NEVADA STATE BOARD of DENTAL EXAMINERS

Anesthesia Committee & Subcommittee

Teleconference Meeting

Tuesday, April 13, 2021

6:00 p.m.

PUBLIC BOOK

Statutes and Regulations

NRS 449.442 Permit required for certain physicians' offices and facilities to offer services; national accreditation required; cessation of services for failure to maintain accreditation.

1. An office of a physician or a facility that provides health care, other than a medical facility, must obtain a permit pursuant to NRS 449.443 before offering to a patient a service of general anesthesia, conscious sedation or deep sedation. An office of a physician or a facility that provides health care, other than a medical facility, which operates at more than one location must obtain a permit for each location where a service of general anesthesia, conscious sedation or deep sedation is offered.

2. To offer to a patient a service of general anesthesia, conscious sedation or deep sedation in this State, an office of a physician or a facility that provides health care, other than a medical facility, must maintain current accreditation by a nationally recognized organization approved by the Board. Upon receiving an initial permit, the office or facility shall, within 6 months after obtaining the permit, submit proof to the Division of accreditation by such an organization.

3. If an office of a physician or a facility that provides health care, other than a medical facility, fails to maintain current accreditation or if the accreditation is revoked or is otherwise no longer valid, the office or facility shall immediately cease offering to patients a service of general anesthesia, conscious sedation or deep sedation.

(Added to NRS by 2009, 529)

NRS 631.265 Permit to administer or supervise administration of general anesthesia, minimal sedation, moderate sedation or deep sedation; regulations.

1. No licensed dentist or person who holds a restricted license issued pursuant to NRS 631.275 may administer or supervise directly the administration of general anesthesia, minimal sedation, moderate sedation or deep sedation to dental patients unless the dentist or person has been issued a permit authorizing him or her to do so by the Board.

2. The Board may issue a permit authorizing a licensed dentist or person who holds a restricted license issued pursuant to NRS 631.275 to administer or supervise directly the administration of general anesthesia, minimal sedation, moderate sedation or deep sedation to dental patients under such standards, conditions and other requirements as the Board shall by regulation prescribe.

(Added to NRS by 1983, 278; A 1989, 1740; 2001, 2692; 2015, 3876)

ADMINISTRATION OF GENERAL ANESTHESIA, MODERATE SEDATION OR DEEP SEDATION

NAC 631.2211 Scope; restrictions on administration of oral medication. (NRS 631.190**,** 631.265**)**

1. NAC 631.2213 to 631.2256, inclusive, do not apply to the administration of:

(a) Local anesthesia;

(b) Nitrous oxide-oxygen analgesia, if the delivery system for the nitrous oxide-oxygen contains a mechanism which guarantees that an oxygen concentration of at least 25 percent will be administered to the patient at all times during the administration of the nitrous oxide; and

(c) Oral medication that is administered to a patient to relieve anxiety in the patient, if the medication is not given in a dosage that is sufficient to induce in a patient a controlled state of depressed consciousness or unconsciousness similar to the state produced pursuant to the administration of general anesthesia, deep sedation or moderate sedation.

2. Any oral medication administered as described in paragraph (c) of subsection 1 must not be combined with the administration of any other method of sedation, including, without limitation, nitrous oxide-oxygen analgesia. A single dosage of a single sedative agent administered must be appropriate for anxiolysis. The dosage of enteral drugs must not be more than the maximum recommended dosage that can be prescribed for unmonitored home use.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2212 Board to determine degree of sedation. (NRS 631.190**,** 631.265**)** In a proceeding of the Board at which the Board must determine the degree of sedation or level of consciousness of a patient, the Board will base its findings on:

1. The type and dosage of medication that was administered or is proposed for administration to the patient; and

2. The degree of sedation or level of consciousness that should reasonably be expected to result from that type and dosage of medication.

(Added to NAC by Bd. of Dental Exam'rs by R005-99, eff. 9-7-2000)

NAC 631.2213 Permit required; qualifications of applicants. (NRS 631.190, 631.265)

1. Except as otherwise set forth in NAC 631.2211 to 631.2256, inclusive, no dentist may:

(a) Use general anesthesia or deep sedation for dental patients, except in a facility for which a permit is held as required by NRS 449.442, unless he or she first:

(1) Obtains a general anesthesia permit; or

(2) Employs a dentist who is licensed in this State and who holds a general anesthesia permit to administer general anesthesia to his or her patients, and obtains a certificate of site approval for each location at which general anesthesia, deep sedation or moderate sedation is administered to his or her patients;

(b) Use moderate sedation for dental patients who are 13 years of age or older, except in a facility for which a permit is held as required by NRS 449.442, unless he or she first:

(1) Obtains a general anesthesia permit or a moderate sedation permit pursuant to paragraph (a) of subsection 2; or

(2) Employs a dentist who is licensed in this State and who holds a general anesthesia permit or a moderate sedation permit pursuant to paragraph (a) of subsection 2 to administer moderate sedation to his or her patients who are 13 years of age or older, and obtains a certificate of site approval for each location at which moderate sedation is administered to his or her patients who are 13 years of age or older; or

(c) Use moderate sedation for dental patients who are 12 years of age or younger, except in a facility for which a permit is held as required by NRS 449.442, unless he or she first:

(1) Obtains a moderate sedation permit pursuant to paragraph (b) of subsection 2; or

(2) Employs a dentist who is licensed in this State and who holds a general anesthesia permit or a moderate sedation permit pursuant to paragraph (b) of subsection 2 to administer moderate sedation to his or her patients who are 12 years of age or younger, and obtains a certificate of site approval for each location at which moderate sedation is administered to his or her patients who are 12 years of age or younger.

2. To obtain a general anesthesia permit or moderate sedation permit, a dentist must apply to the Board for such a permit on a form prescribed by the Board, submit any fees that are set by the Board pursuant to NRS 631.345 and produce evidence showing that he or she is a dentist who is licensed in this State, and:

(a) For a moderate sedation permit to administer moderate sedation to a patient 13 years of age or older, the applicant must show evidence of:

(1) The completion of a course of study, subject to the approval of the Board, of not less than 60 hours dedicated exclusively to the administration of moderate sedation, and the successful administration as the operator of moderate sedation to not less than 20 patients; or

(2) The completion of a program for specialty training which is approved by the Commission on Dental Accreditation of the American Dental Association and which includes education and training in the administration of moderate sedation that is equivalent to the education and training described in subparagraph (1) and:

(I) Valid certification in Advanced Cardiac Life Support by the American Heart Association; or

(II) The completion of a course approved by the Board that provides instruction on medical emergencies and airway management.

(b) For a moderate sedation permit to administer moderate sedation to a patient 12 years of age or younger, the applicant must show evidence of:

(1) The completion of a course of study, subject to the approval of the Board, of not less than 60 hours dedicated exclusively to the administration of moderate sedation to patients 12 years of age or younger, and the successful administration as the operator of moderate sedation to not less than 25 patients who are 12 years of age or younger; or

(2) The completion of a program for specialty training which is approved by the Commission on Dental Accreditation of the American Dental Association and which includes education and training in the administration of moderate sedation that is equivalent to the education and training described in subparagraph (1) and:

(I) Valid certification in Pediatric Advanced Life Support by the American Heart Association; or

(II) The completion of a course approved by the Board that provides instruction on medical emergencies and airway management.

(c) For a general anesthesia permit, the applicant must show evidence of the completion of an Advanced Cardiac Life Support course given by the American Heart Association or a course providing similar instruction that is approved by the Board, and:

(1) The completion of a program, subject to the approval of the Board, of advanced training in anesthesiology and related academic subjects beyond the level of undergraduate dental school in a training program as described in

the *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, published by the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611, and available, free of charge, at the Internet address **http://www.ada.org/~/media/ADA/Education%20and%20Careers/Files/ADA_Sedation_Teaching_Guidelines.pdf?la=en**; or

(2) The completion of a graduate program in oral and maxillofacial surgery or dental anesthesiology which has been approved by the Commission on Dental Accreditation of the American Dental Association.

3. A holder of a general anesthesia permit may administer general anesthesia, deep sedation or moderate sedation to a patient of any age.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R159-08, 4-23-2009; R004-17, 5-16-2018)

NAC 631.2217 Review of holder of permit; renewal of permit. (NRS 631.190**,** 631.265**)**

1. The holder of a general anesthesia permit or moderate sedation permit is subject to review by the Board at any time.

2. Each general anesthesia permit and moderate sedation permit must be renewed annually or biennially, as applicable, based on the renewal period set forth in NRS 631.330 for the type of license held by the holder of the permit.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R158-08, 12-17-2008; R004-17, 5-16-2018)

NAC 631.2219 Inspection and evaluation; renewal of permit; reevaluation of credentials. (NRS 631.190**,** 631.265**)**

1. The Board will require an inspection and evaluation of the facility, equipment, personnel, records of patients and the procedures used by every dentist who seeks or holds a general anesthesia permit or moderate sedation permit, and of the dentist himself or herself, before issuing such an original permit to the dentist, and at least once in every 5-year period thereafter.

2. The Board will renew general anesthesia permits and moderate sedation permits annually or biennially, as applicable, based on the renewal period set forth in NRS 631.330 for the type of license held by the holder of the permit, unless the holder is informed in writing, 60 days before the date for renewal, that a reevaluation of his or her credentials is required. In determining whether reevaluation is necessary, the Board will consider, among other factors, complaints by patients and reports of adverse occurrences. A reevaluation will, if appropriate, include an inspection of the facility, equipment, personnel, records of patients and the procedures used by the holder, and an examination of his or her qualifications.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A 7-30-84; R005-99, 9-7-2000; R158-08, 12-17-2008; R004-17, 5-16-2018)

NAC 631.2221 Inspections and evaluations: Qualifications of inspectors and evaluators; authorized participation by members of Board. (NRS 631.190**,** 631.265**)**

1. When an inspection or evaluation is required to issue or renew a general anesthesia permit or moderate sedation permit, the Board may designate two or more persons, each of whom holds a general anesthesia permit or moderate sedation permit and has practiced general anesthesia, deep sedation or moderate sedation, as applicable, for a minimum of 3 years preceding his or her appointment, exclusive of his or her training in the administration of anesthesia or sedation. At least one of the inspectors or evaluators must have had experience in the evaluation of dentists using general anesthesia, deep sedation or moderate sedation, as applicable. At least one member of the inspection or evaluation team must have had substantial experience in the administration of the type of anesthesia or sedation contemplated for use by the dentist being evaluated and must hold the type of permit for which the dentist is applying.

2. Any member of the Board who is a dentist may observe or consult in any inspection or evaluation. A member of the Board who is not a dentist may be present at an observation but may not participate in any grading or evaluation resulting from the inspection or evaluation.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A 7-30-84; R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2223 Inspections and evaluations: General requirements. (NRS 631.190**,** 631.265**)** An inspection or evaluation ordered by the Board must be conducted in all offices where general anesthesia, deep

sedation or moderate sedation is to be administered and, except as otherwise required in NAC 631.2236, must consist of:

1. An evaluation of the office's facilities and equipment, records and emergency medications; and
2. A demonstration of:

(a) The administration to a patient who is receiving dental treatment of the type of anesthesia or sedation for which the dentist is applying for a permit;

(b) Simulated emergencies in the surgical area of the dental office with participation by the members of the staff who are trained to handle emergencies;

(c) A dental procedure utilizing the type of anesthesia or sedation for which the dentist is applying for a permit;

(d) Any anesthesia or sedation technique that is routinely employed during the administration of anesthesia or sedation;

(e) The appropriate monitoring of a patient during anesthesia or sedation; and

(f) The observation of a patient during recovery and the time allowed for recovery.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2225 Inspections and evaluations: Minimum standards for simulated emergencies. (NRS 631.190**,** 631.265**)** A dentist's office inspected or evaluated for the issuance or renewal of a general anesthesia permit or moderate sedation permit must meet the following minimum standards with regard to simulated emergencies. The dentist and his or her staff must demonstrate a knowledge of and a method of treatment for the following types of emergencies:

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. Overdose from local anesthesia;
15. Hyperventilation syndrome; and
16. Syncope.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2227 Inspections and evaluations: Minimum standards for physical facilities and equipment. (NRS 631.190**,** 631.265**)** A dentist's office inspected or evaluated for the issuance or renewal of a general anesthesia permit, moderate sedation permit or certificate of site approval must meet the following minimum standards with regard to physical facilities and equipment:

1. The operating theater must be large enough to accommodate the patient adequately on a table or in a dental chair and to allow an operating team consisting of at least three persons to move freely about the patient.
2. The operating table or dental chair must:

(a) Allow the patient to be placed in a position such that the operating team can maintain the airway;

(b) Allow the operating team to alter the patient's position quickly in an emergency; and

(c) Provide a firm platform for the management of cardiopulmonary resuscitation.

3. The lighting system must be adequate to allow an evaluation of the patient's skin and mucosal color. An alternate lighting system must derive its power from batteries and must be sufficiently intense to allow completion of any procedure underway at the time of a general power failure.
4. Suction equipment must be available that allows aspiration of the oral and pharyngeal cavities. An alternate suction device that will function effectively during a general power failure must be available.

5. A system for delivering oxygen must have adequate full-face masks and appropriate connectors, and be capable of delivering oxygen to the patient under positive pressure. An adequate alternate system for delivering oxygen is also required.

6. A recovery area must be provided that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area may be the operating theater. A member of the staff must be able to observe the patient at all times during the recovery.

7. Except as otherwise provided in this subsection, ancillary equipment must include:

(a) A laryngoscope complete with an adequate selection of blades and spare batteries and bulbs;

(b) Endotracheal tubes and appropriate connectors;

(c) Oral airways;

(d) A tonsillar or pharyngeal suction tip adaptable to all office suction outlets;

(e) An endotracheal tube type forcep;

(f) A sphygmomanometer and stethoscope;

(g) An electrocardioscope and defibrillator;

(h) Adequate equipment for the establishment of an intravenous infusion;

(i) A pulse oximeter; and

(j) A capnography monitor.

Ê Except as otherwise provided in subsection 8, a dentist's office inspected or evaluated for the issuance or renewal of a moderate sedation permit is not required to have the ancillary equipment described in paragraphs (a), (b), (e), (g) and (j).

8. In addition to the requirements of subsection 7, if general anesthesia, deep sedation or moderate sedation is administered at the dentist's office to a patient 12 years of age or younger, the following equipment must be available at the dentist's office:

(a) A pediatric size ambu bag and masks;

(b) Pediatric blood pressure cuffs;

(c) A laryngoscope complete with an adequate selection of blades for use on pediatric patients;

(d) Appropriately sized endotracheal tubes and appropriate connectors;

(e) An electrocardioscope and defibrilator;

(f) Pediatric pads for use with an electrocardioscope and defibrillator; and

(g) Small oral and nasal airways.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2229 Inspections and evaluations: Minimum standards for records of patients. (NRS 631.190**,** 631.265**)** A dentist's office inspected or evaluated for the issuance or renewal of a general anesthesia permit, moderate sedation permit or certificate of site approval must meet the following minimum standards with regard to the records of patients:

1. Adequate medical history, records of physical evaluation and American Society of Anesthesiologists acuity classification.

2. Records of the administration of anesthesia must include:

(a) The patient's vital signs;

(b) The names of the drugs and the amounts and times administered;

(c) The length of the procedure; and

(d) Any complications of anesthesia.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2231 Inspections and evaluations: Maintenance of emergency drugs. (NRS 631.190**,** 631.265**)**

1. Except as otherwise provided in this section, a dentist's office inspected or evaluated for the issuance or renewal of a general anesthesia permit, moderate sedation permit or certificate of site approval must maintain emergency drugs of the following categories which must be immediately available for use on the patient:

(a) Vasopressor;

(b) Corticosteroid;

(c) Bronchodilator;

(d) Muscle relaxant;

(e) Intravenous medication for the treatment of cardiopulmonary arrest;

(f) Appropriate drug antagonist;
(g) Antihistaminic;
(h) Anticholinergic;
(i) Antiarrhythmic;
(j) Coronary artery vasodilator;
(k) Anti-hypertensive; and
(l) Anti-convulsive.

2. In addition to the requirements of subsection 1, if general anesthesia, deep sedation or moderate sedation is administered at a dentist's office to a patient 12 years of age or younger, the dentist's office must maintain the following emergency drugs:

(a) Appropriate dosages of epinephrine or a pediatric epinephrine auto-injector;
(b) Adenosine;
(c) Aminodarone;
(d) Magnesium sulfate; and
(e) Procainamide.

3. Except as otherwise provided in subsection 2, a dentist's office that is inspected or evaluated for the issuance or renewal of a moderate sedation permit is not required to maintain the emergency drugs described in paragraphs (d), (e), (i) and (k) of subsection 1.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2235 Inspections and evaluations: Grading; report of recommendation of evaluator; issuance of permit for passing; failure to pass; request for reevaluation; issuance of order for summary suspension. (NRS 631.190**,** 631.265**)**

1. The persons performing an inspection or evaluation of a dentist and his or her office for the issuance or renewal of a general anesthesia permit or moderate sedation permit shall grade the dentist as passing or failing to meet the requirements set forth in NAC 631.2219 to 631.2231, inclusive. Within 72 hours after completing the inspection or evaluation, each evaluator shall report his or her recommendation for passing or failing to the Executive Director, setting forth the details supporting his or her conclusion.

2. If the dentist meets the requirements set forth in NAC 631.2219 to 631.2231, inclusive, the Board will issue the general anesthesia permit or moderate sedation permit, as applicable.

3. If the dentist does not meet the requirements set forth in NAC 631.2219 to 631.2231, inclusive, the Executive Director shall issue a written notice to the dentist that identifies the reasons he or she failed the inspection or evaluation.

4. A dentist who has received a notice of failure from the Board pursuant to subsection 3:

(a) Must cease the administration of any general anesthesia, deep sedation or moderate sedation until the dentist has obtained the general anesthesia permit or moderate sedation permit, as applicable; and

(b) May, within 15 days after receiving the notice, request the Board in writing for a reevaluation. The request for a reevaluation must state specific grounds supporting it.

5. If the reevaluation is granted by the Board, it will be conducted by different persons in the manner set forth by NAC 631.2219 to 631.2231, inclusive, for an original evaluation.

6. No dentist who has received a notice of failing an inspection or evaluation from the Board may request more than one reevaluation within any period of 12 months.

7. Pursuant to subsection 3 of NRS 233B.127, if an inspection or evaluation of a dentist or his or her office indicates that the public health, safety or welfare imperatively requires emergency action, the President of the Board may, without any further action by the Board, issue an order of summary suspension of the license of the dentist pending proceedings for revocation or other action. An order of summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order of summary suspension. The President of the Board shall not participate in any further proceedings relating to the order.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2236 Certificate of site approval: Application; inspection; report of determination of inspector; issuance of certificate for passing; failure to pass; request for reevaluation; issuance of order for summary suspension. (NRS 631.190**,** 631.265**)**

1. A dentist who is licensed in this State may employ a dentist who is licensed in this State and who holds a general anesthesia permit or moderate sedation permit to administer general anesthesia, deep sedation or moderate sedation, as appropriate, to his or her patients at his or her office if he or she holds a certificate of site approval issued pursuant to this section.

2. A dentist who is licensed in this State and who desires to receive or renew a certificate of site approval must submit to the Board:

(a) An application for a certificate or for the renewal of a certificate, in a form approved by the Board;

(b) The fee for the inspection of a facility which is established by the Board pursuant to NRS 631.345; and

(c) Written documentation which demonstrates that the dentist who is to be employed to administer the general anesthesia, deep sedation or moderate sedation holds an appropriate permit issued by the Board to administer such anesthesia or sedation.

3. Upon receipt of an application pursuant to this section, the Board will appoint one of its members or a representative of the Board to inspect the office of the applicant to determine whether the office complies with the requirements set forth in NAC 631.2227, 631.2229 and 631.2231. The person conducting the inspection shall report his or her determination to the Board.

4. If the person conducting the inspection determines that the office of the applicant complies with the requirements of NAC 631.2227, 631.2229 and 631.2231 and the applicant has otherwise met the requirements of this section, the Executive Director shall issue a certificate of site approval to the applicant.

5. A holder of a certificate of site approval shall maintain the information described in paragraph (c) of subsection 2 at his or her office at all times.

6. If the office of the applicant does not meet the requirements set forth in NAC 631.2227, 631.2229 and 631.2231, the Executive Director shall issue a written notice to the licensed dentist who owns the dental practice conducted at the office that identifies the reasons the office failed the inspection.

7. A dentist who has received a notice of failure from the Executive Director pursuant to subsection 6:

(a) Must cease the administration of any general anesthesia, deep sedation or moderate sedation at his or her office until the Board has issued a certificate of site approval for the office; and

(b) May, within 15 days after receiving the notice, request the Board in writing for a reevaluation.

8. If the reevaluation is granted by the Board, it will be conducted by different persons in the manner set forth by NAC 631.2227, 631.2229 and 631.2231 for an original inspection.

9. Pursuant to subsection 3 of NRS 233B.127, if an evaluation or inspection of a dentist's office indicates that the public health, safety or welfare imperatively requires emergency action, the President of the Board may, without any further action by the Board, issue an order of summary suspension of the license of the dentist who owns the dental practice conducted at the office and the licenses of any or all of the other licensees employed at the office pending proceedings for revocation or other action. An order of summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order of summary suspension. The President of the Board shall not participate in any further proceedings relating to the order.

