STATE OF RHODE ISLAND
CENTER FOR PROFESSIONAL BOARDS AND COMMISSIONS
BOARD OF EXAMINERS IN DENTISTRY

DENTAL FACILITY ANESTHESIA PERMIT
MODERATE SEDATION OFFICE EVALUATION FORM

This form must be completed by **site inspector(s) only**. Inspector(s) must indicate "NA" if not applicable

NAME OF PRACTITIONER: _____ **INDIVIDUAL ANESTHESIA PERMIT #**: _____

LOCATION INSPECTED:

_____
NAME OF FACILITY

_____
STREET **CITY/TOWN/STATE** **ZIP**

PRACTITIONER CONTACT INFORMATION:

_____/_____/_____
TELEPHONE **FAX** **E-MAIL**

DATE OF EVALUATION: _____/_____/_____

A. PRACTITIONER INFORMATION:

1. BCLS Certificate Yes_____ No_____ Expiration date____/___/_____
2. ACLS Certificate Yes_____ No_____ Expiration date____/___/_____
3. PALS Certificate Yes_____ No_____ Expiration date____/___/_____
4. Yearly OSHA training Yes____ No_____
   Course date____/___/_____
5. Insurance coverage for office sedation Yes_____ No_____
6. Hospital affiliations:

   _____

   _____
7. On call 24 hour coverage Yes_____ No_____

B. **ASSISTANTS INFORMATION:** (additional forms available as needed)
*__Minimum of one clinical staff and one office staff member present during sedation__

1) NAME:

_____

__DAANCE Certified__: Yes_____ No_____ Expiration date____/___/_____

1. BLS Certificate Yes_____ No_____ Expiration date____/___/_____
   Level_____
2. ACLS Certificate Yes_____ No_____ Expiration date____/___/_____
3. PALS Certificate Yes_____ No_____ Expiration date____/___/_____
4. Yearly OSHA training Yes____ No_____
   Course date____/___/_____

2) NAME:

_____

__DAANCE Certified__: Yes_____ No_____ Expiration date____/___/_____

1. BLS Certificate Yes_____ No_____ Expiration date____/___/_____
   Level_____
2. ACLS Certificate Yes_____ No_____ Expiration date____/___/_____
3. PALS Certificate Yes_____ No_____ Expiration date____/___/_____
4. Yearly OSHA training Yes____ No_____
   Course date____/___/_____

C. **REQUIRED EQUIPMENT:**
***If the practice is a multiple doctor facility, redundant equipment to handle simultaneous procedures/emergencies is REQUIRED**

1. Noninvasive blood pressure monitor
   Yes_____ No_____
2. Electrocardiograph with the ability to print tracing
   Yes_____ No_____
3. Defibrillator/Automated External Defibrillator/pacer with battery back-up
   Yes_____ No_____
4. Pulse oximeter
   Yes_____ No_____
5. End-tidal carbon dioxide monitor (suggested)
   Yes_____ No_____
6. Equipment maintained and inspected
   Yes_____ No_____
7. Operating Theater:
   a. Is the operating theater easily accessible to emergency personnel and their equipment?
      Yes_____ No_____

b. Is the operating theater large enough to adequately accommodate the patient on a table or in an operating chair?
Yes_____ No_____

c. Does the operating theater permit an operating team consisting of at least three (3) individuals to move freely about the patient?
Yes_____ No_____

8. Operating Chair or Table:

a. Does the operating chair or table permit the patient to be positioned so the operating team can adequately maintain the airway?
Yes_____ No_____

b. Does the operating chair or table permit the team to alter the patient's position quickly in an emergency?
Yes_____ No_____

c. Does the operating chair or table provide a firm platform for the management of cardiopulmonary resuscitation?
Yes_____ No_____

9. Lighting System:

a. Does the lighting system permit evaluation of the patient's skin and mucosal color?
Yes_____ No_____

b. Is there a battery powered backup lighting system?
Yes_____ No_____

c. Is the backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure?
Yes_____ No_____

10. Suction Equipment:

a. Does the suction equipment permit aspiration of the oral and pharyngeal cavities?
Yes_____ No_____

b. Is there a backup suction device available?
Yes_____ No_____

c. Is there suction equipment for use during a power failure?
Yes_____ No_____

d. Is there capability to suction in all operatories and recovery rooms?
Yes_____ No_____

11. Oxygen Delivery System:

a. Does the oxygen delivery system have adequate, clear face masks with appropriate connectors and sizes for adults and children, and is it capable of delivering oxygen to the patient under positive pressure?
Yes_____ No_____

b. Is there an adequate backup oxygen delivery system in the event of a power failure?
***Minimum of four (4) E size oxygen tanks on site**
Yes_____ No_____

