

Chairman's Report 2009



Dr Lesley Longman
DSTG Chairman

I am thrilled (and a little bit anxious) to take up the post of Chair of DSTG. DSTG has a history of dynamic and progressive chairpersons so I hope that I can be as effective as those that have held this office before me. DSTG has achieved much in its short history and is nationally recognised as an authoritative body within dental education. It is my role, like past Chairs, to ensure that we maintain this position within dentistry. It is also important that we are recognised within the broader medical and surgical communities who use sedation. This process is ongoing and our presence at the first meeting of The Conscious Sedation Forum held in March 2009 and organised by the Royal College of Anaesthetists was beneficial to DSTG's profile. DSTG is now a member of the International Federation of Dental Anesthesiology Societies (IFDAS) it is hoped that this will also raise the profile of the group. In order to guide DSTG I need to listen to the views of both the Committee and the membership. I would therefore be grateful if you would email me any vision, strategy or plans that you have and feel are appropriate for DSTG. Now seems to be a good time to be reminded of the aims of the group as these should be foremost in our minds and

should shape the future direction of DSTG. The aims of our group are as follows:

- To improve standards of teaching of conscious sedation in dentistry.
- To act as a point of reference on matters of dental sedation.
- To continue to develop a common curriculum in sedation.
- To encourage the practice of sedation in all branches of dentistry.
- To exchange ideas on practice and research in the field of conscious sedation in dentistry.

I would like to thank Professor Paul Coulthard, the immediate past Chairman, for his leadership during his term of office; it was a pleasure to work with Paul in my role as Secretary to DSTG. I would also like to thank Chris Dickinson who has spent many hours updating our membership database. He has modernised and streamlined the system so that it is now more accurate, user friendly and responsive to changes within the membership. Chris's role as honorary treasurer has also kept him busy and he remains an excellent advocate for all the membership in terms of all matters fiscal to DSTG. Chris carries out his two onerous roles with exceptional dedication and attention to detail and I am therefore delighted that he is serving another term of office as Honorary Treasurer and Membership Secretary.

I would like it noted in this newsletter that the Committee of DSTG is sincerely grateful to Steve Jones who has quietly

served the group over the years by producing excellent meeting reports that have been published in the annual newsletters. Steve did this without any honorarium or arm-twisting. His service has been remarkable and DSTG have sent Steve a small gift to say thank you for his sustained hard work in producing the meeting reports.

School representatives have been up for election this year and this has resulted in new faces on the Committee. Welcome to Cathy Bryant (Kings College Hospital), Robert McGeogh (Barts and the London) and also to Angela Magee (University of Central Lancashire) and Paul Brady (University College Cork). Angela and Paul's Dental Schools are being represented for the first time on DSTG. I would like to thank Professor Phil Rood and Dr Chris Mercer who have represented their respective schools over the past few years for their contributions to DSTG. Phil has represented both Manchester and Kings on DSTG and is known for his plain speaking and sound advice.

I would like to thank Chris Bell and his team for organising a successful annual Symposium in Bristol this April. The program was varied and informative. Moreover the two days were enjoyable. Organising a symposium is a difficult and time-consuming business. DSTG's task is made

Inside this issue:

<i>DSTG Annual Symposium 2009</i>	2
<i>Symposium Abstracts</i>	6
<i>Annual Symposium 2010</i>	7
<i>Committee Members 2009</i>	8

more difficult by the fact that the topic of sedation education is quite narrow, in addition study leave is getting more difficult to justify and the economic downturn adds to the uncertainty of numbers attending conferences. Despite these problems DSTG has a record of delivering excellent symposia and I am sure that the annual conference Mary Clarke (Honorary Secretary) is organising in Dublin for the 14th and 15th of May 2010 will be well worth attending. The famous Irish welcome will be assured and the conference could easily be linked to a weekend break in Dublin or the surrounding area. I do hope that you can come to Dublin and look forward to seeing you there.

Lesley Longman
DSTG Chairman

Diary Date

**Annual DSTG Symposium
Dublin**

14 - 15 May 2010

Details on page 7

DSTG Annual Symposium

The Education Centre Bristol Royal Infirmary

24 - 25 April 2009

Dr Sandra Zijlstra-Shaw

This year's DSTG Symposium was held in Bristol, once one of the most important trading ports in England and now home to the BBC's world famous Natural History Unit, Aardman animations (creators of Wallace and Gromit) and Deal or No Deal!

