New Hampshire Board of Dental Examiners

Facility Inspection and Comprehensive Evaluation Form for Moderate Sedation – Restricted Permit

Version 2021_3_15

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 (Part 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

PART 2: FACILITY, EQUIPMENT and DRUGS (All Mandatory)

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

1) Operatory - large enough to accommodate a patient and a team of three to freely move around the patient. **Yes No**

2) Oxygen/Gas Delivery System

A) Fail-safe O_2 anesthesia machines (if inhalation used) **Yes No**
B) Capable of positive pressure ventilation **Yes No**
C) Safety keyed hose attachments **Yes No**
D) Portable Oxygen **Yes No**
E) Gas Storage Adequate (Inside Outside) **Yes No**

2) Suction Equipment

A) Tonsil tip suction **Yes No**
B) Capable of suctioning throat in all operatories and recovery rooms (i.e., battery/Venturi/mechanical) **Yes No**
C) Capable of use during power failure **Yes No**

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

4) Light Source (Auxiliary)

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

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

5) Transportation Equipment for Patients (appropriate for facility)

A) Used Not used
B) Wheel Chair Stretcher
Comments _____

PART 2: FACILITY, EQUIPMENT and DRUGS (All Mandatory except as noted) (continued)

6) Airway Equipment

A) Full Face Mask	**Yes**	**No**
B) Nasal Hood or Cannula	**Yes**	**No**
C) Oral Airways---Several Sizes	**Yes**	**No**
D) Advanced Airway and necessary equipment for connection to O_2 source	**Yes**	**No**
(Circle available airway) (LMA, Combitube, ET Tube)		
Demonstrate connection to airway and O_2 source	**Yes**	**No**
E) Appropriate Equipment for Advanced Airway	**Yes**	**No**
F) Magill Forceps	**Yes**	**No**
G) Ambu-Bag or other positive pressure delivery system	**Yes**	**No**
Circle or indicate available system_____		
H) Tongue Grasping Forceps	**Yes**	**No**

7) Monitoring Equipment

A) Means of monitoring pulse		
i) EKG (Recommended for anyone with significant CV Disease)	**Yes**	**No**
ii) Continual Palpation	**Yes**	**No**
iii) Pulse Oximeter	**Yes**	**No**
B) Means of monitoring oxygenation and ventilation		
i) Continual direct observation of chest excursion by anesthesia assistant/dentist	**Yes**	**No**
ii) Pulse Oximeter	**Yes**	**No**
(one of the following three means of monitoring ventilation must be used)		
iii) Precordial/Pre-tracheal Stethoscope	**Yes**	**No**
iv) Verbal communication	**Yes**	**No**
v) Capnography or other $EtCO_2$ measure	**Yes**	**No**
C) Means of continual monitoring blood pressure		
Adult cuff and large cuff	**Yes**	**No**
D) Anesthesia Assistant (recommended but not required for moderate sedation)	**Yes**	**No**

8) 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: _____	**Yes**	**No**

PART 2: FACILITY, EQUIPMENT and DRUGS (All Mandatory except as noted) (continued)

9) Board or Rigid Surface for CPR **Yes** **No**

10) Emergency Drugs (the following must be maintained and up to date)

1) Epinephrine/Adrenalin® (minimum of 2 doses for anaphylaxis treatment) **Yes** **No**
_____
_____
2) Bronchodilator eg. Albuterol/Proventil® or Ventolin®_____ **Yes** **No**
3) Appropriate Drug Antagonists
eg. Naloxone/Narcan® and Flumazenil/Romazicon®_____ **Yes** **No**
4) Antihistamine eg. Diphenhydramine/Benadryl®_____ **Yes** **No**
5) Anticholinergic eg. Atropine/AtroPen®_____ **Yes** **No**
6) Anticonvulsant eg. Diazepam/Valium® **OR** Midazolam/Versed_____ **Yes** **No**
7) Dextrose/Glucose® or other antihypoglycemic_____ **Yes** **No**
8) Nitroglycerin/Nitrostat®_____ **Yes** **No**
9) Aspirin (non-enteric coated)_____ **Yes** **No**
10) Appropriate syringes and needles for drug delivery _____ **Yes** **No**

PART 3: RECORDS

1. Written Anesthesia Consent **Yes No**

2. Time Oriented Anesthesia Record (attach copy)

All practitioners must maintain a time oriented anesthesia or sedation record which includes the date of procedure, nothing by mouth (NPO) status, availability of responsible adult escort, vital signs and monitored physiologic parameters (pulse oximetry, heart rate, respiratory rate, and blood pressure which must be recorded continually), drugs and doses administered, including local anesthetics.

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 & current medications	**Yes No**
D. Time of onset	**Yes No**
E. Vital signs onset & continual monitoring	**Yes No**
F. State of consciousness	**Yes No**
G. Administered drugs, doses, route and time	**Yes No**
H. Time 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)

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**

PART 4: CLINICAL

Clinical Team and Roles	Name	Role
Doctor		
Assistant 1		
Assistant 2		

Patient #1 Male / Female Age _____ ASA CL I II III
Procedure: _____
Sedation Technique: IVSED / OTHER _____
_____
Drugs Used/Dose/Route: A. _____mg PO B. _____mg PO

C. Nitrous oxide/Oxygen Yes / No Concentration N2O_____%/ O2 _____%
Comments:_____

Medical History Adequate: Yes No

Monitoring: BP: (auto / manual), HR: (EKG / pulse-ox / precordial / palpation)
R: (visual / pretracheal / oximeter / capnography), Frequency: Q _____min. Adequate: Yes No

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 / OTHER _____
Drugs Used/Dose/Route: A. _____mg PO B. _____mg PO

C. Nitrous oxide/Oxygen Yes/No Concentration N2O_____%/ O2 _____%
Comments:_____

Medical History Adequate: Yes No

Monitoring: BP: (auto / manual), HR: (EKG / pulse-ox / precordial / palpation)
R: (visual / pretracheal / oximeter / capnography), Frequency: Q _____min. Adequate: Yes No

Post-Op Monitoring Adequate: Yes No
Transport Adequate: Yes No
Instructions: written / verbal / none

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

_____

_____

_____

PART 5: SIMULATED EMERGENCIES

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

Comments:

_____

_____

_____

_____

_____

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)

_____

_____

_____

_____

_____

_____

_____

_____

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