

New Hampshire Board of Dental Examiners

Facility Inspection and Comprehensive Evaluation Form for Moderate Sedation – Unrestricted Permit
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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 (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

PART 2: FACILITY, EQUIPMENT and DRUGS

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

1. Oxygen/Gas Delivery Systems (M)

- | | | |
|--|------------|-----------|
| A. Fail-Safe O ₂ anesthesia machines (If Inhalation Used) | Yes | No |
| B. Capable of positive pressure ventilation 100% O ₂ | Yes | No |
| C. Safety keyed hose attachments (i.e. green, blue, yellow) | Yes | No |
| D. Portable Oxygen | Yes | No |
| E. Gas storage: Inside Outside Adequate Inadequate | Yes | No |

2. Suction Equipment (M)

- | | | |
|---|------------|-----------|
| A. Tonsil tip suction | Yes | No |
| B. Capable of suctioning the throat in all operatories and recovery room | Yes | No |
| C. Capable of use during power failure (i.e., battery/Venturi/mechanical) | 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 (appropriate for facility)

- | |
|--|
| A. Used Not Used |
| B. Wheel Chair Stretcher |

Comments: _____

5. Equipment to Manage Patient Airway (M)

(Pediatric equipment if children are sedated)

- | | | | |
|--------------------------------|------------|-----------|------------|
| A. Full Face Masks | | | |
| i) Adult | Yes | No | |
| ii) Child | Yes | No | N/A |
| B. Nasal Hood or Nasal Cannula | Yes | No | |
| C. Oral Airways | | | |
| i) Adult | Yes | No | |
| ii) Child | Yes | No | N/A |
| D. Nasopharyngeal Airways | | | |
| i) Adult | Yes | No | |
| ii) Child | Yes | No | N/A |

(M) Mandatory
 (R) Recommended

PART 2: FACILITY, EQUIPMENT and DRUGS (continued) (Pediatric equipment if children are sedated)

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

E. Advanced Airway (at least one of the following mandatory)			
i) LMA	Yes	No	
ii) Combitube	Yes	No	
iii) King Airway	Yes	No	
Advanced Airway and appropriate connections	Yes	No	
Demonstrate connection to airway and O ₂ source	Yes	No	
F. If Endotracheal Tube – Laryngoscope	Yes	No	
i) Adult blade	Yes	No	
ii) Child blade	Yes	No	N/A
iii) Extra batteries	Yes	No	
iv) Extra bulbs	Yes	No	
G. Magill Forceps	Yes	No	
H. Portable Bag-mask Ventilator (AMBU-Bag)	Yes	No	
I. Tongue Grasping Forceps	Yes	No	

6. Monitoring Equipment and Personnel for Continuous Patient Monitoring

Must have at least one in each category. (circle one)

A. Means of monitoring heart rate (pulse)			
i) ECG (M)(Recommended for anyone with significant CV disease)	Yes	No	
ii) Other means of monitoring pulse			
a) Pulse Oximeter	Yes	No	
B. Means of monitoring respirations, as follows:			
i) Direct observation of chest by anesthesia assistant	Yes	No	
ii) Pulse Oximeter (M)	Yes	No	
iii) Precordial Stethoscope	Yes	No	
iv) Capnography (M)	Yes	No	
C. Means of monitoring blood pressure			
i) Adult Cuff (M)	Yes	No	
ii) Adult Large Cuff (M)	Yes	No	
iii) Child Cuff (M)	Yes	No	N/A
D. Anesthesia Assistant (M) (if applicable)	Yes	No	N/A

(M) Mandatory
(R) Recommended

PART 2: FACILITY, EQUIPMENT and DRUGS (continued) (Pediatric equipment if children are sedated)

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: _____	Yes	No

8. Board or Rigid Surface for CPR (M) **Yes** **No**

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

A. Intravenous Access Equipment (sterile/disposable)

i) I.V. Fluids (M)	Yes	No
ii) I.V. Tubing (M)	Yes	No
iii) Needles and/or Catheters (M)	Yes	No

B. Vasopressors

i) Epinephrine/Adrenalin® 1:10,000 (M)	Yes	No
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(Minimum of 3 doses [per ACLS protocol] required)

ii) Epinephrine/Adrenalin® 1:1,000 (M)	Yes	No
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(Minimum of 2 doses for anaphylaxis; two pens if Epi Pen,
OR one ampule/SDV 1mg)

C. Anti-arrhythmic/Rate Control Drugs (ACLS) (one of the following is mandatory)

i) Lidocaine/Xylocaine®	Yes	No
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ii) Amiodarone/Cordarone®	Yes	No
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(450mg required [2 doses per ACLS protocol])

D. Antagonists (as indicated)

i) Naloxone/Narcan® (M)	Yes	No
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ii) Flumazenil/Romazicon® (M)	Yes	No
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(M) Mandatory
(R) Recommended

PART 2: FACILITY, EQUIPMENT and DRUGS (continued) (Pediatric equipment if children are sedated)

E. Antihypertensive of Doctor's Choice (M) **Yes No**

Examples below (circle one):

- i) Nitroprusside/Nitropress®
- ii) Esmolol/Brevibloc®
- iii) Labetalol/Trandate®
- iv) Other _____

F. Accessory Drugs

- i) Dextrose 50%/Glucose® (M) **Yes No**
- ii) Atropine Sulfate/Atropen® (M) **Yes No**
- iii) Diphenhydramine/Benadryl® (M) **Yes No**
- iv) Succinylcholine/Quelicin® (R) (if ETT trained) **Yes No**
- v) Normal Saline for Injection (M) **Yes No**
- vi) Bronchodilator inhalant (Albuterol/Proventil®) (M) **Yes No**
- vii) Diazepam/Valium® (M) **OR** **Yes No**
Midazolam/Versed® (M)
- ix) Morphine Sulfate/Astramorph® etc (R) **OR** **Yes No**
Fentanyl/Sublimaze® (R)
- x) Aspirin (non-enteric coated) (M) **Yes No**
- xi) Nitroglycerin/Nitrostat® (sublingual) (M) **Yes No**

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

Access for emergency drugs, O₂, suction, monitoring, observation, electrical supply

(M) Mandatory
(R) Recommended

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 **Yes No**
i.e laryngospasm, cardiac arrest
- C. Medical history & current medications **Yes No**
- D. Time of onset **Yes No**
- E. Vital signs onset and continuing 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**
- I. Time of transfer and by whom **Yes No**
- J. 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**

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: 1. _____ mg 2. _____ mg 3. _____ mg 4. _____ mcg

1. Medical History Adequate: Yes No
2. Monitoring: BP: (auto / manual), HR: (EKG / pulse-ox / precordial / palpation)
R: (visual / pretracheal / oximeter / capnography), Frequency: Q ___ min. Adequate: 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 / OTHER _____

Drugs Used/Dose: 1. _____ mg 2. _____ mg 3. _____ mg 4. _____ mcg

1. Medical History Adequate: Yes No
2. Monitoring: BP: (auto / manual), HR: (EKG / pulse-ox / precordial / palpation)
R: (visual / pretracheal / oximeter / capnography), Frequency: Q ___ min. Adequate: 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)

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

PART 5: SIMULATED EMERGENCIES

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

Comments:

PART 6: EXIT INTERVIEW / COMMENTS

Recommended Outcome of Inspection:

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 to:

Office of Professional Licensure and Certification
Division of Enforcement
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