10. Each certificate of site approval issued by the Board must be renewed annually or biennially, as applicable, based on the renewal period set forth in NRS 631.330 for the type of license held by the holder of the certificate.

11. The Board may reinspect the office of the holder of a certificate of site approval at any time.

(Added to NAC by Bd. of Dental Exam'rs by R005-99, eff. 9-7-2000; A by R231-03, 5-25-2004; R158-08, 12-17-2008; R159-08, 4-23-2009; R004-17, 5-16-2018)

NAC 631.2237 Written consent and medical history of patient required before administration of anesthetic or sedation. (NRS 631.190**,** 631.265**)**

1. Written consent of the patient must be obtained before the administration of a general anesthetic, deep sedation or moderate sedation, unless the dentist determines that an emergency situation exists in which delaying the procedure to obtain the consent would likely cause permanent injury to the patient. If the patient is a minor, the consent must be obtained from his or her parent or legal guardian.

2. A medical history must be taken before the administration of a general anesthetic, deep sedation or moderate sedation. A patient should be asked to describe any current medical conditions or treatments, including, without limitation, medications, drug allergies, impending or past operations and pregnancy, and to give other information that may be helpful to the person administering the anesthetic or sedation. The dentist is not required to make a complete medical examination of the patient and draw medical diagnostic conclusions. If a dentist suspects a medical problem and calls in a physician for an examination and evaluation, he or she may then rely upon that

conclusion and diagnosis. Questions asked of and answers received from the patient must be permanently recorded and signed by the patient before the administration of any general anesthetic, deep sedation or moderate sedation, and this record must be a permanent part of the patient's record of treatment.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2239 Properly equipped facility required; qualifications of auxiliary personnel. (NRS 631.190**,** 631.265**)**

1. A dentist using general anesthesia, deep sedation or moderate sedation shall maintain a properly equipped facility for the administration of the anesthesia or sedation which is staffed with supervised auxiliary personnel who are capable of reasonably handling procedures, problems and emergencies incident thereto.

2. A dentist using general anesthesia, deep sedation or moderate sedation shall ensure that his or her auxiliary personnel are certified in basic cardiopulmonary resuscitation by the American Heart Association or a course providing similar instruction approved by the Board.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.224 Employment of certified registered nurse anesthetist to administer anesthesia or sedation; restrictions on allowing persons to administer treatment. (NRS 631.190**,** 631.265**)**

1. Any dentist who holds a general anesthesia permit pursuant to the provisions of NAC 631.2211 to 631.2256, inclusive, may employ a certified registered nurse anesthetist to administer the general anesthesia, deep sedation or moderate sedation to a patient if the dentist is physically present and directly supervises the administration of the general anesthesia, deep sedation or moderate sedation to the patient. The holder of the permit must maintain at his or her office evidence in writing that the certified registered nurse anesthetist is licensed to practice in the State of Nevada and maintains unrestricted active staff privileges within the department of anesthesiology at a hospital or surgical center for which a permit is held as required by NRS 449.442.

2. Except as otherwise provided in NAC 631.2236, a dentist who does not hold a general anesthesia permit may not allow any person to administer general anesthesia, deep sedation or moderate sedation to his or her patients unless the treatment is rendered within a facility for which a permit is held as required by NRS 449.442.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-7-85; A by R005-99, 9-7-2000; R159-08, 4-23-2009; R004-17, 5-16-2018)

NAC 631.2241 Submission of report of injuries to patients; revocation of permit authorized for failure to report. (NRS 631.190**,** 631.265**)** Each holder of a general anesthesia permit, moderate sedation permit or certificate of site approval shall submit to the Board a complete report regarding any mortality or unusual incident which occurs outside a facility for which a permit is held as required by NRS 449.442 and which results in permanent physical or mental injury to a patient or requires the hospitalization of a patient, as a direct result of the administration of general anesthesia, deep sedation or moderate sedation. The report must be submitted within 30 days after the date of the incident. If a dentist fails to report any incident as required by this section, his or her permit may be revoked.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R159-08, 4-23-2009; R004-17, 5-16-2018)

NAC 631.2254 Temporary permits. (NRS 631.190**,** 631.265**)**

1. The Board may grant a temporary permit to administer general anesthesia and deep sedation or a temporary permit to administer moderate sedation to an applicant who meets the qualifications for a permit to administer that type of anesthesia or sedation pursuant to NAC 631.2213.

2. A temporary permit is valid for not more than 90 days, but the Board may, in any case it deems appropriate, grant a 90-day extension of the permit.

3. The Board may require the holder of a temporary permit to pass an on-site inspection as a condition of retaining the permit. If the holder fails the inspection, his or her permit will be revoked. In case of revocation, the holder of a temporary permit may apply to be reinspected in accordance with the procedures set forth in NAC 631.2235.

(Added to NAC by Bd. of Dental Exam'rs, eff. 11-28-90; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.2256 Continuing education required. (NRS 631.190**,** 631.265**,** 631.342**)** Every 2 years, the holder of a general anesthesia permit or moderate sedation permit must complete at least 6 hours in courses of study that specifically relate to anesthesia or sedation, as applicable, before the permit may be renewed. This training will be credited toward any continuing education required by NAC 631.173.

(Added to NAC by Bd. of Dental Exam'rs, eff. 11-28-90; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

NAC 631.173 Continuing education: Required hours; types of courses and activities; approval of provider or instructor. (NRS 631.190, 631.342)

1. Each dentist licensed to practice in this State must annually complete at least 20 hours of instruction in approved courses of continuing education or biennially complete at least 40 hours of instruction in approved courses of continuing education, as applicable, based on the renewal period set forth in NRS 631.330 for the type of license held by the dentist. Hours of instruction may not be transferred or carried over from one licensing period to another.

2. Each dental hygienist licensed to practice in this State must annually complete at least 15 hours of instruction in approved courses of continuing education or biennially complete at least 30 hours of instruction in approved courses of continuing education, as applicable, based on the renewal period set forth in NRS 631.330 for the type of license held by the dental hygienist. Hours of instruction may not be transferred or carried over from one licensing period to another.

3. In addition to the hours of instruction prescribed in subsections 1 and 2, each dentist and dental hygienist must maintain current certification in administering cardiopulmonary resuscitation or another medically acceptable means of maintaining basic bodily functions which support life. Any course taken pursuant to this subsection must be taught by a certified instructor.

4. Any provider of or instructor for a course in continuing education relating to the practice of dentistry or dental hygiene which meets the requirements of this section must be approved by the Board, unless the course is for training in cardiopulmonary resuscitation or is approved by:

   (a) The American Dental Association or the societies which are a part of it;

   (b) The American Dental Hygienists' Association or the societies which are a part of it;

   (c) The Academy of General Dentistry;

   (d) Any nationally recognized association of dental or medical specialists;

   (e) Any university, college or community college, whether located in or out of Nevada;or

   (f) Any hospital accredited by The Joint Commission.

5. To be approved as a provider of a course in continuing education, the instructor of the course must complete a form provided by the Board and submit it to the Board for review by a committee appointed by the Board not later than 45 days before the beginning date of the course. Upon receipt of the form, the committee shall, within 10 days after receiving the form, approve or disapprove the application and inform the applicant of its decision.

6. Study by group may be approved for continuing education if the organizer of the group complies with the requirements of subsection 5 and furnishes the Board with a complete list of all members of the group, a synopsis of the subject to be studied, the time, place and duration of the meetings of the group, and the method by which attendance is recorded and authenticated.

7. Credit may be allowed for attendance at a meeting or a convention of a dental and dental hygiene society.

8. Credit may be allowed for courses completed via home study, on-line study, self-study or journal study which are taught through correspondence, webinar, compact disc or digital video disc.

9. Credit may be allowed for dental and dental hygiene services provided on a voluntary basis to nonprofit agencies and organizations approved by the Board.

NAC 631.224 Employment of certified registered nurse anesthetist to administer anesthesia or sedation; restrictions on allowing persons to administer treatment. (NRS 631.190, 631.265)

1. Any dentist who holds a general anesthesia permit pursuant to the provisions of NAC 631.2211 to 631.2256, inclusive, may employ a certified registered nurse anesthetist to administer the general anesthesia, deep sedation or moderate sedation to a patient if the dentist is physically present and directly supervises the administration of the general anesthesia, deep sedation or moderate sedation to the patient. The holder of the permit must maintain at his or her office evidence in writing that the certified registered nurse anesthetist is licensed to practice in the State of Nevada and maintains unrestricted active staff privileges within the department of anesthesiology at a hospital or surgical center for which a permit is held as required by NRS 449.442.

2. Except as otherwise provided in NAC 631.2236, a dentist who does not hold a general anesthesia permit may not allow any person to administer general anesthesia, deep sedation or moderate sedation to his or her patients unless the treatment is rendered within a facility for which a permit is held as required by NRS 449.442.

OLD BUSINESS ITEMS:

Meeting Minutes - 01/12/2021

Anesthesia Committee and Sub-Committee Teleconference Meeting

For Reference Only

Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste.1 • Las Vegas, NV 89118 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

Notice of Agenda & *Combined* Teleconference Meeting of (1) The Anesthesia Committee and (2) The Anesthesia Sub-Committee

Meeting Date & Time

Tuesday, January 12, 2021
6:00 p.m.

This meeting was exclusively through teleconference means, in accordance with Emergency Directives issued by Governor Sisolak

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PUBLIC NOTICE:

***** This meeting will be held via TELECONFERENCE ONLY, pursuant to Section 1 of the DECLARATION OF EMERGENCY DIRECTIVE 006 ("DIRECTIVE 006") issued by the State of Nevada Executive Department and as extended by Directives 016, 018, 021, 026, and 029. There will be no physical location for this meeting*****

Public Comment by pre-submitted email/written form, only, is available after roll call (beginning of meeting); **Live Public Comment by teleconference** is available prior to adjournment (end of meeting). Live Public Comment is limited to three (3) minutes for each individual.

Pursuant to Section 2 of Directive 006, members of the public may participate in the meeting by submitting public comment in written form to: **Nevada State Board of Dental Examiners, 6010 S. Rainbow Blvd, A-1, Las Vegas, Nevada 89118; FAX number (702) 486-7046; e-mail address** nsbde@nsbde.nv.gov. Written submissions received by the Board on or before **Monday, January 11, 2021 by 4:00 p.m.** may be entered into the record during the meeting. Any other written public comment submissions received prior to the adjournment of the meeting will be included in the permanent record.

The Nevada State Board of Dental Examiners may 1) address agenda items out of sequence to accommodate persons appearing before the Board or to aid the efficiency or effectiveness of the meeting; 2) combine items for consideration by the public body; 3) pull or remove items from the agenda at any time. The Board may convene in closed session to consider the character, alleged misconduct, professional competence or physical or mental health of a person. *See* NRS 241.030. Prior to the commencement and conclusion of a contested case or a quasi-judicial proceeding that may affect the due process rights of an individual the board may refuse to consider public comment. *See* NRS 233B.126.

Persons/facilities who want to be on the mailing list must submit a written request every six (6) months to the Nevada State Board of Dental Examiners at the address listed in the previous paragraph. With regard to any board meeting or telephone conference, it is possible that an amended agenda will be published adding new items to the original agenda. Amended Nevada notices will be posted in compliance with the Open Meeting Law.

We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Board, at (702) 486-7044, no later than 48 hours prior to the meeting. Requests for special arrangements made after this time frame cannot be guaranteed.

Pursuant to NRS 241.020(2) you may contact at (702) 486-7044, to request supporting materials for the public body or you may download the supporting materials for the public body from the Board's website at http://dental.nv.gov In addition, the supporting materials for the public body are available at the Board's office located at 6010 S Rainbow Blvd, Ste. A-1, Las Vegas, Nevada.

Note: Asterisks (*) **"For Possible Action"** denotes items on which the Board may take action.
Note: Action by the Board on an item may be to approve, deny, amend, or tabled.

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1. **Call to Order**

- Roll call/Quorum

Chairman Moore called the meeting to order at approximately 6:06 p.m. Mr. Frank DiMaggio conducted the following roll call:

Anesthesia Committee Roll Call:	
Dr. D. Kevin Moore (Chair)	PRESENT
Dr. Ron West	PRESENT
Dr. W. Todd Thompson	PRESENT

Anesthesia Sub-Committee Roll Call:	
Dr. D. Kevin Moore (Chair)	PRESENT
Dr. Brendan Johnson	PRESENT
Dr. Amanda Okundaye	PRESENT
Dr. Edward Gray	PRESENT
Dr. Jade Miller	PRESENT
Dr. Joshua Saxe	PRESENT
Dr. Ted Twesme	EXCUSED
Dr. Tomas Kutansky	EXCUSED

Others present: Phil Su, General Counsel; Frank DiMaggio, Executive Director; Sandra Spilsbury, Site Inspection – CE Coordinator.

2. **Public Comment (By pre-submitted email/written form):** The public comment period is limited to matters specifically noticed on the agenda. No action may be taken upon the matter raised during public comment unless the matter itself has been specifically included on the agenda as an action item. Comments by the public may be limited to three (3) minutes as a reasonable time, place and manner restriction, but may not be limited based upon viewpoint. The Chairperson may allow additional time at his/her discretion.

   Pursuant to Section 2 of Directive 006, and extended by Directives 016, 018, 021, 026, and 029, members of the public may participate in the meeting without being physically present by submitting public comment via email to nsbde@nsbde.nv.gov, or by mailing/faxing messages to the Board office. Written submissions received by the Board on or before **Monday, January 11, 2021 by 4:00 p.m.** may be entered into the record during the meeting. Any other written public comment submissions received prior to the adjournment of the meeting will be included in the permanent record.

   In accordance with Attorney General Opinion No. 00-047, as restated in the Attorney General's Open Meeting Law Manual, the Chair may prohibit comment if the content of that comment is a topic that is not relevant to, or within the authority of, the Nevada State Board of Dental Examiners, or if the content is willfully disruptive of the meeting by being irrelevant, repetitious, slanderous, offensive, inflammatory, irrational, or amounting to personal attacks or interfering with the rights of other speakers.

Mr. DiMaggio read a statement into the record regarding public comment.

*3. **Chairman's Report**: D. Kevin Moore, DDS (For Possible Action)

(a) Request to remove agenda item(s) (For Possible Action)

No requests were made.

(b) Approve Agenda (For Possible Action)

MOTION: Committee Member West moved to approve the agenda. Committee Member Thompson seconded the motion. All in favor, motion passed.

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***Old Business:** (For Possible Action)

***4. Discussion, review, and consideration of the Dental IV Sedation Certification Program offered through the Academy of Dental and Medical Anesthesia (ADMA) to make recommendations on whether it satisfies program requirements for a moderate sedation (on patients 13 years of age & older) administering permit for possible reinstatement of their prior Board approval [by *combined* Anesthesia Sub-Committee and Anesthesia Committee] – NAC 631.2213(2)(a)(1)** (For Possible Action) - Dr. Moore

***a. Discussion and recommendations [by the Anesthesia Committee] regarding agenda item (4) to present to the Full Board** (For Possible Action)

Committee Member Moore asked to go into closed session pursuant to NRS 241.030.

MOTION: Committee Member West motioned to go in to closed session at approximately 6:14 p.m. Committee Member Thompson seconded the motion. All were in favor, motion passed.

MOTION: Committee Member Thompson motioned to return to open session at approximately 6:58 p.m. Committee Member Moore seconded the motion. All were in favor, motion passed.

Mr. DiMaggio conducted Roll call to re-establish a quorum:

Anesthesia Committee Roll Call:	
Dr. D. Kevin Moore(Chair)	PRESENT
Dr. Ron West	PRESENT
Dr. W. Todd Thompson	PRESENT

Anesthesia Sub-Committee Roll Call:	
Dr. D. Kevin Moore(Chair)	PRESENT
Dr. Brendan Johnson	PRESENT
Dr. Amanda Okundaye	PRESENT
Dr. Edward Gray	PRESENT
Dr. Jade Miller	PRESENT
Dr. Joshua Saxe	PRESENT
Dr. Ted Twesme	EXCUSED
Dr. Tomas Kutansky	EXCUSED

MOTION: Committee Member Moore moved to recommend that the Board deny the ADMA's Dental IV Sedation Certification Program request to reinstate approval of their program. Committee Member West seconded the motion. All were in favor, motion passed.

Committee Member Moore noted that some Committee Members needed to leave at 7:00 p.m., however, he asked that they review what was left to discuss on the agenda prior to tabling these items and adjourning.

***New Business:** (For Possible Action)

***5. Discussion and consideration of possible revision(s) to the current Anesthesia Algorithms for simulated emergencies [by Anesthesia Sub-Committee and Anesthesia Committee] – NAC 631.2225** (For Possible Action)

***a. Discussion and recommendations by the [Anesthesia Committee] of the possible revision(s) to the current Anesthesia Algorithms for simulated emergencies to present to the Full Board** (For Possible Action)

Committee Member Moore commented that the Nevada Administrative Codes (NAC) sets forth what the Board is required to implement. He further commented that if there is a specific algorithm the committee and subcommittee members believe should be permanent, then it would behoove

them to permanently add it to the regulations.

*6. **Reconsideration, Discussion, and Recommendations of possible revision(s) to the Current Anesthesia Evaluation/Inspection Forms [by the Anesthesia Sub-Committee and Anesthesia Committee] – NAC 631.2227 & NAC 631.2231** (For Possible Action)

i) Moderate Sedation
ii) General Anesthesia

*a. **Discussion and recommendation [by the Anesthesia Committee] of the possible revision(s) to the current Anesthesia/Inspection forms to present to the Full Board** (For Possible Action)

Committee Member Moore went over purpose of this agenda item and that any changes made to the regulations, should be reflected in the evaluation/inspection forms, as well.

*7. **Discussion and consideration of possible revision(s) to the current Anesthesia Evaluation process [by Anesthesia Sub-Committee and Anesthesia Committee] - NRS 631.265 & NAC 631.2211 – NAC 631.2256** (For Possible Action)

*a. **Discussion and recommendations by the [Anesthesia Committee] of the possible revision(s) to the current Anesthesia Evaluation process to present to the Full Board** (For Possible Action)

Committee Member Moore stated that Subcommittee Member Twesme and another subcommittee or Committee Member had previously questioned if it was truly necessary for evaluators to physically visit the offices that required inspections and that, perhaps, the Committee and Subcommittee could explore virtual options to conduct evaluations/inspections. He noted that if there were any recommended modifications to the process, it would need to be presented to the Board for consideration and approval.

8. **Discussion if active Nevada licensed MD anesthesiologists and/or Certified Registered Nurse Anesthetists may administer moderate sedation and/or general anesthesia in a dental facility permitted by the Nevada State Dental Board – NRS 631.265 & NAC 631.224** (For Informative Purposes Only)

Committee Member Moore spoke in regards to the disconnection in language between NRS 631.265 and NAC 631.224, and noted the concern for public safety.

Committee Member Moore tabled agenda items (5) through (8) for discussion at a future meeting. He stated that a quorum will be sent for a future meeting to start at 6:00 p.m. and please allocate at least an hour and a half for the meeting.

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9. **Public Comment (Live public comment by teleconference):** This public comment period is for

any matter that is within the jurisdiction of the public body. No action may be taken upon the matter raised during public comment unless the matter itself has been specifically included on the agenda as an action item. Comments by the public may be limited to three (3) minutes as a reasonable time, place and manner restriction, but may not be limited based upon viewpoint. The Chairperson may allow additional time at his/her discretion.

Pursuant to Section 2 of Directive 006, and extended by Directives 016, 018, 021, 026, and 029, members of the public may participate in the meeting without being physically present by submitting public comment via email to nsbde@nsbde.nv.gov, or by mailing/faxing written messages to the Board office. Written submissions should be received by the Board on or before **Monday, January 11, 2021 by 4:00 p.m.** in order to make copies available to members and the public.

In accordance with Attorney General Opinion No. 00-047, as restated in the Attorney General's Open Meeting Law Manual, the Chair may prohibit comment if the content of that comment is a topic that is not relevant to, or within the authority of, the Nevada State Board of Dental Examiners, or if the content is willfully disruptive of the meeting by being irrelevant, repetitious, slanderous, offensive, inflammatory, irrational, or amounting to personal attacks or interfering with the rights of other speakers.

Mr. DiMaggio read a statement into the record.

There was no public comment.

10. Announcements

No announcements were made.

*11. Adjournment (For Possible Action)

Committee Member Moore called for a motion to adjourn.

MOTION: Committee Member West motioned to adjourn the meeting at approximately 7:08 p.m. Committee Member Thompson seconded the motion. All were in favor, motion passed.

Respectfully submitted by:

Frank DiMaggio, Executive Director

Old Business:

Anesthesia Committee and Subcommittee Teleconference Meeting Minutes - 07/29/2020

For Reference Only

NEVADA STATE BOARD OF DENTAL EXAMINERS

Meeting Location:

Nevada State Board of Dental Examiners
6010 S. Rainbow Blvd, Suite A-1
Las Vegas, NV 89118

Zoom Video and Teleconferencing Available for this meeting
Meeting Call-In Number: (669) 900 6833
Meeting ID#: 931 0144 5434
Zoom Video (via app) Password: 113631

Meeting Date & Time

Wednesday, July 29, 2020
6:00 p.m.

