# New Hampshire Board of Dental Examiners

## Facility Inspection and Comprehensive Evaluation Form for Deep Sedation / General Anesthesia Permit

**Version 2021_4_13**

**Doctor's Name(s):** _____

_____

**Date of Inspection:** _____

**Facility Address:** _____

**Additional Office Address(es):** _____

_____

**Evaluator(s):** _____

_____

**Type of Anesthesia provider (Check one):**

☐**Licensed NH Dentist** ☐**CRNA** ☐**MD/DO** ☐**Dentist Anesthesiologist**

☐ **Facility Inspection (Parts 1, 2, 3, and 6)**

☐ **Comprehensive Evaluation (Parts 1, 2, 3, 4, 5 and 6)**

*** TO BE FILLED OUT PRIOR TO EVALUATION ***

Please Note: Attach copies (front and back) of all original documents of completion/ certification

## PART 1: CREDENTIALS

| Doctor Name | BLS / HCP | Renewal Date | ACLS | Renewal Date | PALS | Renewal Date |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

Auxiliary Personnel (personnel involved in patient care *must* have BLS-for health care providers) (clerical personnel *should* have BLS-for health care providers)

| Name | Job Title | BLS / HCP | Renewal Date | ACLS | Renewal Date | Other | Renewal Date |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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| | | | | | | | |

## PART 2: FACILITY, EQUIPMENT and DRUGS

(M) Mandatory (R) Recommended (N/A) Not applicable

***ALL DRUGS AND EQUIPMENT MUST BE WITHIN "USE BY" DATE

**1. Oxygen/Gas Delivery Systems (M)**

| | | | |
|---|---|---|---|
| A. Fail-Safe $O_2$ anesthesia machines/Flowmeter (if gas used) | **N/A** | **Yes** | **No** |
| B. Gas analyzer (if potent inhalation agent used i.e., sevoflurane) | **N/A** | **Yes** | **No** |
| C. Capable of positive pressure ventilation 100% $O_2$ | | **Yes** | **No** |
| D. Safety keyed hose attachments (i.e. green, blue, yellow) | | **Yes** | **No** |
| E. Portable $O_2$ | | **Yes** | **No** |
| F. Gas storage: Inside Outside Adequate Inadequate | | **Yes** | **No** |

**2. Suction Equipment (M)**

| | | |
|---|---|---|
| A. Capable of suctioning the throat in all operatories and recovery rooms | **Yes** | **No** |
| B. Capable of use during power failure (i.e., battery/Venturi/mechanical) | **Yes** | **No** |
| C. Tonsillar suction tip | **Yes** | **No** |
| D. Catheter for pulmonary suction via Endotracheal Tube | **Yes** | **No** |

*** NOTE THAT A GENERATOR ALONE IS NOT ACCEPTABLE**

**3. Light Source (Auxiliary) (M)**

| | | |
|---|---|---|
| A. Capable of use during power failure i.e, battery headlight/ large flashlight | **Yes** | **No** |

