



MINNESOTA BOARD OF DENTISTRY

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Inspection/Self Evaluation for Dentists & Dental Offices Offering Moderate Sedation, Deep Sedation, General Anesthesia and/or Contract Sedation Provider

A. INSPECTION: All providers of moderate, deep sedation, general anesthesia and those dentists who contract for sedation services (CSS), are required to comply with Board regulations concerning office inspections/credentialing. Inspections/credentialing are not necessary for doctors only providing minimal sedation (anxiolysis). The Board requires the sedation dentist to be present at the on-site inspection, and have the ability to participate to an agreed upon level, as requested by the inspector. If a dentist is contracting with a sedation provider, **BOTH** the dentist (CSS) and the sedation provider must be present at the inspection.

Dentists and CSS providing moderate or deep sedation and/or general anesthesia are to provide a completed copy of this form to the inspector one week before the inspection with sections 1 – 7 completed. Section 8 is for Board use. **Choose and call an inspector from the list of Board-contracted inspectors on the Board's web site:**
<http://mn.gov/health-licensing-boards/dentistry/sedation/inspectorsform.jsp>

The facility, equipment, medication, record keeping, and emergency preparedness will be evaluated by using the current "Office Anesthesia Evaluation Manual" of the American Association of Oral and Maxillofacial Surgeons. Items of difference between this manual and the Board of Dentistry's rules and regulations will be resolved according to the Board of Dentistry's determination. The Board of Dentistry may modify, supplement or eliminate all or parts of this document at the Board's discretion.

B. TIME FRAME: Initial – An initial inspection must be completed within the first **12 months** of the dentist obtaining Minnesota certification in moderate sedation, deep sedation, or general anesthesia.
Renewal – After an initial inspection has been achieved, a subsequent on-site inspection must be completed at least once every (5) years.

C. MULTIPLE OFFICES: All offices where sedation is performed must comply with the minimum standards established by the Board for a sedation practice. A dentist providing moderate or deep sedation and/or general anesthesia or a CSS who travels to other office locations to administer sedation will be responsible for ensuring that each office location has the equipment and emergency medications required by this guideline and that the staff is properly trained to handle sedation-related emergencies.

D. INSPECTION FEES: The fee for the inspection may not exceed \$250 plus the cost of travel expenses. Fees are to be paid by the applicant directly to the inspector. The Minnesota Board of Dentistry does not receive any fees for the sedation inspection.

E. SUSPENSION: If a sedation dentist is non-compliant or fails an inspection, their sedation certificate will be suspended until such time that they complete successfully an on-site inspection. This means they are prohibited from providing sedation services until they can meet the inspection requirement.

F. COMPLETENESS/ACCURACY: Failure to complete any portion of the Credential Review or Renewal requirements, i.e. application/renewal forms, proof of emergency management course certification, proof of sedation training, completion of self-evaluation or the submission of appropriate fees, etc. could result in disciplinary action.

G. DEFINITIONS:

- *Minimal Sedation* – a drug-induced state during which patients respond normally to verbal commands (also referred to as *anxiolysis*)
- *Moderate Sedation* – a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation (also referred to as *conscious sedation*)
- *Deep Sedation* – a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation
- *General Anesthesia* – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation.
- *Requirements* – defined by MN Rule 3100.3600
- *Recommendation* – determined by dentist's skill and knowledge
- *Wrongful Event Prevention* – protocol by the dentist to prevent the event of wrong treatment, anesthesia, sedation, patient, medication
- *Adverse Reaction/Reporting of Incidents* (MN Rule 3100.3600 Subp.8) – "... any incident that arises from the administration of nitrous oxide inhalation analgesia, deep sedation, general anesthesia, moderate sedation, local anesthesia, analgesia or minimal sedation (anxiolysis) that results in: A. serious or unusual outcome; B. a sedation state becoming a deeper stage than originally intended ..."