MINUTES

NOTICE OF AGENDA & *COMBINED* TELECONFERENCE MEETING OF 1) THE ANESTHESIA COMMITTEE and 2) THE ANESTHESIA SUB-COMMITTEE

PUBLIC NOTICE:

The Nevada State Board of Dental Examiners may hold board meetings via video conference or telephone conference call. The public is welcomed to attend the meeting at The Board of Dental Examiners office located at 6010 S. Rainbow Blvd, Suite A1 Las Vegas, NV 89118.

Public Comment time is available after roll call (beginning of meeting) and prior to adjournment (end of meeting). Public Comment is limited to three (3) minutes for each individual. You may provide the Board with written comment to be added to the record.

Persons wishing to comment may appear at the scheduled meeting/hearing or may address their comments, data, views, arguments in written form to: **Nevada State Board of Dental Examiners, 6010 S. Rainbow Blvd, A-1, Las Vegas, Nevada 89118, Attn: Angelica Bejar; FAX number (702) 486-7046; e-mail address** nsbde@nsbde.nv.gov . Written submissions should be received by the Board on or before **July 28, 2020 at 3:00 p.m.** in order to make copies available to members and the public.

The Nevada State Board of Dental Examiners may 1) address agenda items out of sequence to accommodate persons appearing before the Board or to aid the efficiency or effectiveness of the meeting; 2) combine items for consideration by the public body; 3) pull or remove items from the agenda at any time. The Board may convene in closed session to consider the character, alleged misconduct, professional competence or physical or mental health of a person. *See* NRS 241.030. Prior to the commencement and conclusion of a contested case or a quasi-judicial proceeding that may affect the due process rights of an individual the board may refuse to consider public comment. *See* NRS 233B.126.

Persons/facilities who want to be on the mailing list must submit a written request every six (6) months to the Nevada State Board of Dental Examiners at the address listed in the previous paragraph. With regard to any board meeting or telephone conference, it is possible that an amended agenda will be published adding new items to the original agenda. Amended Nevada notices will be posted in compliance with the Open Meeting Law.

We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify Angelica Bejar, at (702) 486-7044, option 4, no later than 48 hours prior to the meeting. Requests for special arrangements made after this time frame cannot be guaranteed.

Pursuant to NRS 241.020(2) you may contact Angelica Bejar at (702) 486-7044, option 4, to request supporting materials for the public body or you may download the supporting materials for the public body from the Board's website at http://dental.nv.gov In addition, the supporting materials for the public body are available at the Board's office located at 6010 S Rainbow Blvd, Ste. A-1, Las Vegas, Nevada.

Note: Asterisks (*) **"For Possible Action"** denotes items on which the Board may take action.
Note: Action by the Board on an item may be to approve, deny, amend, or tabled.

1. Call to Order

- Roll call/ Quorum

Committee Member Moore called the meeting to order at approximately 6:04 p.m., and Mr. Frank DiMaggio conducted the following roll call:

Anesthesia Committee:	
Dr. D. Kevin Moore(Chair)	PRESENT
Dr. Ron West	PRESENT
Dr. W. Todd Thompson	PRESENT

Executive Staff Present: Phil Su, Esquire, General Counsel; Frank DiMaggio, Executive Director; Angelica Bejar, Public Information- Travel Administrator; Sandra Spilsbury, Site Inspection-CE Coordinator.

2. **Public Comment:** The public comment period is limited to matters specifically noticed on the agenda. No action may be taken upon the matter raised during public comment unless the matter itself has been specifically included on the agenda as an action item. Comments by the public may be limited to three minutes as a reasonable time, place and manner restriction, but may not be limited based upon viewpoint. The Chairperson may allow additional time at his/her discretion.

Mr. Cory Pickens commented that he was on the agenda for a re-review of their program. Gave a brief history of the reason why they were being re-reviewed. He explained that a Nevada dentist was registered to take their course at a location and program that was not approved by the board. When the error was realized they refunded the dentist and had the dentist registered into the correct program at the correct location and noted that they have since then corrected the issue. He asked that they verify the legitimacy of any negative comments that may have gone around regarding ADMA. He thanked the committee for their time.

***3. Chairman's Report**: *D Kevin Moore, DDS* (For Possible Action)

(a) Request to remove agenda item(s) (For Possible Action)

Committee member Moore requested to table agenda item 4 due to receiving additional information prior to the meeting, and the committee needing time to review the additional information received.

(b) Approve Agenda (For Possible Action)

MOTION: Committee Member West moved to table agenda item (4) and to approve the agenda. Committee Member Thompson seconded the motion. All were in favor, motion passed.

***4. ~~Discussion, review, and consideration of the Dental IV Sedation Certification Program offered through the Academy of Dental and Medical Anesthesia (ADMA) to make recommendations on whether it satisfies program requirements for a moderate sedation (on patients 13 years of age & older) administering permit for possible reinstatement of their prior Board approval – NAC 631.2213(2)(a)(1) [by *combined* Anesthesia Sub-Committee and Anesthesia Committee]~~** (For Possible Action) - Dr. Moore

***a. ~~Discussion and recommendations [by the Anesthesia Committee] regarding agenda item (4) to present to the Full Board~~** (For Possible Action)

Agenda item (4) was tabled.

***5. Discussion and consideration of possible revisions to the current Moderate Sedation (for patients 13 years of age & older) Program Provider Application Form [by *combined* Anesthesia Sub-Committee and Anesthesia Committee]** (For Possible Action) - Dr. Moore

***a. Discussion and recommendations [by the Anesthesia Committee] regarding agenda item (5) to present to the Full Board** (For Possible Action)

Committee Member Moore stated that they would be looking at the Moderate Sedation Program Provider Application Form, and called for discussion. He noted that his would be a review of the application and process, and to see if the committee members were comfortable with the current structure of the form, which he briefly reviewed.

Committee Member Moore called for a roll call of the Anesthesia Sub-Committee. Mr. DiMaggio conducted the following roll call of the Anesthesia Sub-Committee:

Anesthesia Sub-Committee Roll Call:	
Dr. D. Kevin Moore(Chair)	PRESENT
Dr. Brendan Johnson	PRESENT
Dr. Amanda Okundaye	PRESENT
Dr. Edward Gray	EXCUSED
Dr. Jade Miller	PRESENT
Dr. Joshua Saxe	EXCUSED
Dr. Ted Twesme	PRESENT
Dr. Tomas Kutansky	PRESENT

A quorum of the Anesthesia Sub-Committee was confirmed at approximately 6:14 p.m.

Committee Member Thompson noted that the form was last revised in August of 2018 and he did not see any revisions to be made to the form. Committee Member West stated that there was not that many approved courses for Moderate Sedation available. He inquired if they wanted licensees to continue to participate in live training programs since some of the programs currently available are offering virtual training programs and if they were inclined to accept such course, which would allow programs to be tailored to fit the Board's training requirements; or would they continue to require that the courses remain face-to-face live training. Committee Member Johnson stated that from an academics perspective virtual learning would be doable, however, that doing away with a live training course with a live patient where they are also trained to monitor and on emergency scenarios, would not be ideal. He added that it would a great liability risk and was grossly opposed to allowing them to change it to virtual training. Committee Member West clarified that meant that the didactic aspect of the training possibly could be completed virtually. Sub-Committee Member Okundaye noted that while they are moving to a more virtual world, her input was that should the 60 hours be done virtually that they would need to have something to show that those 60 hours were actually completed since it wasn't in person. Her only concern with virtual training was she would want proof showing that they have reviewed and grasped the materials of the training. She noted the importance of having the administration of anesthesia training be done in person. There was discussion of considering having the didactic portion be completed virtually and the administration training completed in person, while considering the important aspects to keep in mind should they consider allowing a portion of the requirements be virtually completed. Committee Member Thompson stated that the application in question does not state how the training must be completed, and therefore did not feel that the review of the application merited a discussion of changing the form as presented.

MOTION: Committee Member Thompson made a motion to accept the current agenda item with the application form as is. Discussion: Committee Member West read section 2 of the form into the record and clarified that he was looking at the manner, purpose and method of how the education might be completed. Committee Member Moore inquired if any of the sections listed on the application would disallow part of the course from being completed virtually. Sub-Committee Member Okundaye stated that this year her course that she is teaching is part hybrid, and therefore, part of it is being completed virtually. She noted that given the current times they would not want to be so strict in this new climate. Additional discussion ensued regarding the possibility of allowing a portion of the training be completed virtually and the possible number of hours they would allow to be done virtually, and how many hours must be live training. There was discussion of possibly tabling the discussion of online training and live training hours. Committee Member Moore inquired if Committee Member Thompson stated a motion. Committee Member Thompson stated that his motion was to keep the form as is. He expressed his concerns with some of the discussion regarding changing the number of hours of live patient training and allowing for a portion of the hours to be completed virtually, while trying to be realistic of some of the hybrid courses currently being offered at the universities. He noted that he was against the idea of allowing a 60-hour course that consisted of all virtual training. Committee Member Moore seconded the motion. Discussion: Sub-Committee Member Miller noted that one option is that when a program provider submits an application, upon review they should be able to determine if that particular program had too many hours completed virtually. Ms. Sandra Spilsbury stated that she receives numerous calls from providers regarding concerns of their course possibly not meeting the requirements. Furthermore, that they hesitate submitting an application for their program and pay the application fee when the fee is not refundable, if they cannot guarantee that their program would be approved because it is not clearly defined if the didactic portion of the course may be completed online. She noted that many courses do offer the didactic portion online and will only know if their course meets the requirements by submitting the provider application and potentially lose the money should the course be denied for not meeting the criteria. Additional discussion ensued regarding where the live patient training be completed. She noted that the Board historically has not accepted courses that have the live patient training conducted in a private practice setting. Committee Member West inquired if the Sub-Committee members who are practicing permit holders, if they would be opposed to having a course done in a private practice versus requiring it be done in a hospital or approved Continuing Education setting. Sub-Committee Member Kutansky stated that

there have been some evaluations he has conducted where the permit holder had their training done at a university setting and were scary to proctor because they were undertrained. He noted that he was reluctant to make the criteria easier. There were concerns that with COVID-19, hospital settings may not be available for individuals to get the training. Sub-Committee Member Kutansky expressed his concern regarding the delicacy of the area that individuals are being trained for, the administration of anesthesia. There was some discussion regarding the settings that the training would take place. Sub-Committee Member Okundaye stated that the locations that the training takes place at must have ADA/CERP/AGD certification, which the certification criteria requires that the training must be in a university based program. Additionally, that it is nearly impossible to obtain ADA/CERP/AGD certification in a private practice setting. All were in favor of the motion, motion passed.

Committee Member Moore stated that he would make a note of Sub-Committee Member Okundaye's suggestion that the matter regarding the hours of training be revisited by the Committee at the end of the year, when they may have a better understanding of the effects of COVID-19.

***6. Discussion and consideration of possible revisions to the current Anesthesia Evaluator/Inspector Application Form [by Anesthesia Sub-Committee and Anesthesia Committee]**

(For Possible Action) - Dr. Moore

***a. Discussion and recommendations by the [Anesthesia Committee] of the possible revisions to the current Anesthesia Evaluator/Inspector Application Form to present to the Full Board**

(For Possible Action)

Committee Member Moore referred the committee and sub-committee members to the page with the requirements listed on the application form, and he proceeded to review each requirement. He continued on to discuss the terms "good standing" and how it may be defined, which he deferred to Mr. DiMaggio for discussion. Mr. DiMaggio stated that currently "good standing" was not defined in Nevada Chapter 631. He noted that it would be at the Board's discretion to define it. He added that he provided proposed drafts for the committee and sub-committee members to consider. Mr. DiMaggio briefly went over the proposed drafts he created for consideration. There was light discussion regarding liability coverage concerns, where it was noted that Nevada currently does not mandate liability coverage for dentists. Several committee and sub-committee members favored the proposed drafts as presented. Committee Member Moore asked Mr. DiMaggio to include a question regarding liability insurance coverage to the proposed drafts. He noted that he was not certain if the Board could require coverage if the statutes do not require licensees to obtain such coverage.

MOTION: Committee Member Thompson made the motion to accept the draft changes proposed by the Executive Director on the Anesthesia evaluator/inspector application form. Committee Member West seconded the motion. All were in favor, motion passed.

***7. Discussion and recommendations of possible revisions to the current Anesthesia Administering Permit Application Forms [by Anesthesia Sub-Committee and Anesthesia Committee]**

(For Possible Action) - Dr. Moore

i. General Anesthesia (For Possible Action)
ii. Moderate Sedation (pediatric specialty) (For Possible Action)
iii. Moderate Sedation (for patients 13 years of age & older) (For Possible Action)

***a. Discussion and recommendations [by the Anesthesia Committee] of the possible revisions to the current Anesthesia Administering Permit Application Forms to present to the Full Board**

(For Possible Action) - Dr. Moore

Committee Member Moore stated he listed these as a group and opens it up to suggestions for proposed changes. He inquired if there were any proposed changes to the forms. No proposed changes were offered.

MOTION: Committee Member Thompson made the motion to keep the forms as is. Committee Member West seconded the motion. All were in favor, motion passed.

***8. Discussion, review, and possible consideration of revisions to the current Anesthesia Evaluation/Inspection Forms [by the Anesthesia Sub-Committee and Anesthesia Committee]** (For Possible Action) - Dr. Moore

i. General Anesthesia (For Possible Action)
ii. Moderate Sedation (For Possible Action)

Committee Member Moore stated this was to review the evaluation/inspection forms currently being used. It was briefly noted that it was suggested that they possibly change the headings where the drugs are listed. Sub-Committee Member Twesme noted that on the General Anesthesia (GA) Evaluation/Inspection form under section (7) Ancillary Equipment item (i) it states "electrocardioscope and defibrillator" which should be listed separately as they are two different items. Ms. Spilsbury noted that pursuant to NAC 631.2227, they had both items listed together, and therefore was unsure if they would be able to list them separately on the evaluation/inspection form. Sub-Committee Member Twesme stated that they would still be in compliance with the regulation if they were to separate them on the form as both items were still required equipment. It was noted to separate item (c) and make sphygmomanometer and stethoscope two separate items, since they must have both. Sub-Committee Twesme noted that it would be best separate them as there have been times where an office is only equipped with one item and not both as listed.

Sub-Committee Member Okundaye noted that on page 4 of the GA Evaluation/inspection form, under item (1) Bag valve mask with appropriate size masks, she noted that an adult sized masked would be more appropriate since the kids they see are measured by weight, which many of them better fit an adult sized mask, and therefore, did not feel that inspectors should be limiting it to certain offices only providing pediatric sized masks. She noted, however, that it could be addressed during calibration and didn't necessitate a change on the form. Sub-Committee Member Okundaye clarified that the bag can be an adult sized bag, however, that the mask sizes they must carry are from neo-natal to adult sized. It was agreed that the way it is written on the evaluation form is acceptable, but would like it addressed during calibration.

Sub-Committee Member Okundaye noted that there was one other area that she felt should also be discussed at a future calibration, which was on page three of the Moderate Sedation (MS) site inspection form, specifically under "'Drugs' item 1 – Vasopressor drug available?" it should be made clear that providers may use any of the acceptable drugs listed that may be used as a vasopressor. She suggested that they list the three that are acceptable and have the provider or inspector indicate which of the three drugs they have elected to use to satisfy this requirement for their MS permit. Sub-Committee Member Twesme asked for clarification if an epi-pen would be appropriate. Sub-Committee Member Okundaye stated yes. Additional discussion ensued on the list of appropriate drugs that inspectors should be referring to when conducting the inspections and that the provider should be allowed to select from the list of acceptable drugs to satisfy a particular category during inspection. Committee Member Moore stated that during calibration it will be noted that so long as the provider has a drug that is on the list of acceptable drugs then the provider should not be delayed in receiving a passing inspection. Sub-Committee Member Twesme suggested that perhaps Sub-Committee Member Okundaye could put together a list of acceptable drugs for the different categories that providers and inspectors could refer to. Committee Member Moore stated that they should have a class of drugs that would be acceptable and not have it so limited and specific based on preferred medications. He added further that the updated list of drugs be provided to providers and inspectors in their packets.

Sub-Committee Member Okundaye referred the committees to the Simulated Emergencies section, specifically item 14, that instead of stating Local Anesthesia "overdose" she preferred the term "toxicity" and suggested it be changed.

Sub-Committee Member Okundaye suggested removing 'Laryngospasm' from the simulated emergencies of the moderate sedation evaluation forms as they do not use it under that permit type. She noted, however, that if they do not change it, she would like it to be discussed at calibration. She stated they could discuss that scenario during the exam, and should they feel it fits that simulated emergency then they would be fine; she just wanted to point out that for moderate sedation providers it was not something they would see. Ms. Spilsbury noted that under NAC 631.2225, it did list an airway obstruction laryngospasm as one of the scenarios that is required for both the issuance of a permit and

for renewals of a permit, whether a general anesthesia permit or moderate sedation permit. Ms. Spilsbury noted further that for the use of the term "toxicity" instead of "overdose" the regulation lists "overdose" and perhaps that is why the form uses that term. Committee Member Moore stated he appreciated them bringing these suggestions to their attention, as he would like them to be reviewed by Mr. Phil Su for future regulation changes. There was lengthy discussion regarding the term 'laryngospasm' and the legal requirements of having to use the term in the emergency scenarios for general anesthesia and moderate sedation permits, with offered opinions from several committee members on its necessity as it related to general anesthesia and moderate sedation. Committee and sub-committee members appeared to agree to include 'airway obstructions/laryngospasms' to the moderate sedation permit evaluation form and to leave the language as is on the general anesthesia evaluation/inspection form.

***a. Discussion and recommendations [by the Anesthesia Committee] of the possible revisions to the current Anesthesia Evaluation/Inspection Form to present to the Full Board**
(For Possible Action) - Dr. Moore

MOTION: Committee Member West made the motion to recommend the following changes to the General Anesthesia Form: (1) under ancillary equipment split items (c) and (i) to list the equipment separately; and (2) change number 14 under emergency scenarios to read 'local anesthesia overdose/ toxicity. Committee Member Thompson seconded the motion. All were in favor, motion passed.

MOTION: Committee Member West made the motion to recommend the following changes to the Moderate Sedation form: (1) under emergency scenarios change the moderate sedation form to read 'airway obstructions/laryngospasm; and (2) change number 14 under emergency scenarios to read 'local anesthesia overdose/ toxicity. Committee Member Thompson seconded the motion. All were in favor, motion passed.

***9. Discussion and consideration of possible revisions to the current Simulated Emergencies & Responses for corresponding anesthesia permits [by Anesthesia Sub-Committee and Anesthesia Committee]** (For Possible Action) - Dr. Moore

i. General Anesthesia (For Possible Action)
ii. Moderate Sedation (pediatric specialty) (For Possible Action)
iii. Moderate Sedation (for patients 13 years of age & older) (For Possible Action)

***a. Discussion and recommendations [by the Anesthesia Committee] of the possible revisions to the current Simulated Emergencies & Responses for corresponding anesthesia permits to present to the Full Board** (For Possible Action) - Dr. Moore

Committee Member Moore stated that they would only be required to go into closed session if they were going to go into specifics. He noted that the scenarios were deemed confidential and that they had not been revised in years, and that he would like new scenarios written. Sub-Committee Okundaye stated that she would like to have both the Anesthesia Sub-committee and Anesthesia Committee members to meet during calibration and, perhaps, review and revise the emergency scenarios at that time. It was clarified that the Anesthesia Sub-Committee meet to review and revise the emergency scenarios during calibration, and then present the proposed revisions to the Anesthesia Committee for review and possible recommendation to the Board for approval.

MOTION: Committee Member West made the motion to have the Anesthesia Sub-Committee to thoroughly review the emergency scenarios to make appropriate changes to submit to the Anesthesia Committee for approval. At the request of Committee Member Moore, Committee Member West added to his motion to have the Anesthesia Evaluators partake in the review and revision of the emergency scenarios. Committee Member Thompson seconded the motion. All were in favor, motion passed.

Sub-Committee Member Twesme stated that he currently sat on the CDCA Anesthesia Committee and noted that they have an Anesthesia exam that can be purchased from CDCA for general anesthesia, pediatric moderate sedation, and moderate sedation, that included an exam that they could take; which includes them doing a virtual evaluation where they will review the appropriate drugs as it pertained to each permit type. He explained what the virtual evaluation entailed. He went on to briefly

discuss certain instances where evaluators have had to step in during an evaluation to help control a potential emergency situation, specifically in California. Committee Member Moore inquired if it would be possible to have him request for CDCA to give a presentation of this option, and that he would list it on a future agenda.

10. Public Comment: This public comment period is for any matter that is within the jurisdiction of the public body. No action may be taken upon the matter raised during public comment unless the matter itself has been specifically included on the agenda as an action item. The Chairperson of the Board will impose a time limit of three (3) minutes. The Chairperson may allow additional time at his/her discretion.

