Nevada State Board of Dental Examiners
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CONSCIOUS SEDATION
INSPECTION AND EVALUATION

☐ ON-SITE/ADMINISTRATOR	☐ SITE ONLY	
Name of Practitioner:	Proposed Dates:	
Location to be Inspected:	Telephone Number:	
Date of Evaluation:	Time of Evaluation:	
	Start Time:	Finish Time:

Evaluators

1.
2.
3.

INSTRUCTIONS FOR COMPLETING CONSCIOUS SEDATION ON-SITE INSPECTION AND EVALUATION FORM:

1. Prior to evaluation, review criteria and guidelines for Conscious Sedation (CS) On-Site/Administrator and Site Only Inspection and Evaluation in the Examiner Manual.

2. Each evaluator should complete a CS On-Site/Administrator or Site Only Inspection and Evaluation form independently by checking the appropriate answer box to the corresponding question or by filling in a blank space.

3. After answering all questions, each evaluator should make a separate overall "pass" or "fail" recommendation to the Board. "Fail" recommendations must be documented with a narrative explanation.

4. Sign the evaluation report and return to the Board office within ten (10) days after evaluation has been completed.

SITE INSPECTION

OFFICE FACILITIES AND EQUIPMENT	YES	NO
1. Operating Theater		
a. Is operating theater large enough to adequately accommodate the patient on a table or in an operating chair?		
b. Does the operating theater permit an operating team consisting of at least three individuals to freely move about the patient?		
2. Operating Chair or Table		
a. Does operating chair or table permit the patient to be positioned so the operating team can maintain the airway?		
b. Does operating chair or table permit the team to quickly alter the patient's position an emergency?		
c. Does operating chair or table provide a firm platform for the management of cardiopulmonary resuscitation?		
3. Lighting System		
a. Does lighting system permit evaluation of the patient's skin and mucosal color?		
b. Is there a battery powered backup lighting system?		
c. Is backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure?		
4. Suction Equipment		
a. Does suction equipment permit aspiration of the oral and pharyngeal cavities?		
b. Is there a backup suction device available which can operate at the time of General power failure?		
5. Oxygen Delivery System		
a. Does oxygen delivery system have adequate full face masks and appropriate connectors and is capable of delivering oxygen to the patient under positive pressure?		
b. Is there an adequate backup oxygen delivery system which can operate at the Time of general power failure?		
6. Recovery Area (Recovery area can be operating theater)		
a. Does recovery area have available oxygen?		
b. Does recovery area have available adequate suction?		
c. Does recovery area have adequate lighting?		
d. Does recovery area have available adequate electrical outlets?		
7. Ancillary Equipment in Good Operating Condition?		
a. Are there oral airways?		
b. Is there a tonsilar or pharyngeal type suction tip adaptable to all office outlets?		
c. Is there a sphygmomanometer and stethoscope?		
d. Is there adequate equipment for the establishment of an intravenous infusion?		
e. Is there a pulse oximeter?		

SITE INSPECTION

DRUGS	**DRUG NAME**	**EXPIRES**	**YES**	**NO**
1. Vasopressor drug available?				
2. Corticosteroid drug available?				
3. Bronchodilator drug available?				
4. Appropriate drug antagonists available?				
5. Antihistaminic drug available?				
6. Anticholinergic drug available?				
7. Coronary artery vasodilator drug available?				
8. Anticonvulsant drug available?				
9. Oxygen available?				

RECORDS **–** Are the following records maintained?	**YES**	**NO**
1. An adequate medical history of the patient?		
2. An adequate physical evaluation of the patient?		
3. Sedation records show blood pressure reading?		
4. Sedation records show pulse reading?		
5. Sedation records listing the drugs administered, amounts administered, and time administered?		
6. Sedation records reflecting the length of the procedure?		
7. Sedation records reflecting any complications of the procedure, if any?		
8. Written informed consent of the patient, or if the patient is a minor, his or her parent or guardian's consent for sedation?		

Evaluator Overall Recommendation of Site Inspection

☐ Pass ☐ Fail ☐ Pass Pending*

If Pass Pending please list all deficiency's

Comments: _____

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_____ _____

Signature of Evaluator Date

EVALUATION

DEMONSTRATION OF CONSCIOUS SEDATION	**YES**	**NO**
1. Who administered conscious sedation? Dentist's Name**:** _____		
2. Was sedation case demonstrated within the definition of conscious sedation?		
3. While sedated, was patient continuously monitored during the procedure with a pulse oximeter? If not, what type of monitoring was utilized? _____		
4. Was the patient monitored while recovering from sedation? Monitored by whom**:** _____		
5. Is this person a licensed health professional experienced in the care and resuscitation of patients recovering from conscious sedation?		
6. Were personnel competent?		
7. Are all personnel involved with the care of patients certified in basic cardiac life support?		
8. Was dentist able to perform the procedure without any action or omission that could have resulted in a life threatening situation to the patient?		
9. What was the length of the case demonstrated? _____		

EVALUATION

SIMULATED EMERGENCIES – Was dentist and staff able to demonstrate knowledge and ability in recognition and treatment of:	**YES**	**NO**
1. Airway obstruction laryngospasm?		
2. Bronchospasm?		
3. Emesis and aspiration of foreign material under anesthesia?		
4. Angina pectoris?		
5. Myocardial infarction?		
6. Hypotension?		
7. Hypertension?		
8. Cardiac arrest?		
9. Allergic reaction?		
10. Convulsions?		
11. Hypoglycemia?		
12. Asthma?		
13. Respiratory depression?		
14. Allergy to or overdose from local anesthesia?		
15. Hyperventilation syndrome?		
16. Syncope?		

Evaluator Overall Recommendation of Evaluation

☐ Pass ☐ Fail

Comments:_____

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Signature of Evaluator Date