At this year's Symposium there were sessions devoted to Governance, teaching, research and practice, thus echoing Bristol's claim to provide something for everybody.

Chris Bell, the local organiser, welcomed us to Bristol and thanked everyone for coming, before chairing the first session, "Patient Assessment and Contracts".

The first speaker was Dr Roger Yates, Consultant in Restorative Dentistry at Bristol Dental School, which was only around the corner from the symposium venue. Dr Yates led us through the ups and downs of setting up a restorative sedation teaching service at Bristol Dental School. He explained that he discovered a lack of any service between conventional delivery of restorative treatment and treatment under general anaesthesia. Furthermore the GDC inspection report in 2003 noted that undergraduates received little experience in sedation, which isn't surprising as one of the general recommendations from the 2003-5 visitation report is that "The teaching of

conscious sedation needs to be reviewed, in order to increase students' hands-on experience before graduation".

Roger went on to explain how he had used the opportunities provided by the increase in student numbers, the changes in the NHS contracts and a curriculum review within his five year plan to develop and deliver a restorative sedation programme for the undergraduates. He explained that he encountered problems with allocation of chair space and time, but that the biggest obstacle was related to the "Mystery" surrounding sedation, most colleagues who didn't understand sedation thought it was either inappropriate or dangerous. He went on to address the needs of the course which included a teaching site with the appropriate facilities, appropriately trained staff and a pool of suitable patients. He found one area of the clinics which was underutilised, looked for staff across the whole hospital and found sedation trained staff in restorative, oral surgery and oral medicine and found a dozen sedation certified dental nurses. Roger pointed out that sometimes you would need to "borrow" staff from different departments. Much of the teaching is done using a "Blackboard" based electronic learning environment in conjunction with the practical sessions. He took advice on staff:student ratios and discovered that a ratio of 3

staff to 5 student pairs allowed for maximum flexibility and safety. Roger also emphasised the need for good nursing support.

The patients were fed through from consultant clinics and often came through Oral Surgery; they were generally dental phobics, ASA II/III, drug abusers or alcoholics. A large group of patients is needed as getting them to turn up to appointments is not easy, in fact, Roger's staff telephone them 2 days before to confirm the appointment.

Despite presenting his plan in 2006 with a view to beginning in September 2007, modifications were needed and the course began a year later, since when he has received very good feedback from the students. Roger concluded by stating that sedation experience was vital for undergraduates and that it must be protected. A thought echoed by all those present.

Chris Bell then introduced the next speaker, Dr Michael Allen who runs a Specialist Sedation Referral Practice in Monmouthshire and is also a Lecturer in Sedation and Special Care Dentistry, and Postgraduate Trainer in Conscious Sedation at University Dental Hospital, Cardiff.

Once again the theme was ups and downs, this time we were treated to Dr Allen's description of his experiences of setting up a primary care sedation service. Using a cinematic theme, which included; a "Tale of Two PCOs", "Close Encounters", "The Good, The Bad and The Ugly", "Hannah and Her Sisters" and finally "Touching the Void" Michael took us on the journey from before the arrival of the New Contract in April 2006 to the present day.

Michael began by describing his original practice in Cardiff where he had provided a sedation service for 12 years, however the new contract arrived and there was no provision for sedation at all! The Cardiff Local Health Board expected him to provide this treatment at no extra cost to themselves.

Michael had previously tried to set up a practice in Monmouthshire and had received a favourable response from the Local Health Board. Despite this plan stalling due to the imminent arrival of the New Contract, he went back to reopen discussions with them. This time they awarded him a contract which did include provision for sedation in Abergavenny. However the premises which he had chosen were considered too rural, so it was back to the drawing board again.

Michael explained how he had contacted Paul Averley, who provided him with lots of advice and this helped him become better equipped to enter into further discussion with the LHB about allocation of UDAs and performance monitoring.

Suffice to say, the practice is now up and running and becoming more successful each year. Michael not only provides a sedation service but has become the "gatekeeper" for all but emergency treatment under GA in the area and now has training places for both postgrads based at Cardiff and for dental nurses who want to take the NEBDN qualification in conscious sedation. Local GDP support and patient satisfaction is very high and there are plans to increase the service to include a DwSI Oral Surgery provision.