Dr. Cory Pickens, with the ADMA, commented on the virtual training as it pertained to the 60 hours of live training required, and stated that he believed that the 60 hours could be done virtually if they have a live instructor training them where questions can be answered in live time. He added that there should be testing in general areas based on those 60 hours, which would be based on whether or not the state wants to add a participation/proficiency aspect to the didactics and clinical portions of the training. He noted that the ADMA will not further anyone unless they can prove proficiency on the topics covered in the 60 hours; which included them having to pass a test on each topic, including clinical. He made additional comments regarding evaluations and stated that Nevada has always led the way in being progressive and issuing strong regulations for public safety that have a lot of common sense. He noted that he agreed with Sub-Committee Member Okundaye's recommendation to have an educational component added to the site inspection and to hold calibrations to ensure that the inspectors/evaluators and committee members are all on the same page.

Mr. Mercer, with the ADMA, stated that he had been in touch with Sandra Spilsbury via email and he respectfully requested an update on that agenda item and wanted to know if there was any additional information needed so that the board could move forward with their application. Ms. Spilsbury noted that the application was already reviewed by the Continuing Education Committee and their recommendations were presented to the Board for approval; however, the Board tabled the application pending review of the sedation course by the Anesthesia Committee. Mercer stated that he was inquiring specifically about the neuromodulators application and its status. Committee Member Moore stated that their application was tabled as the Board members wanted additional information regarding ADMA. Dr. Pickens stated that it was clearly understood.

Dr. Pickens commented that it appeared that there were emails with additional information provided to the Committee regarding ADMA and wondered if they would be provided with copies of the information that the Board was in receipt of so that they may provide a response. Committee Member Moore responded affirmatively.

11. Announcements

No announcements were made.

***12. Adjournment** (For Possible Action)

Committee member Moore called for a motion to adjourn the meeting.

MOTION: Committee Member West motioned to adjourn the meeting at approximately 7:38 p.m. Committee Member Thompson seconded the motion. All were in favor, motion passed.

Respectfully submitted:

Frank DiMaggio, Executive Director

Agenda Item (4):

Current Anesthesia Algorithms for Simulated Emergencies

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Laryngospasm Algorithm (AO)

R - Recognition of Emergency

Assess mild vs. severe airway obstruction

Mild: good air exchange; responsive and can cough forcefully

Severe: poor or no air exchange; weak or ineffective cough or no cough; high-pitched noise while inhaling or no noise at all; increased respiratory difficulty; possible cyanosis; unable to speak; unable to move air

Typically caused by water, fluid, foreign body or tooth debris when a patient is too deeply sedated

Most often, patient will cough, then show signs of difficulty breathing

Remove all retrievable material from mouth

Call for assistance: retrieve O_2, AED, and emergency kit

P - Position

Supine

A - Airway

Suction airway with yankauer suction device

Perform head tilt-chin lift, jaw thrust

If partial obstruction and can cough, encourage vigorous coughing; call 911 if problem worsens or persists

If total obstruction or with significant partial obstruction and inability to cough, call 911; place in supine position; begin positive pressure ventilation using BVM at 10 L/min 100% O_2; begin CPR if no pulse

If patient becomes unresponsive, call 911; place in supine position; begin positive pressure ventilation using BVM at 10 L/min 100% O_2; begin CPR if no pulse

B - Breathing

Breathing check incorporated above

C - Circulation

If no pulse, move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy

Moderate sedation providers: Administer reversal agents until the patient is able to breath on their own or until EMS arrives

Naloxone 0.4 mg IV (every 2-3 minutes) [Opioid reversal]

Flumazenil 0.5 mg IV only per package insert (repeat twice if needed every 1 minute)

General Anesthesia providers: Administer **Succinylcholine 20mg IV push**

E - Emergency Medical Services - *If EMS is activated*, facilitate access of emergency personnel by waiting for arrival and escort to office

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Bronchospasm (Asthma Attack) Algorithm (AO 2015)

R - Recognition of Emergency

Check for evidence of bronchospasm (expiratory wheezing; dyspnea; may be gradual to sudden in onset)
May have increased respiratory efforts
Call for assistance: retrieve O_2, AED, and emergency kit
Remove materials from mouth

P - Position

Comfortable for patient, usually sitting upright

A - Airway

Assess airway patency

B - Breathing

Assess breathing
If breathing, reassure patient; may consider oxygen as directed by pulse oximetry; otherwise 100% O_2 @ 10 L/min via facemask
If not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O_2*

C - Circulation

Assess pulse
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy

Auscultate lungs; examine airway for signs of airway edema
Administer ***albuterol*** inhaler 1-3 puffs (90 mcg each puff) repeat every 2-3 minutes up to 12 puffs
Consider calling 911 if symptoms not relieved
May use spacer (*AeroChamber*) for child or sedated/unconscious adult
For severe bronchospasm not responsive to ***albuterol***
  Administer ***1:1000 epinephrine*** (1mg/mL), 0.3 mg (0.3 mL) IM (upper thigh), repeat every 5 minutes until stable
  May use *EpiPen* IM (upper thigh) in adults, *EpiPen Jr* IM (upper thigh) in children
  Call 911

E - Emergency Medical Services

If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

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Airway Obstruction–Foreign Body Algorithm (AO 2015)

R - Recognition of Emergency

Assess mild vs. severe airway obstruction

Mild: good air exchange; responsive and can cough forcefully

Severe: poor or no air exchange; weak or ineffective cough or no cough; high-pitched noise while inhaling or no noise at all; increased respiratory difficulty; possible cyanosis; unable to speak; clutching the neck with the thumb and fingers, making the universal choking sign; unable to move air

Sudden disappearance of tooth, instrument or foreign object/debris in mouth

Remove all retrievable material from mouth

Call for assistance: retrieve O_2, AED, and emergency kit

P - Position

If sudden loss of object without airway obstruction, let the patient attempt to expel the foreign object

If acute partial or total loss of airway, position yourself to perform the Heimlich maneuver

If patient is unconscious, place into supine position

A - Airway

If patient is cooperative and breathing, let the patient attempt to expel the foreign object

If partial obstruction and can cough, encourage vigorous coughing; examine airway for retrieval of lost object; repeat sequence; call 911 if problem worsens or persists

If total obstruction or with significant partial obstruction and inability to cough, perform *Heimlich* maneuver (ages ≥ 1 year; chest thrusts in pregnant women, obese patients; back blows and chest compressions in infants) until ventilation restored or patient becomes unresponsive

If patient becomes unresponsive, call 911; place in supine position; examine airway quickly and remove an object if you see it; begin CPR

B - Breathing

Breathing check incorporated above

C - Circulation

If awake, check pulse and blood pressure; record vital signs at least every 5 minutes

If pulse but unresponsive, call 911; open the airway, remove the object if you see it; begin CPR; each time you give breaths, open the victim's mouth wide and look for the object; if you see an object, remove it with your fingers; if you do not see an object, keep doing CPR

If no pulse, move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy

Consider chest, head and neck, and/or abdominal radiographs to identify location of object

E - Emergency Medical Services

If EMS is activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

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Respiratory Depression Algorithm (AO 2015)

R-Recognition of emergency
Absence of breathing or decrease in respiratory rate/volume
Generally associated with loss of consciousness or altered mental status
Call for assistance: retrieve O2, AED, and emergency kit
Remove materials from mouth

P-Position
Comfortable position if conscious
If unconscious, supine position with legs elevated

A-Airway
Assess airway patency
If obstructed, head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)
If apneic, perform rescue breathing*

B-Breathing
Check breathing
If breathing, oxygen as directed by pulse oximetry; otherwise 100% O2, 10 L/min via facemask
If not breathing, call 911; positive pressure ventilation using BVM at 10L/min 100% O2*

C-Circulation
Check pulse (up to 10 seconds; carotid artery ages ≥ 1 year)
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D-Diagnosis, Definitive Therapy
Auscultate lungs
May consider the use of airway adjuncts
Search for cause of respiratory depression (e.g., syncope, medications, hypoglycemia, stroke, hypercarbia)
Call 911 if the respiratory depression is not easily managed (difficult airway), no likely cause is identified (e.g., syncope), or does not resolve within a few minutes

E-Emergency medical services
If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

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Allergic Reaction Algorithm (AO 2015)

R - Recognition of Emergency

Check for evidence of an acute allergy (flushing, urticaria, nausea, angioedema, wheezing, hypotension, itching)
Call for assistance: retrieve O_2, AED, and emergency kit
Remove all materials from mouth

P - Position

Position patient comfortably
With airway compromise, sit upright

A - Airway

Assess airway patency
If obstructed, head tilt-chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)
Monitor for upper airway obstruction (due to airway edema)

B - Breathing

Check breathing
If breathing, O_2 as directed by pulse oximetry; otherwise 100% O_2 @ 10 L/min via facemask
If not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O_2

C - Circulation

Assess pulse (carotid artery)
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy

Auscultate lungs; examine airway for signs of airway edema
For cutaneous reaction, consider ***diphenhydramine*** (***Benadryl***), 50 mg (0.5 mg/kg in children) IM (deltoid or upper thigh)
For anaphylaxis
(1.) Administer ***1:1,000 epinephrine*** (1mg/mL) 0.3mg IM (upper thigh), repeat every 5 minutes until stable
May use ***EpiPen*** IM (upper thigh) in adults, ***EpiPen Jr*** IM (upper thigh) in children
(2.) Call 911
(3.) Administer ***diphenhydramine***, 50 mg (0.5 mg/kg in children) IM (deltoid or upper thigh)
(4.) Consider ***albuterol***, 4-6 puffs inhalation for bronchospasm
If hypotensive, place in supine position with legs elevated

E - Emergency Medical Services

If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

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Seizure Algorithm (6/2015)

R - Recognition of Emergency
Generalized tonic-clonic (*grand mal*) or clonic seizures
Call for assistance: retrieve O2, AED, and emergency kit

P - Position
Remove materials from mouth only if possible to do so safely
Supine position
Protect the patient against physical injury

A - Airway
Assess airway patency
If obstructed, perform head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)

B - Breathing
Assess breathing
If breathing, O2 as directed by pulse oximetry; otherwise 100% O2 @ 10 L/min via facemask
If not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O2*
Patient may experience respiratory depression while in a postictal state; be prepared to assist breathing

C - Circulation
Assess pulse (carotid artery)
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes if possible
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy
Call for family member to come assist you in evaluating the seizure (they will have a better idea of what is typical vs. atypical for this particular patient)
Look for specific cause of seizure (e.g., epilepsy history, syncope)
May administer ***midazolam,*** 0.1 – 0.2 mg/kg up to a total dose of 10mg IM (adults) or 0.1 mg/kg up to a total dose of 3 mg IM (children), usually for prolonged, repeated seizures
May administer ***midazolam*** IN (intra-nasally) 0.2mg/kg up to 10mg
Call 911 for new, continuous, or recurring seizures

E - Emergency Medical Services
If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

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Local Anesthesia Overdose Algorithm (AO 2015)

R - Recognition of Emergency

Patient begins to act differently after local anesthesia is given (agitated, confused, slurred speech, drowsy/unconscious, seizures)
Call for assistance: retrieve O_2, AED, and emergency kit

P - Position

Remove materials from mouth
Supine position
Protect the patient against physical injury

A - Airway

Assess airway patency
If obstructed, perform head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)

B - Breathing

Check breathing
If breathing, O_2 as directed by pulse oximetry; otherwise 100% O_2 @ 10 L/min via facemask
If not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O_2*
If the patient has a seizure, they may experience respiratory depression while in a postictal state; be prepared to assist breathing

C - Circulation

Check pulse (carotid artery)
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy

Call 911, inform them that you think it might be a local anesthetic overdose
For the most part, this is a preventable condition

E - Emergency Medical Services

If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

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Hyperglycemia Algorithm (AO 2015)

R - Recognition of emergency
Hyperventilation, tachycardia, confusion, possibly 'sweet' breath, hypotension
Medical history evidence of hyperglycemia risk (e.g., history of insulin-dependent diabetes)
Call for assistance: retrieve O_2, AED, and emergency kit
Remove materials from mouth

P - Position
Comfortable for patient, usually sitting upright
If unconscious, supine with legs elevated

A - Airway
Assess airway patency
If obstructed, head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)

B - Breathing
Check breathing
If breathing, O_2 as directed by pulse oximetry; otherwise 100% O_2 @ 10 L/min via facemask
If not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O_2*

C - Circulation
Check pulse (up to 10 seconds; carotid artery ages ≥ 1 year)
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy
Call 911-EMS will administer *insulin* as needed
If glucometer is available, measure blood glucose (best to check blood sugar on diabetic patients before and after treatment)

E - Emergency medical services
If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

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Hypoglycemia Algorithm (AO 2015)

R - Recognition of emergency
Diaphoresis, tachycardia, confusion, and potentially loss of consciousness
Medical history evidence of hypoglycemia risk (e.g., history of insulin-dependent diabetes)
Call for assistance: retrieve O_2, AED, and emergency kit
Remove materials from mouth

P - Position
Comfortable for patient, usually sitting upright
If unconscious, supine with legs elevated

A - Airway
Assess airway patency
If obstructed, head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)

B - Breathing
Assess breathing
If breathing, oxygen as directed by pulse oximetry; otherwise 100% O_2 @ 10 L/min via facemask
If not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O_2*

C - Circulation
Assess pulse
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy
If glucometer is available, measure blood glucose (best to check blood sugar on diabetic patients before and after treatment)
If awake, administer oral fluids containing *sugar*
If unconscious, call 911

E - Emergency medical services
If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

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Hypertension Algorithm (AO 2015)

R - Recognition of Emergency

Take blood pressure
Hypertensive urgency: BP above 220/120 mm Hg but no signs or symptoms
Hypertensive crisis: hypertension with evidence of myocardial ischemia, neurologic dysfunction, significant bradycardia, pulmonary edema, signs of stroke or visual disturbances
Call for assistance: retrieve O_2, AED, and emergency kit
Remove materials from mouth

P - Position

Comfortable for patient, usually sitting upright

A - Airway

Assess airway patency
If obstructed, head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)

B - Breathing

Assess breathing
If breathing, oxygen as directed by pulse oximetry; otherwise 100% O_2 @ 10 L/min via facemask
If not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O_2*

C - Circulation

Assess pulse
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy

Look for specific cause of hypertension (e.g., anxiety, cardiovascular disease, drug interaction, full bladder, hypoxia, pain) and treat specific cause (e.g., provide additional local anesthesia for pain control)
If hypertensive urgency, consider immediate physician referral
If hypertensive crisis, call 911

E - Emergency Medical Services

If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

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Hypotension Algorithm (AO 2015)

R - Recognition of emergency

Blood pressure is significantly below normal for the patient or causing signs and symptoms of hypoperfusion (e.g., dizziness, lightheadedness, nausea)
Call for assistance: retrieve O_2, AED, and emergency kit
Remove materials from mouth

P - Position

Supine with legs elevated

A - Airway

Assess airway patency
If obstructed, head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)

B - Breathing

Check breathing
If breathing, oxygen as directed by pulse oximetry; otherwise, 100% O_2 @ 10 L/min via facemask
If *not breathing,* call 911; positive pressure ventilation with BVM @ 10L/min 100% O_2*

C - Circulation

Check pulse (carotid artery)
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy

Look for specific cause of hypotension (e.g., anxiety, cardiovascular disease, hypovolemia, drugs, hypercarbia, hypoxia, pain, postural change)
Treat the specific cause (e.g., give O_2 for hypoxia)
If treatment of the specific cause fails to resolve the problem, call 911

E - Emergency medical services

If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

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Hyperventilation Syndrome Algorithm (AO 2015)

R - Recognition of Emergency
Increased rate of ventilation; patient visibly anxious; chest pain/palpitation, paresthesia
Call for assistance: retrieve O_2, AED, and emergency kit
Remove materials from mouth

P - Position
Comfortable for patient, usually sitting upright

A - Airway
Monitor for upper airway obstruction

B - Breathing
Monitor breathing rate-try to get them to slow down and relax
Reassure patient

C - Circulation
Check heart rate and blood pressure; record vital signs at least every 5 minutes

D - Diagnosis, Definitive Therapy
Auscultate lungs
If wheezing, go to **Bronchospasm Algorithm**
Coach patient to breathe more slowly
Have patient rebreathe CO_2
Consider *nitrous oxide*
If unable to reverse signs and symptoms, consider calling 911

E - Emergency Medical Services
If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

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Syncope Algorithm (AO 2015)

R - Recognition of emergency

Sudden loss of consciousness
Call for assistance: retrieve O_2, AED, and emergency kit
Remove materials from mouth

P – Position

Supine with legs elevated

C – Circulation

Check pulse (up to 10 seconds; carotid artery ages ≥ 1 year)
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

A – Airway

Assess airway patency
If obstructed, head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)

B – Breathing

Check breathing
If breathing, oxygen as directed by pulse oximetry; otherwise 100% oxygen, 10 L/min via facemask
If not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O_2*

D - Diagnosis, Definitive Therapy

Search for cause of syncope (e.g., fear, hypotension, hypoxia, hypoglycemia, arrhythmia, stroke, postural hypotension, epilepsy)
Call 911 if there is suspicion that the loss of consciousness may reflect a potentially serious condition

E - Emergency medical services

If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

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Angina Algorithm (6/2015)

R - Recognition of Emergency

Patient complains of chest/upper gastric pain/pressure; may radiate to left arm, jaw, back
May have nausea, dyspnea, palpitation, dizziness, anxiety, diaphoresis, hypotension, jugular venous distension
Call for assistance: retrieve O2, AED, and emergency kit
Remove material from mouth

P - Position

Comfortable for patient, usually sitting upright

A - Airway

Assess airway patency
If obstructed, head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)

B - Breathing

Assess breathing
If breathing, provide supplement oxygen via facemask @ 10L/min 100% O2
If evidence of breathing difficulty not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O2

C - Circulation

Assess pulse
If pulse, check heart rate and blood pressure, record vital signs at least every 5 minutes
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

D - Diagnosis, Definitive Therapy

If no history of angina pectoris or pain different from patient's experience, call 911
If systolic BP > 90mm Hg and no recent phosphodiesterase inhibitor use (e.g., Viagra ®, Cialis ®, Levitra ®), administer ***nitroglycerin*** 0.4mg sublingual tablet or spray*
May give up to 3 doses over 10 minutes
If no relief after one dose of nitroglycerin, consider it to be a myocardial infarction; call 911
If 911 called, administer 325mg ***aspirin*** chewed then swallowed with water (*Contraindicated* if aspirin allergy)
If chest pain is severe, may consider 50% ***nitrous oxide***

E - Emergency Medical Services

Facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Nitrates may cause severe hypotension refractory to vasopressor agents

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Myocardial Infarction Algorithm (AO 2019)

R - Recognition of Emergency

Patient may complain of substernal, crushing chest pain or pressure that may radiate to the left side of the body (shoulder, jaw, arm); nausea; dyspnea; palpitation; dizziness; anxiety; diaphoresis
Call for assistance: retrieve O_2, AED, and emergency kit
Call 911
Remove all materials from mouth

P - Position

Position patient comfortably, usually sitting upright

C - Circulation

Assess pulse (carotid artery)
If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes; continuously monitor pulse oximetry and heart rate
If no pulse, call 911; move to **Cardiac Arrest Algorithm**

A - Airway

Patients will be conscious and talking to you verifying a patent airway

B - Breathing

Patients will be conscious and talking to you verifying breathing

D - Drugs

Administer *O_2* via facemask @ 10L/min 100% O_2
If systolic BP > 90mm Hg and no recent phosphodiesterase inhibitor use (e.g., Viagra ®, Cialis ®, Levitra ®), administer *nitroglycerin* 0.4mg sublingual tablet or spray*
Administer 50% *nitrous oxide*
Administer 325mg *aspirin* chewed then swallowed with water (*Contraindicated* if aspirin allergy)

E - Emergency Medical Services

Facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

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Cardiac Arrest Algorithm (AO 2015)

R - Recognition of Emergency
Sudden loss of consciousness (not breathing and no pulse)
Call for assistance: retrieve O_2, AED, and emergency kit
Remove all materials from mouth

P - Position
Supine with legs elevated

C - Circulation
Assess pulse (up to 10 sec; carotid artery for ages ≥ 1 year)
If no pulse, call 911; start BLS: "*Push Hard, Push Fast*," at least 100 compressions/min; 30:2 compressions:breaths; 15:2 for children (ages 1 year to prepubescent) with 2 rescuers; continue until AED available or patient starts to move

A - Airway
Head tilt-chin lift
If it is difficult to provide positive pressure ventilation with BVM, consider airway adjuncts (jaw thrust, oral/nasal airway)

B - Breathing
Positive pressure ventilation with BVM @ 10L/min 100% O_2 (2 breaths for every 30 compressions)

D - Defibrillation *(ages ≥ 1 year)*
As soon as AED is available, turn it on
Follow instructions from AED
Connect adult or pediatric pads
Stop compressions while AED is analyzing rhythm
Immediately resume compressions after shock or no shock
AED will prompt you to the analyze rhythm every 2 minutes

E - Emergency Medical Services
Facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

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Stroke Algorithm (AO 2015)

R - Recognition of emergency

Sudden headache, loss of balance, or altered consciousness, thought, speech, or vision; complaint of sudden numbness or weakness of the face, arm, or leg, especially on one side of the body

Call for assistance: retrieve O_2, AED, and emergency kit

Remove materials from mouth

P - Position

Comfortable for patient, usually sitting upright

A - Airway

Assess airway patency

If obstructed, head tilt–chin lift (reposition if necessary with airway adjuncts like jaw thrust, oral/nasal airway)

B - Breathing

Assess breathing

If breathing, oxygen as directed by pulse oximetry; otherwise 100% O_2 @ 10 L/min via facemask

If not breathing, call 911; positive pressure ventilation with BVM @ 10L/min 100% O_2*

C - Circulation

Assess pulse

If pulse, check heart rate and blood pressure; record vital signs at least every 5 minutes

If no pulse, call 911; move to ***Cardiac Arrest Algorithm***

D - Diagnosis, Definitive Therapy

Look for altered speech, facial droop, arm drift (Cincinnati Prehospital Stroke Scale)

If stroke suspected, call 911

E - Emergency medical services

If EMS activated, facilitate access of emergency personnel by waiting for arrival and escorting to office (if third office person)

*Adults: 1 breath every 5-6 seconds; infants to adolescents: 1 breath every 3-5 seconds. Watch for chest rise; avoid stomach insufflation

Agenda Item (5):

Current Anesthesia Evaluation/Inspection Forms

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GENERAL ANESTHESIA INSPECTION AND EVALUATION REPORT

☐ **SITE/ADMINISTRATOR EVALUATION** ☐ **SITE ONLY INSPECTION**

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 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) ALL 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 631.2227) ALL operatories used must meet criteria (continued)	YES	NO
7. Ancillary Equipment *Must be* in Good Operating Condition?	**YES**	**NO**
a. Are there oral airways?		
b. Is there a tonsilar or pharyngeal type suction tip adaptable to all office *suction* 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

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. 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

☐ Pass ☐ Fail ☐ Pass Pending*

If Pass Pending, please list all deficiencies

Comments: _____

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_____ _____

Signature of Evaluator Date

THIS CONCLUDES THE SITE INSPECTION REPORT.

