



TEXAS STATE BOARD OF DENTAL EXAMINERS
ANESTHESIA WORK GROUP MEETING

9:30 a.m. – 11:30 a.m.
April 15, 2016
333 Guadalupe Street, Tower 2, Suite 225
Austin, TX 78701-3942

AGENDA

- I. CALL TO ORDER BY CHAIR OF WORK GROUP.**
- II. ROLL CALL OF BOARD MEMBER PARTICIPANTS.**
- III. INTRODUCTION OF STAKEHOLDER MEMBERS.**
- IV. REVIEW:**
 - a. TSBDE's Strategic Plan regarding anesthesia.
 - b. TSBDE's Statutes & Rules regarding anesthesia.
 - c. The Sunset Commission's recommendations regarding anesthesia.
- V. DISCUSSION TOPICS:**
 - a. Rule Review of Chapter 110.
 - b. Continuing Education for Anesthesia.
 - c. Emergency Plans.
 - d. Inspections:
 - i. Pre-permit.
 - ii. Random.
 - iii. Routine.
 - iv. Compliance.
- VI. PLANNING FOR FUTURE MEETINGS.**
- VII. PUBLIC COMMENTS.**
- VIII. ANNOUNCEMENTS.**
 - a. Next Board Meeting: June 3, 2016.
- IX. ADJOURN.**

ANESTHESIA WORK GROUP

TEXAS STATE BOARD OF DENTAL EXAMINERS - ANESTHESIA WORKGROUP

GROUP NAME	GROUP ACRONYM	GROUP REPRESENTATIVE	GROUP REPRESENTATIVE CONTACT INFORMATION	GROUP CONTACT PERSON	GROUP CONTACT INFORMATION
Texas State Board of Dental Examiners	TSBDE	Dr. Jason Zimmerman	333 Guadalupe Street, Tower 3, Suite 800, Austin, TX 78701-3942, 512-463-6400	Dr. Jason Zimmerman, Anesthesia Work Group Chair	333 Guadalupe Street, Tower 3, Suite 800, Austin, TX 78701-3942, 512-463-6400
Texas State Board of Dental Examiners	TSBDE	Dr. Kirby Bunel, Jr.	333 Guadalupe Street, Tower 3, Suite 800, Austin, TX 78701-3942, 512-463-6400	Dr. Kirby Bunel, Jr., Anesthesia Work Group Member	333 Guadalupe Street, Tower 3, Suite 800, Austin, TX 78701-3942, 512-463-6400
Texas State Board of Dental Examiners	TSBDE	Dr. D. Bradley Dean	333 Guadalupe Street, Tower 3, Suite 800, Austin, TX 78701-3942, 512-463-6400	Dr. D. Bradley Dean, Anesthesia Work Group Member	333 Guadalupe Street, Tower 3, Suite 800, Austin, TX 78701-3942, 512-463-6400
Texas Academy of General Dentistry	TAGD	Dr. David Roberts	7777 Forest Lane, #C104, Dallas, TX 75230, 972-768-1911, dave@robertsdds.com	Ms. Francine A. Johannesen	Executive Director, TAGD, 1016 La Posada Drive, Suite 200, Austin, TX 78752, 512-371-7144, francine@tagd.org, www.TAGD.org
Texas Academy of Pediatric Dentistry*	TAPD	Dr. Kelly Gonzalez	drkellymg@hotmail.com	Mr. Tyler Rudd	Legislative Consultant, 208 W. 14th Street, Austin, TX 78701, 512-293-0247, tyler Rudd@ruddattorneys.com, www.tapd.org

TEXAS STATE BOARD OF DENTAL EXAMINERS - ANESTHESIA WORKGROUP

GROUP NAME	GROUP ACRONYM	GROUP REPRESENTATIVE	GROUP REPRESENTATIVE CONTACT INFORMATION	GROUP CONTACT PERSON	GROUP CONTACT INFORMATION
Texas Dental Association	TDA	Dr. Arthur "Art" H. Jeske	UTHealth School of Dentistry, Room 6336, 7500 Cambridge Street, Houston, TX 77054, 713-486-4506, Arthur.H.Jeske@uth.tmc.edu	Ms. Diane Rhodes	Senior Policy Manager, TDA, 1946 S IH 35 Frontage Road, Austin, TX 78704, 512-443-3675, diane@ida.org, www.ida.org
Texas Society of Dentist Anesthesiologists	TSDA	Dr. Frank E. Ford	Past President, 817-422-4132 - Cell, 972-296-0101 - Office, feford@tx.rr.com	Dr. Frank E. Ford	Past President, 817-422-4132 - Cell, 972-296-0101 - Office, feford@tx.rr.com
Texas Society of Oral and Maxillofacial Surgeons	TSOMS	Dr. Mark A. Craig	5971 Virginia Parkway, Suite #200, McKinney, TX 75071, 972-542-4700, mcddsm@aol.com	Ms. Kelly Ann Shy, MHSM	Executive Director, TSOMS, 4499 Medical Drive, Suite #190, San Antonio, TX 78229, 210-614-3915, kellyannshy@alamoOMS.com, www.tx-oms.org
Texas Society of Periodontists	TSP	Dr. Charles Rader	507 E. Brazos, Victoria, TX 77904, 361-576-5155, craderdds@gmail.com	Cindy Wainscott, Executive Director	TSP, 8514 Fairway Trail Drive, Fair Oaks Ranch, TX 78015, info@texasperio.org

TEXAS STATE BOARD OF DENTAL EXAMINERS - ANESTHESIA WORKGROUP

NOTES:	INVITATION LETTER SENT:	REQUESTED REPLY DATE:	REPLIED RECEIVED:	TSBDE BOARD/STAFF LIAISONS:	ANESTHESIA WORKGROUP MEETING DATE, LOCATION, TIME:
				Dr. Jason Zimmerman, Ms. Kelly Parker	April 15, 2016, Tower 2, Suite 225, 9:30 AM - 11:30 AM
				Dr. Jason Zimmerman, Ms. Kelly Parker	April 15, 2016, Tower 2, Suite 225, 9:30 AM - 11:30 AM
				Dr. Jason Zimmerman, Ms. Kelly Parker	April 15, 2016, Tower 2, Suite 225, 9:30 AM - 11:30 AM
cc: David Mintz, Legislative Consultant	March 8, 2016	April 1, 2016	March 10, 2016	Dr. Jason Zimmerman, Ms. Kelly Parker	April 15, 2016, Tower 2, Suite 225, 9:30 AM - 11:30 AM
* Dr. Zimmerman is Member-at-Large for this organization.	March 8, 2016	April 1, 2016	March 29, 2016	Dr. Jason Zimmerman, Ms. Kelly Parker	April 15, 2016, Tower 2, Suite 225, 9:30 AM - 11:30 AM

TEXAS STATE BOARD OF DENTAL EXAMINERS - ANESTHESIA WORKGROUP

NOTES:	INVITATION LETTER SENT:	REQUESTED REPLY DATE:	REPLIED RECEIVED:	TSBDE BOARD/STAFF LIAISONS:	ANESTHESIA WORKGROUP MEETING DATE, LOCATION, TIME:
	March 8, 2016	April 1, 2016	March 28, 2016	Dr. Jason Zimmerman, Ms. Kelly Parker	April 15, 2016, Tower 2, Suite 225, 9:30 AM - 11:30 AM
	March 14, 2016	April 1, 2016		Dr. Jason Zimmerman, Ms. Kelly Parker	April 15, 2016, Tower 2, Suite 225, 9:30 AM - 11:30 AM
cc: Jim D. Rudd, Attorney/Government Relations to TSOMS	March 8, 2016	April 1, 2016	March 10, 2016	Dr. Jason Zimmerman, Ms. Kelly Parker	April 15, 2016, Tower 2, Suite 225, 9:30 AM - 11:30 AM
	March 8, 2016	April 1, 2016	April 1, 2016	Dr. Jason Zimmerman, Ms. Kelly Parker	April 15, 2016, Tower 2, Suite 225, 9:30 AM - 11:30 AM

TSBDE'S STRATEGIC PLAN

AGENCY STRATEGIC PLAN

FISCAL YEARS 2015 – 2019

TEXAS STATE BOARD OF DENTAL EXAMINERS



Board Member	Dates of Term	Hometown
Dr. Rodolfo G. Ramos, Jr.	2009 – 2015	Houston, Texas
Dr. Steven J. Austin	2013 – 2019	Amarillo, Texas
Dr. Kirby Bunel, Jr.	2013 – 2019	Texarkana, Texas
Dr. James W. Chancellor	2009 – 2015	Garden Ridge, Texas
Ms. Emily W. Christy	2011 – 2017	San Antonio, Texas
Ms. Renee S. Cornett, RDH	2009 – 2015	Austin, Texas
Dr. D. Bradley Dean	2011 – 2017	Frisco, Texas
Dr. Tamela L. Gough	2011 – 2017	McKinney, Texas
Ms. Whitney Hyde	2009 – 2015	Midland, Texas
Dr. Christine M. Leedy	2011 – 2017	Abilene, Texas
Ms. Evangelia V. Mote	2011 – 2017	Katy, Texas
Mr. Timothy J. O'Hare, JD	2013 – 2019	Farmers Branch, Texas
Ms. Lois M. Palermo, RDH	2013 – 2019	League City, Texas
Mr. Lewis M. White, JD	2013 – 2019	Katy, Texas

DATE OF SUBMISSION:

June 23, 2014

Julie Hildebrand, Executive Director

Rudolfo G. Ramos Jr., DDS, Presiding Officer

by the expansion of public programs. Dental benefits are likely to continue to erode for adults, which could negatively influence dental care utilization.

Commercial dental plans will increasingly use more selective networks, demanding increased accountability through data and performance measures.¹ All of these trends will affect the services of the Board. The Board will have to focus on an increased child patient population, decreased dental care utilization by adults, and increased accountability from commercial dental plans, and institute changes as necessary to accommodate these trends.

In addition, the following major issues listed below were gleaned from Stakeholder, Board Member and Staff input.

1. Major Practice Issues

 With growing numbers of adults and children receiving anesthesia for dental procedures from providers with variable training, it is imperative to be able to track anesthesia-related adverse outcomes.² Dental office anesthesia poses an increased risk of death and other negative patient outcomes, especially in emergency situations. A review of the credentialing of training programs, licensee anesthesia permit requirements, anesthesia relation to dental office deaths, and emergency preparedness by licensees, will advance patient safety and quality.

The Dental Practice Act states that the Board may investigate infection control in the dental profession and adopt and enforce rules to control the spread of infection in the practice of dentistry as necessary to protect the public health and safety. The implementation of infection control recommendations is not uniform across all practices. Board rules relating to infection control should be reviewed and the standards communicated to licensees. In addition, investigations and enforcement should be increased to address this issue.

Texas is a plenary license state and dentists are allowed to practice in any specialty area without restriction. The Board does not have authority to grant specialty licenses. However, in order to make sound rulemaking and business decisions and to enforce the Dental Practice Act, it is important for the Board to be knowledgeable regarding a licensee's specialty qualification. The Board should be more diligent in its collection of information regarding a licensee's specialty. An additional issue related to dental specialties is in the area of business promotion. These rules should be reviewed by the Board and amended as necessary to protect the public.

Medicaid fraud by a dentist, although under the jurisdiction of the Health and Human Services Commission (HHSC), is a concern for the Board since it subjects the dentist to

¹ American Dental Association, *A Profession in Transition: Key Forces Reshaping the Dental Landscape*, 2013.

² Lee, H. H., Milgrom, P., Starks, H., Burke, W. (2013), Trends in death associated with pediatric dental sedation and general anesthesia. *Pediatric Anesthesia*, 23: 741–746. doi: 10.1111/pan.12210

**CURRENT
ANESTHESIA PERMIT
REQUIREMENTS**

Licensure and Permit Requirements
Dentist Anesthesia and Portability Permitting

Permit Type	Requirements	Fees
Anesthesia Permitting – Administration of Nitrous Oxide/Oxygen Inhalation Sedation	<ul style="list-style-type: none"> • completion of a minimum 14 hours of comprehensive training consistent with the American Dental Association (ADA) Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or • completion of a CODA-accredited or recognized pre-doctoral dental or post-doctoral dental training program. • current BLS CPR certification. 	<ul style="list-style-type: none"> • \$32 Application Fee. • \$10 Renewal Fee.
Anesthesia Permitting – Level 1 Minimal Sedation	<ul style="list-style-type: none"> • completion of a minimum 16 hours of training consistent with the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or • completion of comprehensive training taken through a CODA-accredited advanced education program. • current BLS CPR certification. • maintain permit by taking 6 hours of CE biennially on medical emergencies associated with a Level 1 Permit. 	<ul style="list-style-type: none"> • \$32 Application Fee. • \$10 Renewal Fee.
Anesthesia Permitting – Level 2 Moderate Enteral Sedation	<ul style="list-style-type: none"> • completion of a minimum 24 hours of comprehensive training consistent with the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; and • management of 10 case experiences in enteral moderate sedation, (3 live clinical case experiences managed by participants in groups no larger than 5. Remaining cases may include simulation and/or video presentations, but must include experience in returning (rescuing) a patient from deep to moderate sedation. • current BLS CPR certification; and • current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) certification if treating adults and children 13 years of age and older; or • current PALS certification if treating children 12 years of age or younger. • maintain permit by taking 8 hours of CE biennially on medical emergencies associated with a Level 2 Permit. 	<ul style="list-style-type: none"> • \$60 Application Fee. • \$10 Renewal Fee.
Anesthesia Permitting - Level 3 Moderate Parenteral Sedation	<ul style="list-style-type: none"> • completion of a minimum 60 hours of comprehensive training consistent with the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; and • management of 20 dental patient, under supervision, using moderate parenteral sedation; or • completion of an CODA-accredited advanced education program; or • completion of an internship or residency which includes intravenous moderate sedation training. • current BLS CPR certification and • current ACLS or PALS certification if treating adults and children 13 years of age and older; or 	<ul style="list-style-type: none"> • \$60 Application Fee. • \$10 Renewal Fee.

	<ul style="list-style-type: none"> • current PALS certification if treating children 12 years of age or younger. • maintain permit by taking 8 hours of CE biennially on medical emergencies associated with a Level 3 Permit. 	
Anesthesia Permitting - Level 4 Deep Sedation or General Anesthesia	<ul style="list-style-type: none"> • completion of a CODA-accredited advanced education program that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia. • current BLS CPR certification; and • current ACLS or PALS certification if treating adults and children 13 years of age and older; or • current PALS certification if treating children 12 years of age or younger. • maintain permit by taking 12 hours of CE biennially on medical emergencies associated with a Level 4 Permit. 	<ul style="list-style-type: none"> • \$60 Application Fee. • \$10 Renewal Fee.
Anesthesia Portability Privilege – Level 3 Moderate Parenteral Sedation	<ul style="list-style-type: none"> • holds a Level 3 – Moderate Enteral Sedation Permit. • submit proof of administration of 30 cases of personal administration of Level 3 sedation. • current BLS CPR certification; and • current ACLS or PALS certification if treating adults and children 13 years of age and older; or • current PALS certification if treating children 12 years of age or younger. 	<ul style="list-style-type: none"> • \$100 Application Fee.
Anesthesia Portability Privilege – Level 4 Deep Sedation or General Anesthesia	<ul style="list-style-type: none"> • holds a Level 4 – General Anesthesia or Deep Sedation Permit. • current BLS CPR certification; and • current ACLS or PALS certification if treating adults and children 13 years of age and older; or • current PALS certification if treating children 12 years of age or younger. 	<ul style="list-style-type: none"> • \$100 Application Fee.

DENTAL PRACTICE ACT

CH. 258 Practice by Dentist

Subchapter D. Enteral
Administration of Anesthesia

CHAPTER 258. PRACTICE BY DENTIST
SUBCHAPTER D. ENTERAL ADMINISTRATION OF ANESTHESIA

Sec. 258.151. DEFINITION.

In this subchapter, "enteral" means any technique of administering anesthesia in which the anesthetic is absorbed through the gastrointestinal tract or oral mucosa. Examples of enterally administering anesthesia include administering an anesthetic orally, rectally, sublingually, or intranasally.

[Added by Acts 2001, 77th Leg., ch. 349, Sec. 1, eff. Sept. 1, 2001.]

Sec. 258.152. APPLICABILITY.

Rules adopted by the board under this subchapter do not apply to:

- (1) the regional injection of an anesthetic to reduce or eliminate sensation, especially pain, in one part of the body; or
- (2) the administration of anxiolytics and analgesics that are not being used in conjunction with the administration of nitrous oxide and that are administered in doses that do not have the probability of placing the dental patient at risk for loss of the dental patient's life-preserving protective reflexes.

[Added by Acts 2001, 77th Leg., ch. 349, Sec. 1, eff. Sept. 1, 2001.]

Sec. 258.153. RULES.

- (a) The board shall establish by rule the minimum standards for the enteral administration of anesthesia by a dentist.
- (b) The rules must be designed to protect the health, safety, and welfare of the public and must include requirements relating to:
 - (1) the methods used to enterally administer an anesthetic and the anesthetic agents that may be used;
 - (2) dental patient evaluation, diagnosis, counseling, and preparation;
 - (3) dental patient monitoring to be performed and equipment to be used during a procedure and during postprocedure monitoring;
 - (4) emergency procedures, drugs, and equipment, including education, training, and certification of personnel, as appropriate, and including protocols for transfers to a hospital;
 - (5) the documentation necessary to demonstrate compliance with this subchapter; and
 - (6) the period in which protocols or procedures covered by rules of the board shall be reviewed, updated, or amended.

