenter's view choosing to have sedation should ultimately be up to the patient and not the dentist. Having said that, most phobic patients desire oblivion during sedation and it is the responsibility of the Sedationist and the Dentist to ensure that the patient remains conscious throughout.

Further points to consider regarding responsibilities are *Pre op assessment*, *Consent*, provision of an *Escort*, *Drugs and equipment*, the *Airway*, *Post op care* such as analgesia, bleeding and infection. The nurse has particular responsibilities regarding aspirating correctly and diligently.

The presentation is concluded with a Case study during which the audience is invited to offer answers to common dilemmas emanating from a real life case.

Is blind nasal and awake fibreoptic intubation a core skill of the Dental Anaesthetist and Sedationist?

Dr Diana Terry Consultant Anaesthetist



Recent Professional governance has focussed on how skills and knowledge are acquired but also maintained during clinical practice. Patients presenting for Dental treatment are recognised to present particular challenges in airway management for the Dentists and Doctors undertaking their care.

In recent years the incidence of complaints has risen dramatically, and the expectations of patients have been raised by political agenda in healthcare, and concern about adverse incidents which have been made public. It is therefore important that as leaders, trainers and specialists in dental anaesthesia, we set out clear guidance as to what standards and skills are expected.

What are the core skills?

- The curriculum for training is agreed by the Royal College of Anaesthetists and the Faculty of Dentistry of the Royal College of Surgeons, and with the Association of Anaesthetists of Great Britain and Ireland, the delivery and quality assurance of airway skills is delivered.
- The General Medical Council and General Dental Council, set out clear requirements detailing the duties of practitioners to deliver safe care and to be suitably trained and expert.

The Indemnity Organisations issues clear guidance as to standards of practice that are expected.

In Dental Anaesthesia and sedation, there can be tricky airway situations which require the practitioners to have a range of airway skills to hand. Dental airway management may be complicated by obesity, poor patient cooperation, and psychological factors. All professionals are expected to be competent at skills such as bag-valve-mask ventilation, but worryingly there are many examples of poor practice illustrated on the internet, and some evidence that this skill is not often delivered effectively.

Blind nasal intubation for anaesthesia has lost popularity in recent years with the advent of new drugs and improved apparatus for viewing the glottis- without experienced trainers to pass on their skills, it is unlikely that younger practitioners would feel confident to undertake blind nasal intubation. There may be a place for skills that do not require expensive or rarely used equipment.

Advances in fibreoptic apparatus has enabled this to be a routine technique for all anticipated difficult airways, and is a mandatory skill for all trainee Anaesthetists. However, the equipment is expensive, requires careful maintenance, and skills rapidly deteriorate unless practiced at regular intervals. So what is the Dental Anaesthetist to do? Current guidance is best summarised by the publications from the Difficult Airway Society (DAS)

What about those whose practice in Dental Sedation; what are the core skills?

There have been many expert reports since the Poswillo report, addressing what is realistic for practitioners delivering Dental Conscious Sedation, where by definition, there should be no loss of airway or need for the invasive interventions of tracheal intubation. It is up to each Dental team to agree the standards for airway management which currently pertain and ensure skills and knowledge are maintained. So, whatever your team does, it should do it well and providing;

- Evidence of training
- Evidence of quality assurance

- Current practice and standards
- Risk assessment record keeping

In summary, your prime duty to keep the patients safe, is to examine the total patient journey and the skill set within the team to manage both the expected and the unexpected airway challenges of the dental patient.

You must be confident you have the skills and knowledge to manage and risk assess;

- Sedation techniques
- Operation challenges
- Operator sedationist issues
- Patient assessment and education
- Team training
- Emergency procedures

So to answer the question of which techniques should the Sedationist or Dental Anaesthetist should be able to demonstrate competency, I would argue that each professional should weigh the evidence above.

Diana Terry

October 2009

References can be obtained from the following links

www.das.uk.com	Difficult airway society
www.library.nhs.uk	Current evidence and educational resource
nap4.das.uk.com	Latest National Audit of airway complications
www.rcoa.ac.uk	Royal College of Anaesthetists
www.gmc-uk.org	General Medical Council
www.gdc-uk.org	General Dental Council
www.saad.org.uk	SAAD



Dr Ken Ruiz and Dr
Diana Terry at the
Annual Conference
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