*** NOTE THAT A GENERATOR ALONE IS NOT ACCEPTABLE**

**4. Transportation Equipment to Transport Patients** **Yes** **No**

A. Used Not Used

B. Wheel Chair Stretcher

C. Comments: _____

_____

(M) Mandatory
(R) Recommended
(N/A) Not applicable

## PART 2: FACILITY, EQUIPMENT and DRUGS (continued)

(M) Mandatory (R) Recommended (N/A) Not applicable

### 5. Equipment to Manage Patient Airway (M)

| | | | |
|---|---|---|---|
| A. Full Face Masks | | | |
| i) Adult | | **Yes** | **No** |
| ii) Child | **N/A** | **Yes** | **No** |
| B. Nasal Hood or Cannula | | **Yes** | **No** |
| C. Oral Airways | | | |
| i) Adult | | **Yes** | **No** |
| ii) Child | **N/A** | **Yes** | **No** |
| D. Nasopharyngeal Airways | | | |
| i) Adult | | **Yes** | **No** |
| ii) Child | **N/A** | **Yes** | **No** |
| E. Endotracheal Tubes with inflatable cuffs, appropriate connectors and syringe for inflatable cuffs, as follows: | | | |
| i) Adult | | **Yes** | **No** |
| ii) Child | **N/A** | **Yes** | **No** |
| iii) Connectors | | **Yes** | **No** |
| Demonstrate connection to airway and $O_2$ source | | **Yes** | **No** |
| iv) Syringe for cuff inflation | | **Yes** | **No** |
| F. Laryngoscope (straight or curved blade) as follows: | | | |
| i) Adult Blade | | **Yes** | **No** |
| ii) Child Blade | **N/A** | **Yes** | **No** |
| iii) Extra Batteries | | **Yes** | **No** |
| iv) Extra Bulbs ( or extra blade if fiberoptic) | | **Yes** | **No** |
| G. Magill Forceps | | **Yes** | **No** |
| H. Portable Bask-Mask ventilator (i.e. AMBU-Bag) | | **Yes** | **No** |
| I. Equipment for emergency cricothyrotomy or tracheostomy and appropriate connectors for administration of 100% $O_2$ | | **Yes** | **No** |
| J. Tongue Grasping Forceps | | **Yes** | **No** |
| K. LMA's | | **Yes** | **No** |
| L. Combitubes (not required) | | **Yes** | **No** |

(M) Mandatory
(R) Recommended
(N/A) Not applicable

## PART 2: FACILITY, EQUIPMENT and DRUGS (continued)

(M) Mandatory (R) Recommended (N/A) Not Applicable

### 6. Monitoring Equipment and personnel for continuous patient monitoring

| | | |
|---|---|---|
| A. Means of monitoring heart rate (pulse) | **Yes** | **No** |
| i) ECG (M) | **Yes** | **No** |
| ii) Other means of monitoring pulse | **Yes** | **No** |
| a. Precordial stethoscope (pcs) (R) | | |
| b. Pulse Oximeter (M) | | |
| c. Direct palpation of pulse by anesthesia assistant (M) | | |
| B. Means of monitoring respirations, as follows: | **Yes** | **No** |
| i) Pre-tracheal or precordial stethoscope (R) | **Yes** | **No** |
| ii) Direct observation of chest by anesthesia assistant (M) | **Yes** | **No** |
| iii) Pulse Oximeter (M) | **Yes** | **No** |
| iv) Capnography (M) | **Yes** | **No** |
| C. Means of monitoring blood pressure, each of the following required (M) | | |
| i) Adult Cuff | **Yes** | **No** |
| ii) Adult oversize cuff | **Yes** | **No** |
| iii) Child Cuff **N/A** | **Yes** | **No** |
| D. Anesthesia Assistant (M for all practicing under dental license) **N/A** | **Yes** | **No** |
| E. Anesthesia monitoring equipment adequate | **Yes** | **No** |

### 7. Defibrillator (M) (circle one or both)

| | | | | |
|---|---|---|---|---|
| Manual AED (automatic external defibrillator) | | | **Yes** | **No** |
| Back up Battery | | | **Yes** | **No** |
| Back up Battery check log | | | **Yes** | **No** |
| Adult pads | Expiration date:_____ | | **Yes** | **No** |
| Pediatric pads | Expiration date: _____ | **N/A** | **Yes** | **No** |

### 8. Board or rigid surface for CPR (M) **Yes** **No**

(M) Mandatory
(R) Recommended
(N/A) Not Applicable

**9. Drugs (the following must be maintained and up to date)**

A. Intravenous Access Equipment (sterile/single-use) (M)

i) I.V. Fluids **Yes No**

ii) I.V. Tubing **Yes No**

iii) Needles and/or catheters **Yes No**

B. Vasopressors

i) Epinephrine/Adrenalin® 1:10,000 (M) **Yes No**

(Minimum of 3 doses [per ACLS protocol] required)

ii) Epinephrine/Adrenalin® 1:1,000 (M) **Yes No**

(Minimum of 2 doses for anaphylaxis; two pens if Epi Pen, OR one ampule/SDV 1mg)

iii) Direct or indirect acting pressor of doctor's choice (M) **Yes No**

Examples below (circle one):

a. Phenelyephrine/Neo-synephrine® 10mg/ml

b. Ephedrine Sulfate 50mg/ml

c. Dopamine

d. Dobutamine

e. Vasopressin 40 IU

f. Other (Please list)_____

C. Anitarrhythmic/Rate Control Drugs, as follows:

i) Lidocaine/Xylocaine® (M) **Yes No**

ii) Amiodarone/Cordarone® (M) **Yes No**

(450mg required [2 doses per ACLS protocol] )