[Added by Acts 2001, 77th Leg., ch. 349, Sec. 1, eff. Sept. 1, 2001.]

Sec. 258.154. COMPLIANCE WITH ANESTHESIA RULES.

- (a) On and after August 31, 2002, a dentist who practices dentistry in this state and who enterally administers anesthesia or performs a procedure for which anesthesia is enterally administered shall comply with the rules adopted under this subchapter.
- (b) The board may require a dentist to submit and comply with a corrective action plan to remedy or address any current or potential deficiencies with the dentist's enteral administration of anesthesia in accordance with this subtitle or rules of the board.

[Added by Acts 2001, 77th Leg., ch. 349, Sec. 1, eff. Sept. 1, 2001.]

Sec. 258.155. ANNUAL PERMIT.

- (a) Not later than September 1, 2002, the board shall require each dentist who enterally administers anesthesia or performs a procedure for which anesthesia is enterally administered to annually obtain a permit from the board by completing a form prescribed by the board. The board shall set and impose a fee for the permit in an amount designed to recover the costs of regulating a permit holder under this subchapter.
- (b) The board shall coordinate the times at which a permit must be renewed with the times at which a dentist's license must be renewed under Chapter 257 so that the times of registration, payment, notice, and imposition of penalties for late payment are similar and provide a minimum of administrative burden to the board and to dentists.

[Added by Acts 2001, 77th Leg., ch. 349, Sec. 1, eff. Sept. 1, 2001.]

Sec. 258.156. INSPECTIONS.

- (a) The board may conduct inspections to enforce this subchapter, including inspections of an office site and of documents of a dentist's practice that relate to the enteral administration of anesthesia. The board may contract with another state agency or qualified person to conduct these inspections.
- (b) Unless it would jeopardize an ongoing investigation, the board shall provide at least five business days' notice before conducting an on-site inspection under this section.
- (c) This section does not require the board to make an on-site inspection of a dentist's office.

[Added by Acts 2001, 77th Leg., ch. 349, Sec. 1, eff. Sept. 1, 2001.]

Sec. 258.157. REQUESTS FOR INSPECTION AND ADVISORY OPINION.

- (a) The board may consider a request by a dentist for an on-site inspection. The board may, in its discretion and on payment of a fee in an amount established by the board, conduct the inspection and issue an advisory opinion.
- (b) An advisory opinion issued by the board under this section is not binding on the board, and the board, except as provided by Subsection (c), may take any action under this subtitle in relation to the situation addressed by the advisory opinion that the board considers appropriate.
- (c) A dentist who requests and relies on an advisory opinion of the board may use the opinion as mitigating evidence in an action or proceeding to impose an administrative or civil penalty under this subtitle. The board or court, as appropriate, shall take proof of reliance

TEXAS ADMIN. CODE

Title 22, Part 5, Chapter 110

Sedation & Anesthesia

Texas Administrative Code

[Next Rule>>](#)TITLE 22

EXAMINING BOARDS

PART 5

STATE BOARD OF DENTAL EXAMINERS

CHAPTER 110

SEDATION AND ANESTHESIA

RULE §110.1

Definitions

Unless the context clearly indicates otherwise, the following words and terms shall have the following meaning when used in this chapter.

- (1) Analgesia--the diminution or elimination of pain.
- (2) Behavioral management--the use of pharmacological or psychological techniques, singly or in combination, to modify behavior to a level that dental treatment can be performed effectively and efficiently.
- (3) Board/Agency--the Texas State Board of Dental Examiners, also known as the State Board of Dental Examiners, and, for brevity, the Dental Board, the Agency, or the Board.
- (4) Child/children--a patient twelve (12) years of age or younger.
- (5) Competent--displaying special skill or knowledge derived from training and experience.
- (6) Deep sedation--a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- (7) Direct supervision--the dentist responsible for the sedation/anesthesia procedure shall be physically present in the facility and shall be continuously aware of the patient's physical status and well-being.
- (8) Enteral--any technique of administration of sedation in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa (i.e., oral, rectal, sublingual).
- (9) Facility--the location where a permit holder practices dentistry and provides anesthesia/sedation services.
- (10) Facility inspection--an on-site inspection to determine if a facility where the applicant proposes to provide anesthesia/sedation is supplied, equipped, staffed and maintained in a condition to support provision of anesthesia/sedation services that meet the minimum standard of care.
- (11) General anesthesia--a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
- (12) Immediately available--on-site in the facility and available for immediate use.
- (13) Incremental dosing--administration of multiple doses of a drug until a desired effect is reached,

but not to exceed the maximum recommended dose (MRD).

(14) Local anesthesia--the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

(15) Maximum recommended dose (applies to minimal sedation)--FDA maximum recommended dose (MRD) of a drug, as printed in FDA-approved labeling for unmonitored home use.

(16) Minimal sedation--a minimally depressed level of consciousness, produced by a pharmacological method, which retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected. Medication administered for the purpose of minimal sedation shall not exceed the maximum doses recommended by the drug manufacturer. Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation. During longer periods of minimal sedation in which the total amount of time of the procedures exceeds the effective duration of the sedative effect of the drug used, the supplemental dose of the sedative shall not exceed total safe dosage levels based on the effective half-life of the drug used. The total aggregate dose must not exceed one and one-half times the MRD on the day of treatment. The use of prescribed, previsit sedatives for children aged twelve (12) or younger should be avoided due to the risk of unobserved respiratory obstruction during the transport by untrained individuals.

(17) Moderate sedation--drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. A Level 2 permit is required for moderate sedation limited to enteral routes of administration. A Level 3 permit is required for moderate sedation including parenteral routes of administration. In accordance with this particular definition, the drugs or techniques used shall carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. A patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

(18) Parenteral--the administration of pharmacological agents intravenously, intraosseously, intramuscularly, subcutaneously, submucosally, intranasally, or transdermally.

(19) Patient Physical Status Classification:

(A) ASA--American Society of Anesthesiologists

(B) ASA I--a normal health patient

(C) ASA II--a patient with mild systemic disease

(D) ASA III--a patient with severe systemic disease

(E) ASA IV--a patient with severe systemic disease that is a constant threat to life

(F) ASA V--a moribund patient who is not expected to survive without the operation

(G) ASA VI--a declared brain-dead patient whose organs are being removed for donor purposes

(H) E--emergency operation of any variety (used to modify ASA I - ASA VI).

(20) Portability--the ability of a permit holder to provide permitted anesthesia services in a location other than a facility or satellite facility.

(21) Protective reflexes--includes the ability to swallow and cough effectively.

(22) Satellite facility--an additional office or offices owned or operated by the permit holder, or owned or operated by a professional organization through which the permit holder practices dentistry, or a licensed hospital facility.

(23) Supplemental dosing (applies to minimal sedation)--during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The aggregate dose must not exceed one and one-half times the MRD on the day of treatment.

(24) Time-oriented anesthesia record--documentation at appropriate time intervals of drugs, doses, and physiologic data obtained during patient monitoring. Physiologic data for moderate sedation, deep sedation and general anesthesia must be taken and recorded at required intervals unless patient cooperation interferes or prohibits compliance.

(25) Titration (applies to moderate sedation)--administration of incremental doses of a drug until the desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over-sedation. When the intent is moderate sedation, one must know whether the previous dose has taken full effect before administering an additional drug increment.

Source Note: The provisions of this §110.1 adopted to be effective May 10, 2011, 36 TexReg 2833

Texas Administrative Code

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EXAMINING BOARDS

PART 5

STATE BOARD OF DENTAL EXAMINERS

CHAPTER 110

SEDATION AND ANESTHESIA

RULE §110.2

Sedation/Anesthesia Permit

(a) A dentist licensed under Chapter 101 of this title shall obtain an anesthesia permit for the following anesthesia procedures used for the purpose of performing dentistry:

- (1) Nitrous Oxide/Oxygen inhalation sedation;
- (2) Level 1: Minimal sedation;
- (3) Level 2: Moderate sedation limited to enteral routes of administration;
- (4) Level 3: Moderate sedation which includes parenteral routes of administration; or
- (5) Level 4: Deep sedation or general anesthesia.

(b) A dentist licensed to practice in Texas who desires to administer nitrous oxide/oxygen inhalation sedation or Level 1, Level 2, Level 3 or Level 4 sedation must obtain a permit from the State Board of Dental Examiners (Board). A permit is not required to administer Schedule II drugs prescribed for the purpose of pain control or post-operative care.

- (1) A permit may be obtained by completing an application form approved by the Board.
- (2) The application form must be filled out completely and appropriate fees paid.
- (3) Prior to issuance of a sedation/anesthesia permit, the Board may require that the applicant undergo a facility inspection or further review of credentials. The Board may direct an Anesthesia Consultant, who has been appointed by the Board, to assist in this inspection or review. The applicant will be notified in writing if an inspection is required and provided with the name of an Anesthesia Consultant who will coordinate the inspection. The applicant must make arrangements for completion of the inspection within 180 days of the date the notice is mailed. An extension of no more than ninety (90) days may be granted if the designated Anesthesia Consultant requests one.
- (4) An applicant for a sedation/anesthesia permit must be licensed by and should be in good standing with the Board. For purposes of this chapter "good standing" means that the dentist's license is not suspended, whether or not the suspension is probated. Applications from licensees who are not in good standing may not be approved.

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EXAMINING BOARDS

PART 5

STATE BOARD OF DENTAL EXAMINERS

CHAPTER 110

SEDATION AND ANESTHESIA

RULE §110.3

Nitrous Oxide/Oxygen Inhalation Sedation

(a) Education and Professional Requirements. A dentist applying for a nitrous oxide/oxygen inhalation sedation permit shall meet one of the following educational/professional criteria:

(1) satisfactory completion of a comprehensive training program consistent with that described for nitrous oxide/oxygen inhalation sedation administration in the American Dental Association (ADA) Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. This includes a minimum of fourteen (14) hours of training, including a clinical component, during which competency in inhalation sedation technique is achieved. Acceptable courses include those obtained from academic programs of instruction recognized by the ADA Commission on Dental Accreditation (CODA); or courses approved and recognized by the ADA Continuing Education Recognition Program (CERP); or courses approved and recognized by the Academy of General Dentistry (AGD) Program Approval for Continuing Education (PACE);

(2) satisfactory completion of an ADA/CODA approved or recognized pre-doctoral dental or postdoctoral dental training program which affords comprehensive training necessary to administer and manage nitrous oxide/oxygen inhalation sedation; or

(3) is a Texas licensed dentist, has a current Board-issued nitrous oxide/oxygen inhalation sedation permit, and has been using nitrous oxide/oxygen inhalation sedation in a competent manner immediately prior to the implementation of this chapter on June 1, 2011. Any dentist whose Board-issued nitrous oxide/oxygen inhalation sedation permit is active on June 1, 2011 shall automatically continue to hold this permit.

(b) Standard of Care Requirements. A dentist performing nitrous oxide/oxygen inhalation sedation shall maintain the minimum standard of care for anesthesia, and in addition shall:

(1) adhere to the clinical requirements as detailed in this section;

(2) maintain under continuous direct supervision auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of nitrous oxide/oxygen inhalation sedation;

(3) maintain current certification in Basic Life Support (BLS) for Healthcare Providers for the assistant staff by having them pass a course that includes a written examination and a hands-on demonstration of skills; and

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a nitrous oxide/oxygen inhalation sedation procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed. This provision and similar provisions in subsequent sections address dentists and are not intended to address the scope of practice of persons licensed by any other agency.

(c) Clinical Requirements. A dentist must meet the following clinical requirements to utilize nitrous oxide/oxygen inhalation sedation:

(1) Patient Evaluation. Patients considered for nitrous oxide/oxygen inhalation sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II), this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with the patient's primary care physician or consulting medical specialist.

(2) Pre-Procedure Preparation and Informed Consent.

(A) The patient, parent, guardian, or care-giver must be advised of the risks associated with the delivery of nitrous oxide/oxygen inhalation sedation and must provide written, informed consent for the proposed sedation.

(B) The dentist shall determine that an adequate oxygen supply is available and evaluate equipment for proper operation and delivery of inhalation agents prior to use on each patient.

(C) Baseline vitals must be obtained in accordance with §108.7 and §108.8 of this title.

(3) Personnel and Equipment Requirements.

(A) In addition to the dentist, at least one member of the assistant staff should be present during the administration of nitrous oxide/oxygen inhalation sedation in nonemergency situations.

(B) The inhalation equipment must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either:

(i) a functioning device that prohibits the delivery of less than 30% oxygen; or

(ii) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

(C) If nitrous oxide and oxygen delivery equipment capable of delivering less than 30% oxygen is used, an in-line oxygen analyzer must be utilized.

(D) The equipment must have an appropriate nitrous oxide/oxygen scavenging system.

(E) The ability of the provider and/or the facility to deliver positive pressure oxygen must be maintained.

(4) Monitoring.

(A) The dentist must induce the nitrous oxide/oxygen inhalation sedation and must remain in the room with the patient during the maintenance of the sedation until pharmacologic and physiologic vital sign stability is established.

(B) After pharmacologic and physiologic vital sign stability has been established, the dentist may delegate the monitoring of the nitrous oxide/oxygen inhalation sedation to a dental auxiliary who has been certified to monitor the administration of nitrous oxide/oxygen inhalation sedation by the State Board of Dental Examiners.

(5) Documentation.

(A) Pre-operative baseline vitals must be documented.

(B) Individuals present during administration must be documented.

(C) Maximum concentration administered must be documented.

(D) The start and finish times of the inhalation agent must be documented.

(6) Recovery and Discharge.

(A) Recovery from nitrous oxide/oxygen inhalation sedation, when used alone, should be relatively quick, requiring only that the patient remain in an operatory chair as needed.

(B) Patients who have unusual reactions to nitrous oxide/oxygen inhalation sedation should be assisted and monitored either in an operatory chair or recovery room until stable for discharge.

(C) The dentist must determine that the patient is appropriately responsive prior to discharge. The dentist shall not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

(7) Emergency Management. Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation. The dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of the nitrous oxide, and providing the equipment and protocols for patient rescue. A dentist must be able to rescue patients who enter a deeper state of sedation than intended. The dentist, personnel and facility must be prepared to treat emergencies that may arise from the administration of nitrous oxide/oxygen inhalation sedation.

(8) Management of Children. For children twelve (12) years of age and under, the dentist should observe the American Academy of Pediatrics/American Academy of Pediatric Dentists Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(d) A dentist who holds a nitrous oxide/oxygen inhalation sedation permit shall not intentionally administer minimal sedation, moderate sedation, deep sedation, or general anesthesia.

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CHAPTER 110

SEDATION AND ANESTHESIA

RULE §110.4

Minimal Sedation

(a) Education and Professional Requirements. A dentist applying for a Level 1 Minimal Sedation permit shall meet one of the following educational/professional criteria:

(1) satisfactory completion of training to the level of competency in minimal sedation consistent with that prescribed in the American Dental Association (ADA) Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, or a comprehensive training program in minimal sedation that satisfies the requirements described in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. This includes a minimum of sixteen (16) hours of didactic training and instruction in which competency in enteral and/or combined inhalation-enteral minimal sedation technique is demonstrated; or

(2) satisfactory completion of an advanced education program accredited by the ADA Commission on Dental Accreditation (CODA) that affords comprehensive training necessary to administer and manage minimal sedation, commensurate with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or

(3) is a Texas licensed dentist, has a current Board-issued enteral permit, and has been using minimal sedation in a competent manner immediately prior to the implementation of this chapter on June 1, 2011. Any Texas licensed dentist who was issued an enteral sedation permit before June 1, 2011 and whose enteral sedation permit was active on June 1, 2011 shall automatically have the permit reclassified as a Level 1 Minimal Sedation permit on June 1, 2011. A Texas licensed dentist whose permit is reclassified from an enteral sedation permit to a Level 1 Minimal Sedation permit on June 1, 2011 may continue to administer enteral sedation until January 1, 2013. On or before January 1, 2013, the dentist shall either provide proof that adequate education has been obtained by submitting an application for a Level 2 permit on or before that date, or shall comply with the requirements of a Level 1 permit after that date. A dentist shall always follow the standard of care and clinical requirements for the level of sedation he or she is performing.

(b) Standard of Care Requirements. A dentist performing minimal sedation shall maintain the minimum standard of care for anesthesia, and in addition shall:

(1) adhere to the clinical requirements as detailed in this section;

(2) maintain under continuous direct supervision auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of minimal sedation;

(3) maintain current certification in Basic Life Support (BLS) for Healthcare Providers for the assistant staff by having them pass a course that includes a written examination and a hands-on demonstration of skills; and

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a minimal sedation procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed.

(c) Clinical Requirements. A dentist must meet the following clinical requirements for utilization of minimal sedation:

(1) Patient Evaluation. Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II), this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

(2) Pre-Procedure Preparation and Informed Consent.

(A) The patient, parent, guardian, or care-giver must be advised regarding the procedure associated with the delivery of any sedative agents and must provide written, informed consent for the proposed sedation.