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

EVALUATION

DEMONSTRATION OF GENERAL ANESTHESIA / DEEP SEDATION	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 *and knowledgeable of equipment operation and location*?		
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? _____		

SIMULATED EMERGENCIES – Was dentist and staff able to demonstrate knowledge and ability in recognition and treatment of:	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?		

SIMULATED EMERGENCIES – 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?		

Evaluator Overall Recommendation of Evaluation

☐ Pass ☐ Fail

Comments: _____

_____

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_____ _____

Signature of Evaluator Date

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MODERATE SEDATION
INSPECTION AND EVALUATION REPORT

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

Evaluators

1.
2.
3.

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

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

2. Each evaluator should complete a MS On-Site/Administrator or Site Only Inspection report 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 report and return to the Board office within **72 hours** after evaluation has been completed.

SITE INSPECTION

OFFICE FACILITIES AND EQUIPMENT	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 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 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?		
7. Ancillary Equipment *Must be* in Good Operating Condition		
a. Are there oral airways?		
b. Is there a tonsilar or pharyngeal type suction tip adaptable to all office suction 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 patient's vital signs?		
4. Includes American Society of Anesthesiologists physical status classification?		
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?		

	YES	NO
Is there 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. Appropriate size oral and nasal airways		
ADDITIONAL EMERGENCY DRUG 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. Sedation records reflecting monitoring of patient that is consistent with the guide-lines of the American Academy of Pediatric Dentistry		

Evaluator Overall Recommendation of Site Inspection

☐ Pass ☐ Fail ☐ Pass Pending*

If Pass Pending, please list all deficiencies

Comments: _____

_____

_____

_____

_____ _____

Signature of Evaluator Date

THIS CONCLUDES THE SITE INSPECTION REPORT.

FOR AN <u>EVALUATION OF AN ADMINISTERING PERMIT</u>, CONTINUE TO NEXT SECTION.

EVALUATION

DEMONSTRATION OF MODERATE SEDATION	YES	NO
1. Who administered moderate sedation? Dentist's Name: _____		
2. Was sedation case demonstrated within the definition of moderate sedation?		
3. While sedated, was patient continuously monitored during the procedure with a pulse oximeter?		
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 moderate 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? _____		
SIMULATED EMERGENCIES – Was dentist and staff able to demonstrate knowledge and ability in recognition and treatment of:	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?		
11. Hypoglycemia?		
12. Asthma?		
13. Respiratory depression?		
14. Local anesthesia overdose?		
15. Hyperventilation syndrome?		
16. Syncope?		

Evaluator Overall Recommendation of Evaluation

☐ Pass ☐ Fail

Comments: _____

_____

_____

_____

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_____

_____ _____

Signature of Evaluator Date

Agenda Item (6):

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES, INC.

AAAASF ACCREDITATION APPLICATION

Application will not be processed if failed to complete in its entirety

Date:	
Type of Accreditation: Pediatric Dentistry	Facility Class (check one only): ☐ A ☐ B ☐ C-M ☐ C

Specialty Information (to be determined by the Facility/Medical Director)
Please list primary specialty, if more than one, add secondary specialty. **List all specialties as stated on board certification.**

Primary: _____
Secondary: _____
Legal Business Name (not DBA name): _____
Facility/Medical Director: _____
Facility/Medical Director E-mail address: _____
Name of office manager/head nurse: _____

Previously accredited or denied accreditation by any accrediting organization

☐ No ☐ Previously Accredited ☐ Denied Name of Accrediting Organization:

Please Note:

- Previous denial by AAAASF or another accreditation agency does not preclude application for accreditation. Any facility may reapply for accreditation at any time following receipt of a denial notification
- Failure to disclose previous accreditation, denial or revocation thereof may result in denial or loss of AAAASF Accreditation

Alternate Facility Name (if applicable):	Type of Alternate Facility Name: ☐ Doing Business As Name ☐ Other (Specify):

Identify the type of organizational structure (Check one):

☐ Sole Proprietor ☐ Business Corporation ☐ Limited Liability Company ☐ General Partnership
☐ Registered Limited Liability Partnership ☐ Professional Corporation ☐ Professional Limited Liability Company
☐ University Faculty Practice Corporation (501(c)(3), not-for-profit) ☐ Other (Please Specify):

Is the facility entirely physician owned (specify percentage that each physician owns): ☐ Yes ☐ No	Please Note: Changes in facility ownership must be reported to the AAAASF Office within thirty (30) days.

Name(s) of facility owner(s), controlling stockholder and/or beneficial ownership	
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Telephone #:	Telephone #:
License Number:	License Number:
Percent of Business Owned: %	Percent of Business Owned: %
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Telephone #:	Telephone #:
License Number:	License Number:
Percent of Business Owned: %	Percent of Business Owned: %

Facility State License Information: License Not Applicable ☐		
License Number:	State Where Issued:	
Effective Date (mm/dd/yyyy):	Expiration/Renewal Date (mm/dd/yyyy):	
Facility Location Information:		
Address Line 1:		
Address Line 2:		
City/Town:	State:	Zip:
Telephone Number:	Fax Number:	
Website Address:	E-mail Address:	
Contact Person -We will contact this person if questions arise during the processing of this application:		
Contact Name:	E-mail Address:	
Telephone Number:	Fax Number:	

Physician/Dentist Name:	**Board Certification:**	**State License Number:**
1.		
Email address:		
2.		
Email address:		
3.		
Email address:		
4.		
Email address:		
5.		
Email address:		
6.		
Email address:		
7.		
Email address:		
8.		
Email address:		
9.		
Email address:		
10.		
Email address:		

Additionally, please submit the following documentation along with the completed application either by mail or fax to:

AAAASF Office
7500 Grand Ave, Suite 200
Gurnee, IL 60031
Or
Fax: 847-775-1985

- A floor plan or diagram of the facility clearly labeling rooms, including: Dental Room, Prep area, Clean area, Dirty area, etc. (does not need to be to scale and must clearly identify each room purpose and dimensions)
- Copy of each physician/dentist State Medical License
- Copy of each physician/dentist Board Certificate or letter of admissibility by the certifying board

The following forms also need to be completed.

- Completed HIPAA Business Agreement signed by Medical Director
- Completed Anesthesia Validation Form
- Authorization to Release Form completed and signed by each physician/surgeon
- Facility Identification Form signed by Medical Director
- Staff Identification Form
- Facility Director's Attestation signed by Medical Director

	ANNUAL FEES FOR ACCREDITATION Pediatric Dentistry			
Number of dentists on staff	Class A	Class A	Classes B, C-M, C	Classes B, C-M, C
	Standard Cost	Class A FIRST YEAR DISCOUNT	Standard Cost	Classes B, C-M, C FIRST YEAR DISCOUNT
1-2	$790	$400	$1,160	$586
3-5	$1100	$556	$1,610	$814
6-9	$3490	$1,764	$4,210	$2,128
10 plus	$4910	$2,482	$6,210	$3234

- *10% discount offered for AAPD members after the first year*

Survey Fees for Pediatric Dentistry Accreditation

$2,100 Survey Fee for any size facility or any class.
Facilities may request an expedited survey for an additional $500 (ask for details).
All credentials must be submitted and processed prior to survey.

Annual Fee (see schedule above): $ _____ + $2,100 Survey Fee = Total amount of payment: $ _____

Payment by credit card

Submit your application via email to info@aaaasf.org or via fax to 847-775-1985. You may pay with a credit card over the phone by calling the accounting department directly at 888-545-5222.

Check type of credit card: Visa MasterCard American Express

Name on card: Card #:

Billing zip code: Three-digit code: Exp. Date: Signature:

OR

Payment by check

Submit completed application with supporting documentation and check made out to AAAASF.

AAAASF Office
7500 Grand Ave, Suite 200
Gurnee, IL 60031

Fee and refund policy:

The first-year accreditation annual fee plus initial survey fee is due with each accreditation application. Additional fees will apply if special survey requests are made or for those facilities located outside the continental USA. After an application has been submitted and processed, AAAASF will refund 50% of the annual fee and 100% of the survey fee if the facility has not been surveyed. If the facility was surveyed, only 50% of the annual fee will be refunded. If the accreditation process is not completed within one year of the received date, a new application and appropriate fee is required. No refunds will be issued if the application expires. Upon receiving accreditation and once an anniversary date is established, the facility will be invoiced 6 months prior to the anniversary date. Fees must be paid by the due date on the invoice for the accreditation process to begin. Otherwise, late fees will be applied and other penalties will follow.

American Association for Accreditation of Ambulatory Surgery Facilities

7500 Grand Ave, Suite 200
Gurnee, Illinois 60031

Toll Free: 1-888-545-5222
Phone: 847-775-1970
Fax: 847-775-1985
reception@aaaasf.org
www.aaaasf.org

Anesthesia Validation Form

Date:	Click or tap to enter a date.	Facility ID:	[Facility ID]
Facility Name:	[Company]	Medical Director name:	Click or tap here to enter text.

Facilities seeking initial survey must have performed at least ten (10) cases.

To complete the application process, the facility's Medical Director must provide confirmation of 10 cases with anesthesia within the class for which the facility is applying (except for local). Of these 10 cases, at least 2 must be of the highest level of anesthesia in that class.

The facility must complete this Anesthesia Validation form demonstrating that the facility has performed the requisite cases. Submission of this form constitutes an attestation on behalf of the facility that the above criteria have been met.

Surgical date:	Click or tap to enter a date.	Operating Surgeon:	Click or tap here to enter text.
Patient initials:	Click or tap here to enter text.	Type of anesthesia:	Click or tap here to enter text.
Procedure:	Click or tap here to enter text.		

Surgical date:	Click or tap to enter a date.	Operating Surgeon:	Click or tap here to enter text.
Patient initials:	Click or tap here to enter text.	Type of anesthesia:	Click or tap here to enter text.
Procedure:	Click or tap here to enter text.		

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Procedure:	Click or tap here to enter text.		

Surgical date:	Click or tap to enter a date.	Operating Surgeon:	Click or tap here to enter text.
Patient initials:	Click or tap here to enter text.	Type of anesthesia:	Click or tap here to enter text.
Procedure:	Click or tap here to enter text.		

Surgical date:	Click or tap to enter a date.	Operating Surgeon:	Click or tap here to enter text.
Patient initials:	Click or tap here to enter text.	Type of anesthesia:	Click or tap here to enter text.
Procedure:	Click or tap here to enter text.		

Pediatric Dentistry Facility Standards and Checklist

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES, INC.

WWW.AAAASF.ORG

Pediatric Dentistry Facility Standards and Checklist for Accreditation of Ambulatory Surgery Facilities

Version 1 ● 2019

Table of Contents

Pediatric Dentistry Standards

The AAAASF Pediatric Dentistry Facility Accreditation Program

The American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) conducts an accreditation program that verifies that a facility meets nationally recognized safety standards. The procedural facility accreditation program is conducted by dentists, physicians and nurses who determine the standards under the direction of a Board of Directors. Pediatric Dentistry facility accreditation is intended for ambulatory facilities performing procedures under sedation or general anesthesia which would include Pediatric Dentists and others. The AAAASF strives for the highest standards of excellence for its facilities by regularly revising and updating its requirements for patient safety and quality of care.

The following list of Pediatric Dentistry Office-Based procedures are permitted under this current version of the AAAASF Pediatric Dentistry Facility Standards. The AAAASF Board of Directors reserves the right to review and edit these procedures at any time based upon differing scopes of practice standards and changing state and federal regulations and laws.

<u>Dentoalveolar</u>

- Extractions
  - Simple
  - Complex
- Dental Restorations
- Pulpal Treatment
- Soft Tissue Graft
- Frenuloplasty
- Frenectomy

Space Maintenance

<u>Trauma</u>

- Hard and Soft Tissue Trauma
- Lacerations
- Hard Tissue Dental Fractures including Alveolus

<u>Pathology</u>

- Hard and Soft Tissue
- Management of Odontogenic Infection
- Soft and Hard Tissue Biopsy

Definition of AAAASF Facility Classes

Class A:

In a Class A Facility, all pediatric dental procedures may be performed under the following anesthesia:

1. Topical Anesthesia
2. Local Anesthesia
3. Low-Flow Nitrous Oxide/oxygen with a failsafe/flow-safe machine

Agents 1 through 3 may be administered by:

- An appropriately credentialed Pediatric Dentist (DDS or DMD).

Class A Facilities must meet all Class A standards.

Minimal sedation (anxiolysis) − A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected.

Definition of AAAASF Facility Classes

Class B:

In a Class B facility, all pediatric dental procedures may be performed under the following anesthesia:

1. Topical Anesthesia
2. Local Anesthesia
3. Low-Flow Nitrous Oxide/oxygen with a failsafe/flow-safe machine
4. Oral or Intranasal Sedation
5. Parenteral Sedation
6. Dissociative Drugs (excluding Propofol)

Agents 1 through 5 may be administered by:

- An appropriately credentialed Pediatric Dentist (DDS or DMD).

Agents 4 through 6 may be administered by:

- An appropriately credentialed Medical Anesthesiologist (MD or DO)
- An appropriately credentialed Dentist Anesthesiologist
- An appropriately credentialed Certified Registered Nurse Anesthetist (CRNA)
- An appropriately credentialed Anesthesia Assistant (as certified by the National Commission for the Certification of Anesthesiologist Assistants) under direct supervision of an Anesthesiologist

The use of Propofol, Endotracheal Intubation Anesthesia, Laryngeal Mask Airway Anesthesia, and/or Inhalation General Anesthesia are prohibited in a Class B facility

Class B facilities must meet all Class A and Class B standards.

Moderate Sedation - An induced state of sedation characterized by a minimally depressed consciousness such that the patient is able to continuously and independently maintain a patent airway, retain protective reflexes, and remain responsive to verbal commands and physical stimulation.

Definition of AAAASF Facility Classes

Class C-M:

In a Class C-M facility, all pediatric dental procedures may be performed under the following anesthesia:

1. Topical Anesthesia
2. Local Anesthesia
3. Low-Flow Nitrous Oxide/oxygen with a failsafe/flow-safe machine
4. Oral or Intranasal Sedation
5. Parenteral Sedation
6. Dissociative Drugs (including Propofol)

Agents 1 through 5 may be administered by:

- An appropriately credentialed Pediatric Dentist (DDS or DMD).

Agents 4 through 6 (excluding Propofol) may be administered by:

- An appropriately credentialed Medical Anesthesiologist (MD or DO)
- An appropriately credentialed Dentist Anesthesiologist
- An appropriately credentialed Certified Registered Nurse Anesthetist (CRNA)
- An appropriately credentialed Anesthesia Assistant (as certified by the National Commission for the Certification of Anesthesiologist Assistants) under direct supervision of an Anesthesiologist

Propofol anesthesia may be administered only by:

- An appropriately credentialed Medical Anesthesiologist
- An appropriately credentialed Dentist Anesthesiologist
- An appropriately credentialed Certified Registered Nurse Anesthetist (CRNA)

The use of Endotracheal Intubation Anesthesia, Laryngeal Mask Airway Anesthesia, and/or Inhalation General Anesthesia is prohibited in a Class C-M facility.

Class C-M facilities must meet all Class A, Class B and Class C-M standards.

Deep sedation− An induced state of sedation characterized by depressed consciousness such that the patient is unable to continuously and independently maintain a patent airway and experiences a partial loss of protective reflexes and ability to respond to verbal commands or physical stimulation.

Definition of AAAASF Facility Classes

Class C:

In a Class C facility all pediatric dental procedures may be performed under the following anesthesia:

1. Topical Anesthesia
2. Local Anesthesia
3. Low-Flow Nitrous Oxide/oxygen with a failsafe/flow-safe machine
4. Oral or Intranasal Sedation
5. Parenteral Sedation
6. Dissociative Drugs (including Propofol)
7. General Anesthesia (with or without Endotracheal Intubation or Laryngeal Mask Airway Anesthesia)

Agents 1 through 5 may be administered by:

- An appropriately credentialed Pediatric Dentist (DDS or DMD).

Agents 4 through 6 (excluding Propofol) may be administered by:

- An appropriately credentialed Medical Anesthesiologist (MD or DO)
- An appropriately credentialed Dentist Anesthesiologist
- An appropriately credentialed Certified Registered Nurse Anesthetist (CRNA)
- An appropriately credentialed Anesthesia Assistant (as certified by the National Commission for the Certification of Anesthesiologist Assistants) under direct supervision of an Anesthesiologist

Propofol anesthesia may be administered only by:

- An appropriately credentialed Medical Anesthesiologist
- An appropriately credentialed Dentist Anesthesiologist
- An appropriately credentialed Certified Registered Nurse Anesthetist (CRNA)

General anesthetics (agent 7) may be administered only by:

- An appropriately credentialed Medical Anesthesiologist
- An appropriately credentialed Dentist Anesthesiologist
- An appropriately credentialed Certified Registered Nurse Anesthetist (CRNA)

Class C facilities must meet all Class A, Class B, Class C-M and Class C standards.

Onsite Inspection

A facility is inspected every three years at a minimum or as state laws require or sooner if for cause. The facility inspector will review any deficiencies with the Medical Director and forward the Standards and Checklist answer sheet to the AAAASF Central Office. To be accredited by AAAASF, a facility must meet every standard for its Class (A, B, C-M or C).

Onsite Inspection Privacy Policy

Onsite AAAASF Inspections typically involve the attention of the facility Medical Director, the anesthesia provider, and the facility staff working intently with the AAAASF surveyor(s). The inspection process must remain focused, and therefore, AAAASF has directed that equipment representatives not be present during AAAASF's announced or unannounced inspections/surveys. Accreditation consultants may be present during the surveys; however, AAAASF asks that consultants remain silent during the inspection process until it is completed. All AAAASF surveyor(s) have the authority to request any participants to leave the inspection process if interference becomes a problem. AAAASF greatly appreciates the cooperation of all concerned parties by complying with this directive.

Self-Evaluation Inspection

A facility is evaluated by the Medical Director each year between inspections, and the Standards and Checklist answer sheet is sent to the AAAASF Office. A facility's AAAASF accreditation remains valid if it continues to meet every standard for its Class (A, B, C-M or C). Otherwise, accreditation is revoked.

Denial or Loss of Accreditation

The AAAASF will deny or revoke accreditation of a facility if the facility fails to satisfy every standard for its Class (A, B, C-M or C), or if any Pediatric Dentist or Physician performing procedures at the facility that:

- Has had their privileges to perform procedures restricted or limited by any hospital at which the Pediatric Dentist has privileges, related to lack of clinical competence, ethical issues, or professional problems other than economic competition.
- Has been found to be in violation of the Code of Ethics of any professional medical society or association of which they are a member.
- Has had their right to practice medicine, and/or dentistry limited, suspended, terminated or otherwise affected by any state, province, or country, or if they have been disciplined by any medical and/or dentistry licensing authority.
- Non-reporting of any of the above to the AAAASF.

Hearing

Any facility whose accreditation has been revoked or denied by the AAAASF has the right to a Hearing at which it may present information to show that it has satisfied the requirements for accreditation. The Hearing process is described in the AAAASF Bylaws, available from the AAAASF Central Office.

Emergency Suspension or Emergency Probation

The AAAASF may place a facility on Emergency Suspension or Emergency Probation status upon receiving information that a state medical or dental board has taken action or begun formal proceedings which may result in it taking action against a license held by a Pediatric Dentist practicing at the facility, or the Board of Directors determining that the facility may no longer meet AAAASF standards for accreditation. A facility that has been placed on Emergency Suspension or Emergency Probation status will remain in such status pending an investigation and possible Hearing, conducted in accordance with AAAASF procedures that are available from the AAAASF Central Office.