Please Complete the Attached Pages

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SECTION 1

I. Dentist Name: _____ **License #:** _____ **CS/CSS/GA#** _____
If the dentist is **NOT providing the sedation, Section 1/Part II below **MUST** be completed, and a copy of the contracted individual's licensure must be supplied to the Board.*

II. Sedation Provider Information:

Nurse Anesthetist

Dentist Certified in Sedation

Oral Maxillofacial Surgeon

Other: _____

Sedation Provider Name: _____ License #: _____

Signature: _____

III. Primary Location Information:

Location Name: _____ Inspection Date: _____

Address: _____ Telephone #: _____

If the Dentist providing moderate or deep sedation and/or general anesthesia or the CSS provide sedation at more than one location, they certify that each of their offices/clinics have the required emergency equipment and emergency medication.

Yes No No Other Locations

SD/CSS Signature: _____ Date: _____

**Please attach supplemental information indicating other sedation locations*
*If at any time a new sedation location is added, please notify the board in writing or by email**

SECTION 2

Type of Sedation To Be Provided (Check all that apply):

Moderate Sedation

Enteral Sedation (Oral)

Parenteral Sedation (IV)

Deep Sedation/General Anesthesia

Intermuscular (IM)

SECTION 3

Attach a copy of current CPR Certification for the CS/GA/CSS Dentist

Proof of BLS in an AHA Healthcare Provider Course or an ARC Professional Rescuer Course

Expiration Date: _____

Attach a copy of current ACLS or PALS Certification for the Professional Providing Sedation

Proof of ACLS Certification

Expiration Date: _____

OR

Proof of PALS Certification

Expiration Date: _____

SECTION 4

Facility, Equipment, and Emergency Medication Checklists

I. Facility & Equipment:

Applicant must Initial each of the following boxes to indicate compliance

	A. All appropriate Sedation Certificates supplied by the Board must be displayed in the facility/clinic		
	B. Routine equipment maintenance record is kept by the dentist to ensure that the equipment is kept in working order		
	C. Enteral & Parenteral Sedation Facility Equipment- REQUIREMENTS		
	The following equipment is REQUIRED for the emergency kit/cart for sedation/anesthesia emergency management. The equipment should be readily accessible and should be used in a manner that is consistent with the practitioner's level of training and skill. The equipment must be age and weight appropriate for pediatric and adult patients. There must be a routine equipment maintenance record kept by the dentist to ensure that the equipment is kept in working order.		
Requirements for Sedation:			
	Automated external defibrillator or full function defibrillator is immediately accessible		Gas storage facility
	<i>Positive pressure oxygen delivery system</i>		<i>Functional suctioning device and backup suction device</i>
	Oxygen delivery system has adequate full-face masks		Backup suction device available
	Oxygen delivery system has appropriate connectors		Suction equipment permits aspiration of the oral & pharyngeal cavities
	Adequate backup oxygen delivery system provided		
	Pulse oximetry device (audible and/or visual)	<i>Auxiliary Lighting</i>	
			Lighting system permits evaluation of the patient's skin & mucosal color
			Battery-powered backup lighting system provided
			Backup lighting system is of sufficient intensity to permit completion of any treatment underway at the time of general power failure
	Board-approved emergency cart or kit that must be available and readily accessible, and includes necessary and appropriate drugs and equipment to resuscitate a non-breathing or unconscious patient, and provide continuous support while the patient is transported to a medical facility	<i>Recovery Area</i>	
			Recovery area has oxygen available
			Recovery area has adequate suction available
			Recovery area has adequate lighting
			Recovery area has adequate electrical outlets
			Patient can be monitored by an allied member who is appropriately qualified by their licensing board at all times during the recovery period

D. Enteral & Parenteral Sedation Facility Equipment- **RECOMMENDATIONS**

The following equipment is **RECOMMENDED** for the emergency kit/cart for sedation/anesthesia emergency management. The equipment should be readily accessible and should be used in a manner that is consistent with the practitioner's level of training and skill. The equipment must be age and weight appropriate for pediatric and adult patients. There must be a routine equipment maintenance record kept by the dentist to ensure that the equipment is kept in working order. Please attach a separate sheet (if needed) with rationale for absent or substituted equipment.