(B) The dentist shall determine that an adequate oxygen supply is available and evaluate equipment for proper operation and delivery of adequate oxygen under positive pressure.

(C) Baseline vital signs must be obtained in accordance with §108.7 and §108.8 of this title.

(D) A focused physical evaluation must be performed as deemed appropriate.

(E) Pre-procedure dietary restrictions must be considered based on the sedative technique prescribed.

(F) Pre-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver.

(3) Personnel and Equipment Requirements.

(A) In addition to the dentist, at least one additional person trained in Basic Life Support (BLS) for Healthcare Providers must be present.

(B) A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.

(C) When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either:

(i) a functioning device that prohibits the delivery of less than 30% oxygen; or

(ii) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

(D) An appropriate scavenging system must be available if gases other than oxygen or air are used.

(4) Monitoring. The dentist administering the sedation must remain in the operatory room to monitor the patient until the patient meets the criteria for discharge to the recovery area. Once the patient meets the criteria for discharge to the recovery area, the dentist may delegate monitoring to a qualified dental auxiliary. Monitoring during the administration of sedation must include:

(A) Oxygenation.

(i) Color of mucosa, skin, or blood must be evaluated continually.

(ii) Oxygen saturation monitoring by pulse-oximetry should be used when a single drug minimal sedative is used. The additional use of nitrous oxide has a greater potential to increase the patient's level of sedation to moderate sedation, and a pulse oximeter must be used.

(B) Ventilation. The dentist (or appropriately qualified individual) must observe chest excursions and must verify respirations continually.

(C) Circulation. Blood pressure and heart rate should be evaluated preprocedurally, post-procedurally and intra-procedurally as necessary.

(5) Documentation.

(A) Documentation must be made in accordance with §108.7 and §108.8 of this title and must include the names and dosages of all drugs administered and the names of individuals present during administration of the drugs.

(B) A time-oriented sedation record may be considered for documentation of all monitoring parameters.

(C) Pulse oximetry, heart rate, respiratory rate, and blood pressure are the parameters which may be documented at appropriate intervals of no more than 10 minutes.

(6) Recovery and Discharge.

(A) Oxygen and suction equipment must be immediately available in the recovery area if a separate recovery area is utilized.

(B) The qualified dentist must monitor the patient during recovery until the patient is ready for discharge by the dentist. The dentist may delegate this task to an appropriately qualified dental auxiliary.

(C) The dentist must determine and document that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory prior to discharge. The dentist shall not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

(D) Post-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver. Post-procedure, patients should be accompanied by an adult caregiver for an appropriate period of recovery.

(7) Emergency Management. Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation. The dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation, and providing the equipment and protocols for patient rescue. A dentist must be able to rescue patients who enter a deeper state of sedation than intended.

(8) Management of Children. For children twelve (12) years of age and under, the dentist should observe the American Academy of Pediatrics/American Academy of Pediatric Dentists Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(d) A dentist who holds a minimal sedation permit shall not intentionally administer moderate sedation,

deep sedation, or general anesthesia.

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CHAPTER 110

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RULE §110.5

Moderate Sedation

(a) Education and Professional Requirements.

(1) A dentist applying for a Level 2 Moderate Sedation permit (limited to enteral route of administration) must satisfy at least one of the following educational/professional criteria:

(A) satisfactory completion of a comprehensive training program consistent with that described for moderate enteral sedation in the American Dental Association (ADA) Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. This includes a minimum of twenty-four (24) hours of instruction, plus management of at least ten (10) case experiences in enteral moderate sedation. These ten (10) case experiences must include at least three live clinical dental experiences managed by participants in groups of no larger than five (5). The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate sedation; or

(B) satisfactory completion of an advanced education program accredited by the ADA Commission on Dental Accreditation (CODA) that affords comprehensive and appropriate training necessary to administer and manage enteral moderate sedation, commensurate with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or

(C) is a Texas licensed dentist who was issued an enteral sedation permit before June 1, 2011 and whose enteral sedation permit was active on June 1, 2011. Dentists in this category shall automatically have their permit reclassified as a Level 1 Minimal Sedation permit on June 1, 2011. A Texas licensed dentist whose permit is reclassified from an enteral sedation permit to a Level 1 Minimal Sedation permit on June 1, 2011 may continue to administer enteral sedation until January 1, 2013. On or before January 1, 2013, the dentist shall either provide proof that adequate education has been obtained by submitting an application for a Level 2 permit on or before that date, or shall comply with the requirements of a Level 1 permit after that date. A dentist shall always follow the standard of care and clinical requirements for the level of sedation he or she is performing.

(2) A dentist applying for a Level 3 Moderate Sedation permit (inclusive of parenteral routes of administration) must satisfy at least one of the following educational/professional criteria:

(A) satisfactory completion of a comprehensive training program consistent with that described for parenteral moderate sedation in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. This includes a minimum of sixty (60) hours of didactic training and instruction and satisfactory management of a minimum of twenty (20) dental patients, under supervision, using intravenous sedation; or

(B) satisfactory completion of an advanced education program accredited by the ADA/CODA that affords comprehensive and appropriate training necessary to administer and manage parenteral moderate sedation, commensurate with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or

(C) satisfactory completion of an internship or residency which included intravenous moderate sedation training equivalent to that defined in this subsection; or

(D) is a Texas licensed dentist who had a current parenteral sedation permit issued by the Board and has been using parenteral sedation in a competent manner immediately prior to the implementation of this chapter on June 1, 2011. A Texas licensed dentist whose Board-issued permit to perform parenteral sedation is active on June 1, 2011 shall automatically have the permit reclassified as a Level 3 Moderate Sedation (inclusive of parenteral routes of administration) permit.

(3) A dentist applying for a Level 2 or 3 Moderate Sedation permit must satisfy the following emergency management certification criteria:

(A) Licensees holding moderate sedation permits shall document:

(i) Current (as indicated by the provider), successful completion of Basic Life Support (BLS) for Healthcare Providers; AND

(ii) Current (as indicated by the provider), successful completion of an Advanced Cardiac Life Support (ACLS) course, OR current (as indicated by the provider), successful completion of a Pediatric Advanced Life Support (PALS) course.

(B) Licensees holding Level 2 or Level 3 Moderate Sedation permits who provide anesthesia services to children (age twelve (12) or younger) must document current, successful completion of a PALS course.

(b) Standard of Care Requirements. A dentist must maintain the minimum standard of care as outlined in §108.7 of this title and in addition shall:

(1) adhere to the clinical requirements as detailed in this section;

(2) maintain under continuous personal supervision auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of moderate sedation;

(3) maintain current certification in Basic Life Support (BLS) for Healthcare Providers for the assistant staff by having them pass a course that includes a written examination and a hands-on demonstration of skills; and

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a moderate sedation procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed.

(c) Clinical Requirements.

(1) Patient Evaluation. Patients considered for moderate sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should consist of at least a review of the patient's current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

(2) Pre-Procedure Preparation and Informed Consent.

(A) The patient, parent, guardian, or care-giver must be advised regarding the procedure associated

with the delivery of any sedative agents and must provide written, informed consent for the proposed sedation. The informed consent must be specific to the procedure being performed and must specify that the risks related to the procedure include cardiac arrest, brain injury, and death.

(B) The dentist shall determine that an adequate oxygen supply is available and evaluate equipment for proper operation and delivery of adequate oxygen under positive pressure.

(C) Baseline vital signs must be obtained in accordance with §108.7 and §108.8 of this title.

(D) A focused physical evaluation must be performed as deemed appropriate.

(E) Pre-procedure dietary restrictions must be considered based on the sedative technique prescribed.

(F) Pre-procedure verbal or written instructions must be given to the patient, parent, escort, guardian, or care-giver.

(3) Personnel and Equipment Requirements.

(A) In addition to the dentist, at least one additional person trained in Basic Life Support (BLS) for Healthcare Providers must be present.

(B) A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.

(C) When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either:

(i) a functioning device that prohibits the delivery of less than 30% oxygen; or

(ii) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

(D) An appropriate scavenging system must be available if gases other than oxygen or air are used.

(E) The equipment necessary to establish intravenous access must be available.

(4) Monitoring. The dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level, the dentist may delegate a qualified dental auxiliary to remain with the patient and continue to monitor the patient until he/she is discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

(A) Consciousness. Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed.

(B) Oxygenation.

(i) Color of mucosa, skin, or blood must be evaluated continually.

(ii) Oxygen saturation must be evaluated by pulse-oximetry continuously.

(C) Ventilation.

(i) Chest excursions must be continually observed.

(ii) Ventilation must be continually evaluated. This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO₂ or by verbal communication with the patient.

(D) Circulation.

(i) Blood pressure and heart rate must be continually evaluated.

(ii) Continuous EKG monitoring of patients sedated under moderate parenteral sedation is required.

(5) Documentation.

(A) Documentation must be made in accordance with §108.7 and §108.8 of this title.

(B) A written time-oriented anesthetic record must be maintained and must include the names and dosages of all drugs administered and the names of individuals present during administration of the drugs.

(C) Pulse-oximetry, heart rate, respiratory rate, and blood pressure must be continually monitored and documented at appropriate intervals of no more than ten (10) minutes.

(6) Recovery and Discharge.

(A) Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.

(B) While the patient is in the recovery area, the dentist or qualified clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation, and level of consciousness.

(C) The dentist must determine and document that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory for discharge. The dentist shall not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

(D) Post-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver. Post-procedure, patients should be accompanied by an adult caregiver for an appropriate period of recovery.

(E) If a reversal agent is administered before discharge criteria have been met, the patient must be monitored until recovery is assured.

(7) Emergency Management.

(A) The dentist is responsible for the sedation management, adequacy of the facility and staff, diagnosis and treatment of emergencies associated with the administration of moderate sedation, and providing the equipment and protocols for patient rescue. This includes immediate access to pharmacologic antagonists and equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.

(B) Advanced airway equipment and resuscitation medications must be available.

(C) A defibrillator should be available when ASA I and II patients are sedated under moderate

sedation. A defibrillator must be available when ASA III and IV patients are sedated under moderate sedation.

(D) Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation. The dentist administering moderate sedation must be able to recover patients who enter a deeper state of sedation than intended.

(8) Management of Children. For children twelve (12) years of age and under, the dentist should observe the American Academy of Pediatrics/American Academy of Pediatric Dentists Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(d) A dentist who holds a moderate sedation permit shall not intentionally administer deep sedation or general anesthesia.

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CHAPTER 110

SEDATION AND ANESTHESIA

RULE §110.6

Deep Sedation or General Anesthesia

(a) Education and Professional Requirements.

(1) A dentist applying for a permit to administer deep sedation or general anesthesia must satisfy one of the following criteria:

(A) satisfactory completion of an advanced education program accredited by the American Dental Association (ADA) Commission on Dental Accreditation (CODA) that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia; or

(B) is a Texas licensed dentist who holds a current permit to administer deep sedation or general anesthesia issued by the Board and who has been using deep sedation or general anesthesia in a competent manner immediately prior to the implementation of this chapter on June 1, 2011. A Texas licensed dentist whose Board-issued permit to perform deep sedation or general anesthesia is active on June 1, 2011 shall automatically have the permit reclassified as a Level 4 Deep Sedation or General Anesthesia permit.

(2) A dentist applying for a permit to administer deep sedation or general anesthesia must satisfy the following emergency management certification criteria:

(A) Licensees holding deep sedation or general anesthesia permits shall document:

(i) Current (as indicated by the provider), successful completion of Basic Life Support (BLS) for Healthcare Providers; AND

(ii) Current (as indicated by the provider), successful completion of an Advanced Cardiac Life Support (ACLS) course, OR current (as indicated by the provider), successful completion of a Pediatric Advanced Life Support (PALS) course.

(B) Licensees holding deep sedation or general anesthesia permits who provide anesthesia services to children (age twelve (12) or younger) must document current, successful completion of a PALS course.

(b) Standard of Care Requirements. A dentist must maintain the minimum standard of care for the administration of anesthesia as outlined in §108.7 of this title and in addition shall:

(1) adhere to the clinical requirements as detailed in this section;

(2) maintain under continuous direct supervision a minimum of two qualified dental auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of deep sedation and/or general anesthesia;

(3) maintain current certification in Basic Life Support (BLS) for Healthcare Providers for the assistant staff by having them pass a course that includes a written examination and a hands-on demonstration of skills; and

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a deep sedation/general anesthesia procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed.

(c) Clinical Requirements.

(1) Patient Evaluation. Patients considered for deep sedation or general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this must consist of at least a review of their current medical history, medication use, and NPO status. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

(2) Pre-Procedure Preparation and Informed Consent.

(A) The patient, parent, guardian, or care-giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and must provide written, informed consent for the proposed deep sedation or general anesthesia procedure. The informed consent must be specific to the deep sedation and/or general anesthesia procedure being performed and must specify that the risks related to the procedure include cardiac arrest, brain injury, and death.

(B) The dentist shall determine that an adequate oxygen supply is available and evaluate equipment for proper operation and delivery of adequate oxygen under positive pressure.

(C) Baseline vital signs must be obtained in accordance with §108.7 and §108.8 of this title.

(D) A focused physical evaluation must be performed as deemed appropriate.

(E) Pre-procedure dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.

(F) Pre-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver.

(G) An intravenous line, which is secured throughout the procedure, must be established except as provided in paragraph (7) of this subsection, regarding Pediatric and Special Needs Patients.

(3) Personnel and Equipment Requirements.

(A) Personnel. A minimum of three (3) individuals must be present during the procedure:

(i) a dentist who is qualified to administer the deep sedation or general anesthesia who is currently certified in ACLS and/or PALS; and

(ii) two additional individuals who have current certification of successfully completing a course in Basic Life Support (BLS) for Healthcare Providers, one of which must be dedicated to assisting with patient monitoring.

(B) Equipment.

(i) A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.

(ii) When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either:

(I) a functioning device that prohibits the delivery of less than 30% oxygen; or

(II) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

(iii) An appropriate scavenging system must be available if gases other than oxygen are used.

(iv) The equipment necessary to establish intravenous access must be available.

(v) Equipment and drugs necessary to provide advanced airway management and advanced cardiac life support must be immediately available.

(vi) If volatile anesthetic agents are utilized, an inspired agent analysis monitor and capnograph should be considered.

(vii) Emergency medications and a defibrillator must be immediately available.

(4) Monitoring. A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

(A) Oxygenation.

(i) Color of mucosa, skin, or blood must be continually evaluated.

(ii) Oxygenation saturation must be evaluated continuously by pulse oximetry.

(B) Ventilation.

(i) Intubated patient: End-tidal CO₂ must be continuously monitored and evaluated.

(ii) Non-intubated patient: Breath sounds via auscultation and/or end-tidal CO₂ must be continually monitored and evaluated.

(iii) Respiration rate must be continually monitored and evaluated.

(C) Circulation.

(i) Heart rate and rhythm via EKG and pulse rate via pulse oximetry must be evaluated throughout the procedure.

(ii) Blood pressure must be continually monitored.

(D) Temperature.

(i) A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.

(ii) The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

(5) Documentation.

(A) Documentation must be made in accordance with §108.7 and §108.8 of this title and must include the names, times and dosages of all drugs administered and the names of individuals present during administration of the drugs.

(B) A written time-oriented anesthetic record must be maintained.

(C) Pulse oximetry and end-tidal CO₂ measurements (if taken with an intubated patient), heart rate, respiratory rate, and blood pressure must be continually recorded at five (5) minute intervals.

(6) Recovery and Discharge.

(A) Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.

(B) The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation, and level of consciousness.

(C) The dentist must determine and document that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory prior to discharge. The dentist shall not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

(D) Post-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver. Post-procedure, patients should be accompanied by an adult caregiver for an appropriate period of recovery.

(7) Special Situations.

(A) Special Needs Patients. Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia shall document the reasons preventing the pre-procedure management.

(B) Management of Children. For children twelve (12) years of age and under, the dentist should observe the American Academy of Pediatrics/American Academy of Pediatric Dentists Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(8) Emergency Management.

(A) The dentist is responsible for the sedation management, adequacy of the facility and staff, diagnosis and treatment of emergencies associated with the administration of deep sedation or general anesthesia, and providing the equipment and protocols for patient rescue. This includes immediate access to pharmacologic antagonists and equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.

(B) Advanced airway equipment, emergency medications and a defibrillator must be immediately available.

(C) Appropriate pharmacologic agents must be immediately available if known triggering agents of

malignant hyperthermia are part of the anesthesia plan.

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PART 5

STATE BOARD OF DENTAL EXAMINERS

CHAPTER 110

SEDATION AND ANESTHESIA

RULE §110.7

Portability

(a) A sedation/anesthesia permit is valid for the dentist's facility, if any, as well as any satellite facility.

(b) A Texas licensed dentist who holds the Board-issued privilege of portability on or before June 1, 2011 will automatically continue to hold that privilege provided the dentist complies with the renewal requirements of this section.