Michael concluded by reminding us that perseverance can pay off. You really need to educate PCOs who are usually

not aware of the increasing need for a sedation service, he suggested that you need to present an unanswerable case using literature and papers as evidence. This way you can remind the PCO that GA is riskier, more expensive and solves little for the patient's future care.

Chris Bell, continued this information packed morning by introducing the next speakers, Dr Martin Sasada, Consultant Anaesthetist Bath RUH and Specialist Referral Sedation Clinic and Dr Ian Skerrat a dental practitioner who runs a sedation referral practice with Dr Sasada. Their presentation "Clinical governance and the PCT, High BMI patients and Recreation Drugs" was brave and salutary, leaving many of us with the "There but by the grace of God" feeling.

Dr Sasada and Dr Skerrat began a GA referral service for both adult and child patients which was primarily NHS funded and for minor oral surgery procedures about 15 years ago. Over the years this had become a sedation referral service and they had developed an excellent relationship with the local secondary referral centre at Bristol dental Hospital. An increasing number of their patients were drug abusers, and what started out as a trickle of patients from a rehabilitation unit who arrived with good supervision rapidly became bus loads without! This led to a number of problems including physical attacks on the practice staff and increasing concerns about the levels of post-op care provided for this group of patients which finally culminated in the death of a patient during the aftercare period following sedation. These circumstances led to the decision by Dr Sasada and Dr Skerrat to withdraw their service from drug abusers and so they contacted their PCT who informed them that if they did they would be in breach of

their terms of service. Thus they contacted the BDA (who suggested they should use LA only). The matter was also discussed in SAAD Council. They continued to discuss the problem with the PCT until a second death during the aftercare period occurred. Finally the PCT agreed to the suspension of the service whilst they investigated alternatives.

This resulted in the practice having to notify GDPs in the area about the change to their referral acceptance criteria. One would imagine that this was the end of the matter, however one helpful GDP then wrote anonymously to the GDC accusing the practice of discriminating against a group of patients on the grounds of a medical condition. The GDC then referred Dr Skerrat to the Fitness to Practice committee who, having read the robust defence and discovered how conscientious and thorough the partners had been, dismissed the case.

What the anonymous G.DP (and many more of us) don't realise is how highly volatile cannabis users can become under benzodiazepines. They can become violent or psychotic and most centres now insist that patients must refrain from cannabis use for at least 4 weeks before treatment under sedation.

The other group of patients Dr Sasada and Dr Skerrat find unsafe to treat in a practice situation are patients with morbid obesity. Patients with a BMI above 40 are either only treated under L.A. or are asked to lose weight, or are recommended to be seen in hospital with an overnight stay. The airway management of these patients is a particularly important issue and these patients are now treated at Bristol Dental Hospital where a consultant anaesthetist led sedation service is available.

Chris Bell thanked Dr Sasada and Dr Skerrat for taking time out of their busy schedule to talk to us. During questions he not only confirmed that there was a very good working relationship between Bristol Dental Hospital and their practice, but also that he was now treating many of the patient group they had previously treated and that this group of patients were causing difficulties and damage to Bristol Dental Hospital. This led him into the introduction of Sally Lewis a nurse practitioner working specifically with drug abusers in the Bristol area.

Sally then continued with her presentation "Addiction the Drugs and the Patient's Perspective". She began by explaining that the research on why people became drug addicts was ambivalent. There was no evidence of causative factors, but some protective factors could be seen in the literature. These included a supported childhood with a strong adult figure and regular school attendance. Sally then used a case description to give us insight into the world of a typical drug abuser. Unhappy children are vulnerable children, this leaves them open to abuse which only increases the unhappiness and often leads to the child being taken or put into care because the

parent(s) can't or won't look after them. This situation is worsened by the lack of people willing to adopt or foster older children and results in young adults who feel unwanted. Many teenage girls in these circumstances are introduced to drugs by their "boyfriends" and enter prostitution, often earning to supply drugs to both themselves and the "boyfriend". Finally her life becomes so unbearable she is faced with the question "Is life as a drug addict better than nothing?". When this leads to a suicide attempt, she then faces hostility from staff in the A & E department.