iii) Adenosine/Adenocard® (M) **Yes No**

(18 mg required [ 2 doses per ACLS protocol] )

iv) Other: (Please list) _____

D. Antagonists

i) Naloxone/Narcan® (M) **Yes No**

ii) Flumazenil/Romazicon® (M) **Yes No**

E. Antihypertensive of doctor's choice (M) **Yes No**

Examples below (circle one):

i) Nitroprusside/Nitropress®

ii) Esmolol/Brevibloc®

iii) Labetalol/Trandate®

iv) Other (Please list)_____

## PART 2: FACILITY, EQUIPMENT and DRUGS (continued)

(M) Mandatory (R) Recommended (N/A) Not Applicable

**9. Drugs (the following must be maintained and up to date) Continued**

F. Accessory Drugs

| | | | |
|---|---|---|---|
| i) Steroid of doctor's choice (M) | | **Yes** | **No** |
| a. Dexamethasone/Decadron® | | | |
| b. Hydrocortisone/Solu-Cortef® | | | |
| c. Methylprednisone/Solu-Medrol® or Medrol® | | | |
| ii) Dextrose 50%/Glucose® (M) | | **Yes** | **No** |
| iii) Atropine Sulfate/Atropen® (M) | | **Yes** | **No** |
| iv) Diphenhydramine/Benadryl® (M) | | **Yes** | **No** |
| v) Succinylcholine/Quelicin® (M) | | **Yes** | **No** |
| **OR** Rocuronium/Zemuron®,Esmeron® (M) | | | |
| (and reversal agent _____[recommended]) | | | |
| (name of agent) | | | |
| (circle any that are available) | | | |
| vi) Normal Saline for injection (M) | | **Yes** | **No** |
| vii) Bronchodilator inhalant (Albuterol/Proventil®) (M) | | **Yes** | **No** |
| viii) Diazepam/Valium®(M) **OR** Midazolam/Versed® (M) | | **Yes** | **No** |
| iv) Morphine Sulfate/Astramorph®etc (R) **OR** | | | |
| Fentanyl/Sublimaze® (R) | | **Yes** | **No** |
| v) Aspirin (non-enteric coated) (M) | | **Yes** | **No** |
| vi) Nitroglycerin/Nitrostat® (sublingual) (M) | | **Yes** | **No** |
| vii) Furosemide/Lasix® (R) | | **Yes** | **No** |
| viii) Dantrolene/Dantrium®, Revonto® (M) | **N/A** | **Yes** | **No** |
| (if triggering agents are routinely used) | | | |

**10. Recovery Area (consider the following)** **Yes** **No**

Access for emergency drugs, $O_2$, suction, monitoring, observation, electrical

(M) Mandatory
(R) Recommended
(N/A) Not Applicable

## PART 3: RECORDS

**1. Written Anesthesia Consent** **Yes No**

**2. Time Oriented Anesthesia Record (attach copy)**

All practitioners must maintain anesthesia or sedation records which include the date of procedure, nothing by mouth (NPO) status, availability of responsible adult escort, vital signs, drugs and doses administered.

| | |
|---|---|
| A. Date | **Yes No** |
| B. NPO Status | **Yes No** |
| C. Escort | **Yes No** |
| D. Vital Signs | **Yes No** |
| E. Drugs | **Yes No** |
| F. Doses | **Yes No** |

**3. Anesthetic Emergency Record/ code record (attach copy)**

In the event of an emergency requiring hospitalization all practitioners must maintain an emergency form documenting the following:

| | |
|---|---|
| A. Date | **Yes No** |
| B. Diagnosis of critical event i.e laryngospasm, cardiac arrest | **Yes No** |
| C. Medical history | **Yes No** |
| D. Time of onset | **Yes No** |
| E. Vital signs onset & continuous monitoring | **Yes No** |
| F. Administered drugs | **Yes No** |
| G. Drug doses | **Yes No** |
| H. Route of time of administration | **Yes No** |
| I. When BLS began and ended | **Yes No** |
| J. Time of transfer and by whom | **Yes No** |
| K. Vital signs at transfer | **Yes No** |