(c) Portability of a sedation/anesthesia permit will be granted to a dentist who, after June 1, 2011, applies for portability, if the dentist:

(1) holds a Level 4 Deep Sedation/General Anesthesia permit;

(2) holds a Level 3 Moderate Parenteral Sedation permit and the permit was granted based on education received in conjunction with the completion of a oral and maxillofacial specialty education program or a dental anesthesia program; or

(3) holds a Level 3 Moderate Parenteral Sedation permit and if:

(A) the training for the permit was obtained on the basis of completion of any of the following American Dental Association (ADA) Commission on Dental Accreditation (CODA) recognized or approved programs:

(i) a specialty program;

(ii) a general practice residency;

(iii) an advanced education in general dentistry program; or

(iv) a continuing education program. Dentists seeking a portability privilege designation based on this method of education shall also successfully complete no less than sixty (60) hours of didactic instruction and manage no less than twenty (20) dental patients by the intravenous route of administration; and

(B) the applicant provides proof of administration of no less than thirty (30) cases of personal administration of Level 3 sedation on patients in a primary or satellite practice location within the six (6) month period preceding the application for portability, but following the issuance of the sedation permit. Acceptable documentation shall include, but not be limited to, patient records demonstrating the applicant's anesthetic technique, as well as provision of services by the applicant within the minimum standard of care.

(d) A dentist providing anesthesia services utilizing a portability permit remains responsible for providing these services in strict compliance with all applicable laws and rules. The dentist shall ascertain that the location is supplied, equipped, staffed, and maintained in a condition to support provision of anesthesia services that meet the standard of care.

(e) Any applicant whose request for portability status is not granted on the basis of the application will be provided an opportunity for hearing pursuant to Texas Government Code, Chapter 2001 et seq.

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EXAMINING BOARDS

PART 5

STATE BOARD OF DENTAL EXAMINERS

CHAPTER 110

SEDATION AND ANESTHESIA

RULE §110.8

Provisional Anesthesia and Portability Permits

(a) The Board may elect to issue a temporary sedation/anesthesia and/or portability permit that will expire on a stated date. A full sedation/anesthesia or portability permit may be issued after the dentist has complied with requests of the Board which may include, but shall not be limited to, review of the dentist's anesthetic technique, facility inspection, and/or review of patient records to ascertain that the minimum standard of care is being met. If a full permit is not issued, the temporary permit will expire on the stated date.

(b) A dentist licensed by the Board who is enrolled and approaching graduation in a specialty or General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) program as detailed in this chapter may, upon approval of the Board or its designees, obtain a provisional permit from the Board to administer moderate parenteral sedation and/or deep sedation and general anesthesia. A dentist licensed by the Board who holds a Level IV permit issued by the Board may, upon approval of the Board or its designees, obtain a provisional permit from the Board to provide anesthesia on a portable basis. To qualify for a provisional permit the applicant must:

(1) meet all requirements under this chapter;

(2) have a letter submitted on the applicant's behalf:

(A) on the letterhead of the school administering the program;

(B) signed by the director of the program;

(C) specifying the specific training completed; and

(D) confirming imminent graduation as a result of successful completion of all requirements in the program.

(3) For the purposes of this chapter, "completion" means the successful conclusion of all requirements of the program in question, but not including the formal graduation process.

(4) Any provisional permit issued under this section shall remain in effect until the next-scheduled regular Board meeting, at which time the Board will consider ratifying the provisional permit.

(5) On ratification of a provisional permit, the status of the permit will change to that of a regular permit under this section.

(a) The Board shall renew an anesthesia/sedation permit annually if required fees are paid and the required emergency management training and continuing education requirements are satisfied. The Board shall not renew an anesthesia/sedation permit if, after notice and opportunity for hearing, the Board finds the permit holder has provided, or is likely to provide, anesthesia/sedation services in a manner that does not meet the minimum standard of care. If a hearing is held, the Board shall consider factors including patient complaints, morbidity, mortality, and anesthesia consultant recommendations.

(b) Fees. Annual dental license renewal certificates shall include the annual permit renewal, except as provided for in this section. The licensee shall be assessed an annual renewal fee in accordance with the fee schedule in Chapter 102 of this title.

(c) Continuing Education.

(1) In conjunction with the annual renewal of a dental license, a dentist seeking to renew a minimal sedation, moderate sedation, or deep sedation/general anesthesia permit must submit proof of completion of the following hours of continuing education every two years on the administration of or medical emergencies associated with the permitted level of sedation:

(A) Level 1: Minimal Sedation - six (6) hours

(B) Levels 2 and 3: Moderate Sedation - eight (8) hours

(C) Level 4: Deep Sedation/General Anesthesia - twelve (12) hours

(2) The continuing education requirements under this section shall be in addition to any additional courses required for licensure. Advanced Cardiac Life Support (ACLS) course and Pediatric Advanced Life Support (PALS) course may not be used to fulfill the continuing education requirement for renewal of the permit under this section.

(3) Continuing education courses must meet the provider endorsement requirements of §104.2 of this title.

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EXAMINING BOARDS

PART 5

STATE BOARD OF DENTAL EXAMINERS

CHAPTER 110

SEDATION AND ANESTHESIA

RULE §110.9

Anesthesia Permit Renewal

(a) The Board shall renew an anesthesia/sedation permit annually if required fees are paid and the required emergency management training and continuing education requirements are satisfied. The Board shall not renew an anesthesia/sedation permit if, after notice and opportunity for hearing, the Board finds the permit holder has provided, or is likely to provide, anesthesia/sedation services in a manner that does not meet the minimum standard of care. If a hearing is held, the Board shall consider factors including patient complaints, morbidity, mortality, and anesthesia consultant recommendations.

(b) Fees. Annual dental license renewal certificates shall include the annual permit renewal, except as provided for in this section. The licensee shall be assessed an annual renewal fee in accordance with the fee schedule in Chapter 102 of this title.

(c) Continuing Education.

(1) In conjunction with the annual renewal of a dental license, a dentist seeking to renew a minimal sedation, moderate sedation, or deep sedation/general anesthesia permit must submit proof of completion of the following hours of continuing education every two years on the administration of or medical emergencies associated with the permitted level of sedation:

(A) Level 1: Minimal Sedation - six (6) hours

(B) Levels 2 and 3: Moderate Sedation - eight (8) hours

(C) Level 4: Deep Sedation/General Anesthesia - twelve (12) hours

(2) The continuing education requirements under this section shall be in addition to any additional courses required for licensure. Advanced Cardiac Life Support (ACLS) course and Pediatric Advanced Life Support (PALS) course may not be used to fulfill the continuing education requirement for renewal of the permit under this section.

(3) Continuing education courses must meet the provider endorsement requirements of §104.2 of this title.

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EXAMINING BOARDS

PART 5

STATE BOARD OF DENTAL EXAMINERS

CHAPTER 110

SEDATION AND ANESTHESIA

RULE §110.10

Use of General Anesthetic Agents

(a) No dentist shall administer or employ the general anesthetic agent(s) listed in subsection (b) of this section, which has a narrow margin for maintaining consciousness, unless the dentist possesses a valid Level 4 - General Anesthesia or Deep Sedation permit issued by the Board.

(b) The following drugs are general anesthesia agents with a narrow margin for maintaining consciousness and must only be used by a dentist holding a Level 4 - General Anesthesia or Deep Sedation permit:

(1) short acting barbiturates including, but not limited to thiopental, sodium methohexital, and thiamylal;

(2) short acting analogues of fentanyl including, but not limited to remifentanyl, alfentanil, and sufentanyl;

(3) alkylphenols including precursors or derivatives, which includes, but not limited to propofol and fospropofol;

(4) etomidate;

(5) dissociative anesthetics - ketamine;

(6) volatile inhalation anesthetics including, but not limited to sevoflurane, desflurane and isoflurane; and

(7) similarly acting drugs or quantity of agent(s), or technique(s), or any combination thereof that would likely render a patient deeply sedated, generally anesthetized or otherwise not meeting the conditions of the definition of moderate sedation as stated in §110.1 of this chapter (relating to Definitions).

(c) No permit holder shall have more than one person under general anesthesia at the same time exclusive of recovery.

**TSBDE'S SUNSET
REPORT RE:
SEDATION/ANESTHESIA
PERMITTING
&
THE SUNSET STAFF'S
REPORT
RECOMMENDATIONS**

Self-Evaluation Report



***Texas State Board of Dental Examiners
September 2015***

ISSUE 2: Clarify Sedation/Anesthesia Permitting

A. Brief Description of Issue

The Board does not have statutory authority to adequately protect the public health in the administration of sedation/anesthesia by dentists.

The current statute does not address the regulation of sedation/anesthesia administered through non-enteral methods and utilizes “method of administration” rather than “level of sedation” to discuss a dentist’s administration of anesthesia.

B. Discussion

The current statute authorizes the Board to adopt rules, issue permits, and conduct inspections related to the enteral administration of anesthesia. Tex. Occ. Code §258.151 defines “enteral” to mean “any technique of administering anesthesia in which the anesthetic is absorbed through the gastrointestinal tract or oral mucosa.”

The statute does not authorize the Board to adopt rules, issue permits, and conduct inspections related to other administrations of sedation/anesthesia, including parenteral administration. Parenteral administration of sedation/anesthesia involves an injection or an infusion. In other words, the statute does not explicitly authorize the Board to regulate intravenous anesthesia and other non-enteral administrations of anesthesia¹.

Despite this, the Board has required its licensees to obtain permits to administer various levels of sedation/nesthesia since at least 2001. Repealed Rule 108.33, Sedation/Anesthesia Permit, became effective on February 20, 2001, and refers to three permit levels: nitrous oxide/oxygen inhalation conscious sedation, parenteral conscious sedation, and parenteral deep sedation/general anesthesia. The preamble to the adoption of this rule states that it is a “verbatim repeat of repealed Rule 109.174.” In 2011 the Board amended its sedation/anesthesia rules to reframe them using a “level of sedation” system of classification rather than a “method of administration” classification. The Board currently issues the following permits:

1. Nitrous oxide conscious sedation
2. Level 1 – Minimal Sedation
3. Level 2 – Moderate Enteral Sedation
4. Level 3 – Moderate Parenteral Sedation
5. Level 4 – Deep Sedation or General Anesthesia
6. Portability – Level 3 or 4

Approximately 2000 dentists hold Level 3 or Level 4 permits to parenterally administer sedation.

¹ Tex. Occ. Code §258.001(4) references the use of a “local anesthetic agent, inhalation sedative agent, parenteral sedative agent, or general anesthetic agent” in the context of appropriate delegations to non-dentists.

Second, the current statute utilizes an outdated mode of classification. The current statute classifies sedation/anesthesia based on the method of administration (ie: enteral vs. parenteral). The modern guidelines published by the American Dental Association call for classification of anesthesia based on the level of consciousness or sedation achieved. The Board's most recent sedation/anesthesia rules also adopt this framework. This framework takes into account the fact that drugs administered by any method may be combined to achieve levels of sedation that exceed the level of sedation intended by the practitioner or for which the practitioner was trained.

C. Possible Solutions and Impact

As discussed in Section (II)(J) above, the agency is working to strengthen its ability to monitor anesthesia-related adverse outcomes. This effort is both proactive and reactive. The proactive component is the agency's development of inspection protocols that could be used to randomly audit permit-holders, and the reactive component is the agency's development of more robust data tracking of anesthesia-related complaints it has received.

1. One option is for the Legislature to determine that the Board does not have the authority to regulate non-enteral administration of anesthesia. This would do away with the Level 3 and Level 4 permits currently issued to licensees and limit the Board's authority to inspect and investigate higher levels and/or more serious methods of sedation/anesthesia.
2. Another option is to clarify that the Board regulates all methods of sedation/anesthesia for dental purposes. This may require the Board to amend its sedation/anesthesia rules to revert to the "method of sedation" framework. Alternatively, the statute could reflect a delegation of authority to the Board related to all methods of anesthesia, and the Board could continue its current implementation of anesthesia-related requirements based on the level of sedation achieved.
3. A third option is to clarify that the Board regulates all levels of sedation/anesthesia for dental purposes. This would reflect the current practice of the Board and guidelines issued by the American Dental Association.
4. An additional option is for the Legislature to authorize and direct the Board to engage in regular virtual or on-site inspections of dentists' use of anesthesia at any level. While the agency is planning to do so as an adjunct to its anesthesia permitting and investigations programs, the most aggressive approach to the monitoring and investigation of anesthesia in the dental office would require additional FTEs and funding.

SUNSET ADVISORY COMMISSION

STAFF REPORT

State Board of Dental Examiners



2016–2017
85TH LEGISLATURE

ISSUE 3

The Board Lacks Key Enforcement Tools to Ensure Dentists Are Prepared to Respond to Increasing Anesthesia Concerns.

Background

Dentists administer varying levels of anesthesia to perform procedures ranging from routine preventive care to invasive corrective treatment. Patients typically receive anesthesia in dental office, ambulatory surgical center, or hospital settings using two techniques described in the textbox, *Methods of Anesthesia Administration*. The State Board of Dental Examiners has issued separate permits allowing dentists to administer anesthesia since 2001.¹

Methods of Anesthesia Administration

- **Enteral** anesthetic is absorbed through the intestines, nose, mouth or skin; delivery is typically through pills and liquids.
- **Parenteral** anesthetic is absorbed through intravenous or intramuscular injection; delivery is typically through intravenous therapy or localized injections.

The board's anesthesia permitting structure, depicted in the table, *Dental Anesthesia Permits*, is tiered based on the intended level of consciousness, method of administration, and amount of practitioner training. Dentists must hold a separate permit for each type of anesthesia administration they want to perform, so the numbers include duplicate permit holders. With nitrous oxide permits most numerous, 69 percent of Texas dentists hold at least one anesthesia permit. Level III and IV permit holders can apply separately for portability permits, allowing provision of anesthesia services in locations other than a dentist's primary office.² Dentists with portability permits often administer anesthesia for other dentists who do not have the same credentials. Nearly 700 Texas dentists held one or more portability permits in fiscal year 2015.

Dental Anesthesia Permits – Fiscal Year 2016

Type	Number*	Application/Renewal Fees
Nitrous Oxide/Oxygen inhalation sedation	12,086	\$32 / \$10
Level I: Minimal sedation	7,357	\$60 / \$10
Level II: Moderate sedation limited to enteral routes of administration	3,075	\$60 / \$10
Level III: Moderate sedation which includes parenteral routes of administration	1,668	\$60 / \$10
Level IV: Deep sedation or general anesthesia	558	\$60 / \$10

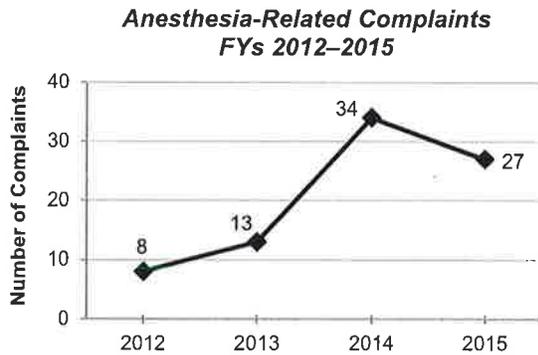
* Counts reflect individual permits issued, not individual permit holders.

Parenteral administration of anesthesia was once the only way to achieve deep sedation in patients, but advances in pharmacology now allow deep sedation using enteral anesthesia delivery. As a result, method of administration of anesthesia is less indicative of patient level of consciousness than it once was. Because individuals respond differently to anesthesia, the board requires all permit holders to have certain equipment to rescue patients experiencing adverse reactions or patients who enter a deeper state of sedation than intended.³

Findings

Anesthesia can be high risk to patients, and related complaints to the board have increased.

As highlighted by recent media coverage, complications from dental procedures using anesthesia have caused serious harm to Texas patients, including death.⁴



To provide a more complete picture of this situation, a manual examination of standard of care complaints received by the board from fiscal year 2011 to mid-fiscal year 2016 was performed for this review. Even without the assurance that the resulting data set is comprehensive, the number of complaints involving anesthesia has increased in recent years, as illustrated by the chart, *Anesthesia-Related Complaints*. In addition, the 17 complaints received midway through fiscal year 2016 were on pace to equal the previous high number of anesthesia-related complaints in 2014.

Anesthesia can cause serious harm even if correctly administered and supervised. Of the 100 anesthesia-related complaints compiled in the review, 41 involve a patient death during or shortly after a dental procedure involving anesthesia. Board reviewers ultimately determined that most of these deaths were unrelated to the supervising dentist’s performance, but at least 13 of the 41 death cases were found to include violations of the dental standard of care, including inappropriate preparation for or response to anesthesia-related emergencies. The textbox, *Selected Texas Anesthesia-Related Complaint Cases*, offers details of specific harm to patients from recent complaint cases involving dental procedures using anesthesia.

Anesthesia-related complaints received midway through fiscal year 2016 were on pace to equal the previous high.

Selected Texas Anesthesia-Related Complaint Cases

The State Board of Dental Examiners investigated and found:

Case One: A child suffered severe, irreversible brain damage following moderate enteral sedation in a dentist’s office. The treating dentist sedated the patient using oral medications and nitrous oxide to remove decayed teeth. The child began experiencing seizures after administration of the anesthesia, but the dentist did not contact emergency medical services for hours. Instead, the dentist attempted to manage the seizures using oral medications while the child’s oxygen saturation dropped and was not supplemented. As of the release of this report, the dentist’s license was temporarily suspended. Additional enforcement action is expected from the board.

