



Nevada State Board of Dental Examiners

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GENERAL ANESTHESIA INSPECTION AND EVALUATION REPORT

<input type="checkbox"/> SITE/ADMINISTRATOR EVALUATION		<input type="checkbox"/> SITE ONLY INSPECTION	
Name of Practitioner:		Proposed Dates:	
Location to be Inspected:		Telephone Number:	
Date of Evaluation:		Time of Evaluation:	
		Start Time:	Finish Time:

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Evaluators

1.
2.
3.

INSTRUCTIONS FOR COMPLETING GENERAL ANESTHESIA INSPECTION AND EVALUATION FORM:

1. Prior to inspection/evaluation, review criteria and guidelines for General Anesthesia (GA) Inspection and Evaluation in the Examiner Manual.
2. Each evaluator should complete a GA 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 72 hours after inspection/evaluation has been completed.

SITE INSPECTION

OFFICE FACILITIES AND EQUIPMENT (NAC 631.2227) <u>ALL</u> operatories used must meet criteria	YES	NO
1. Operating Room		
a. Is operating room large enough to adequately accommodate the patient on a table or in an operating chair?		
b. Does operating room 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 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 & pharyngeal cavities airway?		
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 room)		
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

OFFICE FACILITIES AND EQUIPMENT (NAC 63L.2227) <u>ALL</u> operatories used must meet criteria (continued)	YES	NO
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. An electrocardioscope and defibrillator?		
j. A capnography monitor		

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?				
10. Muscle relaxant?				
11. Antiarrhythmic?				
12. Antihypertensive?				
13. Intravenous medication for the treatment of cardiopulmonary arrest?				

SITE INSPECTION

<i>RECORDS</i> – Are the following records maintained?	YES	NO
1. An adequate medical history of the patient?		
2. An adequate physical evaluation of the patient?		
3. Includes American Society of Anesthesiologist physical status classification?		
4. Anesthesia records show patient’s vital signs?		
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?		
	YES	NO
Is there general anesthesia or moderate sedation administered at the dentist office to a patient of 12 years of age or younger (if yes, complete section below)		
ADDITIONAL EQUIPMENT FOR 12 YEARS OF AGE AND YOUNGER	YES	NO
1. Bag valve mask with appropriate size masks		
2. Appropriate size blood pressure cuffs		
3. A laryngoscope complete with an adequate selection of blades for use on patients 12 years of age and younger		
4. Appropriately sized endotracheal tubes and appropriate connectors		
5. Appropriate pads for use with an electrocardioscope and defibrillator		
6. Small oral and nasal airways		
ADDITIONAL EMERGENCY DRUGS FOR 12 YEARS OF AGE AND YOUNGER	Yes	NO
1. Appropriate dosages of epinephrine or a pediatric epinephrine auto-injector		
ADDITIONAL RECORDS FOR 12 YEARS OF AGE AND YOUNGER	Yes	NO
1. Anesthesia/Sedation Records reflecting monitoring of patient that is consistent with the guidelines of the American Academy of Pediatric Dentistry		

SITE INSPECTION RESULTS

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 deficiencies*

Comments: _____

Signature of Evaluator _____

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Date _____

THIS CONCLUDES THE SITE INSPECTION REPORT.

FOR AN EVALUATION OF AN ADMINISTERING PERMIT, CONTINUE TO NEXT SECTION.

EVALUATION

<i>DEMONSTRATION OF GENERAL ANESTHESIA / DEEP SEDATION</i>	YES	NO
1. Who administered General Anesthesia? Dentist's Name: _____		
2. Was case demonstrated within the definition of general anesthesia?		
3. While anesthetized was patient continuously monitored during the procedure with a pulse oximeter and other appropriate monitoring equipment?		
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?		
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?		
4. What was the length of the case demonstrated? _____		

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<i>SIMULATED EMERGENCIES – Was dentist and staff able to demonstrate knowledge and ability in recognition and treatment of:</i>	YES	NO
1. 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?		

<i>SIMULATED EMERGENCIES</i> – Was dentist and staff able to demonstrate knowledge and ability in recognition and treatment of: (continued)	YES	NO
11. Hypoglycemia?		
12. Asthma?		
13. Respiratory depression?		
14. Local anesthesia overdose?		
15. Hyperventilation syndrome?		
16. Syncope?		

<p align="center"> Evaluator Overall Recommendation of Evaluation <input type="checkbox"/> Pass <input type="checkbox"/> Fail </p>

Comments: _____

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Signature of Evaluator

Date

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