Applicant must Initial each of the following boxes to indicate compliance

Recommendations for both **Enteral** and **Parenteral** Moderate Sedation

	Blood pressure sphygmomanometer/cuffs of appropriate sizes with stethoscope or automatic blood pressure monitor	
	ECG monitoring device (may be combined with pulse oximetry device)	
	Several types/sizes of resuscitation masks	
	End-tidal carbon dioxide monitor	
Recommendations for Enteral Moderate Sedation		Recommendations for Parenteral Moderate Sedation
<i>IM Equipment</i>		<i>IV and IM equipment</i>
	Gauze sponges	IV fluids, tubing and infusion sets
		Tape
	Needles of various sizes	Sterile water
		Gauze sponges
	Syringes	Needles of various sizes
		Syringes
	Sterile gloves	Tourniquet
		Sterile gloves
		Magill forceps
		Advanced airway management equipment (e.g. LMA, Combi Tube, King Airway, etc.)

Additional items to be evaluated for both **Enteral** and **Parenteral** Sedation:

	Supplemental gas delivery system & back-up system	<i>Treatment room(s)</i>
	Patient transportation protocol is in place	
<i>Sterilization area</i>		Treatment room permits the team (consisting of at least two individuals) to move freely about the patient
	Designated sterile & non-sterile area	
	Sterilization manual and protocol	
	Three months of spore testing logs	Chair utilized for treatment permits the team to alter patient's position quickly in an emergency
<i>Preparation of sedation medication</i>		
	Appropriate storage for medication	Treatment chair provides a firm platform for the management of CPR
	Appropriate mode/method of administration	
	Equipment is readily accessible- consistent with licensee's level of training and skill	Adequate equipment for establishment of an intravenous infusion
	Equipment is age and weight appropriate for pediatric and/or adult patients	Licensee has emergency protocol manual

List any deficiencies:

II. Emergency Medications:

A. Enteral and Parenteral Emergency Medications or Equivalents – **RECOMMENDATIONS**

These drugs may be included in the emergency cart/kit in forms/doses that the dentist can knowledgeably administer, and in typical routes of administration for enteral/parenteral sedation. These drugs are listed by category, not by order of importance. These medications must be used appropriately for both pediatric and adult emergency situations. **Please attach a separate sheet (if needed) with rationale for deficiencies, absent or substituted medications.**

B. _____ Documentation that all emergency medications are checked and maintained on a prudent and regularly scheduled basis

Please indicate the EXPIRATION DATE of the following medications available in your practice