Case Two: An adult patient died after receiving deep parenteral sedation for a root canal procedure. The dentist administering the anesthesia was using a portability permit to provide services in another dentist’s office. When the patient stopped breathing during the procedure, an assistant had to run to the dentist’s car to retrieve resuscitation equipment. The final cause of death was determined to be heart disease, which complicated the effect of the anesthesia on the body. But the board still found that the dentist administering anesthesia violated the standard of care by failing to recognize the patient’s deteriorating situation, have rescue equipment at hand, and immediately call emergency medical services. As a result, the board suspended the dentist’s anesthesia permits until the dentist met a number of requirements including 320 hours of continuing education and an office inspection.

Gaps in regulatory authority and a lack of leadership have left the board unprepared to address anesthesia-related problems.

- Limited inspection authority.** Data from the review of more than five years of complaints related to anesthesia indicates parenteral delivery of anesthesia is involved in nearly two-thirds of such complaints, as shown in the accompanying chart. However, the board only has statutory authority to perform inspections of dental offices, equipment, and documents related to *enteral* anesthesia administration. The invasive nature and demonstrated risk of parenteral delivery, combined with a higher number of associated complaints to the board, suggests a greater need for similar inspection authority related to parenteral delivery as it already has for enteral administration of anesthesia. Without inspection authority, the board is left to react to problems after they have occurred through its complaint process and cannot prevent problems and possible tragedies before they occur by ensuring dentists are ready to respond to an emergency should the need arise.

**Anesthesia-Related Complaints
by Method of Administration
FYs 2012–2016 Year to Date***

Method	Complaints
Parenteral	63
Enteral	25
Unknown or under investigation	12

* Reflects anesthesia-related complaints received in only one-half of fiscal year 2016.

- Lack of board leadership on anesthesia issues.** Although it has had authority since 2001 to routinely inspect the offices of dentists administering enteral anesthesia, the board has never had or sought the financial resources to do so. Until very recently, the board has not even tracked anesthesia-related complaints to fully understand the extent of related issues. This inaction may relate to many factors that have affected the board in recent years, including significant turnover in key staff positions and the board's interest in other projects, as described in Issue 1 of this report. After media attention to dental anesthesia and at the suggestion of the new executive director at the February 2016 board meeting, the board appointed a work group to consider potential inspection criteria, revisions to permit applications, and other efforts intended to improve the board's oversight of anesthesia administration. More of this kind of preventive action is needed to better ensure the safe delivery of anesthesia in the dental context.
- Inconsistent regulation of dental anesthesia administration due to practice location.** Dentists providing anesthesia services in office settings are not subject to the same preventive and oversight measures as their hospital — and ambulatory surgical center—based peers, even though the board has regulatory authority over dentists practicing in both settings.

Inspections. The Department of State Health Services or private accrediting bodies routinely inspect all hospitals and ambulatory surgical centers in the state to ensure safety and anesthesia emergency preparedness. As a result, the workspace of dentists administering anesthesia in those settings is subject to greater oversight through checks for equipment and written protocols to help ensure readiness to address anesthesia emergency situations in a way that does not exist for dentists administering anesthesia in a typical office setting.

Without inspection authority, the board cannot ensure readiness to respond to emergencies.

Plans force practitioners to consider the role of every office member in an anesthesia-related emergency.

Emergency Action Plans. Dentists administering anesthesia in office settings are required to maintain the equipment, drugs, and training necessary to respond appropriately to an anesthesia-related emergency. However, the board has not required dentists practicing in offices to pull all of these efforts together in a written, actionable plan as is required in more sophisticated medical facilities or required of physicians administering moderate anesthesia in office settings. The distinction is important and without a basis, considering the equal inherent risk of anesthesia delivery to patients regardless of treatment location and the danger from mishandling anesthesia-related complications in office settings as described in the tragic cases earlier in this report. Written procedures alone will not save a patient in distress. But, the exercise of developing and writing out a plan forces practitioners to consider the role of every office member when reacting to anesthesia-related emergencies and identify gaps in preparedness. Plans also offer references for support staff that can be used for training, an activity conducive to timely and appropriate reactions should the unexpected occur.

- **Risk-based regulation.** Another way of noting the risk associated with the administration of anesthesia in an office setting is that 69 of 100 recent anesthesia-related complaints resulted from procedures performed in such settings, as noted in the table, *Anesthesia-Related Complaints by Location of Treatment and Method of Administration*. By comparison, 20 complaints emerged from procedures performed in ambulatory surgical centers and hospitals in the same period. With the noted increase in anesthesia-related complaints, and the understanding that more of those complaints come from procedures performed in offices than in other settings, the board has

***Anesthesia-Related Complaints by Location of Treatment and Method of Administration
FYs 2012–2016 Year to Date****

Location of Treatment	Method of Administration
69 Office	43 Parenteral 20 Enteral 6 Unknown or under investigation
7 Ambulatory surgical center	7 Parenteral 0 Enteral 0 Unknown or under investigation
13 Hospital	11 Parenteral 1 Enteral 1 Unknown or under investigation
11 Unknown or under investigation	2 Parenteral 4 Enteral 5 Unknown or under investigation

* Reflects anesthesia-related complaints received in only one-half of fiscal year 2016.

the opportunity to direct additional attention to these practice settings and not wait for additional complaints involving serious patient harm to address current regulatory shortcomings.

Dentists in other states and Texas doctors administering anesthesia in offices are subject to related routine inspections.

- **Most other states require office inspections for dentists delivering parenteral anesthesia.** The inability of the board to routinely inspect the offices of dentists practicing parenteral anesthesia administration methods puts Texans at more risk than patients in most other states. Thirty-nine states require and three states allow office inspections for dentists administering parenteral or general anesthesia, indicating the majority of states have determined the privilege to administer parenteral anesthesia should be accompanied by an additional level of oversight beyond the licensing review of credentials.⁵
- **The Texas Medical Board inspects physicians' facilities providing office-based anesthesia services.** Since 2001, the medical board has had authority to perform inspections related to the provision of anesthesia in outpatient settings, regardless of method of administration.⁶ With funding from the Legislature in 2013, the medical board conducted 239 office anesthesia provider inspections in fiscal year 2014, but had to suspend its inspections later that year to resolve implementation challenges. The medical board has since revised related rules and expects to resume inspections again in fiscal year 2016.

Most states see the need for extra oversight of dentists administering parenteral anesthesia.

Recommendations

Change in Statute

3.1 Authorize the board to conduct inspections of dentists administering parenteral anesthesia in office settings.

This recommendation would eliminate the term and related definition of “enteral” in existing statute to clearly authorize the board to conduct routine, non-complaint based inspections of office sites and documents of the practices of dentists providing all methods of anesthesia administration. The recommendation would not extend existing board inspection authority to licensed hospitals, licensed ambulatory surgical centers, and other facilities or the dentists performing anesthesia procedures exclusively in those settings, because these facilities are already subject to inspections through the Department of State Health Services or other accrediting bodies.⁷ However, the board would retain all existing authority over dentists in those settings. As a management action, the board should adopt rules to support a risk-based inspection schedule, detailing the framework and procedures for inspections of the offices and documents of licensed Texas dentists holding any level of anesthesia permit.

Management Action

3.2 Direct the board to revise rules to ensure dentists with one or more anesthesia permits maintain related written emergency management plans.

This recommendation would direct the board to adopt rules requiring dentists with one or more anesthesia permit to maintain and annually update written policies and procedures incorporating existing equipment, drug, and training requirements for responding to emergency situations involving anesthesia. Similar written procedures are already a part of inspections of licensed hospitals, licensed ambulatory surgical centers, and other facilities conducted by other entities. Requiring written emergency action plans will encourage dentists administering anesthesia in all settings to develop actionable, coordinated responses to adverse reactions or other complications and offer a basis for meaningful related staff training.

Fiscal Implication

Providing the authority for the board to inspect the offices and documents of dentists administering anesthesia parenterally would not have a significant fiscal impact to the state. Implementation of inspections would have a cost, which could be mitigated by an adjustment to existing anesthesia permitting fees, listed in the table *Dental Anesthesia Permits*, on page 27. The board estimates three full-time staff positions would be necessary to coordinate and support inspections as well as an unidentified amount of funding for the inspections themselves and related equipment. Depending on whether the inspections were performed by board staff or contracted reviewers, the board could need additional staff positions. By comparison, the Texas Medical Board has a \$210 biennial fee for physicians offering Level II or higher office-based anesthesia services. As registered office-based anesthesia providers, 2,527 physicians are technically subject to inspections by the medical board in fiscal year 2016, though the Board inspects providers on a four-year cycle.

¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.state.tx.us/>. Section 258.155, Texas Occupations Code.

² 22 T.A.C. Section 110.7.

³ 22 T.A.C. Section 192(c) and (i); 22 T.A.C. Section 110.3(c)(7); 22 T.A.C. Section 110.4(c)(7); 22 T.A.C. Section 110.5(c)(7); 22 T.A.C. Section 110.6(c)(8).

⁴ Brooks Egerton, "Deadly Dentistry" *Dallas Morning News*, December 9, 2015; Larson, Jace, *Deaths at the Dentist*, (Houston, TX: KPRC Channel 2), February 11, 2016.

⁵ American Association of Dental Boards, *The Composite, 26th Ed.*, (Chicago: American Association of Dental Boards, 2015), 64–65.

⁶ Section 162.106(a), Texas Occupations Code.

⁷ Section 162.103, Texas Occupations Code.

**TSBDE'S STAFF
COMPILATION OF
SEDATION/ANESTHESIA
PERMITTING**

STATE	INITIAL FACILITY INSPECTION	CYCLE OF INSPECTIONS	CATEGORIES OF SEDATION TO BE INSPECTED	FEE FOR APPLICATION	FEE FOR INSPECTION	INSPECTOR	NOTES
Alabama	Yes	Annually	All Parenteral Sedation categories	\$900 with permit	\$200		
Alaska	Yes	Initial registration only	All Parenteral Sedation categories	None mentioned	\$100 with permit		
Arizona	Yes	Every 3 years	Deep Sedation/General; Conscious Sedation; Semi-Conscious (Parenteral and Enteral)	None mentioned	\$300 per location	Initial: 2 dds Board members or designees Renewal: 1 dds Board member or designee	No mention of Emergency Plan requirements
Arkansas	Yes	Annually	General /Deep Sedation	\$500 "Permit Fee"	\$500 "facility fee"	2 OMS and 1 Board member as an observer	Written Emergency Plan req; consideration of changes currently to incl extensive Emergency Plan; Moderate Sedation have a Self Inspection Requirement
California	Yes	General Anesthesia: every 5 years with permit Other Parenteral Anesthesia: every 6 years with permit renewal	All Parenteral Sedation categories	\$200	\$250	One person with the same level of sedation permit and has used it for 3 years in a dental facility	Emergency Plan Requirement: demonstrate management of 13 different simulated emergencies
Colorado	Yes	Every 5 years with renewal of permit	Deep Sedation/General; Conscious Sedation(all categories)	None	up to \$500 Charged by Inspector	1 Inspector who is a physician, CRNA, or DDS with the same level of sedation permit	Emergency Plan Requirement: demonstrate management of 8 different simulated emergencies
Connecticut	Yes	Annually	DeepSedation/General; Conscious Sedation (all categories)	\$200 with permit	Charged by Inspector	1 Inspector on list approved by Commissioner in consultation with CT Society of OMS	Emergency Plan Requirement: demonstrate management of 1 simulated emergency
Delaware	Yes	Initial registration only	Deep Sedation/General; Conscious Sedation (Parenteral & Enteral)	\$200 with permit	None mentioned	Member of the Anesthesia Advisory Committee appointed by the Board	No mention of Emergency Plan requirements
Florida	Yes	Every two years with permit renewal	Deep Sedation/General; Conscious Sedation/ Pedo	\$100	\$200 with permit	Licensed dentists contracted by the Board	No mention of Emergency Plan requirements
Georgia	Yes	Every two years with permit renewal	Deep Sedation/General; Conscious Sedation (Parenteral & Enteral)	Initial: \$300 with permit Renewal: \$200 with permit	None mentioned	Not specified	Emergency Plan Requirement: demonstrate management of 5 simulated emergencies
Hawaii	Yes	Every two years with permit renewal	Deep Sedation/General and Moderate Sedation	\$50	None	Members of the Board and consultant as needed	Written Emergency Plan Requirement only
Idaho	Yes	Every 5 years with permit renewal	General /Deep Sedation Parenteral and Enteral Sedation Moderate			Appointed by the Board	Emergency Plan Requirement: Dental team will be evaluated by inspectors for 12 different simulated emergencies.
Illinois	No	NA	NA	NA	NA	NA	Permit form has licensees sign that the required equipment is in the office
Indiana	No	NA	NA	NA	NA	NA	NA

STATE	INITIAL FACILITY INSPECTION	CYCLE OF INSPECTIONS	CATEGORIES OF SEDATION TO BE INSPECTED	FEE FOR APPLICATION	FEE FOR INSPECTION	INSPECTOR	NOTES
Iowa	Yes	Every 5 years	Deep Sedation/General; Moderate Conscious Sedation	None for inspection	\$500 per facility	Member of Anesthesia Credentials Committee appointed by the Board	No Emergency Plan Requirements mentioned; Use of capnography or pretracheal/precordial stethoscope required
Kansas	No	NA	NA	NA	NA	NA	NA
Kentucky	Yes	Renewal required	Deep Sedation /General; Moderate Conscious Sedation; Moderate Enteral; Minimal Peds	None	\$250 initial and \$75 renewal	Not specified	No Emergency Plan Requirements mentioned
Louisiana	Yes	Random announced	All Categories of Sedation except Nitrous Oxide	None	\$400 Parenteral \$100 Enteral	Not specified	No Emergency Plan Requirements mentioned
Maine	Yes	Every 5 years	Deep Sedation/General; Moderate Conscious Sedation (Parenteral and Enteral)	\$500 with permit	None	Member of the Anesthesia Subcommittee appointed by the Board	Proposal to change inspectors, as timely inspections are not being done- considering self evaluations
Maryland	Yes	Every 5 years	Deep Sedation/General; Moderate Conscious Sedation (Parenteral & Enteral)	Enteral & Moderate Parenteral \$1000 with permit; \$700-500 other locations; Renewal \$300 Parenteral; \$1000 with permit; \$600-700 other locations; Renewal \$600	None	Dentists (2) with like permits contracted by the Board	Emergency Plan Requirements include simulated management of an emergency by staff
Massachusetts	Yes	Every 2 years	All Levels of Sedation/Anesthesia including Nitrous Oxide*	\$180 facility/permit fee includes inspection but not sedation permit	None	*Self inspection for Nitrous Oxide only facility permit; OMS Dental Society for members with General Anesthesia and Dept of Health Professions Licensure/ Office of Public Protection inspectors for others	No mention of Emergency Plan Requirements
Michigan	No	NA	NA	NA	NA	NA	NA
Minnesota	Yes	Every 5 years	Deep Sedation/General; Moderate Conscious Sedation; Contract Provider	\$500	\$250 paid to the Inspector	Dentists who are approved by the Board	No mention of Emergency Plan Requirements
Mississippi	Yes	Every 3 years; however, unable to comply and only inspect at initial application	Deep Sedation/General; Conscious Sedation (Parenteral & Enteral)	Initial \$ 300 with permit Renewal \$150 with permit	none	Not specified	No mention of Emergency Plan Requirements
Missouri	Yes	Every 5 years	Deep Sedation/General; Conscious Sedation (Parenteral & Enteral)	\$100	Charged by Inspector	Consultants appointed by the Board	No mention of Emergency Plan Requirements
Montana	Yes	Every 5 years	Deep Sedation/General; Moderate Conscious Sedation	None	Initial \$200 Renewal \$150 (includes all offices by same licensee)	Dentists with like permits	No Emergency Plan Requirements
Nebraska	Yes	Every 5 years	Parenteral Sedation	\$200 with permit	None	Dentist contracted by the Board	No Emergency Plan Requirements
Nevada	Yes	Every 5 years	Deep Sedation/General; Conscious Sedation(all categories)	\$750	\$350 and \$500 for reinspection	2 Inspectors who are dentists holding like permits and approved by the Board	Emergency Plan Requirements include simulated management of an emergency by staff and have knowledge of 16 different emergencies
New Hampshire	Yes	Every 5 years	Deep Sedation/General; Moderate Conscious Sedation	\$35	Paid to the Inspector	Consultants approved by the Board	No Emergency Plan Requirements
New Jersey	No	NA	NA	NA	NA	NA	NA