Sally notes at this point that whilst society has empathy for the children in this situation there does not seem to be any available for adults. She explained that during her work with drug abusers she encounters more problems with people's attitudes towards the users than with the users themselves. Her advice is simple – positive attitudes towards these people can change lives for the better, negativity and a judgemental attitude just makes things worse.

Chris Bell then led a lively questions session during which we all discovered that Cannabis farming is one of the world's great successes in



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Submission deadline 31 December 2009

Dental Student's Essay Prize **£300**

Dental Nurse's Essay Prize **£300**

Submission deadline 31 March 2010

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Dr Chris Dickinson, Dr Lesley Longman and Dr Mary Clarke

genetic modification. There has been an increase in THC in modern cannabis plants from 5% to 35% such that any further increase would actually kill the plant! This results in a drug which gets into the central nervous system much more quickly, has many more drug interactions, especially in the liver and can take up to 100 days to clear from the system. Sally also suggested working with local drug support teams when trying to provide a service to drug users as they could provide advice on general management (eg failed appointments) and members of these teams were often very happy to provide this advice.

Just before we went into the AGM and on to lunch Chris Dickinson asked members of DSTG to confirm their entries in the society's membership data base as he was trying to update it (if you weren't able to, maybe you would like to confirm your details by e-mail).

The afternoon session was ably chaired by Dr Lesley Longman, Clinical Lead for Sedation and Special Care Dentistry, Liverpool University Dental Hospital secretary DSTG and Chairman elect.

She introduced Colette Bridgman, Consultant in Dental Public Health and Professor Paul Coulthard Chairman DSTG, Professor of OMFS & Director of Graduate Education & Research, The

University of Manchester who explained their work towards developing an Indicator of Sedation Needs. They explained that this was as a response to the challenge set by Tony Jenner at last year's symposium, when he suggested that as a group we should assess the need for sedation services in order to put our case towards Service Commissioners and thus manage our own futures. They pointed out that whilst we were all aware that access to a sedation service was generally based mainly on local availability, resources should be available based on informed decisions with regard to the effective use of sedation resources, the equitable provision of care, a responsive access to specialist service and the development of care pathways for anxious patients.

Having briefly outlined current NHS structure, the role of PCTs (PCOs), and the World Class Commissioning Assurance system Colette and Paul went on to explain that within this system the care being delivered should be needs led and focused on outcomes. However, a good enough measure for sedation need is not available and therefore these factors cannot be assessed.

Paul then went on to explain the system they had been piloting. This system was based on a combination of three factors, Anxiety Score (using the modified dental anxiety scale), Medical History

(includes consideration of age and special conditions) and Treatment Complexity. These were combined to produce a score which could then categorise the patient into minimal, moderate, high or very high need. Finally a decision, now based on the needs of the patient, could be made about future treatment management which could be under LA alone or with behavioural management or with sedation in either a primary, or secondary care situation or even GA.

Obviously this presentation resulted in a very lively discussion and Paul was delighted to take members' views to enhance the future development of IoSN. Firstly, in answer to a question from David Craig, Paul emphasised that this scale would be further piloted, but the 2 small pilots already carried out had found it useful. Useful information from the floor included the fact that needle phobics were often not picked up by these types of scales and the need for sedation in some circumstances in order to prevent patients developing dental phobia would probably not be assessed either. The need to increase patient input into the index was also suggested, to which Paul replied that work to do just that had already commenced. The audience was certainly positive about this development.

Lesley Longman then introduced David Wragg, from City of Bristol College who explained about their Preparing to Teach: City & Guilds 7303 course. This course was available to anyone with a subject-specific qualification who wanted to try teaching. The course was designed as a part time flexible blended learning module of 30hours. The course covered managing behaviours, roles and responsibilities, record

keeping, assessing, legislation (mainly covering diversity) key skills (e.g. communication). It is a very practical course where students were expected to write a scheme of work, write lesson plans, do a 30 minute micro-teach on the subject of their choice which they evaluate (to encourage reflection) and keep a journal. Assessment on the course used a variety of techniques, for example written assignments, poster making and the use of Blackboard. David explained that there had been over one thousand students through the course whose feedback was positive. The course was designed as a taster but could also be used to progress onto an advanced course where teaching experience would be essential. As she rounded up the questions, Lesley Longman summarised this "Preparing to Teach in the Lifelong Learning Sector" course as being one which might be useful to encourage dental nurses to enable them to develop their careers teaching for example their own sedation skills to other dental nurses.