Recommended Enteral Sedation Emergency Medications or Current Equivalents*		Recommended Parenteral Sedation Emergency Medications or Current Equivalents*	
	Analgesic (nitrous oxide/oxygen, morphine sulfate IM)		Analgesic (morphine sulfate, fentanyl)
	Anticonvulsant (diazepam IM)		Anticonvulsant (diazepam, midazolam)
	Antihypoglycemic (oral glucose/sucrose, glucagon HCl IM or SC)		Antihypoglycemic (glucagon HCl, 50% dextrose)
	Anti-inflammatory Corticosteroid (dexamethasone)	<i>Allergic reaction, Anaphylaxis</i>	
			Epinephrine IM or SC
			Epinephrine (ana-guard, epi-pen auto injector)
<i>Endogenous Catecholamine</i>			Corticosteroid (anti-inflammatory hydrocortisone, dexamethasone)
	Epinephrine IM or SC for cardiac		Bronchodilator (albuterol)
	Epinephrine IM for allergic reaction (ana-guard, epi-pen auto-injector)		Respiratory stimulant (ammonia inhalant)
			Histamine blocker (diphenhydramine-Benadryl, chlorpheniramine)
	Epinephrine for asthmatic pediatric patients		Narcotic antagonist (naloxone)
	Vasodilator, Antianginal, Antihypertensive (nitroglycerin, SL, SC, IM, PO)		Benzodiazepine Antagonist (flumazenil)
	Bronchodilator (albuterol inhalant)	<i>Cardiac Medications</i>	
			Endogenous Catecholamine (epinephrine)
	Respiratory stimulant (ammonia inhalant)		Anticholinergic, antiarrhythmic (atropine)
			Vasopressor (phenylephrine)
	Histamine blocker (Benadryl PO or IM)		Vasodilator
			Antianginal
	Vasopressor (phenylephrine)		Antihypertensive (nitroglycerin)
			Antiarrhythmics (lidocaine, vasopressin)
	Anticholinergic antiarrhythmic (atropine IM or SC)		Tachycardia (adenosine)
			Ventricular fibrillation (amiodarone)
	ASA (acetylsalicylic acid, aspirin)		Antihypertensive, antianginal, beta-adrenergic blocker (esmolol)
			ASA (acetylsalicylic acid, aspirin)
	Benzodiazepine antagonist (flumazenil SL)		Neuromuscular blocker (succinylcholine)
*Specific medications are provided above as examples, and are subject to change based on currently published ACLS or Board approved standards			

SECTION 5

Office/Clinic & Patient Record Keeping

In addition to the following list, the inspectors will review selected sedation patient records for procedures done within the previous twelve (12) months. **One complete patient record MUST be submitted with this inspection form for review with patient names redacted from it.**

****Applicant must Initial each of the following to indicate compliance****

Health/Medical History Form		Emergency treatment documents in progress notes
Anesthesia chart showing continuous monitoring of blood pressure, heart rate, pulse oximetry and electrocardiographic (EKG) monitoring for mild/moderate sedation (q15 min) and for deep sedation/GA (q5 min)		<i>Narcotic or Scheduled Drug Inventory Log and Record of Drugs Dispensed to Patients</i>
Discharge Criteria Form		Dispensed
Documentation of Adverse Reaction & Board of Dentistry Notified with Form (found online)		Administered

Additional items to be inspected/evaluated

Patient's chief complaint documented		Radiographs – Appropriately labeled
Treatment plan documented		Height and Weight
<i>Core questions included on medical history form</i>		ASA Classification
		<i>Sedation Record</i>
1. Are you now under a physician's care or have you been during the past 5 years, including hospitalization(s) & surgery		1. Agents, amounts, times administered
2. Are you currently under a doctor's orders or taking any medication(s), including any birth control pills, over-the-counter drugs, herbal supplements or homeopathic preparations?		2. Time-oriented anesthesia documented record indicating supplemental oxygen (if used)
3. Do you have any allergies or are you sensitive to any drugs or substances such as penicillin, Novocain, aspirin, latex, codeine?		3. Pre-treatment vital signs
4. Have you ever bled excessively after a cut, wound, or surgery? Have you ever received a blood transfusion?		4. Post-Treatment vital signs
5. Are you subject to fainting, dizziness, nervous disorders, seizures, or epilepsy?		5. Discharge vital signs
6. Have you ever had any breathing difficulty, including asthma, emphysema, chronic cough, pneumonia, TB, or any other lung disorders? Do you snore or have you been diagnosed with sleep apnea? Do you use tobacco products?		6. Airway assessment
		7. Documented continuous or periodic monitoring of
		Blood pressure
		Heart rate
		Pulse oximetry
		Electrocardiographic (EKG) monitoring (if required)
7. Have you or your family members ever had any anesthesia-related problems?		8. Minimum recordings made of
		Before beginning procedure
8. Do you have heart disease or a history of chest pain or palpitations?		Following administration of sedation/analgesic agents
		At completion of procedure
		During initial recovery
		At time of discharge
9. Is there anything you would like to discuss alone with the doctor?		Recording documented every five (5) minutes for moderate sedation, deep sedation/general anesthesia
		9. Patient's status at time of discharge
10. Do you currently use or have a history of using recreational drugs?		Record of prescriptions
11. Are you or might you be pregnant?		<i>Wrongful Event Protocol</i>
Health history accomplished at every visit		Prevention protocol
Examination charted with proposed procedures and probable complications		Event Protocol
Informed consent documented for procedure and sedation/anesthesia		Protocol includes notification to MN Board of Dentistry