STATE	INITIAL FACILITY INSPECTION	CYCLE OF INSPECTIONS	CATEGORIES OF SEDATION TO BE INSPECTED	FEE FOR APPLICATION	FEE FOR INSPECTION	INSPECTOR	NOTES
New Mexico	Yes	Unknown	Deep Sedation/General, Parenteral Conscious Sedation	\$300 with permit	None	Not specified	No Emergency Plan Requirements
New York	No	NA	NA	NA	NA	NA	NA
North Carolina	Yes	Initial registration and if permit lapses longer than 12 mos	Deep Sedation/General: Conscious Sedation; Enteral Conscious Sedation	\$100	\$275 for inspection	2 Dentist with general anesthesia permits	No Emergency Plan Requirements
North Dakota	Yes	5 years General anesthesia; 1-4 years Moderate Sedation	Deep Sedation/General; Conscious Sedation (all categories)	\$200	Paid to the Inspector	OMS dental society for OMS; Other inspectors not specified	No Emergency Plan Requirements
Ohio	Yes	With complaint only after initial	Deep Sedation/General and Moderate Sedation	None	\$400 for General Anesthesia and \$200 Moderate Sedation	Not specified	No Emergency Plan Requirements
Oklahoma	Yes	Every 5 years	Enteral Peds Sedation; Moderate Conscious Sedation; Deep Sedation/General	None	Paid to the Inspector	Consultants approved by the Board's Anesthesia Advisory Committee	No Emergency Plan Requirements
Oregon	No	NA	NA	NA	NA	NA	NA
Pennsylvania	Yes	Initial registration, in the case of an injury or death related to the anesthesia/sedation and in the case of a complaint	Deep Sedation/General; Moderate Conscious Sedation; Moderate Enteral	\$100 with permit	Paid to the Inspector	Members of the AAOMS or OMS dental society or qualifies with various criteria outlined by the Board	No Emergency Plan Requirements
Rhode Island	No	NA	NA	NA	NA	NA	NA
South Carolina	No	NA	NA	NA	NA	NA	NA
South Dakota	Yes	Every 5 years	Deep Sedation/General; Moderate Sedation	None	Paid to the Inspector	Not specified	Emergency Plan Requirements include management of simulated emergencies; designated on list provided on the evaluation form
Tennessee	No	NA	NA	NA	NA	NA	NA
Texas	No	NA	NA	NA	NA	NA	NA
Utah	No	NA	NA	NA	NA	NA	NA
Vermont	No	NA	NA	NA	NA	NA	NA
Virginia	Yes	Unannounced every 3 years	Deep Sedation/General; Moderate Conscious Sedation; Moderate Enteral Exemption for Members of AAOMS	\$100 with permit	None	Inspectors with Enforcement division -don't have to be a dentist	Emergency Plan Requirements include a written plan and staff trainings
Washington	Yes	Every 3 years	Moderate Enteral and All categories of Parenteral	\$500	None	Inspectors with Department of Health	No Emergency Plan Requirements
West Virginia	Yes	Every 5 years	Deep Sedation/General; Moderate Conscious Sedation (Parenteral & Enteral); on-site inspections; Minimal Sedation; Audits only	None	\$200	Not specified on site	No Emergency Plan Requirements
Wisconsin	No	NA	NA	NA	NA	NA	NA
Wyoming	Yes	Every 5 years	Deep Sedation/General; Moderate Conscious Sedation	\$25	Paid to Inspector \$250	2 Inspectors approved by the Board for initial inspection and 1 Inspector for renewals	Emergency Plan Requirements should include management of simulated emergencies.
American Association of Oral Maxillofacial Surgeons (AAOMS)	Yes	Every 5 years	All Levels of Conscious Sedation (as a criteria for membership to the association)	Unknown	Unknown	AAOMS members approved	

**AAPD'S GUIDANCE
MANAGEMENT OF
MEDICAL
EMERGENCIES**

Management of Medical Emergencies

For all emergencies

1. Discontinue dental treatment
2. Call for assistance / someone to bring oxygen and emergency kit
3. Position patient: ensure open and unobstructed airway
4. Monitor vital signs
5. Be prepared to support respiration, support circulation, provide cardiopulmonary resuscitation (CPR), and call for emergency medical services

Condition	Signs and symptoms	Treatment	Drug dosage	Drug delivery*
Allergic reaction (mild or delayed)	Hives; itching; edema; erythema—skin, mucosa conjunctiva	<ol style="list-style-type: none"> 1. Discontinue all sources of allergy-causing substances 2. Administer diphenhydramine 	Diphenhydramine 1 mg/kg Child: 10-25 mg qid Adult: 25-50 mg qid ¹	Oral
Allergic reaction (sudden onset): anaphylaxis	Urticaria-itching, flushing, hives; rhinitis; wheezing/difficulty breathing; broncho-spasm; laryngeal edema; weak pulse; marked fall in blood pressure; loss of consciousness	<p>This is a true, life-threatening emergency</p> <ol style="list-style-type: none"> 1. Call for emergency medical services 2. Administer epinephrine 3. Administer oxygen 4. Monitor vital signs 5. Transport to emergency medical facility by advanced medical responders 	Epinephrine 1:1000 0.01 mg/kg every 5 min until recovery or until help arrives ^{1,2}	IM or SubQ
Acute asthmatic attack	Shortness of breath; wheezing; coughing; tightness in chest; cyanosis; tachycardia	<ol style="list-style-type: none"> 1. Sit patient upright or in a comfortable position 2. Administer oxygen 3. Administer bronchodilator 4. If bronchodilator is ineffective, administer epinephrine 5. Call for emergency medical services with transportation for advanced care if indicated 	<ol style="list-style-type: none"> 1. Albuterol (patient's or emergency kit inhaler) 2. Epinephrine 1:1000 0.01 mg/kg every 15 min as needed^{1,2} 	Inhale IM or SubQ
Local anesthetic toxicity	Light-headedness; changes in vision and/or speech; metallic taste; changes in mental status—confusion; agitation; tinnitus; tremor; seizure; tachypnea; bradycardia; unconsciousness; cardiac arrest	<ol style="list-style-type: none"> 1. Assess and support airway, breathing, and circulation (CPR if warranted) 2. Administer oxygen 3. Monitor vital signs 4. Call for emergency medical services with transportation for advanced care if indicated 	Supplemental oxygen	Mask
Local anesthetic reaction: vasoconstrictor	Anxiety; tachycardia/palpitations; restlessness; headache; tachypnea; chest pain; cardiac arrest	<ol style="list-style-type: none"> 1. Reassure patient 2. Assess and support airway, breathing, and circulation (CPR if warranted) 3. Administer oxygen 4. Monitor vital signs 5. Call for emergency medical services with transportation for advanced care if indicated 	Supplemental oxygen	Mask
Overdose: benzodiazepine	Somnolence; confusion; diminished reflexes; respiratory depression; apnea; respiratory arrest; cardiac arrest	<ol style="list-style-type: none"> 1. Assess and support airway, breathing, and circulation (CPR if warranted) 2. Administer oxygen 3. Monitor vital signs 4. If severe respiratory depression, establish IV access and reverse with flumazenil 5. Monitor recovery (for at least 2 hours after the last dose of flumazenil) and call for emergency medical services with transportation for advanced care if indicated 	Flumazenil 0.01 - 0.02 mg/kg (maximum: 0.2 mg); may repeat at 1 min intervals not to exceed a cumulative dose of 0.05 mg/kg or 1 mg, whichever is lower ¹	IV (if IV access is not available, may be given IM)

Tables continues on next page

For all emergencies

1. Discontinue dental treatment
2. Call for assistance / someone to bring oxygen and emergency kit
3. Position patient: ensure open and unobstructed airway
4. Monitor vital signs
5. Be prepared to support respiration, support circulation, provide cardiopulmonary resuscitation (CPR), and call for emergency medical services

Condition	Signs and symptoms	Treatment	Drug dosage	Drug delivery*
Overdose: narcotic	Decreased responsiveness; respiratory depression; respiratory arrest; cardiac arrest	<ol style="list-style-type: none"> 1. Assess and support airway, breathing, and circulation (CPR if warranted) 2. Administer oxygen 3. Monitor vital signs 4. If severe respiratory depression, reverse with naxolone 5. Monitor recovery (for at least 2 hours after the last dose of naxolone) and call for emergency medical services with transportation for advanced care if indicated 	Naxolone 0.1 mg/kg up to 2 mg. ^{1,2} May be repeated to maintain reversal.	IV, IM, or SubQ
Seizure	Warning aura—disorientation, blinking, or blank stare; uncontrolled muscle movements; muscle rigidity; unconsciousness; postictal phase—sleepiness, confusion, amnesia, slow recovery	<ol style="list-style-type: none"> 1. Recline and position to prevent injury 2. Ensure open airway and adequate ventilation 3. Monitor vital signs 4. If status is epilepticus, give diazepam and call for emergency medical services with transportation for advanced care if indicated 	Diazepam Child up to 5 yrs: 0.2-0.5 mg slowly every 2-5 min with maximum=5 mg Child 5 yrs and up: 1 mg every 2-5 min with maximum=10 mg ¹	IV
Syncope (fainting)	Feeling of warmth; skin pale and moist; pulse rapid initially then gets slow and weak; dizziness; hypotension; cold extremities; unconsciousness	<ol style="list-style-type: none"> 1. Recline, feet up 2. Loosen clothing that may be binding 3. Ammonia inhales 4. Administer oxygen 5. Cold towel on back of neck 6. Monitor recovery 	Ammonia in vials	Inhale

* Legend: IM = intramuscular IV = Intravenous SubQ = subcutaneous

References:

1. Hegenbarth MA, Committee on Drugs. Preparing for Pediatric Emergencies: Drugs to Consider, American Academy of Pediatrics. Pediatrics 2008;121(2):433-43.
2. Pediatric Advanced Life Support: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation 2010;122:S876-S908.

DISCLAIMER: This information is not intended to be a comprehensive list of all medications that may be used in all emergencies. Drug information is constantly changing and is often subject to interpretation. While care has been taken to ensure the accuracy of the information presented, the AAPD is not responsible for the continued currency of the information, errors, omissions, or the resulting consequences. Decisions about drug therapy must be based upon the independent judgment of the clinician, changing drug information, and evolving healthcare practices.

**EXAMPLE
INSPECTION
FORM
(TSOMS)**

TEXAS SOCIETY OF ORAL & MAXILLOFACIAL SURGEONS

Office Anesthesia Evaluation. Negative responses detailed on last page.

OPERATING ROOM:

- Is of adequate size and design to permit physical access of emergency equipment and personnel to permit effective emergency management. YES NO
- Is equipped with a chair or board suitable for CPR or has adequate free floor space to permit effective resuscitation. YES NO
- Is equipped with adequate lighting to permit evaluation of the patient's skin and mucosal color, as well as emergency lighting in the event of a power outage. YES NO
- Is equipped with adequate central or portable suction with back up suction in the event of a power outage or loss of water pressure. YES NO
- Scavenging equipment utilized with N2O/O2 administration. YES NO
- Recovery area (if separate from above) to include all of the above. YES NO
- Periodic inspection/calibration of monitors (recommended) YES NO

MONITORS:

- Blood pressure cuff and stethoscope OR automated blood pressure device YES NO
- Pulse Oximeter YES NO
- EKG and defibrillator YES NO
- ET CO2 Monitor YES NO

AIRWAY MANAGEMENT EQUIPMENT:

- Oral and nasal airways of appropriate sizes YES NO
- Endotracheal tubes of appropriate sizes YES NO
- Laryngoscope and intubation forceps YES NO
- Suction tips for oral and tonsillar suction YES NO
- Laryngoscope with functioning batteries and replacement bulbs YES NO
- Positive pressure oxygen that can be delivered to an available full face mask or the endotracheal tube, pediatric equipment available if pediatric patients are treated. YES NO
- Secure Oxygen/Nitrous tank storage YES NO
- Portable/secondary Oxygen source YES NO

EDUCATION RECORDS: OMS will have the following available:

- Documentation of current ACLS/PALS for the OMS and current BLS for appropriate staff YES NO
- Documentation of in-office training of OMS staff in emergency procedures including protocol to be followed in the event of an emergency YES NO
Monthly Quarterly Annually

EMERGENCY DRUGS & SUPPLIES:

The following drugs and supplies are available to operating and recovery room.

- | | | | |
|--------------------------|--|---|--|
| • Epinephrine | YES <input type="checkbox"/> NO <input type="checkbox"/> | • Narcotic Antagonist | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| • Atropine | YES <input type="checkbox"/> NO <input type="checkbox"/> | • Benzodiazapine Antagonist | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| • Nitroglycerine | YES <input type="checkbox"/> NO <input type="checkbox"/> | • Antiemetic | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| • Antihypertensive | YES <input type="checkbox"/> NO <input type="checkbox"/> | • Anectine/Rocuronium | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| • Vasopressor | YES <input type="checkbox"/> NO <input type="checkbox"/> | • Appropriate Antiarrhythmic Medication | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| • Bronchial Dilator | YES <input type="checkbox"/> NO <input type="checkbox"/> | • Antihistamine | |
| • Anticonvulsant | YES <input type="checkbox"/> NO <input type="checkbox"/> | • Ammonia Inhalant | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| • Antihypoglycemic Agent | YES <input type="checkbox"/> NO <input type="checkbox"/> | • IV fluids & equipment needed to establish IV line | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| • Corticosteroid | YES <input type="checkbox"/> NO <input type="checkbox"/> | • Tape, tourniquet, syringes, needles | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| • Analgesic | YES <input type="checkbox"/> NO <input type="checkbox"/> | • Record demonstrating drugs are current | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| • ACLS Recommended Drugs | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |

RECORDS REVIEW FOR OFFICE ANESTHESIA: The following records are required when sedation or general anesthesia is administered. Previous patient records will provide documentation for the evaluator's thorough review. These records will contain the following:

- Current Written medical history including drug allergies, previous surgeries, current medications YES NO
- Baseline vital signs including heart rate, blood pressure, Oxygen saturation and ETCO2 at minimum YES NO
- Periodic vital signs recorded at appropriate intervals during the surgery YES NO
- Appropriate consent form, completed and signed (includes death and brain damage) YES NO
- A time oriented recording of drugs administered during the procedure including the amount, route and location of administration and physiologic data obtained during patient monitoring YES NO
- Duration of procedure; Start / Finish times YES NO
- A complete listing of the names of the surgical / operative team present YES NO
- A description of complications and unusual reactions related to administration of anesthesia YES NO
- The status of patient at the time of discharge / post operative instructions given to escort YES NO
- Appropriate record keeping for tracking/inventory of controlled substances/verifications of such substances are kept in appropriate secured storage unit/syringe labeling. Separate IV fluid, tubing, syringes and medications for each patient. YES NO
- Recording of ASA classifications YES NO
- Recording of post-op medications given/prescribed to patient. YES NO

EMERGENCY MANAGEMENT: Thorough oral discussion with evaluator, OMS demonstrates satisfactory knowledge in managing the following clinical emergencies.

Laryngospasm: Satisfactory Unsatisfactory

- Problem recognition
- Stop procedure and pack off bleeding
- Evaluation of head position and upper Suction
- Positive pressure Oxygen with a full face mask
- Use and appropriate dosage of Anectine
- Airway maintenance

Vomiting/Aspiration: Satisfactory Unsatisfactory

- Problem recognition and proper patient positioning
- Removal of foreign bodies and adequate suction
- Secure and evaluate adequacy of airway
- Positive pressure Oxygen
- Tracheal intubation when necessary
- Recognition of complication of associated bronchospasm
- Active EMS

Bronchospasm: Satisfactory Unsatisfactory

- Problem Recognition
- Bronchial dilators
- Positive Pressure Oxygen and airway maintenance

Syncope: Satisfactory Unsatisfactory

- Problem recognition
- Patient position
- Oxygen
- Drug therapy

Convulsion: Satisfactory Unsatisfactory

- Problem recognition
- Patient position and supportive measures
- Anticonvulsant drug therapy

Insulin Shock: Satisfactory Unsatisfactory

- Problem recognition and diagnosis
- Office testing available
- Oral and/or IV drug therapy

Respiratory Depression & Arrest: Satisfactory Unsatisfactory

- Problem recognition and monitoring
- Proper patient position
- Oxygen with respiratory support
- Narcotic antagonist when appropriate

Hypotension / Hypertension: Satisfactory Unsatisfactory

- Problem recognition
- Pre-operative pulse and blood pressure
- Patient position
- Oxygen
- Continuous monitoring and recording
- Drug therapy

Allergic Reactions: Satisfactory Unsatisfactory

- Problem recognition
- Oxygen, ventilation support
- Epinephrine
- Vasopressors
- Bronchodilators
- Antihistamine
- Corticosteroids

Angina Pectoris: Satisfactory Unsatisfactory

- Problem recognition and differential diagnosis
- Patient position and supportive measures
- Oxygen
- Monitoring drug therapy, Nitroglycerin and Amyl Nitrate
- Transfer when indicated

Bradycardia: Satisfactory Unsatisfactory

- Problem recognition and differentiation of hemodynamically significant bradycardia
- Monitor and record keeping
- Oxygen
- Drug therapy, Atropine

Cardiac Arrest: Satisfactory Unsatisfactory

- Problem recognition and differential diagnosis
- CPR
- ACLS/PALS to the extent the facility is capable
- Activation of EMS

Myocardia Infarction: Satisfactory Unsatisfactory

- Problem recognition of differential diagnosis
- Oxygen
- Patient positioning
- Pain relief
- Monitor and record keeping
- Activation of EMS

OFFICE ANESTHESIA EVALUATION

OMS: _____

Address: _____

City: _____ Zip: _____

Office Phone: () _____

Evaluator's comments on deficiencies:

Evaluator's recommendations to correct deficiencies:

Evaluator: _____

Address: _____

Phone: _____

Signature

Date

**TEXAS SOCIETY
OF
ORAL & MAXILLOFACIAL SURGEONS**

CONSENT FOR ANESTHESIA EVALUATION

The undersigned oral and maxillofacial surgeon hereby consents to have his/her office and its premises inspected by the Texas Society of Oral and Maxillofacial Surgeons, hereinafter referred to as TSOMS, as a condition of membership in TSOMS and AAOMS. Such inspection shall be carried out by one or more oral and maxillofacial surgeons designated by TSOMS.

