South Dakota State Board of Dentistry
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OFFICE ANESTHESIA ON-SITE INSPECTION AND EVALUATION FORM

Anesthesia Inspectors: Please complete only one form per evaluation. Both inspectors should sign the evaluation form before submitting this form to the Board. To help expedite processing, please email a copy of the evaluation form to contactus@sdboardofdentistry.com after completing the evaluation and then mail the original evaluation form to the Board of Dentistry office.

Date this form was emailed to the Board of Dentistry Office: _____

Date original form was mailed to the Board of Dentistry Office: _____

_____ _____
Name of Practitioner Evaluated (Permit Applicant) License Number

_____ _____
Office Name Telephone Number

_____
Address of Office Evaluated

_____ _____
Date of Evaluation Time of Evaluation

Name of Anesthesia Inspector: _____

Evaluation Completed:

____ General Anesthesia and Deep Sedation Evaluation

____ Moderate Sedation Evaluation (Adult Only)

____ Moderate Sedation Evaluation (Pediatric and Adult)

A. PERSONNEL

1. **Moderate Sedation**: Two staff members must be present during the procedure, including one assistant that is registered to monitor patients under anesthesia that must be continuously present and only monitoring the patient during the procedure and one assistant that is assisting the dentist with the procedure. The assistant that is assisting the dentist with the procedure need not be registered to monitor patients under anesthesia. If an assistant will be injecting medication, all requirements of ARSD 20:43:09:10.01 must be met, including *current* DAANCE certification:

Names of Qualified Assistants:

a. _____

Assistant's Permit or Registration Number: _____

b. _____

Assistant's Permit or Registration Number: _____

Assistant Injecting Medication (if applicable): _____

Y N Assistant injecting medication holds a *current* DAANCE certification.

Y N Requirements of ARSD 20:43:09:10.01 understood.

2. **General Anesthesia/Deep Sedation**: Two staff members must be present during the procedure. Both assistants must be registered to monitor patients under anesthesia. One assistant must be continuously present and monitoring the patient during the procedure and one assistant must be assisting the dentist with the procedure. If an assistant will be injecting medication, all requirements of ARSD 20:43:09:10.01 must be met, including *current* DAANCE certification:

Names of Qualified Assistants:

a. _____

Assistant's Permit or Registration Number: _____

b. _____

Assistant's Permit or Registration Number: _____

Assistant Injecting Medication (if applicable): _____

Y N Assistant injecting medication holds a *current* DAANCE certification.

Y N Requirements of ARSD 20:43:09:10.01 understood.

B. RECORDS

Review three charts of patients who have been treated by permit applicant with moderate sedation, deep sedation or general anesthesia.

1. An adequate medical history of the patient.

2. An adequate physical evaluation of the patient.

3. Anesthesia records showing continuous monitoring of heart rate, blood pressure, and respiration using electrocardiographic monitoring and pulse oximetry.

4. Recording of monitoring every 5 minutes.

5. Evidence of continuous recovery monitoring, with notation of patient's condition upon discharge and person to whom the patient was discharged.

6. Accurate recording of medications administered, including amounts and time administered.

7. Records illustrating length of procedure.

8. Records reflecting any complications of anesthesia.

C. OFFICE FACILITY AND EQUIPMENT (Circle Y or N)

Y N **1.** ***Noninvasive Blood Pressure Monitor***

Y N **2.** ***Electrocardiograph***

Y N **3.** ***Defibrillator/Automated External Defibrillator***

Y N **4.** ***Pulse Oximeter***

Y N **5.** ***Measurement of EtCO2/Capnography (General Anesthesia and Deep Sedation Permit Inspections Only)***

Y N **6.** ***Precordial Stethoscope (General Anesthesia and Deep Sedation Permit Inspections Only)***

Y N 7**.** ***Emergency medications organized and labeled, located within or near operating theater.***

8. ***Operating Theater***

Y N a. Is the operating theater large enough to accommodate the patient on a table or in an operating chair adequately?

Y N b. Does the operating theater permit an operating team consisting of at least three individuals to move freely about the patient?

9. ***Operating Chair or Table***

Y N a. Does the operating chair or table permit the patient to be positioned so the operating team can maintain the airway?

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

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

10. ***Lighting System***

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

Y N b. Is there a battery-powered backup lighting system?

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

11. ***Suction Equipment***

Y N a. Does the suction equipment permit aspiration of the oral and pharyngeal cavities?

Y N b. Is there a backup suction device available?