We all took a well earned tea break before returning to the final session of the day, ably chaired by Mary Clarke, Specialist in oral surgery/lecturer in sedation Dublin Dental School and secretary elect DSTG. This session was the five free papers and included three from Cardiff, which I was assured, is a beautiful scenic trip away from Bristol! Dr Steve Woolley, a Clinical Research Fellow from Cardiff, began with a paper entitled "Paediatric conscious sedation: views and experience of Specialists in Paediatric Dentistry" in which he argued that sedation training should be part of the core training for specialists in paediatric dentistry.

This was followed by a presentation by Anjali Kandiah

an SpR in Paediatric Dentistry at Leeds Dental Institute. Anjali explained how, having assessed the need using an audit, an IV sedation service was set up for children aged 12+. She reminded us that this was an especially difficult age group as many of them have already had an experience in the dental chair which led to their phobia. Her interesting paper led to a number of questions which revealed that both Kings and Dublin Dental Hospitals provided sedation services to 12-16 year olds which they found very successful and had cut the need for G.A services in this group of patients.

Sonita Koshal from King College Dental Institute then outlined their study of hypertension in patients attending their Oral Surgery department. The study revealed a significant prevalence of undiagnosed and poorly controlled hypertension in the general population. The group also concluded that there was a "clear indication for use of IV midazolam for oral surgery procedures in patients with a high BP recording at pre-assessment, irrespective of the degree of patient anxiety or complexity of the surgical procedure" (which, incidentally, we might want to note as part of IoSN). A lively discussion followed this interesting paper.

The next paper described an audit of consent at the sedation unit at the School of dentistry in Cardiff. Dr. Shelagh Thompson gave a very open and honest presentation on behalf of the audit team. She pointed out that we all believed that consent was important and that we followed the correct procedure all the time, the central question was "Do we?". At the point when she suggested that the patient's copy wasn't always given to the patient, I remembered running down two flights of

stairs to hand one of my patients her copy as she had left the surgery without it, and that was only a couple of days before the Symposium. I am sure we would all agree with her conclusions that the Consent Form is complex and time consuming and that redesigning the form with a simpler layout would improve the situation.

Finally we heard Dr Steve Woolley *again* (his word not mine). This time Steve presented "An Audit of Referrals to a Secondary Care Sedation Unit". Now if the title looks familiar, that's because the paper had now been published in the British Dental Journal (Mar 2009; 206(5):E10). Steve had discussed whether he should present the paper now that it had been published, but Chris Bell had assured him we would be disappointed if he didn't and the lively discussion at the end just demonstrated how right Chris had been.

This rounded off a busy and informative day and we were then able to find our accommodation and explore the further delights of Bristol.

Chris Dickinson, Consultant in Special Care Dentistry, Kings College London, treasurer and membership secretary DSTG, welcomed us all to the second day of the symposium and introduced Professor Tim Newton, Professor of psychology as applied to dentistry at Kings College Dental Institute in London. Tim is now a TV star having appeared on BBC's "The One Show", he received the 2007 Gidden award for his work on self-perceived oral health and is also Chairman of one of the charities for eating disorders.

Tim, in his own inimitable style, described the psychological methods used to treat dental phobics at Kings College. Leading us through a



*Update your details,
contact Chris at
chris.dickinson@kcl.ac.uk
ASAP!*

description of phobias and anxiety, Tim explained how cognitive behavioural therapy could be used to help dental phobics and how they had developed a model, using computerized CBT to create a patient pathway for extremely anxious or phobic patients which Kings hoped could then be more widely used. At the moment patients were able to be either treated using CBT or using sedation, but the team at Kings was hoping to develop a trial in which highly phobic patients could be given CBT to help them receive treatment under sedation. Questions about dropout rates (variable stages in the process and for different reasons), cost (expensive but did free up sedation slots and you could train dental nurses or Hygienist/therapists to give the CBT) and patient care pathways abounded. Chris Dickinson, fortunately ever mindful of resources, was able to round off the session on time and sent us all for coffee.