Such inspection shall be for the purpose of ascertaining whether the undersigned oral and maxillofacial surgeon is in compliance with applicable anesthesia standards of TSOMS as set forth by the Committee on Anesthesia of the AAOMS and to meet the requirements of the bylaws of AAOMS and TSOMS.

The undersigned oral and maxillofacial surgeon agrees to release TSOMS, all members, officers and employees of TSOMS, and all oral and maxillofacial surgeons designated by TSOMS to inspect the undersigned oral and maxillofacial surgeon's office and premises, from any liability for said inspection, including but not limited to any negligence on the part of said designated inspectors, TSOMS, or any members, officers or employees of TSOMS.

OMS EVALUATED: _____

Signature: Oral and Maxillofacial Surgeon

Date

TSOMS Inspector Oral and Maxillofacial Surgeon

Date



**TEXAS SOCIETY
OF
ORAL & MAXILLOFACIAL SURGEONS
AFFIDAVIT FOR CONTINUITY OF CARE
OFFICE ANESTHESIA EVALUATION**

The undersigned oral and maxillofacial surgeon hereby certifies that he/she has undergone inspection of his/her office and its premises through the Texas Society of Oral and Maxillofacial Surgeons Office Anesthesia Evaluation Process, hereinafter referred to as TSOMS and recognizes this as a condition of membership in TSOMS and AAOMS.

The Office Anesthesia Evaluation process took place at

_____. The inspection is for the purpose of ascertaining whether the undersigned oral and maxillofacial surgeon is in compliance with applicable anesthesia standards of TSOMS as set forth by the Committee on Anesthesia of the AAOMS. The undersigned further certifies that he/she practices in multiple office locations as listed below and that his/her anesthesia practices are consistent throughout all office locations.

Through successful completion of this evaluation process in one office location, the TSOMS, in good faith, is certifying that all practicing locations for the undersigned are in compliance with applicable anesthesia standards.

Signature: Oral and Maxillofacial Surgeon

Date

TSOMS Inspector Oral and Maxillofacial Surgeon

Date

Principle Location: _____

Location 2: _____

Location 3: _____

Location 4: _____

Location 5: _____

Location 6: _____

**EXAMPLE
INSPECTION
FORM
(IDAHO STATE BOARD
OF DENTISTRY)**

IDAHO STATE BOARD OF DENTISTRY

PO Box 83720
Boise, ID 83720-0021

MODERATE SEDATION PERMIT OFFICE EVALUATION FORM

EVALUATOR #1 (PLEASE PRINT):		
EVALUATOR #2 (PLEASE PRINT):		
NAME OF SEDATION PROVIDER BEING EVALUATED (PLEASE PRINT):		
SEDATION PRACTICE ADDRESS (PLEASE PRINT):		
IS SEDATION ADMINISTERED AT AN ADDITIONAL LOCATION (PLEASE PRINT): <div style="text-align: center;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </div>		
ADDRESS OF SATELLITE OFFICE WHERE SEDATION IS ADMINISTERED (PLEASE PRINT):		
<input type="checkbox"/> MODERATE ENTERAL PERMIT <input type="checkbox"/> MODERATE PARENTERAL PERMIT		
DATE:	EVALUATION START TIME:	EVALUATION END TIME:
<input type="checkbox"/> INITIAL EVALUATION	<input type="checkbox"/> RE-EVALUATION	<input type="checkbox"/> SITE EVALUATION

FACILITY, EQUIPMENT, AND DRUG REQUIREMENTS		
An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two (two) individuals to freely move about the patients?	YES	NO
An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support?	YES	NO
A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure?	YES	NO
Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure?	YES	NO
An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system?	YES	NO
A recovery area that has available oxygen, adequate lighting, suction and electrical outlets? (The recovery area can be the operating room)	YES	NO
A sphygmomanometer, pulse oximeter, oral and nasopharyngeal airways, supraglottic airway devices, and automated external defibrillator (AED)?	YES	NO
Emergency drugs including, but not limited to, pharmacologic antagonists appropriate to the drugs used, bronchodilators, and antihistamines?	YES	NO
FOR MODERATE PARENTERAL ONLY – Precordial/pretracheal stethoscope, intravenous fluid administration equipment, vasopressors, and anticonvulsants?	YES	NO

OVERALL FACILITY, EQUIPMENT, AND DRUG REQUIREMENTS? Adequate Inadequate

PERSONNEL (Please provide a copy of each to the evaluator)		
ACLS/PALS Certification of Sedation Provider?	YES	NO
Assistant and/or Auxiliary personnel Basic Life Support for Healthcare Providers Certification?	YES	NO
Documentation of periodic reviews of office emergency protocol, including simulated exercises, to assure proper equipment function and staff interaction?	YES	NO

OVERALL PERSONNEL? ___ Adequate ___ Inadequate

RECORDS (Please provide a copy of each to the evaluator)		
Medical History Form (which should include ASA Patient Physical Status Classifications)	YES	NO
Preoperative Instructions	YES	NO
Sedation Consent Form	YES	NO
Postoperative Instructions	YES	NO

OVERALL RECORDS? ___ Adequate ___ Inadequate

SIMULATED EMERGENCIES – The DDS/DMD and his/her clinical team must indicate competency (by demonstration or discussion) in treating the following emergencies.		
Laryngospasm	___ Satisfactory	___ Unsatisfactory
Bronchospasm and Airway Obstruction	___ Satisfactory	___ Unsatisfactory
Emesis and Aspiration	___ Satisfactory	___ Unsatisfactory
Angina Pectoris	___ Satisfactory	___ Unsatisfactory
Myocardial Infarction	___ Satisfactory	___ Unsatisfactory
Cardiac Arrest	___ Satisfactory	___ Unsatisfactory
Hypotension	___ Satisfactory	___ Unsatisfactory
Hypertension	___ Satisfactory	___ Unsatisfactory
Acute Allergic Reaction	___ Satisfactory	___ Unsatisfactory
Syncope, Loss of Consciousness	___ Satisfactory	___ Unsatisfactory
Hyperventilation	___ Satisfactory	___ Unsatisfactory
Convulsions	___ Satisfactory	___ Unsatisfactory

PATIENT CONSENT FORM

I, the undersigned, am a patient of _____ (hereinafter "dentist/dental specialist"). My dentist/dental specialist has explained to me that a periodic evaluation is required in connection with the anesthesia permit issued to him/her by the Idaho State Board of Dentistry ("Board of Dentistry"). The Board of Dentistry is required to routinely conduct evaluations of all the anesthesia permit holders in Idaho. My dentist/dental specialist has further explained to me that it is necessary for one (1) or more Idaho State Board of Dentistry evaluators to personally observe the treatment provided to a patient. The evaluators are also dentists/dental specialists who are anesthesia permits holders in Idaho. My dentist/dental specialist has requested my consent to allow the Board of Dentistry's evaluators to observe the treatment provided to me. Although my dentist/dental specialist may discuss my treatment with the evaluators and that the evaluators may discuss my treatment between themselves, I understand that the evaluators will treat any of the information they receive during their evaluation as confidential. Therefore, I hereby freely, knowingly and voluntarily consent to and authorize the Board of Dentistry's evaluators to observe the treatment provided to me by my dentist/dental specialist. This consent shall be in full force and effect for a period of fourteen (14) days from the date of its execution, at which time it will expire.

Patient Signature

Date

IDAHO STATE BOARD OF DENTISTRY
 PO Box 83720
 Boise, ID 83720-0021
GENERAL ANESTHESIA/DEEP SEDATION PERMIT
OFFICE EVALUATION FORM

EVALUATOR #1 (PLEASE PRINT):		
EVALUATOR #2 (PLEASE PRINT):		
NAME OF SEDATION PROVIDER BEING EVALUATED (PLEASE PRINT):		
SEDATION PRACTICE ADDRESS (PLEASE PRINT):		
IS SEDATION ADMINISTERED AT AN ADDITIONAL LOCATION (PLEASE PRINT): <div style="text-align: center;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </div>		
ADDRESS OF SATELLITE OFFICE WHERE SEDATION IS ADMINISTERED (PLEASE PRINT):		
DATE:	EVALUATION START TIME:	EVALUATION END TIME:
<input type="checkbox"/> INITIAL EVALUATION	<input type="checkbox"/> RE-EVALUATION	<input type="checkbox"/> SITE EVALUATION

FACILITY, EQUIPMENT, AND DRUG REQUIREMENTS		
An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two (two) individuals to freely move about the patients?	YES	NO
An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support?	YES	NO
A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure?	YES	NO
Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure?	YES	NO
An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system?	YES	NO
A recovery area that has available oxygen, adequate lighting, suction and electrical outlets? (The recovery area can be the operating room)	YES	NO
A sphygmomanometer, precordial/pretracheal stethoscope, end-tidal carbon dioxide monitor, pulse oximeter, oral and nasopharyngeal airways, supraglottic airway devices, intravenous fluid administration equipment, and automated external defibrillator (AED)?	YES	NO
Emergency drugs including, but not limited to, pharmacologic antagonists appropriate to the drugs used, vasopressors, bronchodilators, antihistamines, and anticonvulsants?	YES	NO

OVERALL FACILITY, EQUIPMENT, AND DRUG REQUIREMENTS? Adequate Inadequate

PERSONNEL (Please provide a copy of each to the evaluator)		
ACLS/PALS Certification of Sedation Provider?	YES	NO
Assistant and/or Auxiliary personnel Basic Life Support for Healthcare Providers Certification?	YES	NO

OVERALL PERSONNEL? ___ Adequate ___ Inadequate

RECORDS (Please provide a copy of each to the evaluator)		
Medical History Form (which should include ASA Patient Physical Status Classifications)	YES	NO
Preoperative Instructions	YES	NO
Sedation Consent Form	YES	NO
Postoperative Instructions	YES	NO

OVERALL RECORDS? ___ Adequate ___ Inadequate

SIMULATED EMERGENCIES – The DDS/DMD and his/her clinical team must indicate competency (by demonstration or discussion) in treating the following emergencies.		
Laryngospasm	___ Satisfactory	___ Unsatisfactory
Bronchospasm and Airway Obstruction	___ Satisfactory	___ Unsatisfactory
Emesis and Aspiration	___ Satisfactory	___ Unsatisfactory
Angina Pectoris	___ Satisfactory	___ Unsatisfactory
Myocardial Infarction	___ Satisfactory	___ Unsatisfactory
Cardiac Arrest	___ Satisfactory	___ Unsatisfactory
Hypotension	___ Satisfactory	___ Unsatisfactory
Hypertension	___ Satisfactory	___ Unsatisfactory
Acute Allergic Reaction	___ Satisfactory	___ Unsatisfactory
Syncope, Loss of Consciousness	___ Satisfactory	___ Unsatisfactory
Hyperventilation	___ Satisfactory	___ Unsatisfactory
Convulsions	___ Satisfactory	___ Unsatisfactory

PATIENT CONSENT FORM

I, the undersigned, am a patient of _____ (hereinafter “dentist/dental specialist”). My dentist/dental specialist has explained to me that a periodic evaluation is required in connection with the anesthesia permit issued to him/her by the Idaho State Board of Dentistry (“Board of Dentistry”). The Board of Dentistry is required to routinely conduct evaluations of all the anesthesia permit holders in Idaho. My dentist/dental specialist has further explained to me that it is necessary for one (1) or more Idaho State Board of Dentistry evaluators to personally observe the treatment provided to a patient. The evaluators are also dentists/dental specialists who are anesthesia permits holders in Idaho. My dentist/dental specialist has requested my consent to allow the Board of Dentistry’s evaluators to observe the treatment provided to me. Although my dentist/dental specialist may discuss my treatment with the evaluators and that the evaluators may discuss my treatment between themselves, I understand that the evaluators will treat any of the information they receive during their evaluation as confidential. Therefore, I hereby freely, knowingly and voluntarily consent to and authorize the Board of Dentistry’s evaluators to observe the treatment provided to me by my dentist/dental specialist. This consent shall be in full force and effect for a period of fourteen (14) days from the date of its execution, at which time it will expire.

Patient Signature

Date

**EXAMPLE
INSPECTION
FORM
(SOUTH DAKOTA STATE
BOARD OF DENTISTRY)**



South Dakota State Board of Dentistry

P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079

Ph: 605-224-1282 Fax: 1-888-425-3032

E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.com

OFFICE ANESTHESIA ON-SITE INSPECTION AND EVALUATION FORM

Date Sent to STATE BOARD _____

Name of Practitioner Evaluated

Anesthesia Permit Number (if applicable)

Location Inspected

Telephone Number

Date of Evaluation

Time of Evaluation

Name(s) of Evaluators

Evaluation Completed:

____ General Anesthesia and Deep Sedation Evaluation

____ Moderate Sedation Evaluation (Adult Only)

____ Moderate Sedation Evaluation (Pediatric and Adult)

A. PERSONNEL

1. Training certification of provider:

- a. Current ACLS Certification from a program approved by the Board and one of the following:
- b. Diplomate of the American Board of Oral and Maxillofacial Surgery;
- c. Fellow/member of the American Association of Oral and Maxillofacial Surgeons;
- d. Fellow of the American Dental Society of Anesthesiology;
- e. Completion of ADA accredited residency in oral and maxillofacial surgery;
- f. Completion of an ADA accredited residency in Dental Anesthesia; or
- g. Has completed a Board approved course that meets the objectives and contents as described in Part 5 of the "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," 2007 Edition or current version. Board approved courses must include management of at least 20 patients and clinical experience in management of the compromised airway and establishment of intravenous access; and

-
2. **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:

a. _____

b. _____

3. **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:

a. _____

b. _____

B. RECORDS

Have available three charts of patients who have been treated in your office with intravenous 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)**

7. 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?

8. 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?

9. 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?

10. 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?

11. 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?

12. 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?

13. 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? Morphine sulfate, Nitroglycerin, Aspirin
 - 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)?

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

F. PROCEDURE OBSERVATION

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:** Dentist has _____ days to rectify deficiencies noted below.
The dentist's anesthesia permit remains active during this time.

_____ **FAIL:** Dentist's anesthesia permit is suspended until 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 _____

**INFORMATION ONLY:
TEXAS MEDICAL
BOARD'S REGULATIONS
ON OFFICE-BASED
ANESTHESIA SERVICES**

Texas Administrative Code

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TITLE 22

EXAMINING BOARDS

PART 9

TEXAS MEDICAL BOARD

CHAPTER 192

OFFICE-BASED ANESTHESIA SERVICES

RULE §192.2

Provision of Anesthesia Services in Outpatient Settings

(a) The purpose of this chapter is to identify the roles and responsibilities of physicians providing, or overseeing by proper delegation, anesthesia services in outpatient settings and to provide the minimum acceptable standards for the provision of anesthesia services in outpatient settings.

(b) The rules promulgated under this title do not apply to:

(1) an outpatient setting in which only local anesthesia, peripheral nerve blocks, or both are used in a total dosage amount that does not exceed 50 percent of the recommended maximum safe dosage per outpatient visit;

(2) any setting physically located outside the State of Texas;

(3) a licensed hospital, including an outpatient facility of the hospital that is separately located apart from the hospital;

(4) a licensed ambulatory surgical center;

(5) a clinic located on land recognized as tribal land by the federal government and maintained or operated by a federally recognized Indian tribe or tribal organization as listed by the United States secretary of the interior under 25 U.S.C. §479-1 or as listed under a successor federal statute or regulation;

(6) a facility maintained or operated by a state or governmental entity;

(7) a clinic directly maintained or operated by the United States or by any of its departments, officers, or agencies;

(8) an outpatient setting where the facility itself is accredited as an office-based surgery facility or treatment room by:

(A) The Joint Commission relating to ambulatory surgical centers;

(B) the American Association for Accreditation of Ambulatory Surgery Facilities; or

(C) the Accreditation Association for Ambulatory Health Care; and

(9) the performance of Mohs micrographic surgery.

(c) Standards for Anesthesia Services. The following standards are required for outpatient settings providing anesthesia services that are administered within two hours before an outpatient procedure. If personnel and equipment meet the requirements of a higher level, lower level anesthesia services may also be provided.

(1) Level I services:

(A) at least two personnel must be present, including the physician who must be currently certified by AHA or ASHI, at a minimum, in BLS; and

(B) the following age-appropriate equipment must be present:

(i) bag mask valve; and

(ii) oxygen.

(2) Level II services:

(A) at least two personnel must be present, including the physician who must be currently certified by AHA or ASHI, at a minimum, in ACLS or PALS, as appropriate;

(i) another person must be currently certified by AHA or ASHI, at a minimum, in BLS; and

(ii) a licensed health care provider, who may be one of the two required personnel, must attend the patient, until the patient is ready for discharge; and

(B) a crash cart must be present containing drugs and equipment necessary to carry out ACLS protocols, including, but not limited to, the following age-appropriate equipment:

(i) bag mask valve and appropriate airway maintenance devices;

(ii) oxygen;

(iii) AED or other defibrillator;

(iv) pre-measured doses of first line cardiac medications, including epinephrine, atropine, adrenocorticoids, and antihistamines;

(v) IV equipment;

(vi) pulse oximeter;

(vii) EKG Monitor;

(viii) benzodiazepines for intravenous or intramuscular administration; and lipid emulsion if, (except as provided by subsection (b)(9) of this section) administering local anesthesia, peripheral nerve blocks, or both in a total dosage amount that exceeds 50 percent of the recommended maximum safe dosage per outpatient visit, or if administering tumescent anesthesia, for treating local anesthetic systemic toxicity; and

(ix) specific reversal agents, Flumazenil and Naloxone, if benzodiazepines or narcotics are used for sedation.