12. ***Oxygen Delivery System***

Y N a. Does the oxygen delivery system have adequate full-face masks and appropriate connectors, and is it capable of delivering oxygen to the patient under positive pressure?

Y N b. Is there an adequate backup oxygen delivery system?

13. ***Recovery Area*** (*recovery area can be the operating theater*)

Y N a. Does the recovery area have available oxygen?

Y N b. Does the recovery area have available adequate suction?

Y N c. Does the recovery area have adequate lighting?

Y N d. Does the recovery area have adequate electrical outlets?

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

14. ***Ancillary Equipment***

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

Y N b. Are there endotracheal tubes and appropriate connectors?

Y N c. Are there oral airways?

Y N d. Are there any laryngeal mask airways?

Y N e. Is there a tonsillar or pharyngeal type suction tip adaptable to all office outlets?

Y N f. Are there endotracheal tube forceps?

Y N g. Is there a sphygmomanometer and stethoscope?

Y N h. Are there an electrocardioscope and defibrillator/automated external defibrillator?

Y N i. Is there a pulse oximeter?

Y N j. Is there adequate equipment for an establishment of an intravenous infusion?

Y N k. Are the emergency algorithms available?

Y N l. Glucose test device

D. DRUGS (Circle Y or N)

Y N 1. Vasopressor drug available?

Y N 2. Corticosteroid drug available ?

Y N 3. Bronchodilator drug available?

Y N 4. Muscle relaxant drug available?

Y N 5. Intravenous medication for treatment of cardiopulmonary arrest available?

Y N 6. Narcotic antagonist drug available?

Y N 7. Benzodiazepine antagonist drug available?

Y N 8. Antihistamine drug available?

Y N 9. Antiarrhythmic drug available?

Y N 10. Anticholinergic drug available?

Y N 11. Coronary artery vasodilator drug available?

Y N 12. ACLS Algorithm Drugs for Acute Coronary Syndromes?
Nitroglycerin, Aspirin, and Morphine sulfate or Fentanyl (sublimaze).

Y N 13. Antihypertensive drug available?

Y N 14. Mechanism of response for Malignant Hyperthermia dantrolene (Dantrium®)?

(*If the provider uses inhalation anesthetics other than nitrous oxide*)

Y N 15. All drugs are current (no expired drugs were found)?

Y N 16. Controlled substance log and lock up, if applicable?

E. SIMULATED EMERGENCIES *(Please choose four from Inspector Manual)*

F. PROCEDURE OBSERVATION

_____ I witnessed the permit applicant starting an intravenous line during the procedure (*this is required)*.

OVERALL EQUIPMENT / FACILITY: _____ADEQUATE _____INADEQUATE

COMMENTS: _____

OVERALL INSPECTION: *Please check one. Refer to Inspector Manual for evaluation criteria for pass, fail and rectification of deficiencies.*

_____ **PASS**

_____ **RECTIFY DEFICIENCIES:** We recommend that the dentist have _____ days to rectify the deficiencies noted below. We recommend that the dentist's anesthesia permit remain active during this time.

_____ **FAIL:** We recommend that the dentist's anesthesia permit be suspended until the deficiencies noted below are rectified.

DEFICIENCIES:

1. _____
2. _____
3. _____
4. _____

RECOMMENDATIONS: _____

_____

_____

_____

_____

_____

_____

_____

Signature of Evaluator _____

Printed Name of Evaluator _____

Signature of Evaluator _____

Printed Name of Evaluator _____

TO BE COMPLETED BY PERMIT APPLICANT:

Please verify the level of sedation or anesthesia that you provide:

____ General Anesthesia and Deep Sedation

____ Moderate Sedation (Adult Only)

____ Moderate Sedation (Pediatric and Adult)

Please verify all offices at which you provide sedation or anesthesia:

Primary Office:_____

Phone: _____

Physical Address:_____

Mailing Address:_____

Satellite Office:_____

Phone: _____

Physical Address:_____

Mailing Address:_____

Satellite Office:_____

Phone: _____

Physical Address:_____

Mailing Address:_____

Satellite Office:_____

Phone: _____

Physical Address:_____

Mailing Address:_____

☐ ***By checking this box, I hereby certify under penalty of law that I am the licensee named herein and that I have reviewed and I am compliant with the requirements of ARSD 20:43:09 and any additional statutes or administrative rules that pertain to my sedation or anesthesia permit in all offices at which I provide sedation or anesthesia.***

Signature of Permit Applicant _____

Printed Name of Permit Applicant _____

Date _____