The final session was chaired by Nigel Robb, Senior Lecturer in Sedation in Relation to Dentistry / Honorary Consultant in Restorative Dentistry, Glasgow Dental Hospital and President elect of SAAD council. Nigel had ensured that we each had a précis of the Rapid Response Report on midazolam sent out by the NHS in December 2008. The report asked for a response

to be lodged by June 2009 and Nigel was concerned that the Dental Profession should produce a considered response to this issue. Nigel had broken down a possible response into four main questions; How do we risk assess sedation in a dental setting? What are the risks of changing to a new formulation? Do we need a written protocol, (or would that be making a rod for our own back)? Who should be the responsible clinician? (Bearing in mind the report suggests a consultant anaesthetist).

These questions were discussed in the breakaway groups and the results reported back to the meeting. Nigel then promised to collect all the results and produce a document in response to the report. Further details of this will be available from DSTG.

This lively discussion ended a very fruitful and successful meeting. Our thanks must go to Chris Bell and his team for looking after us so well. The thought that next year's symposium was to be held in Dublin only increased our enthusiasm to put this date in our diaries.

Symposium Abstracts

DSTG Annual Symposium

The Education Centre, Bristol Royal Infirmary

24 - 25 April 2009

Paediatric conscious sedation: views and experience of Specialists in Paediatric Dentistry

Steve Woolley

Objectives.

The objectives were three-fold: to investigate the level of conscious sedation training received prior to and during specialist training in Paediatric Dentistry; to establish the use of conscious sedation during and following specialisation and to determine the attitudes of specialists in Paediatric Dentistry to conscious sedation.

Subjects and methods.

A self-administered postal questionnaire was sent to all Specialists in Paediatric Dentistry registered with the General Dental Council in January 2008. Non-responders were contacted again after a four-week period.

Results.

A response rate of 60% was achieved. Of the 122 respondents, 67 (55%) had received sedation training as an undergraduate; 89 (75%) had been trained during specialisation. All respondents performed dental treatment under sedation as a trainee and the majority used nitrous oxide inhalation sedation (NOIS). Over 90% respondents felt that NOIS should be available to all children, both in appropriate primary care settings and in hospitals. One hundred and twenty-one (99%) respondents thought that all trainees in paediatric dentistry should have sedation training.

Conclusions.

The most popular form of sedation amongst Specialists in Paediatric Dentistry was NOIS. However, some of the respondents felt that children should have access to other forms of sedation in both the primary care and hospital setting. Additional research on other forms of sedation is required to evaluate their effectiveness and safety.

An Audit of Referrals to a Secondary Care Sedation Unit

Steve Woolley

Aims and Objectives

This audit was carried out to assess referrals received by a clinic treating anxious patients within a dental hospital setting. The audit aimed to provide a baseline measurement prior to the publication of a referral protocol. Referral frequencies were examined to explore the concept of 'serial referrers'.

Methods

A retrospective design was used. The referrals of all patients given assessment appointments for treatment within the Sedation Suite between 1st January and 31st December 2006 were examined. In addition, a random sample of 100 cases was examined for the referral request.

Results

Three hundred and six referrals were sent assessment appointments by the Sedation Suite in 2006. The majority of referrals received (76.1%, n=233) were from practitioners working in the General Dental Services. On average 1.68

referrals were received per clinician, with a maximum of 18 referrals from one clinician. The majority of patients were female and had an average age of 33.5. One hundred and eighty seven patients attended for assessment. One hundred and forty three (46.7%) were treatment planned to receive treatment with pharmacological help. Twenty two (7.2%) were planned to receive treatment without pharmacological help, though none of the referrals received had considered requesting behavioural management.

Conclusion

This audit confirmed results from previous audits. The standards set for referral were not met. Despite the efficacy of psychological treatments, referring clinicians do not seem to consider their use for anxious patients. Referral patterns seemed to support the idea that a minority of practitioners refer significantly higher numbers of patients than their peers.

Setting up an IV Sedation Service for Adolescent Patients at the Leeds Dental Institute

Anjali Kandiah

Aims

Adolescent patients are infrequently offered the option of IV Midazolam sedation, by paediatric dentists. This may be related to training issues as well as lack of resources. In this article we will discuss the setting up of an IV sedation service for the adolescent patients at the Leeds Dental Institute (LDI).

Design

An Audit carried out in Dec 2007 at the LDI suggested that over 24% of paediatric patients on the GA waiting list for comprehensive care may have been suitable for IV sedation. In response to that, an IV sedation service for the older

child was set up.