**4. Emergency Patient Transfer Form- Site specific for each location (attach copy)** **Yes No**

**5. Scripted Emergency 911 Call (attach copy)** **Yes No**

**6. Your plan for roles and responsibilities for each team member in an emergency (attach copy)** **Yes No**

**7. Post-anesthesia instructions (attach copy)** **Yes No**

| Clinical Team and Roles | Name | Role |
|---|---|---|
| Doctor | | |
| Assistant 1 | | |
| Assistant 2 | | |

## PART 4: CLINICAL

**Patient #1** Male / Female Age _____ ASA CL I II III
Procedure: _____
Sedation Technique: IVSED / DEEP SED / GA / Other _____
Drugs Used/Dose: 1. _____mg 2. _____mg 3. _____mg 4. _____mcg

1. Medical History Adequate: Yes No
2. Monitoring: Adequate: Yes No
   BP: ( auto / manual ), HR: ( EKG / pulse-ox / precordial / palpation )
   R: ( visual / pretracheal / oximeter / capnography), Frequency: Q _____min.,
   $CO_2$ Sampling: Yes No
3. IV Access Type: ( needle / butterfly / catheter ) Fluids: _____
   IV Technique Adequate: Yes No
4. Drug Management: Sterile Technique Adequate: Yes No
   Labeling Adequate: Yes No
   Administrations Adequate: Yes No
   Dosage Adequate: Yes No
5. Post-Op Monitoring Adequate: Yes No
   Transport Adequate: Yes No
   Instructions: ( written / verbal / none )

**Patient #2** Male / Female Age _____ ASA CL I II III
Procedure: _____
Sedation Technique: IVSED / DEEP SED / GA / Other _____
Drugs Used/Dose: 1. _____mg 2. _____mg 3. _____mg 4. _____mcg

1. Medical History Adequate: Yes No
2. Monitoring: Adequate: Yes No
   BP: ( auto / manual ), HR: ( EKG / pulse-ox / precordial / palpation )
   R: ( visual / pretracheal / oximeter / capnography ), Frequency: Q _____min.,
   $CO_2$ Sampling: Yes No
3. IV Access Type: ( needle / butterfly / catheter ) Fluids: _____
   IV Technique Adequate: Yes No
4. Drug Management: Sterile Technique Adequate: Yes No
   Labeling Adequate: Yes No
   Administrations Adequate: Yes No
   Dosage Adequate: Yes No
5. Post-Op Monitoring Adequate: Yes No
   Transport Adequate: Yes No
   Instructions: ( written / verbal / none )

**PART 4: CLINICAL (continued)**

CLINICAL PART ADEQUATE: Yes No If no, basis for failure:

_____

_____

_____

_____

_____

**PART 5: SIMULATED EMERGENCIES**

| | | | | | |
|---|---|---|---|---|---|
| Syncope | **Pass** | **Fail** | Angina | **Pass** | **Fail** |
| Laryngospasm | **Pass** | **Fail** | Acute MI | **Pass** | **Fail** |
| Bronchospasm | **Pass** | **Fail** | Cardiac Arrest (BLS-HCP) | **Pass** | **Fail** |
| Emesis & Aspiration | **Pass** | **Fail** | Allergic Reaction | **Pass** | **Fail** |
| Foreign Body in Airway | **Pass** | **Fail** | Hyperventilation | **Pass** | **Fail** |
| Hypertension | **Pass** | **Fail** | Seizure/Convulsions | **Pass** | **Fail** |
| Hypotension | **Pass** | **Fail** | Malignant Hyperthermia | **Pass** | **Fail** |

**Comments:**

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## PART 6: EXIT INTERVIEW / COMMENTS

**Recommended Outcome of Inspection/Evaluation:** ☐ **FACILITY** **Pass** **Fail**

☐ **COMPREHENSIVE** **Pass** **Fail**

**Evaluator(s) Signature(s):**

_____ Date: _____

_____ Date: _____

**Comments:** (Please write legibly or attach typed comments)

_____

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Note: Facility inspection, by itself, in no way ensures competency.

**Signature of Doctor Being Evaluated**_____

**Date:**_____

Evaluators only:

Any modifications needed of this form? Yes No

If yes, please note below:

**Please submit completed forms by e-mail to:**

Office of Professional Licensure and Certification
Division of Enforcement
Kathleen Tierney
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(603) 271-6762