SECTION 6

Emergency Preparedness

PART I. Emergency Scenarios – Complete protocols for all scenarios. Attach additional pages if needed.

The SD/CSS and his/her entire clinical team must indicate competency in treating the following emergencies. If any areas of the Mock Emergency Scenarios need immediate correction, then the SD or CSS must keep a record of the systems' failures and write a plan to amend the staff protocol. A second mock drill should be conducted and subsequently evaluated.

Reminder: Clinical staff involved in the delivery of sedation dental services must be CPR certified

ALLERGY

1. Immediate Allergic Reaction/Anaphylaxis – less than one hour

Are you and your staff competent and prepared to recognize and treat Immediate Allergic Reaction/Anaphylaxis?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

2. Delayed Allergic Reaction – greater than one hour

Are you and your staff competent and prepared to recognize and treat Delayed Allergic Reaction?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

RESPIRATORY

3. Asthmatic Attack (Bronchospasm)

Are you and your staff competent and prepared to recognize and treat Asthmatic Attack?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

4. Hyperventilation

Are you and your staff competent and prepared to recognize and treat Hyperventilation?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

5. Apnea – Airway Management

Are you and your staff competent and prepared to recognize and treat Apnea?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

6. Foreign Body Obstruction/Emesis

Are you and your staff competent and prepared to recognize and treat Foreign Body Obstruction/Emesis?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

7. Laryngospasm

Are you and your staff competent and prepared to recognize and treat Laryngospasm?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

CARDIOVASCULAR

8. Syncope

Are you and your staff competent and prepared to recognize and treat Syncope?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

9. Angina Pectoris (Chest Pain)

Are you and your staff competent and prepared to recognize and treat Angina Pectoris?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

10. Myocardial Infarction (Heart Attack)/Sudden Cardiac Arrest

Are you and your staff competent and prepared to recognize and treat Myocardial Infarction/Sudden Cardiac Arrest?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

11. Hypotensive Crisis

Are you and your staff competent and prepared to recognize and treat Hypotensive Crisis?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

12. Hypertensive Crisis

Are you and your staff competent and prepared to recognize and treat Hypertensive Crisis?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

13. Stroke (Cerebrovascular Accident)

Are you and your staff competent and prepared to recognize and treat Stroke?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

NEUROLOGICAL

14. Seizures (Convulsions)

Are you and your staff competent and prepared to recognize and treat Seizures?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

DRUG OVERDOSE

15. Local Anesthetic Overdose

Are you and your staff competent and prepared to recognize and treat Local Anesthetic Overdose?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

16. Narcotic Overdose

Are you and your staff competent and prepared to recognize and treat Narcotic Overdose?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

17. Benzodiazepine Overdose

Are you and your staff competent and prepared to recognize and treat Benzodiazepine Overdose?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

ENDOCRINE

18. Hypoglycemia

Are you and your staff competent and prepared to recognize and treat Hypoglycemia?

Yes No SD/CSS Dentist Initials _____ Clinical Team Initials _____

What is the clinic protocol?

SECTION 7

Personal Attestation – SD/CSS

I attest that I have reviewed the information in this document, and that the information is complete and accurate.

Signature of SD/CSS: _____ **Date:** _____

Signature(s) of CSS Provider: _____ **Date:** _____