Participants

All new patients referred to the paediatric department are assessed on the consultant clinics. Suitability for IV sedation would be carried out by the clinician.

Results

The service was set up in December 2008. Thus far, three patients have been successfully managed under IV sedation. Results:

- Age range: 15-16 years old
- ASA I-II
- Dosage of Midazolam: 5-10mg
- Modified Anxiety Score: 4-5
- Frankl Score during treatment was either + or ++

Conclusion

As paediatric dentists we should be able to offer all reasonable forms of pain and anxiety management options to our patients. IV sedation for the older child is an important treatment option that should be considered.

Investigation and management of hypertensive patients attending the oral surgery department at Kings College Dental Institute.

Sarah Woolcombe and Sonita Koshal

Aims of the study are to:

- Determine the prevalence of undiagnosed / poorly controlled hypertension
- Create a standardised system for GP referral
- Study the demographics of this population
- Assess the degree of "white coat" hypertension
- Study the effects of IV midazolam on peri-operative blood pressure and pulse.

A major goal of the study is to determine successful methods for the safe management of patients with hypertension. In such patients, where treatment under LA would generally be contraindicated, IV sedation appears to be a useful adjunct. Therefore our aim was to investigate its role in lowering and controlling blood pressure in hypertensive patients.

The study was carried out from September to November 2008. Patient BP & pulse were checked at pre-assessment. Patients with BP > 160/100 were then directed for surgery with two designated clinicians (SW, SK). Oral surgery treatment was then prescribed under IV sedation with midazolam unless contra-indicated. BP & pulse was monitored throughout the procedure. Patients also advised to attend their GP, and visit outcome requested.

Results indicated a total of 83 patients had BP > 160/100 at pre-assessment between September and November 2008. (73% no history of previous hypertension)

Conclusions:

- High prevalence of undiagnosed and poorly controlled hypertension in the general population
- BP screening in dental setting is a valuable method for identifying potentially hypertensive patients who may not otherwise attend GP
- "White coat" hypertension significantly greater in oral surgery department than at GP surgery
- Clear indication for use of IV midazolam for oral surgery procedures in patients with a high BP recording at pre-assessment

- Indication is irrespective of degree of patient anxiety or complexity of surgical procedure.
- Dramatic reduction & control in raised blood pressure with the use of IV midazolam, therefore indicating its usefulness as an adjunct to oral surgery in these medically compromised patients.

Sedation Suite , School of Dentistry, Cardiff University
Shelagh Thompson

Informed consent is required from all patients. Without it, dental treatment technically and legally is an assault. Therefore, prior to providing treatment for any patient it is essential to involve them in the decision making and treatment planning in order that they may give their consent to treatment. Obtaining informed consent for dental treatment is a fundamental, ethical, and legal responsibility of all clinicians. Competent adults have the right to give or withhold their

consent to treatment. King *et al* described the stages to the consent process as; initial introduction, explanation of the problem, outlining the treatment options, explaining the risks and benefits, estimating time and cost, inviting questions, reaching mutual understanding, confirming the choice and indicating consent.

The General Dental Council considers that informed consent requires patients to receive sufficient information of their condition to enable them to make a balanced judgement based on options, risks and benefits of the proposed treatment and any alternatives. To ensure the adoption of a consistent approach when seeking consent the NHS introduced a universal consent policy and consent forms.

Informed consent should: -

- provide the patient with information of the nature and purpose of the procedure and include the risks, benefits and alternatives

- ensure the patient understands the information given
- ensure the decision is made by the patient and that the agreement is voluntary

Aim

To audit retrospectively current patient record cards for presence of correct consent documentation.

Objectives

- To review the recent literature regarding patient consent for patient receiving treatment under conscious sedation
- To set a standard for obtaining and documenting patient consent
- To review the documentation of consent in a random sample of current patient record cards.
- To record the results onto a data collection sheet
- To analyse the results and identify weak areas
- To consider how to make and implement improvements



Dental Sedation Teachers' Group

Annual Symposium 2010

Friday 14th May 2010

and

Saturday 15th May 2010

Dublin

Venue to be confirmed

www.dstg.co.uk

Committee Members 2009

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The opinions expressed in this and previous Newsletters are those of the authors and are not necessarily those of the Editor or of the Dental Sedation Teachers Group.

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