(3) Level III services:

(A) at least two personnel must be present, including the physician who must be currently certified by AHA or ASHI, at a minimum, in ACLS or PALS, as appropriate;

- (i) another person must be currently certified by AHA or ASHI, at a minimum, in BLS;
- (ii) a licensed health care provider, which may be either of the two required personnel, must attend the patient, until the patient is ready for discharge; and
- (iii) a person, who may be either of the two required personnel, must be responsible for monitoring the patient during the procedure; and

(B) except for lipid emulsion, the same drugs and equipment required for Level II;

(C) establishment of a working intravenous feed;

(D) the presence of appropriate antagonists (i.e. Naloxone and Flumazenil); and

(E) adherence to ASA Standards for Postanesthesia Care.

(4) Level IV services: Physicians who practice medicine in this state and who administer anesthesia or perform a procedure for which anesthesia services are provided in outpatient settings at Level IV are not required to stock lipid emulsion. Physicians who practice medicine in this state and who administer anesthesia or perform a procedure for which anesthesia services are provided in outpatient settings at Level IV shall follow current, applicable standards and guidelines as put forth by the American Society of Anesthesiologists (ASA) including, but not limited to, the following listed in subparagraphs (A) - (H) of this paragraph:

(A) Basic Standards for Preanesthesia Care;

(B) Standards for Basic Anesthetic Monitoring;

(C) Standards for Postanesthesia Care;

(D) Position on Monitored Anesthesia Care;

(E) The ASA Physical Status Classification System;

(F) Guidelines for Nonoperating Room Anesthetizing Locations;

(G) Guidelines for Ambulatory Anesthesia and Surgery; and

(H) Guidelines for Office-Based Anesthesia.

(d) A physician delegating the provision of anesthesia or anesthesia-related services to a certified registered nurse anesthetist shall be in compliance with ASA standards and guidelines when the certified registered nurse anesthetist provides a service specified in the ASA standards and guidelines to be provided by an anesthesiologist.

(e) In an outpatient setting, where a physician has delegated to a certified registered nurse anesthetist the ordering of drugs and devices necessary for the nurse anesthetist to administer an anesthetic or an anesthesia-related service ordered by a physician, a certified registered nurse anesthetist may select, obtain and administer drugs, including determination of appropriate dosages, techniques and medical devices for their administration and in maintaining the patient in sound physiologic status. This order need not be drug-specific, dosage specific, or administration-technique specific. Pursuant to a physician's order for anesthesia or an anesthesia-related service, the certified registered nurse anesthetist

may order anesthesia-related medications during perianesthesia periods in the preparation for or recovery from anesthesia. In providing anesthesia or an anesthesia-related service, the certified registered nurse anesthetist shall select, order, obtain and administer drugs which fall within categories of drugs generally utilized for anesthesia or anesthesia-related services and provide the concomitant care required to maintain the patient in sound physiologic status during those experiences.

(f) The anesthesiologist or physician providing anesthesia or anesthesia-related services in an outpatient setting shall perform a pre-anesthetic evaluation, counsel the patient, and prepare the patient for anesthesia per current ASA standards. If the physician has delegated the provision of anesthesia or anesthesia-related services to a CRNA, the CRNA may perform those services within the scope of practice of the CRNA. Informed consent for the planned anesthetic intervention shall be obtained from the patient/legal guardian and maintained as part of the medical record. The consent must include explanation of the technique, expected results, and potential risks/complications. Appropriate pre-anesthesia diagnostic testing and consults shall be obtained per indications and assessment findings. Pre-anesthetic diagnostic testing and specialist consultation should be obtained as indicated by the pre-anesthetic evaluation by the anesthesiologist or suggested by the nurse anesthetist's pre-anesthetic assessment as reviewed by the surgeon. If responsibility for a patient's care is to be shared with other physicians or non-physician anesthesia providers, this arrangement should be explained to the patient.

(g) Physiologic monitoring of the patient shall be determined by the type of anesthesia and individual patient needs. Minimum monitoring shall include continuous monitoring of ventilation, oxygenation, and cardiovascular status. Monitors shall include, but not be limited to, pulse oximetry and EKG continuously and non-invasive blood pressure to be measured at least every five minutes. If general anesthesia is utilized, then an O₂ analyzer and end-tidal CO₂ analyzer must also be used. A means to measure temperature shall be readily available and utilized for continuous monitoring when indicated per current ASA standards. An audible signal alarm device capable of detecting disconnection of any component of the breathing system shall be utilized. The patient shall be monitored continuously throughout the duration of the procedure. Postoperatively, the patient shall be evaluated by continuous monitoring and clinical observation until stable by a licensed health care provider. Monitoring and observations shall be documented per current ASA standards. In the event of an electrical outage which disrupts the capability to continuously monitor all specified patient parameters, at a minimum, heart rate and breath sounds will be monitored on a continuous basis using a precordial stethoscope or similar device, and blood pressure measurements will be reestablished using a non-electrical blood pressure measuring device until electricity is restored. There should be in each location, sufficient electrical outlets to satisfy anesthesia machine and monitoring equipment requirements, including clearly labeled outlets connected to an emergency power supply. A two-way communication source not dependent on electrical current shall be available. Sites shall also have a secondary power source as appropriate for equipment in use in case of power failure.

(h) All anesthesia-related equipment and monitors shall be maintained to current operating room standards. All devices shall have regular service/maintenance checks at least annually or per manufacturer recommendations. Service/maintenance checks shall be performed by appropriately qualified biomedical personnel. Prior to the administration of anesthesia, all equipment/monitors shall be checked using the current FDA recommendations as a guideline. Records of equipment checks shall be maintained in a separate, dedicated log which must be made available upon request. Documentation of any criteria deemed to be substandard shall include a clear description of the problem and the intervention. If equipment is utilized despite the problem, documentation must clearly indicate that patient safety is not in jeopardy. All documentation relating to equipment shall be maintained for seven years or for a period of time as determined by the board.

(i) Each location must have emergency supplies immediately available as required by subsection (c) of

this section. Supplies should include emergency drugs and equipment appropriate for the purpose of cardiopulmonary resuscitation. If, (except as provided by subsection (b)(9) of this section) administering local anesthesia, peripheral nerve blocks, or both in a total dosage amount that exceeds 50 percent of the recommended maximum safe dosage per outpatient visit, or if administering tumescent anesthesia, emergency drugs and equipment maintained at the location must include at a minimum lipid emulsion for treating local anesthetic systemic toxicity. If "triggering agents" associated with malignant hyperthermia are used or if the patient is at risk for malignant hyperthermia, required equipment must include a defibrillator, difficult airway equipment, as well as the medication and equipment necessary for the treatment of malignant hyperthermia. Equipment shall be appropriately sized for the patient population being served. Resources for determining appropriate drug dosages shall be readily available. The emergency supplies shall be maintained and inspected by qualified personnel for presence and function of all appropriate equipment and drugs at intervals established by protocol to ensure that equipment is functional and present, drugs are not expired, and office personnel are familiar with equipment and supplies. Records of emergency supply checks shall be maintained in a separate, dedicated log and made available upon request. Records of emergency supply checks shall be maintained for seven years or for a period of time as determined by the board.

Cont'd...

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PART 9

TEXAS MEDICAL BOARD

CHAPTER 192

OFFICE-BASED ANESTHESIA SERVICES

RULE §192.2

Provision of Anesthesia Services in Outpatient Settings

(j) The operating surgeon shall verify that the appropriate policies or procedures are in place. Policies, procedure, or protocols shall be evaluated and reviewed at least annually. Operating surgeons are responsible for verifying the level of advanced life support services the local, county-based emergency medical service (EMS) providers are licensed to provide. Operating surgeons who do not practice in counties with 9-1-1 service entities supported by EMS providers licensed at the advanced life support (ALS) level must enter into agreements with a local licensed EMS provider or accredited hospital-based EMS for purposes of transfer of patients to the hospital in case of an emergency. The EMS agreements must include terms delineating requirements and responsibilities for advanced life support services, including, but not limited to advanced airway management, and at a minimum must provide that the EMS provider or hospital-based EMS bring staff and equipment necessary for advanced airway management equal to or exceeding that which is in place at the surgeon's office. The EMS agreements shall be evaluated and re-signed at least annually. Regardless of the level of advanced life support services furnished by EMS providers, the operating surgeon is responsible for having appropriate advanced life support measures available in the office, sufficient to rescue and stabilize the patient until EMS arrives. Policies, procedure, and transfer agreements shall be kept on file in the setting where procedures are performed and shall be made available upon request. Policies or procedures must include, but are not limited to the following listed in paragraphs (1) - (2) of this subsection:

(1) Management of outpatient anesthesia. At a minimum, these must include written policies, procedures, or protocols that address:

(A) patient selection criteria;

(B) patients/providers with latex allergy;

(C) pediatric drug dosage calculations, where applicable;

(D) ACLS (advanced cardiac life support) or PALS (pediatric advanced life support) algorithms;

(E) infection control;

(F) documentation and tracking use of pharmaceuticals, including controlled substances, expired drugs and wasting of drugs; and

(G) discharge criteria.

(2) Management of life-threatening emergencies. At a minimum, these must include, but not be limited to:

(A) cardiopulmonary emergencies, which must include at a minimum a specific plan for securing a patient's airway pending EMS transfer to the hospital;

(B) fire;

- (C) bomb threat;
- (D) chemical spill; and
- (E) natural disasters.

(k) An anesthesia provider must perform a premeditation assessment of each patient having anesthesia services. The assessment must include, at a minimum:

- (1) an airway evaluation; and
- (2) an ASA physical status classification.

(l) All equipment and anesthesia-related services must remain available at the office-based anesthesia site until the patient is discharged.

(m) Physicians or surgeons must notify the board in writing within 15 days if a procedure performed in any of the settings under this chapter resulted in:

- (1) an unanticipated and unplanned transport of the patient to a hospital for observation or treatment for a period in excess of 24 hours;
- (2) an intraoperative death;
- (3) a death occurring within the first 24 hours of the postoperative time period.

Source Note: The provisions of this §192.2 adopted to be effective May 21, 2000, 25 TexReg 4350; amended to be effective November 30, 2003, 28 TexReg 10498; amended to be effective June 29, 2006, 31 TexReg 5107; amended to be effective January 20, 2009, 34 TexReg 342; amended to be effective May 2, 2010, 35 TexReg 3281; amended to be effective May 15, 2012, 37 TexReg 3583; amended to be effective March 18, 2013, 38 TexReg 1875; amended to be effective January 23, 2014, 39 TexReg 290; amended to be effective March 16, 2015, 40 TexReg 1380

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PART 9

TEXAS MEDICAL BOARD

CHAPTER 192

OFFICE-BASED ANESTHESIA SERVICES

RULE §192.3

Compliance with Office-Based Anesthesia Rules

(a) A physician who provides anesthesia services or performs a procedure for which anesthesia services are provided in an outpatient setting shall comply with the rules adopted under this title.

(b) The board may require a physician to submit and comply with a corrective action plan to remedy or address any current or potential deficiencies with the physician's provision of anesthesia services in an outpatient setting in accordance with the Medical Practice Act, Title 3 Subtitle C §§162.101-.107 of the Texas Occupations Code, or rules of the board.

(c) Any physician who violates these rules shall be subject to disciplinary action and/or termination of the registration issued by the board as authorized by the Medical Practice Act or rules of the board.

Source Note: The provisions of this §192.3 adopted to be effective May 21, 2000, 25 TexReg 4350; amended to be effective November 30, 2003, 28 TexReg 10498; amended to be effective September 12, 2004, 29 TexReg 8512; amended to be effective June 29, 2006, 31 TexReg 5107

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EXAMINING BOARDS

PART 9

TEXAS MEDICAL BOARD

CHAPTER 192

OFFICE-BASED ANESTHESIA SERVICES

RULE §192.4

Registration

(a) Each physician who provides anesthesia services or performs a procedure for which anesthesia services are provided in an outpatient setting, excluding level I services, shall register with the board on a form prescribed by the board and pay a fee to the board in an amount established by the board.

(b) The board shall coordinate the registration required under this section with the registration required under the Medical Practice Act, Texas Occupations Code Chapter 156, so that the times of registration, payment, notice, and imposition of penalties for late payment are similar and provide a minimum of administrative burden to the board and to physicians.

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PART 9

TEXAS MEDICAL BOARD

CHAPTER 192

OFFICE-BASED ANESTHESIA SERVICES

RULE §192.5

Inspections

(a) The board may conduct inspections to enforce these rules, including inspections of an operating surgeon's office site, a mobile anesthesia provider's practice and procedures related to storage, transport, and setup of necessary equipment, and of documents of such physicians' practices. The board may contract with another state agency or qualified person to conduct these inspections.

(b) Unless it would jeopardize an ongoing investigation, the board shall provide at least five business days' notice before conducting an on-site inspection under this section.

(c) This section does not require the board to make an on-site inspection of a physician's office.

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EXAMINING BOARDS

PART 9

TEXAS MEDICAL BOARD

CHAPTER 192

OFFICE-BASED ANESTHESIA SERVICES

RULE §192.6

Requests for Inspection and Advisory Opinion

(a) The board may consider a request by a physician for an on-site inspection offering office-based anesthesia. The board may, in its discretion and on payment of a fee in an amount established by the board, conduct the inspection and issue an advisory opinion.

(b) An advisory opinion issued by the board under this section is not binding on the board, and the board, except as provided by subsection (c) of this section, may take any action under the Medical Practice Act, in relation to the situation addressed by the advisory opinion that the board considers appropriate.

(c) A physician who requests and relies on an advisory opinion of the board may use the opinion as mitigating evidence in an action or proceeding to impose an administrative or civil penalty under the Medical Practice Act. The board or court, as appropriate, shall take proof of reliance on an advisory opinion into consideration and mitigate the imposition of administrative or civil penalties accordingly.

Level I services:

1. at least two personnel must be present, including the physician who must be currently certified by AHA or ASHI, at a minimum, in BLS; and
2. the following age-appropriate equipment must be present:
 1. bag mask valve; and
 2. oxygen.

Level II services:

1. at least two personnel must be present, including the physician who must be currently certified by AHA or ASHI, at a minimum, in ACLS or PALS, as appropriate;
 1. another person must be currently certified by AHA or ASHI, at a minimum, in BLS; and
 2. a licensed health care provider, who may be one of the two required personnel, must attend the patient, until the patient is ready for discharge; and
2. a crash cart must be present containing drugs and equipment necessary to carry out ACLS protocols, including, but not limited to, the following age-appropriate equipment:
 1. bag mask valve and appropriate airway maintenance devices;
 2. oxygen;
 3. AED or other defibrillator;
 4. pre-measured doses of first line cardiac medications, including epinephrine, atropine, adreno-corticoids, and antihistamines;
 5. IV equipment;
 6. pulse oximeter;
 7. EKG Monitor;
 8. benzodiazepines for intravenous or intramuscular administration; and lipid emulsion if, (except in the performance of Mohs micrographic surgery, as provided by rule) administering local anesthesia, peripheral nerve blocks, or both in a total dosage amount that exceeds 50 percent of the recommended maximum safe dosage per outpatient visit, or if administering tumescent anesthesia, for treating local anesthetic systemic toxicity; and
 9. specific reversal agents, flumazenil and nalaxone, if benzodiazepines or narcotics are used for sedation.

Level III services:

1. at least two personnel must be present, including the physician who must be currently certified by AHA or ASHI, at a minimum, in ACLS or PALS, as appropriate;
 1. another person must be currently certified by AHA or ASHI, at a minimum, in BLS;
 2. a licensed health care provider, which may be either of the two required personnel, must attend the patient, until the patient is ready for discharge; and
 3. a person, who may be either of the two required personnel, must be responsible for monitoring the patient during the procedure; and
2. the same equipment required for Level II;
3. establishment of a working intravenous feed;
4. the presence of appropriate antagonists (i.e. Naloxone and Flumazenil); and
5. adherence to ASA Standards for Postanesthesia Care.

Level IV services:

Physicians who practice medicine in Texas and who administer anesthesia or perform a procedure for which anesthesia services are provided in outpatient settings at Level IV shall follow current, applicable standards and guidelines as put forth by the American Society of Anesthesiologists (ASA) including, but not limited to, the following:

1. Basic Standards for Pre-anesthesia Care;
2. Standards for Basic Anesthetic Monitoring;
3. Standards for Post-anesthesia Care;
4. Position on Monitored Anesthesia Care;
5. The ASA Physical Status Classification System;
6. Guidelines for Non-operating Room Anesthetizing Locations;
7. Guidelines for Ambulatory Anesthesia and Surgery; and
8. Guidelines for Office-Based Anesthesia.