



Nevada State Board of Dental Examiners

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GENERAL ANESTHESIA / DEEP SEDATION INSPECTION AND EVALUATION

SITE/ADMINISTRATOR EVALUATION SITE ONLY INSPECTION

| | |
|---------------------------|---------------------|
| Name of Practitioner: | Proposed Dates: |
| Location to be Inspected: | Telephone Number: |
| Date of Evaluation: | Time of Evaluation: |

Evaluators

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|----|
| 1. |
| 2. |
| 3. |

INSTRUCTIONS FOR COMPLETING GENERAL ANESTHESIA/DEEP SEDATION INSPECTION AND EVALUATION FORM:

1. Prior to inspection/evaluation, review criteria and guidelines for General Anesthesia (GA)/Deep Sedation (DS) Inspection and Evaluation in the Examiner Manual.
2. Each evaluator should complete a GA/DS Site/Administrator Evaluation or Site Only Inspection form independently by checking the appropriate answer box to the corresponding question or by filling in a blank space.
3. Answer each question. (For Site Only Inspections, complete Sections A, B, and D)
4. 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.
5. Sign the inspection/evaluation report and return to the Board office within ten (10) days after inspection/evaluation has been completed.

A. OFFICE FACILITIES AND EQUIPMENT (NAC 631.2227) All operatories used must meet criteria

| 1. Operating Theater | YES | NO |
|--|------------|-----------|
| 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 in 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 <i>or generator</i> powered backup lighting system? | | |
| c. Is backup lighting system of sufficient intensity to permit completion <i>or appropriate completion</i> of any operation underway at the time of general power failure? | | |
| 4. Suction Equipment | | |
| a. Does suction equipment permit aspiration <i>provide adequate evacuation</i> of the oral and pharyngeal Cavities <i>airway</i> ? | | |
| 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? Not general power dependent | | |
| 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 <i>Must be</i> in Good Operating Condition? | YES | NO |
|--|-----|----|
| a. Are there oral airways? | | |
| b. Is there a tonsillar or pharyngeal type suction tip adaptable to all office <i>suction</i> 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? | | |
| f. A laryngoscope complete with an adequate selection of blades and spare batteries and bulbs? | | |
| g. Endotracheal tubes and appropriate connectors? | | |
| h. An endotracheal tube type forcep? (<i>Magill Type</i>) | | |
| i. An electrocardioscope and defibrillator? | | |

B. RECORDS – Are the following records maintained?

| | | |
|---|--|--|
| 1. An adequate medical history of the patient? | | |
| 2. An adequate physical evaluation of the patient? | | |
| 3. Anesthesia records show blood pressure reading? | | |
| 4. Anesthesia records show pulse reading? | | |
| 5. Anesthesia records listing the drugs administered, amounts administered, and time administered? | | |
| 6. Anesthesia records reflecting the length of the procedure? | | |
| 7. Anesthesia 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 administration of anesthesia? | | |

C. DEMONSTRATION OF GENERAL ANESTHESIA / DEEP SEDATION

| | | | | |
|--|--|--|------------|-----------|
| 1. Who administered General Anesthesia / Deep Sedation? Dentist's Name: _____ | | | | |
| | | | YES | NO |
| 2. Was case demonstrated within the definition of general anesthesia / deep sedation? | | | | |
| 3. While anesthetized was patient continuously monitored during the procedure with a pulse oximeter and other appropriate monitoring equipment? If not, what type of monitoring was utilized? _____ | | | | |
| 4. Was the patient monitored while recovering from anesthesia? Monitored by whom: _____ Title: _____ | | | | |
| 5. Is this person a licensed health professional experienced in the care and resuscitation of patients recovering from general anesthesia / deep sedation? | | | | |
| 6. Were personnel competent <i>and knowledgeable of equipment operation and location</i> ? | | | | |
| 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? _____ | | | | |

D. DRUGS

| | DRUG NAME | EXPIRES | YES | NO |
|---|------------------|----------------|------------|-----------|
| 1. Vasopressor drug available? | | | | |
| 2. Corticosteroid drug available? | | | | |
| 3. Bronchodilator drug available? | | | | |
| 4. Appropriate drug antagonists available? <i>Narcotic/Benzodiazepine</i> | | | | |

| | DRUG NAME | EXPIRES | YES | NO |
|--|-----------|---------|-----|----|
| 5. Antihistaminic drug available? | | | | |
| 6. Anticholinergic drug available? | | | | |
| 7. Coronary artery vasodilator drug available? | | | | |
| 8. Anticonvulsant drug available? | | | | |
| 9. <i>Dantrolene Sodium</i> | | | | |
| 10. Muscle relaxant? | | | | |
| 11. Antiarrhythmic? | | | | |
| 12. Antihypertensive? | | | | |
| 13. Intravenous medication for the treatment -management of cardiopulmonary arrest? | | | | |
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E. 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? | | |
| 17. <i>Malignant hyperthermia?</i> | | |

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|----------------------------------|-------------------------------|
| Evaluator Overall Recommendation | |
| <input type="checkbox"/> Pass | <input type="checkbox"/> Fail |

Comments: _____

Signature of Evaluator

Date