Important Notice

Optimal patient safety has always been our guiding concern. AAAASF's Standards may be considered the strongest of any agency that accredits ambulatory surgery facilities, and that many consider them to be the Gold Standard. We recognize, however, that they need to be part of a living document, and we continually re-evaluate and revise these Standards in the light of medical advances and changing legislative guidelines.

The AAAASF Accreditation Program requires 100% compliance with each Standard to become and remain accredited. There are no exceptions. However, when a Standard refers to appropriate or proper or adequate, reasonable flexibility and room for individual consideration by the inspector is permitted as long as patient and staff safety remain uncompromised.

Medical Director's Attestation

The Medical Director must ensure and attest that the facility meets all local, state, and federal regulations, since such governmental regulations may supersede AAAASF Standards. Please note, however, that the stricter regulation applies, whether it is the federal, state, or local regulation, or the AAAASF standard.

Please complete and sign the following document and return to the AAAASF office:

MEDICAL DIRECTOR'S ATTESTATION

As Director of the (name of facility) _____,

located at _____, I attest that this facility meets all applicable local, state, and federal zoning and construction codes and regulations, including Certificate of Need requirements, as mandated. I further acknowledge that wherever governmental regulations or codes supersede AAAASF Standards, the stricter rule is applicable, whether it is the local, state, federal regulation or code or AAAASF Standard. Furthermore, I authorize AAAASF to release accreditation reports and corrective action plans to the state Board or Federal government upon request.

_____ _____

Medical Director Date

AAAASF
7500 Grand Ave, Suite 200
Gurnee, IL 60031

Toll-free: 888-545-5222
Phone: 847-775-1970
Fax: 847-775-1985
Web: www.aaaasf.org

100 Basic Mandates

Failure to adhere to the basic mandates of AAAASF will result in referral to the AAAASF Investigative Committee. Sanctions by the Board of Directors may result in emergency suspension and revocation.

100.10 Basic Mandates

100.10.10 A,B,C-M,C

A patient who, by reason of pre-existing or other medical conditions, is at significant risk for outpatient procedure in this facility should be referred to alternative facilities.

100.10.20 A,B,C-M,C

There must be a written policy defining the unique and peri-procedure care of pediatric patients. This is based upon considerations of age, risk categories, procedure, and facility equipment and capability. This policy must be available and current.

100.10.30 A,B,C-M,C

The "AAAASF Patient Rights" document is prominently displayed and/or a copy is provided to each patient. The "AAAASF Patient Rights" document is also adhered to and promoted by all staff.

100.10.40 A,B,C-M,C

Onsite AAAASF Inspections typically involve the attention of the Medical Director, the anesthesia provider, and the facility staff working intently with the AAAASF surveyor(s). The inspection process must remain focused, and therefore, AAAASF has directed that equipment representatives not be present during AAAASF's announced or unannounced inspections/surveys. Accreditation consultants may be present during the surveys; however, AAAASF asks that consultants remain silent during the inspection process until it is completed. All AAAASF surveyor(s) have the authority to request any participants to leave the inspection process if interference becomes a problem. AAAASF greatly appreciates the cooperation of all concerned parties by complying with this directive.

100 Basic Mandates

100.20 AAAASF-Mandated Reporting

100.20.10 A,B,C-M,C

Any change in the Pediatric Dentist's staff must be reported in writing to the AAAASF Central Office within thirty days of such changes. Copies of the credentials of any new staff, including their current medical license, ABMS Board Certification, ABOMS Board Certification, Dentist Anesthesiologist license, and/or letter of eligibility or equivalent documentation must also be sent to the AAAASF Central Office.

100.20.20 A,B,C-M,C

Any action affecting the current professional license of the Medical Director, a member of the medical staff, a member of the Pediatric Dentist and staff or other licensed facility staff must be reported in writing to the AAAASF Central Office within ten (10) days of the time the Medical Director becomes aware of such action.

100.10.30 A,B,C-M,C

Changes in facility ownership must be reported to the AAAASF Office within thirty (30) days of the change and reapply for accreditation.

100.10.40 A,B,C-M,C

Any death occurring in an accredited facility, or any death occurring within thirty (30) days of a procedure performed in an accredited facility, must be reported to the AAAASF office within five (5) business days after the facility is notified or otherwise becomes aware of that death. In addition to this notification, the death must also be reported as an unanticipated procedure sequela in the semi-annual Peer Review report. In the event of a death occurring within thirty (30) days of a procedure done in an AAAASF-accredited facility, an unannounced inspection may be done by a senior inspector.

200 General Safety

AAAASF is committed to establishing guidelines to provide safe and effective outpatient procedure care. The Facility must comply with all applicable Occupational Safety and Health Administration (OSHA), Centers for Disease Control and Prevention (CDC), National Fire Protection Association (NFPA), federal, state and local codes and regulations. The facility must comply with the stricter regulation (whether it is the AAAASF Standard or local, state, or federal law).

200.10 Facility Safety Manual

200.10.10 A,B,C-M,C

There is a facility safety manual.

200.10.20 A,B,C-M,C

Facility safety manual contains all applicable requirements of OSHA.

200.10.30 A,B,C-M,C

Facility safety manual is in accordance with other federal and state regulations.

200.10.40 A,B,C-M,C

Facility safety manual provides employees with information about hazardous chemicals used and methods to minimize hazards to personnel.

200.10.50 A,B,C-M,C

In the facility safety manual, there is a written exposure control plan which is reviewed and updated at least annually.

200.10.60 A,B,C-M,C

In the facility safety manual, there is a written chemical hazard communication program which is reviewed and updated annually.

200 General Safety

200.20 Personnel Safety

200.20.10 C

Personnel are properly trained in the control procedures and work practices that have been demonstrated to reduce occupational exposures to anesthetic gases.

200.20.20 A,B,C-M,C

Personal protective equipment is available and used for all appropriate procedures in accordance with OSHA guidelines.

200.20.30 A,B,C-M,C

Scrub suits, caps or hair covers, gloves, operative gowns, masks, and eye protection are worn as appropriate for all surgery.

200.20.40 A,B,C-M,C

If a gas sterilizer is used, appropriate personnel are badge tested to ensure that there is no significant ethylene oxide exposure.

200 General Safety

200.30 X-Ray and Laser Safety

200.30.10 A,B,C-M,C

Warnings and signs exist to warn patients and staff when x-ray or laser equipment is in use.

200.30.20 A,B,C-M,C

If x-ray equipment is used, safety measures are taken to protect patients and staff from injury.

200.30.30 A,B,C-M, C

If x-ray equipment is used, at least an annual check of x-ray equipment and lead aprons is performed.

200.30.40 A,B,C-M,C

Staff maintains dosimetry badges and records, if applicable, for at least three (3) years.

200.30.50 A,B,C-M,C

If a laser is used, all manufacturer recommended safety precautions are actively in place prior to any usage. All safety measures are taken to protect patients and staff from injury, include appropriate eyewear, covered mirrors, covered windows, signage on the door, etc.

200.30.60 A,B,C-M,C

All appropriate safety measures are taken to avoid open flames and/or lasers in the presence of anesthetic gases, root canal therapy, etc.

200 General Safety

200.40 Hazardous Agents

200.40.10 A,B,C-M,C

All explosive and combustible materials are stored and handled in a safe manner according to state, local and/or National Fire Protection Association (NFPA) codes.

200.40.20 A,B,C-M,C

Compressed gas cylinders are stored and handled according to state, local and/or National Fire Protection Association (NFPA) codes.

200.40.30 A,B,C-M,C

Hazardous chemicals are labeled as hazardous.

200.50 Fire Controls

200.50.10 A,B,C-M,C

The facility is equipped with heat sensors and/or smoke detectors.

200.50.20 A,B,C-M,C

An adequate number of fire extinguishers are available.

200.50.30 A,B,C-M,C

Fire extinguishers are inspected annually and conform to local fire codes.

200 General Safety

200.60 Exits

200.60.10 A,B,C-M,C

Exit signs are posted and illuminated consistent with state, local and/or the NFPA codes and OSHA codes.

200.60.20 A,B,C-M,C

There are sufficient emergency lights for exit routes and patient care areas in case of power failure.

200.60.30 A,B,C-M,C

Hallways, stairways and elevators are sufficiently wide to allow emergency evacuation of a patient by emergency personnel and their equipment.

200.60.40 A,B,C-M,C

If requested, the facility's personnel can demonstrate safe evacuation of a patient.

200.70 Medical Hazardous Waste

200.70.10 A,B,C-M,C

All medical hazardous wastes are stored in OSHA (Occupational Safety and Health Act) acceptable containers and separated from general refuse for special collection and handling.

200.70.20 A,B,C-M,C

Used disposable sharp items are placed in puncture-resistant containers located close to the area in which they are used.

300 In Case of Emergency

300.10 Emergency Equipment

300.10.10 A,B,C-M,C

Emergency cart is available with defibrillator or AED, necessary drugs and other CPR equipment (e.g. suction, pediatric defib pads, current PALS algorithm, and ACLS algorithm if appropriate).

300.10.20 A,B,C-M,C

A standard defibrillator, or an Automated External Defibrillator unit (AED), is present which is checked at least weekly for operability, and the test results are kept for a minimum of three (3) years.

300.10.30 A,B,C-M,C

Self-inflating (Ambu©) bags, if used, are capable of delivering positive pressure ventilation with oxygen.

300 In Case of Emergency

300.20 Emergency Protocols

There is a written protocol for:

300.20.10 A,B,C-M,C

Cardiopulmonary resuscitation.

300.20.20 A,B,C-M,C

Transferring patients in an emergency.

300.20.30 A,B,C-M,C

Return to the procedure room for patient emergencies.

300.20.40 A,B,C-M,C

A situation in which the Pediatric Dentist becomes incapacitated.

300.20.50 B,C-M,C

A situation in which the anesthesia provider becomes incapacitated.

300.20.60 A,B,C-M,C

Fires, fire drills, and surgical fire safety drills

300.20.70 A,B,C-M,C

Plan for emergency evacuation of the facility.

300.20.80 A,B,C-M,C

Response to power failure emergencies.

300 In Case of Emergency

300.20.90 A,B,C-M,C

Security emergencies, such as an intruder in the facility, an unruly patient or visitor, a threat to the staff or patients.

300.30 Emergency Power

300.30.10 A,B,C-M,C

The procedure room has an emergency power source, (e.g., a generator or battery powered inverter), with capacity to operate adequate monitoring, anesthesia, procedure equipment, cautery and lighting for a minimum of thirty (30) minutes. If two of more procedure rooms are used simultaneously, an adequate emergency power source must be available for each procedure room and recovery room. (Alternatively, in case of a power failure, the facility has back-up power on all monitoring equipment.)

300.30.20 A,B,C-M,C

The emergency power source, including internal battery back-up, is able to begin generating ample power to operate essential electrical equipment used in the procedure room within thirty (30) seconds of a power failure.

300.30.30 A,B,C-M,C

The emergency power equipment is checked monthly to insure proper function, and the test results are filed and kept for a period of three (3) years.

400 Environment

400.10 Facility Environment

400.10.10 A,B,C-M,C

The facility displays a professional appearance in keeping with a facility where general anesthesia is administered and designed to carry out dental and surgical procedures. The facility should be neat, comfortable and clean and should include a waiting area, business office and sanitary lavatory facilities. One or more exam rooms should be available that provide for privacy and treatment in a sanitary, orderly environment.

400.10.20 A,B,C-M,C

The floors are covered with an easily cleaned material which is smooth and free from breaks or cracks. If the floors contain seams or individual tiles, they are sealed with an impermeable sealant other than silicone. The floor must be water repellent.

400.10.30 A,B,C-M,C

All openings to facility are effectively protected against the entrance of insects, animals, etc.

400.10.40 A,B,C-M,C

Sufficient electrical outlets are available, labeled and grounded to suit the location (e.g.; wet locations) and connected to emergency power supplies where appropriate.

400.10.50 A,B,C-M,C

There are no overloaded wall plugs or extension cords in use, no altered grounding plugs in use, and wires are not broken, worn or unshielded.

400 Environment

400.20 Procedure Room Environment

400.20.10 A,B,C-M,C

There is a room for use as a procedure room

400.20.20 A,B,C-M,C

An exam room may function as a procedure room.

400.20.30 A,B,C-M,C

Unauthorized individuals are deterred from entering the procedure room by locks, alarms, or facility personnel.

400.20.40 A,B,C-M,C

Each procedure room is of a size adequate to allow for the presence of all equipment and personnel necessary for the performance of the procedures, and must comply with applicable local, state or federal requirements. There must be ample clear space on each side of the procedure table to accommodate emergency personnel and equipment in case of emergency and permit the safe transfer of the patient to a gurney for transport. Facility personnel can physically demonstrate to the inspector that the emergency criteria, as stated above, can be met in the procedure room space available.

400.20.50 A,B,C-M,C

The procedure room(s) is adequately ventilated and temperature controlled.

400.20.60 A,B,C-M,C

The procedure room(s) is properly cleaned, maintained and free of litter and clutter.

400 Environment

400.30 Storage

400.30.10 A,B,C-M,C

There is adequate storage space to hold equipment, supplies and medications. Storage space should be adequate to minimize the need to leave the procedure room for frequently used supplies, equipment and/or medications.

"Adequate" is meant to encompass size, space, maintenance, cleanliness, free of clutter, lighting, appropriately equipped, etc.

400.30.20 A,B,C-M,C

Storage space provides easy access for identification and inventory of supplies.

400.30.30 A,B,C-M,C

Sterile supplies are stored away from potential contamination in closed cabinets/drawers or if not, away from heavy traffic areas.

400 Environment

400.40 Cleaning

400.40.10 A,B,C-M,C

The entire procedural suite is cleaned and disinfected according to CDC-approved standards adequate to prevent cross-contamination.

400.40.20 A,B,C-M,C

Instrument handling and reprocessing areas are cleaned and maintained.

400.40.30 A,B,C-M,C

Between cases, the procedure room(s) is cleaned with intermediate-level, medical-grade disinfectants.

400.40.40 A,B,C-M,C

All blood and body fluid spills are cleaned using germicides that are viricidal, bactericidal, tuberculocidal and fungicidal.

400.40.50 A,B,C-M,C

There is a written policy for cleaning of spills which may contain blood borne pathogens.

400.40.60 A,B,C-M,C

All blood and body fluid spills are cleaned using germicides that are viricidal, bactericidal, tuberculocidal and fungicidal.

500 Equipment

500.10 Facility Equipment

500.10.10 A,B,C-M,C

All equipment is pediatric or adult specific. All equipment needs to be appropriately sized for patients treated concerning age, weight, etc.

500.20 Procedure Room Equipment

500.20.10 A,B,C-M,C

Only inspected equipment is used in the procedure room

500.20.20 A,B,C-M,C

Adequate illumination for patients, machines and monitoring equipment, which can include battery powered illuminating systems.

500.20.30 A,B,C-M,C

The procedure room is provided with adequate lighting.

500.20.40 A,B,C-M,C

There is an adequate and reliable source of suction.

500.20.50 A,B,C-M,C

There is an adequate procedure room table or chair.

500.20.60 A,B,C-M,C

When unipolar electrocautery is used, a single-use/disposable grounding pad is used.

500 Equipment

500.30 Anesthesia Equipment

500.30.10 A,B,C-M,C

All required anesthesia, monitoring, emergency equipment/medications, for general anesthesia/deep sedations anesthesia must be present during the procedure/recovery. This is to allow mobile anesthesia providers to bring in the required equipment rather than the requirement to be located at facility at ALL times. This requires emergency equipment/monitors required to be on site at all times according to state or local laws.

500.30.20 A, B, C-M, C

Blood pressure monitoring equipment is present and appropriate for a pediatric population.

500.30.30 B,C-M,C

An EKG monitor with pulse read-out is present. All monitoring equipment is tested and certified on a yearly basis or per manufacturer's instructions.

500.30.40 A,B,C-M,C

A reliable source of oxygen, adequate for the length of the surgery (back up should consist of at least one full E cylinder).

500.30.50 B,C-M,C

Laryngoscope is present and working. Laryngoscope is appropriately cleaned as appropriate, HLD or sterilized. (If HDL must be vented, etc.)

500.30.60 A,B,C-M,C

Oral and nasopharyngeal airways for each size of patient treated in the facility are present.

500 Equipment

500.30.70 B,C-M,C

A comprehensive assortment of Endotracheal Tubes are present to cover full range of patients being treated.

500.30.80 B,C-M,C

Endotracheal stylet is present.

500.30.90 C

An anesthesia machine is required if volatile agents are available in the facility. If total intravenous anesthesia (TIVA) is used exclusively, and no inhalation agents (volatile) are available, an anesthesia machine is not required.

500.30.100 C

If present, mechanical ventilator should have a continuous use device which indicates a disconnect from the O2 source via an audible signal.

500.40 Recovery Room Equipment

500.40.10 B,C-M,C

A separate pulse oximeter is available for each patient in the recovery area.

500 Equipment

500.50 Maintenance of Equipment

500.50.10 A,B,C-M,C

The equipment's specifications are kept in an organized file.

500.50.20 A,B,C-M,C

A bio-medical technician, which may include manufacturer, at least annually inspects all equipment (including electrical outlets, breaker/ fuse boxes, and emergency light and power supplies) and reports in writing that the equipment is safe and operating according to the manufacturer's specifications.

500.50.30 A,B,C-M,C

All equipment repairs and changes are done by a bio-medical technician with records kept for a minimum of three (3) years.

500.50.40 A,B,C-M,C

All equipment is on a maintenance schedule with records kept for a minimum of at least three (3) years. Stickers may be placed on individual equipment; however written records must be maintained of the yearly inspections.

500.50.50 A,B,C-M,C

All equipment in the procedural suite should be tested by biomedical engineer to verify no electric leakage. Verify safe for use annually.

500.50.60 A,B,C-M,C

Anesthesia gas systems, including nitrous delivery system, are checked by a certified inspector and written reports are available stating that the equipment is safe and operating according to the manufacturer's specifications.

500 Equipment

500.50.70 A,B,C-M,C

If a central source of piped oxygen is used, the system must meet all applicable codes.

500.50.80 A,B,C-M,C

Nitrous oxide/oxygen delivery safety system checks: Annual documented checks of ambient nitrous oxide levels should be less than 25 ppm according to NIOSH.

500.50.90 A,B,C-M,C

Dental Unit Waterlines: The number of bacteria used for coolant/irrigation used for Non-Surgical dental procedures must be as low as reasonably achievable, and at a minimum <500CFU colony forming units, the regulatory standard for safe drinking water established by EPA. Verified documented testing of all dental units must be performed at least annually unless more frequently recommended by the manufacturer.

600 Infection Control

600.10 Infection Control

600.10.10 A,B,C-M,C

The facility policy manual should include infection control and sterilization policies and procedures that are consistent with current CDC guidelines.

600.10.20 A,B,C-M,C

Facility must be compliant with guidelines listed in the CDC Standard Precautions for cross-contamination of syringes, multi-use and single use vials. (Refer to CDC Preventing Transmission of Infectious Agents in Healthcare Settings 2007).

600.10.30 A,B,C-M,C

Hand hygiene is performed in accordance with current CDC guidelines.

600.10.40 A,B,C-M,C

If one sink is used both for dirty instruments and to hand/arm scrub for procedures, there is a written policy to clean and disinfect the sink prior to hand/arm scrubbing.

600 Infection Control

600.20 Sterilization

600.20.10 A,B,C-M,C

All instruments used in patient care are sterilized, where applicable.

600.20.20 A,B,C-M,C

A written protocol is present for the reprocessing all instruments and equipment used in patient care.

600.20.30 A,B,C-M,C

There is strict physical segregation of dirty procedure equipment and instruments that have been cleaned and are in the preparation and assembly area.

600.20.40 A,B,C-M,C

The facility has at least one autoclave which uses high pressure steam/heat or all sterile items are single-use/disposable. All soiled instruments are to be treated with an enzymatic cleaner if not processed immediately for sterilization.

600.20.50 A,B,C-M,C

Gas sterilizers must be vented as per manufacturer's specifications.

600.20.60 A,B,C-M,C

Sterile supplies are labeled to indicate sterility; packaged and sealed to prevent accidental opening.

600.20.70 A,B,C-M,C

Each sterilized pack is marked with the sterilization date, initials of the person performing the sterilization, expiration date (if applicable) and an internal integrator. When more than one autoclave is available, each pack must be labeled to identify in which autoclave it was sterilized.

600 Infection Control

600.20.80 A,B,C-M,C

A weekly spore test, or its equivalent, is performed on each autoclave and the results filed and kept for three (3) years. The sterility of each load in the autoclave is checked with indicator tape, chemical monitors, or other effective means both on the outside and inside of the pack.

600.20.90 A,B,C-M,C

If a spore test is positive, there is a protocol for remedial action to correct the sterilization process.

600.20.100 A,B,C-M,C

Monitoring records are retained for the sterilization or other disinfection process and should be reviewed and stored for a minimum of three (3) years.