12. Recovery Area/Discharge Room:
***Recovery area can be the operating theater**

a. Does the recovery area have available oxygen?
Yes_____ No_____

b. Does the recovery area have available adequate suction?
Yes_____ No_____

c. Does the recovery area have adequate lighting?
Yes_____ No_____

d. Does the recovery area have adequate electrical outlets?
Yes_____ No_____

e. Can the patient be observed by a member of the staff at all times during recovery period?
Yes_____ No_____

f. Does the recovery area/discharge room provide adequate room to address a medical emergency if necessary?
Yes_____ No_____

13. Required Airway Equipment:

a. Is there a working laryngoscope complete with an adequate selection of blades, spare batteries, and bulbs?
Yes_____ No_____

b. Are there endotracheal tubes and appropriate connectors?
Yes_____ No_____

c. Are there oral airways?
Yes_____ No_____

d. Are there any laryngeal mask airways?
Yes_____ No_____

e. Is there a tonsillar or pharyngeal type suction tip adaptable to all the office outlets?
Yes_____ No_____

f. Is there an AED or defibrillator/Pacer with 6 second tape?
Yes_____ No_____

g. Are there endotracheal tube forceps?
Yes_____ No_____

h. Is there a sphygmomanometer and stethoscope?
Yes_____ No_____

i. Are there electrocardiograph and defibrillator/automated external defibrillator?
Yes_____ No_____

j. Is there a pulse oximeter?
Yes_____ No_____

k. Is there adequate equipment for the establishment of an intravenous infusion?
Yes_____ No_____

l. Is there a scavenger system if inhalation agents are used?
Yes_____ No_____

m. Is there a means to monitor temperature?
Yes_____ No_____

n. Are there IV fluids and tubing, catheters, and arm boards?
Yes_____ No_____

o. Is there quicktrach or other method for surgical airway?
Yes_____ No_____

What is the emergency plan, including the role of staff members, should there be a significant anesthesia emergency at the facility?

_____

_____

_____

D. <u>REQUIRED DRUGS</u>:

1. Oxygen – continuous use during general anesthesia and/or parenteral sedation
Yes_____ No_____

2. Epinephrine: 1:10,000 and 1:1,000
Yes_____ No_____

3. Atropine
Yes_____ No_____

4. Lidocaine for arrhythmias
Yes_____ No_____

5. Adenosine or Verapamil
Yes_____ No_____

6. Antihistamine Diphenhydramine
Yes_____ No_____

7. Anticonvulsant (e.g. Valium, Pentobarbital) Versed
Yes_____ No_____

8. Coronary vasodilator (e.g. Nitroglycerine)
Yes_____ No_____

9. IV Antihypoglycemic agent (Glucose) Dextrose 50% or Glucagon
Yes_____ No_____

10. Steroid (Solucortef)
Yes_____ No_____

11. Aerosol Nebulizer (Albuterol B2 agonist) with connector to airway circuitry
Yes_____ No_____

12. Vasopressor (e.g. Phenylephrine, Dopamine, Norepinephrine, Ephedrine)
Yes_____ No_____

13. Narcotic (e.g. Demerol, Morphine, Sublimaze)
    Yes_____ No_____

14. Narcotic antagonist, if narcotics are used (Narcan)
    Yes_____ No_____

15. Antagonist, if Benzodiazepines are used (Romazicon)
    Yes_____ No_____

16. Succinylcholine
    Yes_____ No_____

17. Anti-hypertensive medications (e.g., Ca channel blocker, beta blocker, sodium nitroprusside)
    Yes_____ No_____

18. Dantrolene Sodium – required if a halogenated anesthetic agent (e.g. Halothane, Enflurane, Isoflurane) is used. It is also required if depolarizing skeletal muscle relaxants (e.g. Succinylcholine) are routinely administered, as in intubation.
    Yes_____ No_____

19. Antiemetic or Zofran
    Yes_____ No_____

20. Aspirin (ASA)
    Yes_____ No_____

21. Lasix
    Yes_____ No_____

22. Magnesium Sulfate
    Yes_____ No_____

E. <u>DRUG MANAGEMENT</u>:

1. Sterile techniques
   Yes_____ No_____

2. Labelings
   Yes_____ No_____

3. Inventory control
   Yes_____ No_____

4. Medication refrigerator with thermometer and alarm
   Yes_____ No_____

5. Daily Temperature Log on refrigerator
   Yes_____ No_____

F. <u>POST-OPERATIVE MONITORING</u>:

1. Transport
   Yes_____ No_____

2. Instructions
   Yes_____ No_____

3. Discharge criteria and documentation
   Yes_____ No_____

OVERALL EQUIPMENT/FACILITY:

_____ADEQUATE **_____INADEQUATE**

COMMENTS/RECOMMENDATIONS:_____

_____

_____

_____

SIGNATURE OF EVALUATORS **PRINTED NAME OF EVALUATORS**

1._____ _____

2._____ _____

3._____ _____

****

I, _____, acknowledge that I have received a completed
(PRINT NAME)
copy of this Moderate Sedation Office Evaluation Form.

_____ _____

PRACTITIONER SIGNATURE **DATE**