



# Nevada State Board of Dental Examiners

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## GENERAL ANESTHESIA / DEEP SEDATION INSPECTION AND EVALUATION

<input type="checkbox"/> <b>SITE/ADMINISTRATOR EVALUATION</b> <input type="checkbox"/> <b>SITE ONLY INSPECTION</b>		
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 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. 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 inspection/evaluation report and return to the Board office within ten (10) days after inspection/evaluation has been completed.

## **SITE INSPECTION**

<b>OFFICE FACILITIES AND EQUIPMENT (NAC 631.2227) All operatories used must meet criteria</b>	<b>YES</b>	<b>NO</b>
<b>1. Operating Theater</b>		
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?		
<b>2. Operating Chair or Table</b>		
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?		
<b>3. Lighting System</b>		
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?		
<b>4. Suction Equipment</b>		
a. Does suction equipment permit aspiration of the oral and pharyngeal cavities airway?		
b. Is there a backup suction device available which can operate at the time of general power failure?		
<b>5. Oxygen Delivery System</b>		
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?		
<b>6. Recovery Area (Recovery area can be operating theater)</b>		
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?		

## **SITE INSPECTION**

<b>OFFICE FACILITIES AND EQUIPMENT (NAC 631.2227) All operatories used must meet criteria (continued)</b>	<b>YES</b>	<b>NO</b>
<b>7. Ancillary Equipment <i>Must be</i> in Good Operating Condition?</b>	<b>YES</b>	<b>NO</b>
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. An electrocardioscope and defibrillator?		

<b>DRUGS</b>	<b>DRUG NAME</b>	<b>EXPIRES</b>	<b>YES</b>	<b>NO</b>
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?				
10. Muscle relaxant?				
11. Antiarrhythmic?				
12. Antihypertensive?				
13. Intravenous medication for the treatment of cardiopulmonary arrest?				

## **SITE INSPECTION**

<b>RECORDS – Are the following records maintained?</b>	<b>YES</b>	<b>NO</b>
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?		

Evaluator Overall Recommendation of Site Inspection		
<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Pass Pending*

*\*If Pass Pending please list all deficiency's*

Comments: \_\_\_\_\_

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Signature of Evaluator

\_\_\_\_\_  
Date

## **EVALUATION**

<b>DEMONSTRATION OF GENERAL ANESTHESIA / DEEP SEDATION</b>	<b>YES</b>	<b>NO</b>
1. Who administered General Anesthesia / Deep Sedation? Dentist's Name: _____		
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? _____		

<b>SIMULATED EMERGENCIES – Was dentist and staff able to demonstrate knowledge and ability in recognition and treatment of:</b>	<b>YES</b>	<b>NO</b>
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?		

<b><i>SIMULATED EMERGENCIES</i></b> – Was dentist and staff able to demonstrate knowledge and ability in recognition and treatment of: (continued)	<b>YES</b>	<b>NO</b>
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail
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Comments: \_\_\_\_\_

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Signature of Evaluator

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Date