700 Medical Records

700.10 General Medical Records

700.10.10 A,B,C-M,C

Medical records must be legible, documented and completed accurately.

700.10.20 A,B,C-M,C

Medical records must be retained the number of years as required by state and/or federal law; or a minimum of three (3) years to comply with the AAAASF three-year inspection cycle.

700.10.30 A,B,C-M,C

Medical records are filed for easy accessibility and must be maintained in the procedural facility regardless of the location of the physician's office.

700.10.40 A,B,C-M,C

Medical records must be kept secure and confidential, consistent with HIPAA regulations.

700 Medical Records

700.20 Procedure Log

A procedure log must include:

700.20.10 A,B,C-M,C

A separate procedure log of cases is maintained, either in a hard-copy bound log with sequentially numbered pages or in a secured computer log. A loose leaf or spiral-bound notebook does not meet this requirement.

700.20.20 A,B,C-M,C

Sequential numerical listing of patients either consecutive numbering from the first case carried out in the facility or consecutive numbers starting each year.

700.20.30 A, B,C-M,C

Date of procedure.

700.20.40 A,B,C-M,C

Patient's name and/or identification number.

700.20.50 A,B,C-M,C

Procedure(s).

700.20.60 A,B,C-M,C

The sedation credentialed Pediatric Dentist(s) name.

700.20.70 A,B,C-M,C

Type of anesthesia.

700 Medical Records

700.20.80 A,B,C-M,C

Name of person(s) administering anesthesia.

700.20.90 A,B,C-M,C

Name of person(s) assisting Pediatric Dentist (example: M.D., D.O., Dentist, registered nurse, scrub tech, dental assistant, physician's assistant, anesthesia assistant, or other qualified personnel).

800 Pre-Procedural

800.10 Pre-Procedural Documentation

800.10.10 A,B,C-M,C

A current history and focused/pertinent physical examination by the anesthesia provider or the patient's personal physician is recorded within thirty (30) days of procedures on all patients for major procedures, and for those patients for minor procedures who require a physical exam. The medical record must contain a current medical history taken on the same day as the procedure and recorded by the physician or anesthesia provider prior to the administration of anesthesia. The Pediatric Dentist may do the history and physical examination if permitted by state and federal regulations.

800.10.20 A,B,C-M,C

The history and physical examination should cover the organs and systems commensurate with the procedure(s).

800.10.30 A,B,C-M,C

Drug allergies/sensitivities and reactions, if applicable.

800.10.40 A,B,C-M,C

Current medications.

800.10.50 A,B,C-M,C

Previous serious illness.

800.10.60 A,B,C-M,C

Current and chronic illness.

800.10.70 A,B,C-M,C

Previous surgery.

800 Pre-Procedural

800.10.80 A,B,C-M,C

Bleeding tendencies.

800.10.90 A,B,C-M,C

Treating physicians or consultants are contacted to provide recorded medical clearance in cases where the history and physical examination warrant.

800.10.100 A,B,C-M,C

Appropriate laboratory procedures are performed, when indicated.

800.10.110 B,C-M,C

The Pediatric Dentist and the anesthesia provider should concur on the appropriateness of procedures performed at the facility and document agreement on the chart. This is based on the medical status, age and physiological appropriateness of the patients and qualifications of providers and facility resources.

800 Pre-Procedural

800.20 Informed Consent

800.20.10 A,B,C-M,C

An informed consent is always obtained from legal guardian which authorizes the Pediatric Dentist by name to perform the procedure(s) and describes the procedure(s).

800.20.20 A,B,C-M,C

Expectations, alternatives, risks and complications are discussed with the patient, and these are documented.

800.20.30 A,B,C-M,C

The informed consent provides consent for administration of anesthesia or sedatives under the direction of sedation credentialed Pediatric Dentist, CRNA, Medical Anesthesiologist or Dentist Anesthesiologist.

800 Pre-Procedural

800.30 Anesthesia Care Plan

800.30.10 B,C-M,C

Anesthesia provider or the child's primary care physician is responsible for determining the medical status of the patient.

Immediately before procedures, the anesthesia provider must examine the patient and must:

800.30.20 B,C-M,C

Verify that an anesthesia care plan has been developed and documented.

800.30.30 A,B,C-M,C

Verify that the patient or a responsible adult has been informed about the anesthesia care plan. Class A facilities may meet this requirement through the Informed Consent process when using local, topical, or Low-Flow Nitrous Oxide/Oxygen anesthesia.

800.30.40 B,C-M,C

A properly credentialed sedation professional must be present when any anesthetic agent, other than topical, local, or low-flow nitrous oxide anesthesia, is administered.

The anesthesia care plan is based on:

800.30.50 A,B,C-M,C

A review of the medical record.

800.30.60 A,B,C-M,C

Medical history.

800.30.70 A,B,C-M,C

Prior anesthetic experiences.

800 Pre-Procedural

800.30.80 A,B,C-M,C

Drug therapies.

800.30.90 A,B,C-M,C

Medical examination and assessment of any conditions that might affect the pre-procedure risk.

800.30.100 A,B,C-M,C

A review of the medical tests and consultations.

800.30.110 A,B,C-M,C

A determination of pre-procedure medications needed for anesthesia.

800.30.120 A,B,C-M,C

Providing pre-procedure instructions.

800 Pre-Procedural

800.40 Laboratory, Pathology, X-Ray, Consultation, Treating Physician Reports, etc.

800.40.10 A,B,C-M,C

Printed or written copies of these reports are kept in the medical record.

800.40.20 A,B,C-M,C

All laboratory results must be reviewed by the registered nurse, sedation licensed/credentialed Pediatric Dentist or anesthesia provider. All abnormal results must be reviewed and initialed by the sedation licensed/credentialed Pediatric Dentist within one (1) week of receipt of results.

800.40.30 A,B,C-M,C

All other reports, such as pathology reports and medical clearance reports, must be reviewed and initialed by the sedation licensed/credentialed Pediatric Dentist.

800.40.40 A,B,C-M,C

Outside clinical laboratory procedures must be performed by a licensed and accredited facility.

800.40.50 A,B,C-M,C

The name of the pathologist must be on all pathology reports

900 Intra-Procedural

900.10 Policy

900.10.10 A,B,C-M,C

A policy for a "Procedure Pause" or a "Time Out" protocol is in place and practiced prior to every procedure.

This protocol should include:

- Pre-procedure verification process to include medical records and imaging studies to be reviewed by the procedure room team. Missing information or discrepancies must be addressed at this time.
- Marking the procedure site where appropriate – procedural marking should at least be indicated on a separate dental diagram.
- Side/Site identification will comply with the Universal Protocol standards for dental procedures.
- Documented 'Time Out' and surgical fire risk assessment immediately before starting the procedure
- Conduct a final verification and documentation that at least two (2) members of the procedure team confirming the correct patient, procedure, site marking(s) and, as applicable, special equipment or requirements. As a 'fail-safe' measure, the procedure is not started until any and all questions or concerns are resolved.

900 Intra-Procedural

The following anesthesia standards apply to all patients who receive anesthesia or sedation/analgesia. In extreme emergencies or life-threatening circumstances, these standards may be modified, and all such circumstances should be documented in the patient's record.

900.20 Anesthesia

900.20.10 B,C-M,C

If responsible for supervising anesthesia or providing anesthesia, a properly trained and credentialed sedation professional for the intended level of anesthesia must be present in the procedure suite throughout the anesthetic.

900.20.20 B,C-M,C

Clinical provider monitoring the patient cannot function in any other capacity (e.g., procedure assistant or circulating nurse) during the procedure.

900.20.30 B, C-M, C

If oral, intranasal, or parental sedation provided pre-operatively by the Pediatric Dentist with a period of time allowed for the medication to reach peak effect prior to leaving the pre-operative area, the same Pediatric Dentist may act as the operating dentist. Intra-operatively, this Pediatric Dentist cannot administer additional sedation agents other than low flow nitrous oxide/ oxygen. Intra-operatively (during the procedure), the patient must be observed and monitored by a Medical Anesthesiologist, a Dentist Anesthesiologist, an additional Pediatric Dentist, a CRNA, an RN, or a Dental Assistant (who completed a sedation course recognized by the AAPD).

900.20.40 B,C-M,C

All anesthetics other than topical, local, or low-flow nitrous oxide anesthetic agents are delivered by either an appropriately credentialed Pediatric Dentist (excluding dissociative drugs and general anesthesia), Medical Anesthesiologist, an appropriately trained and credentialed Dentist Anesthesiologist, or by a CRNA (under physician supervision if required by state or federal law or by a policy adopted by the facility). All personnel must abide by all state and federal regulations and laws governing the administration of anesthesia.

900.20.50 B,C-M,C

Propofol anesthesia may be administered only by a CRNA, a Medical Anesthesiologist, an appropriately credentialed Pediatric Dentist, or a Dentist Anesthesiologist.

900 Intra-Procedural

900.30 Anesthesia Monitoring/Documentation

Circulation must be monitored by one or several of the following:

900.30.10 B,C-M,C

Continuous EKG during procedures.

900.30.20 B,C-M,C

Blood pressure documented at least every five (5) minutes.

900.30.30 B,C-M,C

Heart rate documented at least every five (5) minutes.

900.30.40 A,B,C-M, C

Pulse oximetry. Exempt if only topical and/or local anesthetic is used.

900.30.50 C-M,C

Heart auscultation.

900.30.60 B,C-M,C

Temperature should be monitored.

900.30.70 B,C-M,C

Patient monitoring during anesthesia will consist of:
Oxygenation

Assessment by O2 analyzer. If an anesthesia machine is used during general anesthesia, the anesthesia machine has an alarm for low O2 concentration.

900 Intra-Procedural

900.30.80 B,C-M,C

Patient monitoring during anesthesia consists of:
End tidal carbon dioxide ($ETCO_2$) sampling shall be used on all sedation or general anesthetics.

900.30.90 C

When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry, or mass spectroscopy. When capnography or capnometry is utilized, the end tidal carbon dioxide alarm shall be audible to the Anesthesiologist or the anesthesia care team personnel.

A separate anesthesia record is maintained which:

900.30.100 B,C-M,C

All medications given to a patient are recorded including date, time, amount and route of administration.

900.30.110 B,C-M,C

All intravenous and subcutaneous fluids given pre-procedurally, intra-procedurally, and post-procedurally are recorded.

1000 Post-Procedural

1000.10 Recovery Room

1000.10.10 B,C-M,C

There is an adequate recovery area within the procedure suite. If the recovery room is separate from the operating room, the recovery room must contain all appropriate equipment and must be staffed continuously until the patient is discharged.

1000.10.20 B,C-M,C

The procedure room may be used for patient recovery if only one procedure is scheduled that day, or if the recovering patient meets all discharge criteria prior to beginning the next procedure, or if there is another procedure room available for the next procedure.

1000.10.30 B,C-M,C

The recovery area is equipped and readily accessible to handle emergencies.

1000.10.40 B,C-M,C

A minimum of one PALS, and when appropriate ACLS as well, certified staff member must be present in the facility until all patients recovering from anesthesia have met criteria for discharge from the facility.

1000.10.50 B

All recovering patients must be observed and monitored by a Medical Anesthesiologist, a Dentist Anesthesiologist, a Pediatric Dentist, a CRNA, an RN, or a Dental Assistant (who completed a sedation course recognized by the AAPD). The Dental Assistant must be under the supervision of one of the other listed healthcare professionals who is immediately available. Either the supervising healthcare professional or the Dental Assistant must be PALS certified, also ACLS certified if appropriate to patient population being treated in the facility.

1000.10.60 C-M,C

All recovering patients must be observed and monitored by a Medical Anesthesiologist, a Dentist Anesthesiologist, a Pediatric Dentist, a CRNA, or an RN. The monitoring healthcare professional must be PALS certified, also ACLS certified if appropriate to patient population being treated in the facility.

1000 Post-Procedural

1000.20 Transfer to Recovery Room

1000.20.10 B,C-M,C

Patients transferred to the post-anesthetic recovery area are accompanied by a member of the anesthesia team who is knowledgeable about the patient.

1000.20.20 B,C-M,C

Patients transferred to the post-anesthetic recovery area will be continually evaluated and monitored as needed during transport.

1000.20.30 B,C-M,C

A member of the anesthesia team remains in the post-anesthesia area until the post-anesthesia care nurse accepts responsibility for the patient.

1000 Post-Procedural

1000.30 Post-Procedural Documentation

Evaluation in the recovery area following an anesthetic procedure will include documentation of:

1000.30.10 B,C-M,C

Documentation of patient's time of arrival.

1000.30.20 B,C-M,C

Assessment of the patient by the anesthesia recovery staff, as well as by a responsible anesthesia provider.

1000.30.30 B,C-M,C

Transmission of a verbal report on the patient to the recovery staff from a member of the anesthesia team who accompanies the patient.

1000.30.40 B,C-M,C

Transfer of information concerning the pre-procedure condition of the patient and the procedure anesthesia course.

1000.30.50 B,C-M,C

There is a recovery record that includes vital signs, level of consciousness, medications and nurse's notes.

1000.30.60 B,C-M,C

Post-procedure vital signs are recorded until the patient is discharged from the facility.

1000.30.70 A,B,C-M,C

Post-procedure progress notes are recorded.

1000 Post-Procedural

1000.30.80 A,B,C-M,C

There is a procedure report which includes procedure technique and findings.

1000 Post-Procedural

1000.40 Discharge from Recovery Room

1000.40.10 B,C-M,C

There is a written policy that whenever parenteral sedation, dissociative drugs, or general anesthesia is administered, a licensed provider for that level of sedation is immediately available until the patient is discharged from the recovery area.

1000.40.20 B,C-M,C

A qualified and credentialed individual determines that the patient meets discharge criteria based upon input from the post-anesthetic procedure recovery staff. That individual's name must be noted on the record, signed by that individual with the time of discharge.

1000.40.30 B,C-M,C

Approved and standardized discharge criteria for pediatric patients are used and recorded. (e.g. Aldrete score)

1000.40.40 B,C-M,C

Personnel assist with discharge from the recovery area.

1000.40.50 B,C-M,C

Patients receiving anesthetic agents other than topical or local anesthesia or low-flow nitrous oxide/oxygen should be supervised in the immediate post discharge period by a responsible adult for at least 24 hours, depending on the procedure and anesthesia used.

1000.40.60 B,C-M,C

Written instructions, including procedures for emergency situations, are given to the responsible adult who is responsible for the patient's care and transportation following a procedure. A signed copy of the instructions is maintained in the patient's chart.

1100 Medications and IV Fluids

1100.10 Intravenous Fluids

1100.10.10 A,B,C-M,C

Intravenous fluids such as Lactated Ringer's solution and/or normal saline are available in the facility.

1100.20 Medications

1100.20.10 A,B,C-M,C

Emergency medications are readily available and procedure room personnel know their location. All emergency medications are appropriate for the pediatric population, adult population if applicable.

1100.20.20 A,B,C-M,C

Outdated medications are removed and destroyed in accordance with state pharmacy regulation.

1100.20.30 A,B,C-M,C

There is a dated narcotic/controlled substance inventory and control record which includes the use of narcotics/controlled substances on individual patients. Such records must be kept in the form of a sequentially numbered bound journal from which pages may not be removed, or in a tamper-proof and secured computer record, consistent with state and federal law. A loose leaf or spiral-bound notebook does not meet this requirement.

1100.20.40 A,B,C-M,C

The inventory of narcotics/controlled substances is verified by two licensed members of the procedure room team at least weekly, on any day that narcotics are administered, and according to state regulations.

1100.20.50 A,B,C-M,C

All narcotics and controlled substances are secured and locked under supervised access.

1100 Medications and IV Fluids

1100.30 PALS/ACLS Algorithm

1100.30.10 A,B,C-M,C

A complete copy of the current PALS algorithm (and current ACLS algorithm if appropriate) must be available on the emergency cart.

The following medications must be available on the emergency cart at all times as required by current PALS Algorithm (and ACLS algorithm if appropriate):

1100.30.20 A,B,C-M,C

Interosseous and intravenous needles

1100.30.30 A,B,C-M,C

Epinephrine

1100.30.40 A,B,C-M,C

Lidocaine – plain

1100.30.50 B,C-M,C

Narcotic antagonist (e.g. Narcan®)

1100.30.60 A,B,C-M,C

Seizure arresting medication (e.g. a benzodiazepine; example: Midazolam®)

1100.30.70 A,B,C-M,C

Bronchospasm arresting medication (e.g. inhaled beta agonist; example: Albuterol®)

1100.30.80 A,B,C-M,C

Intravenous corticosteroids (example: Dexamethasone®)

1100 Medications and IV Fluids

1100.40 Other Drugs on the Emergency Cart

1100.40.10 A,B,C-M,C

IV Antihistamines (example: Diphenhydramine®)

1100.40.20 B,C-M,C

Short-acting beta-blocker (example: Esmolol® or Labetalol®)

1100.40.30 C

Neuromuscular blocking agents including non-depolarizing agents such as rocuronium or depolarizing agents such as succinylcholine

1100.40.40 B,C-M,C

Benzodiazepine reversing agent (example: Mazicon®, Flumazenil)

1100.40.50 A,B,C-M,C

Atropine

1100 Medications and IV Fluids

1100.50 Malignant Hyperthermia

1100.50.10 C-M,C

The current and complete MHAUS malignant hyperthermia algorithm must be available on the emergency cart. If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility, the following requirements apply.

1100.50.20 C-M,C

If the depolarizing muscle relaxant succinylcholine is present only for use in emergency airway rescue, the facility must document a protocol to manage the possibility of malignant hyperthermia (MH) following its use.

In this instance, MH-related components as outlined in standards 1100.50.70, 1100.50.80, 1100.50.90, 1100.50.100, 1100.50.110, and 1100.50.120 are not required.

1100.50.30 C-M,C

There must be adequate screening for MH risk that includes but is not limited to a family history of unexpected death(s) following general anesthesia or exercise; a family or personal history of MH, a muscle or neuromuscular disorder, high temperature following exercise; a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise.

1100.50.40 C-M,C

The Medical Director and all operating surgeons and anesthesiology providers should be aware of genetic and/or CHCT (Caffeine-Halothane Contracture Testing) for MH and refer patients for appropriate testing if there is a suspicious history as above prior to permitting surgery to take place in the facility.

1100.50.50 C-M,C

The Medical Director should be able to demonstrate that all operating surgeons and anesthesia providers have familiarity with the early recognition of impending MH crisis as defined by MHAUS.

1100 Medications and IV Fluids

1100.50.60 C-M,C

The Medical Director will insure that all staff is trained; annual drills are conducted for MH crisis and management including actual dilution of at least one vial of actual Dantrolene (expired OK). Staff should be assigned roles prior to drills and a written protocol outlining those personnel and their roles is on file. Documentation of drills is required.

1100.50.70 C-M,C

A supply of sterile water for injection USP (without a bacteriostatic agent) is available to mix with dantrolene before injection (i.e., 60ml/vial for Dantrium® and Revonto®, 5ml/vial for Ryanodex®).

1100.50.80 C-M,C

A minimum of 4 ampoules, 50cc's each, of sodium bicarbonate (NaHCO3).

1100.50.90 C-M,C

A minimum supply of dantrolene/Ryanodex should be stocked to treat a patient of average weight (approximately 70kg) with an initial dose: Dantrium®/Revonto® - 12 vials (20 mg/vial) Ryanodex® - 1 vial (250 mg/vial).

1100.50.100 C-M,C

An additional* supply of dantrolene/Ryanodex and diluents are stored in the facility, or the facility has a written agreement with another source that will provide additional* dantrolene/Ryanodex and diluents on a STAT basis within 15 minutes for continued treatment and stabilization of a patient experiencing a MH episode.
*additional supply of dantrolene is defined as: Dantrium®/Revonto® - 24 vials (20 mg/ vial) Ryanodex® - 2 vial (250 mg/vial)

1100.50.110 C-M,C

The current MHAUS Malignant Hyperthermia Algorithms must be available on the emergency cart.

1100 Medications and IV Fluids

1100.50.120 C-M,C

Flow sheets for any MH intervention as well as forms to rapidly communicate progress of intervention with receiving facilities are on the emergency cart and all ASC's must document and report any "adverse metabolic or musculoskeletal reaction to anesthesia". This documentation must be transportable with the patient when transferred to receiving facility.

1100.50.130 C-M,C

Facilities should establish the best destination as a transfer standard, which means the Medical Director would preplan for MH transfer and establish the capabilities of a facility within a reasonable distance. (E.g. a tertiary care center that is further away may be better than a community type ER which is closer.) Arrangements must be made in advance with EMS system if that is to be activated. Ability of receiving transport team to continue MHAUS protocol must be ensured in advance as well as by the Medical Director.

1200 Personnel

1200.10 Facility Personnel

1200.10.10 A,B,C-M,C

All individuals using the facility must meet one of the following criteria (throughout this document the terms, medicine and medical apply to all DMD, DDS, MD, and DO Degrees):

- A Doctor of Dental Medicine or Dental Surgery certified or eligible for certification by training and license to perform deep sedation/general anesthesia.
- A Doctor of Medicine certified or eligible for certification by one of the member boards of the American Board of Medical Specialties (ABMS) or a Doctor of Osteopathy certified or eligible for certification by the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS).

Pediatric Dentists must have:

- DMD or DDS degree or equivalent
- Completion of a Commission on Dental Accreditation (CODA) postgraduate training program in Pediatric Dentistry in the United States or Canada or its equivalent
- Current certification or in pathway for certification by the American Board of Pediatric Dentistry (ABPD).

Individuals administering deep sedation or general anesthesia must have:

- DDS, DMD, MD, DO, or CRNA degree
- Certified or eligibility for certification by American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS). (“Medical Anesthesiologist”)
- Certified or eligible for certification by American Dental Society of Anesthesiology (ASDA). (“Dentist Anesthesiologist”)

1200.10.20 A,B,C-M,C

All procedure room personnel must meet acceptable standards as defined by their professional governing bodies, where applicable.

1200.10.30 A,B,C-M,C

All procedure room personnel are under the immediate supervision of a Pediatric Dentist.

1200 Personnel

1200.20 Medical Director

1200.20.10 A,B,C-M,C

The Medical Director/Pediatric Dentist/Owner of practice must have the appropriate state dental board facility permit if required (for low-flow nitrous oxide/oxygen analgesia, minimal sedation, moderate sedation, or deep sedation/general anesthesia).

1200.20.20 A,B,C-M,C

The Medical Director/Pediatric Dentist/Owner must have the appropriate individual state dental board sedation/anesthesia permit. The anesthesia provider must have the appropriate state board deep sedation/general anesthesia permit.

1200.20.30 A,B,C-M,C

The Medical Director must be a sedation credentialed Pediatric Dentist currently licensed by the state in which the facility is located.

1200.20.40 A,B,C-M,C

The Medical Director must be actively involved in the direction and management of the facility.

1200.20.50 A,B,C-M,C

The Medical Director is responsible for establishing and enforcing policies that protect patients. The director monitors all members of the medical and facility staff for compliance with this policy.

1200 Personnel

1200.30 Pediatric Dentists

1200.30.10 A,B,C-M,C

The Pediatric Dentist is responsible for the operation of the procedure room and patient care areas.

1200.30.20 A,B,C-M,C

All individuals using the facility must meet one of the following criteria:

- A Doctor of Medicine certified or eligible for certification by one of the member boards of the American Board of Medical Specialties (ABMS).
- A Doctor of Osteopathy certified or eligible for certification by the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS).
- A Doctor of Medicine in Dentistry or Doctor of Dental Surgery certified or eligible for certification by the American Board of Pediatric Dentistry (ABPD) or American Board of Oral and Maxillofacial Surgery (ABOMS).

ABMS and/or ABOMS certified or eligible medical and/or dental specialists who perform procedures within the accredited facility may perform only those procedures delineated in their ABMS and/or ABOMS board certification.

1200.30.30 A,B,C-M,C

Pediatric Dentist(s) using the facility are credentialed and qualified for the procedures they perform.

1200.30.40 A,B,C-M,C

Each Pediatric Dentist must currently be licensed by the state in which they practice. A copy of each Pediatric Dentist's current license must be maintained on file in the facility.

1200 Personnel

1200.30.50 A, B, C-M, C

Pediatric Dentists who operate in facilities accredited by AAAASF must hold or demonstrate that they have held valid, unrestricted hospital privileges in their specialty at an accredited and/or licensed hospital within the last two (2) years. Only dental procedures included within those hospital privileges may be performed within the AAAASF accredited facility. If the privilege-granting hospital does not possess equipment or technology to allow a Pediatric Dentists to be credentialed for a specific surgery, the Pediatric Dentists may provide alternative evidence of training and competence in that surgery. Individual consideration will be given if the Pediatric Dentist no longer possesses or cannot obtain such privileges; and can demonstrate that loss of or inability to obtain such privileges was not related to lack of clinical competence, ethical issues or problems other than economic competition.

-OR-

If the Pediatric Dentist has never held privileges, or no longer holds privileges, AAAASF will accept alternate credentialing via primary source verification. Primary source verification must be re-credentialed every two (2) years. Additionally, these Pediatric Dentists who have primary source verification are no longer required to have hospital admitting privileges. However, the facility must have a written transfer agreement with a local hospital. It is the facility's responsibility to conduct the primary source verification and not the Pediatric Dentist's.

Required elements of primary source verification are:

- Verification of dental education directly from institution (DMD or DDS degree)
- Verification of any specialty/subspecialty from sponsoring institution (CODA training of Pediatric Dentistry)
- Verification of all state license(s) with issue date(s), expiration date(s), status (as of current date) and type of license (temporary, limited or unlimited)
- Verification of board certification status (American Board of Pediatric Dentist, American Board of Oral Maxillofacial Surgery) if applicable.
- Drug Enforcement Administration (DEA) registration status
- National Practitioner Databank (NPDB)'s Integrated Querying and Reporting Services (IQRS)

1200 Personnel

1200.40 Anesthesia Providers

1200.40.10 B,C-M,C

If Dentist Anesthesiologists, Medical Anesthesiologists and/or CRNAs participate in patient care at the facility, they are qualified for the procedures they perform, and their credentials have been verified.

1200.40.20 B,C-M,C

Must be licensed or certified by the state in which they practice.

1200.40.30 B,C-M,C

The Dentist Anesthesiologist or Medical Anesthesiologist responsible for supervising the administration of anesthesia must have knowledge of anesthetics and resuscitative techniques and be credentialed to perform such procedures.

1200.40.40 C-M,C

Must be responsible for the administration of dissociative anesthesia with Propofol or general anesthesia and monitoring of all life support systems.

1200.40.50 B,C-M,C

Ensure that all anesthesia equipment is in proper working order.

1200.40.60 A,B,C-M,C

Anesthesia personnel should review and be familiar with the facility's emergency protocol for cardiopulmonary emergencies and other internal and external disasters.

1200.40.70 B,C-M,C

Anesthesia personnel should be trained and knowledgeable about the facility's protocols for safe and timely transfer of a patient to an alternative care facility when extended or emergency services are required.

1200 Personnel

1200.50 Personnel Records

IMPORTANT: Employee information must remain strictly confidential.

Individual or personal information such as previous employment, health information (except state required immunization and tests), disabilities, performance reviews and employment are protected and of no interest to the AAAASF inspector. However, the inspector does need to confirm that an adequate file is kept on each employee relating to the items listed below. Please have only this data available for each employee, separate from employee files.

"Personnel" is defined as any individual who is providing direct patient care (employee or contractor) including but not limited to Pediatric Dentists, Physicians, Physician's Assistants, Nurses (including RNs, APNs, CRNAs), Dental Assistants, Surgical Techs, Medical Assistants, etc. *Non-Clinical Staff are exempt from the personnel record review (i.e. receptionists, secretaries, clerks, billers, etc.).*

1200.50.10 A,B,C-M,C

There is a manual outlining personnel policy.

1200.50.20 A,B,C-M,C

The manual contains personnel policies and records which are maintained according to OSHA and ADA (Americans with Disabilities Act) guidelines.

Personnel records should contain the following:

1200.50.30 A,B,C-M,C

Any health problems of the individual which may be hazardous to the employee, other employees or patients, and a plan of action or special precautions delineated as needed. To be reviewed and updated annually.

1200.50.40 A,B,C-M,C

Resume of training and experience.

1200 Personnel

1200.50.50 A,B,C-M,C

Current certification or license if required by the state.

1200.50.60 A,B,C-M,C

Date of employment.

1200.50.70 A,B,C-M,C

Description of duties.

1200.50.80 A,B,C-M,C

On-going record of continuing education.

1200.50.90 A,B,C-M,C

On-going record of inoculations or refusals.

Personnel records document training in the following:

1200.50.100 A,B,C-M,C

Annual hazard safety training.

1200.50.110 A,B,C-M,C

Annual blood borne pathogens.

1200.50.120 A,B,C-M,C

Annual universal precautions.

1200 Personnel

1200.50.130 A,B,C-M,C

Other annual safety training including surgical fire safety training and structure fire safety including operation of a fire extinguisher.

1200.50.140 A,B,C-M,C

At least Basic Cardiopulmonary Life Support (BLS) certification, but preferably Pediatric Advanced Life Support (PALS) for each procedure room and recovery team member. Additionally, Advanced Cardiac Life Support (ACLS) if appropriate.

1200 Personnel

1200.60 Personnel Continued

1200.60.10 A,B,C-M,C

The procedure room personnel have knowledge to treat cardiopulmonary and anaphylactic emergencies. At least one member of the procedure room team, preferably the Pediatric Dentist or the anesthesia care giver, holds current PALS certification or ACLS if appropriate. Two members of the team must have advanced training in pediatric airways and life support.

1200.60.20 A,B,C-M,C

The procedure room personnel are familiar with equipment and procedures utilized in the treatment of the above emergencies.

1200.60.30 C

Personnel are properly trained in the control procedures and work practices that have been demonstrated to reduce occupational exposures to anesthetic gases.

1200.60.40 A,B,C-M,C

If a gas sterilizer is used, personnel are thoroughly familiar with the operating instructions and properly vented.

1300 Quality Improvement/Quality Assessment/Risk Management

1300.10 Quality Improvement

1300.10.10 B,C-M,C

A licensed or qualified anesthesia provider supervising or providing care in the facility should participate in quality assurance and risk management in the facility.

1300.10.20 A,B,C-M,C

The facility has a written quality improvement program in place which should include surveys or projects which:

1300.10.30 A,B,C-M,C

Monitor and evaluate patient care.

1300.10.40 A,B,C-M,C

Evaluate methods to improve patient care.

1300.10.50 A,B,C-M,C

Identify and correct deficiencies within the facility.

1300.10.60 A,B,C-M,C

Alert the Medical Director to identify and resolve problems.

1300 Quality Improvement/Quality Assessment/Risk Management

1300.20 Peer Review

1300.20.10 A,B,C-M,C

To be HIPAA compliant, a copy of the Business Associates Agreement must be signed by each Pediatric Dentist participating in Peer Review, and a copy retained on file in the facility. For an example of a generic HIPAA Business Associates Agreement, contact the AAAASF Central Office.

1300.20.20 A,B,C-M,C

Peer review is performed at least every three (3) months (quarterly) and includes reviews of both random cases and unanticipated sequelae using the AAAASF forms and reporting format. Peer Review must be reported on line at www.aaaasf.org. A random sample of the cases for each sedation credentialed Pediatric Dentist must include the first case done by each Pediatric Dentist each month during the reporting period for a total of three (3) cases.

1300.20.30 A,B,C-M,C

If peer review sources external to the facility are used to evaluate delivery of medical care, the Business Associates Agreement is so written as to waive confidentiality of the medical records.

1300.20.40 A,B,C-M,C

Peer review may be done by a recognized peer review organization, unless otherwise specified by state regulations.

1300 Quality Improvement/Quality Assessment/Risk Management

1300.30 Random Case Review

1300.30.10 A,B,C-M,C

A minimum of three (3) cases per Pediatric Dentist utilizing the facility are reviewed every three months. If a Pediatric Dentist performs less than three (3) cases in a three-month period, all cases will be reviewed.

Random case reviews must include at a minimum:

1300.30.20 A,B,C-M,C

Adequacy and legibility of history and physical exam.

1300.30.30 A,B,C-M,C

Adequacy of consent.

1300.30.40 A,B,C-M,C

Presence of laboratory, EKG and radiographic reports.

1300.30.50 A,B,C-M,C

Presence of a written procedure report.

1300.30.60 B,C-M,C

Anesthesia and recovery record (with IV sedation or general anesthesia).

1300.30.70 A,B,C-M,C

Presence of instructions for post-procedure care.

1300.30.80 A,B,C-M,C

Documentation of complications.

1300 Quality Improvement/Quality Assessment/Risk Management

1300.40 Unanticipated Procedure Sequelae

All unanticipated procedure sequelae which occur within thirty (30) days of procedures are reviewed, including but not limited to:

1300.40.10 A,B,C-M,C

Unplanned hospital admission.

1300.40.20 A,B,C-M,C

Unscheduled return to the procedure room for a complication of a procedure.

1300.40.30 A,B,C-M,C

Significant and/or unexpected complications such as severe infection, bleeding, or injury to other body structure.

1300.40.40 A,B,C-M,C

Cardiac or respiratory problems during stay at facility or within forty-eight (48) hours of discharge.

1300.40.50 A,B,C-M,C

Allergic reactions.

1300.40.60 A,B,C-M,C

Patient or family complaint.

1300.40.70 A,B,C-M,C

Equipment malfunction leading to injury or potential injury to patient.

1300 Quality Improvement/Quality Assessment/Risk Management

1300.40.80 A,B,C-M,C

Death occurring within thirty (30) days of a procedure performed in the facility.

1300.40.90 A,B,C-M,C

Identification of the problem.

1300.40.100 A,B,C-M,C

Immediate treatment or disposition of the case.

1300.40.110 A,B,C-M,C

Outcome.

1300.40.120 A,B,C-M,C

Reason for problem.

1300.40.130 A,B,C-M,C

Assessment of efficacy of treatment.

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Agenda Item (8):

American Heart Association

Interim Guidance on Card Extensions

During COVID - 19

UPDATED: Interim Guidance on Card Extensions during COVID-19 Outbreak

American Heart Association.

CPR & EMERGENCY CARDIOVASCULAR CARE

July 23, 2020

Dear Global AHA Training Network,

The AHA continues to monitor the COVID-19 pandemic and the ability of Training Centers to conduct training while providing a variety of flexible options for Training Centers. In addition to blended and virtual options outlined here, we are further clarifying the guidance below on card extensions.

- AHA Provider and Instructor cards that expired in March, April, May, and June 2020 can renew their card for up to 120 days from the recommended "Renew By" date on their card. See below for specific recommended renewal and extension dates:

Recommended "Renew By" Date on Card (end of month)	New "Renew By" Due Date with 120-day Extension (end of month)
March 2020	July 2020*
April 2020	August 2020*
May 2020	September 2020
June 2020	October 2020

- Beginning with cards that expire at the end of July, we will resume normal timelines for renewing cards. Those with cards expiring at the end of July should plan to renew their cards by the recommended renewal date on their card (July 2020).

- However, as a special exception, only for those who may be in affected areas with restrictions still in place into July and August, the AHA will allow Training Centers, at their discretion, to consider extending cards that have a "Renew By" date of July or August to no further than October 2020.

  **Per the above table, Training Centers in affected areas may extend March and April expired cards that had a new "Renew By" date, if necessary, to no further than October 2020.*

- As always, AHA TCs are responsible for following the instructions from their local government or public health authority as it relates to actions around COVID-19. In accordance with the guidelines released by local government, the leadership of the TC should use discretion to evaluate the risk of disease transmission in their area before organizing any training events and take necessary precautions to avoid transmissions.

The AHA continues to closely monitor the COVID-19 pandemic and evaluate options for delivering resuscitation education while taking the proper precautions. Our top priority is the safety of both AHA Instructors and learners.

We remain committed to serving you as a trusted resource to allow for the continuance of safe, high-quality CPR training, as feasible. Thank you for everything you are doing during this challenging time.

Sincerely,
American Heart Association

UPDATED: Interim Guidance on Card Extensions during COVID-19 Outbreak

American Heart Association.

CPR & Emergency Cardiovascular Care

March 31, 2020

Purpose: To provide additional flexibility for providers, AHA Instructors, and Instructor candidates during the COVID-19 pandemic. *NOTE: This guidance on card extensions supersedes the guidance outlined in the March 13, 2020, document, "Interim Guidance on Extensions for AHA Instructor & Provider Cards during COVID-19 Outbreak."*

AHA Instructor and Provider Card Extensions

Per the statement regarding further extensions of AHA course completion cards beyond 60 days past the recommended renewal day (in interim guidance released on March 13, 2020), and given the ongoing threat of exposure to COVID-19, with many communities under shelter in place orders to minimize the spread of the disease, the AHA is extending AHA Instructor and Provider Course Completion Cards for 120 days beyond their recommended renewal date, beginning with cards that expire in March 2020.

Please see the AHA's guidance below, and disseminate to anyone who has a business need for this information (e.g., students, employers, medical or safety regulators, etc.).

For Instructor Cards expiring beginning in March 2020:

- AHA Instructor cards will be valid for 120 days beyond their recommended renewal date.
- Instructor candidates will also have 10 months from the completion of their Instructor course to complete monitoring.
- Management of this extension, and any record-keeping, will be the responsibility of the Training Center.

For AHA Provider Cards expiring beginning in March 2020:

- AHA Provider Cards will be valid for 120 days beyond their recommended renewal date.
- Management of this extension, and any record-keeping, will be the responsibility of the Training Center.

AHA Policy on Expired Cards for Update/Renewal Courses:

- Over the next 120 days, for providers whose cards have expired due to inability to complete training during the COVID-19 outbreak, the AHA will allow Instructors to provide remediation during update courses.

Agenda Item (9):

Sample Sedation Records
and
Manufacturers Instructions for Use
(Akorn, Bedford, Hospira)

HL Midazolam 5mg-ml 10ml_P_Akorn

Midazolam should always be titrated slowly; administer over at least 2 minutes and allow an additional 2 or more minutes to fully evaluate the sedative effect.

1. *Healthy Adults Below the Age of 60:* Titrate slowly to the desired effect, e.g., the initiation of slurred speech. Some patients may respond to as little as 1 mg. No more than 2.5 mg should be given over a period of at least 2 minutes. Wait an additional 2 or more minutes to fully evaluate the sedative effect. If further titration is necessary, continue to titrate, using small increments, to theappropriate level of sedation. Wait an additional 2 or more minutes after eachincrement to fully evaluate the sedative effect. A total dose greater than 5 mg is not usually necessary to reach the desired endpoint.

HL Midazolam 5mg-ml 10ml_Bedford

Titration to effect with multiple small doses is essential for safe administration. It should be noted that adequate time to achieve peak central nervous system effect (3 to 5 minutes) for midazolam should be allowed between doses to minimize the potential for oversedation. Sufficient time must elapse between doses of concomitant sedative medications to allow the effect of each dose to be assessed before subsequent drug administration. This is an important consideration for all patients who receive intra- venous midazolam.

Midazolam should always be titrated slowly; administer over at least 2 minutes and allow an additional 2 or more minutes to fully evaluate the sedative effect. Individual response will vary with age, physical status and concomitant medications, but may also vary independent of these factors. (See WARNINGS concerning cardiac/respiratory arrest/airway obstruction/hyperventilation.)

1. *Healthy Adults Below the Age of 60:* Titrate slowly to the desired effect, e.g., the initiation of slurred speech. Some patients may respond to as little as 1 mg. No more than 2.5 mg should be given over a period of at least 2 minutes. Wait an additional 2 or more minutes to fully evaluate the sedative effect. If further titration is necessary, continue to titrate, using small increments, to theappropriate level of sedation. Wait an additional 2 or more minutes after eachincrement to fully evaluate the sedative effect. A total dose greater than 5 mg is not usually necessary to reach the desired endpoint.

HL Midazolam 5mg-ml 10ml_Hospira

1. *Healthy Adults Below the Age of 60:* Titrate slowly to the desired effect, (e.g., the initiation of slurred speech). Some patients may respond to as little as 1 mg. No more than 2.5 mg should be given over a period of at least 2 minutes. Wait an additional 2 or more minutes to fully evaluate the sedative effect. If further titration is necessary, continue to titrate, usingsmall increments, to the appropriate level of sedation. Wait an additional 2 or more minutes after each increment to fullyevaluate the sedative effect. A total dose greater than 5 mg isnot usually necessary to reach the desired endpoint. If narcotic premedication or other CNS depressants are used,patients will require approximately 30% less midazolam thanunpremedicated patients.

2. *Patients Age 60 or Older, and Debilitated or Chronically III Patients:* Because the danger of hypoventilation, airwayobstruction, or apnea is greater in elderly patients and thosewith chronic disease states or decreased pulmonary reserve, and because the peak effect may take longer in these patients, increments should be smaller and the rate of injection slower.Titrate slowly to the desired effect, (e.g., the initiation of slurred speech). Some patients may respond to as little as 1 mg. No more than 1.5 mg should be given over a period of no less than 2 minutes. Wait an additional 2 or more minutes to fully evaluate the sedative effect. If additional titration is necessary, it should be given at a rate of no more than 1 mg over a period of 2 minutes, waiting an additional 2 or more minutes each time to fully evaluate the sedative effect. Total doses greater than 3.5 mg are not usually necessary. If concomitant CNS depressant premedications are used in these patients, they will require at least 50% less midazolamthan healthy young unpremedicated patients.

Introduction of Anesthesia:

In the absence of premedication, an average adult under the age of 55 years will usually require an initial dose of 0.3 to 0.35 mg/kg for induction, administered over 20 to 30 seconds and allowing 2 minutes for effect.

Usual Adult Dose: If a loading dose is necessary to rapidly initiate sedation, 0.01 to 0.05 mg/kg (approximately 0.5 to 4 mg for a typical adult) may be given slowly or infused over several minutes. This dose may be repeated at 10 to 15 minute intervals until adequate sedation is achieved. For maintenance of sedation, the usual initial infusion rate is 0.02 to 0.1 mg/ kg/hr (1 to 7 mg/hr). Higher loading or maintenance infusion rates may occasionally be required in some patients. The lowestrecommended doses should be used in patients with residual effects from anesthetic drugs, or in those concurrently receivingother sedatives or opioids.