Anesthesia Committee Meeting
Materials for 01.25.2017
TEXAS STATE BOARD OF DENTAL EXAMINERS

ANESTHESIA COMMITTEE MEETING
Convenes on January 25, 2017 - 9:00 a.m. to conclusion
333 Guadalupe Street, Tower 2, Room 225
Austin, Texas 78701

AGENDA

I. CALL TO ORDER.

II. ROLL CALL OF COMMITTEE MEMBERS.

III. PUBLIC COMMENTS.

IV. DISCUSSION AND ACTION:
   a. Blue Ribbon Panel Report on Dental Anesthesia/Safety
   b. Sunset Management Actions
   c. Proposed Chapter 110 rules and public comments

V. DISCUSSION AND ACTION ON NEW BUSINESS:
   a. New rule related to high risk patients
   b. New rule related to sedation/anesthesia course approvals
   c. Continue review and modification of Chapter 110 rules

VI. ADJOURN
DISCUSSION MATERIALS – BRP REPORT
JANUARY 25, 2017, ANESTHESIA COMMITTEE MEETING

BRP Clinical Recommendations:

1. Mandate written emergency protocols and practice of protocols at least six times per year

2. Mandate that at least one support staff be trained in recognition and management of sedation/anesthesia emergency

3. Mandate training specific to patients under eight years of age if sedating patients under eight years of age

4. Mandate training specific to high-risk adults if sedating high-risk adults (75 and older, ASA 3 or 4, obese)

5. Mandate that offices where portable providers sedate patients have basic ventilation equipment on-site
6. Mandate capnography and precordial stethoscope for Levels 2, 3 and 4

**BRP Administrative Recommendations:**

1. Create a system to evaluate and approve sedation/anesthesia CE providers

2. Mandate that sedation record is part of dental record, even if sedation provider is non-dentist

**BRP Administrative Suggestions:**

1. Create required sedation/anesthesia rules exam

2. Encourage or mandate pre-operative sedation checklist

3. Detail appropriate pre-operative evaluation and acceptable sedation/anesthesia record
In the six major events studied by BRP, if current rules had been closely followed and the failures avoided, there likely would have been no sedation related event. Every patient would have been thoroughly evaluated pre-operatively for the planned sedation/anesthetic, drugs would have been conservatively and cautiously administered, and keeping patients closely monitored both electronically and personally by the dentist throughout the procedure. For the minimal and moderate sedation providers, patients would never have become unresponsive. If a truly unpredictable emergency event had occurred, the well-trained and practiced team would have worked together to efficiently manage the situation, including a rapid call to 911 when appropriate.

Unfortunately, these events did occur and they appear related to failures by the sedation/anesthesia provider at a basic level: poor preparation, poor technique and poor performance when an emergency did occur. It is unclear why practitioners allow this to happen. Equally challenging is to know how to remedy the situation.

The challenge to this panel is to consider whether or not reasonable changes to laws, rules or enforcement will motivate dentists to not be lax, but be meticulously attentive to each step in the sedation/anesthesia process and maintain the highest standard of safety. Rules changes should not limit access to care and should create a regulatory structure to foster best practices in sedation/anesthesia.

The BRP discussed many possible recommendations and suggestions that might be helpful, some clinical in nature, some administrative.

**Clinical recommendations:**

**The SBDE should have the authority to conduct inspections of dentists administering sedation/anesthesia.** Thirty-six states have some type of sedation/anesthesia office provider inspection. The BRP suggests any inspections emphasize evaluation of the competency of the dentist.

**The SBDE have the authority to review sedation records of level 2, 3 and 4 providers.** Determination that the records did not meet the standard of care would be used as an indicator for an on-site office inspection. In the 19 major events/mishaps, there was a strong correlation between poor documentation and poor performance during an office emergency.

**The SBDE mandate that sedation providers have written emergency protocols and that they be required to practice these protocols six times per year.** Of the cases where an emergency occurred in the office, 11 of 13 mishaps were managed poorly. Literature clearly supports not only the use of emergency protocols (checklists) but also the use of pre-operative checklists. This should include a mechanism to encourage rapid activation of EMS when an emergency occurs and assure adequate access for EMS services.
The SBDE mandate that at least one support staff assisting with a sedation procedure (level 2, 3, 4) receive training in the recognition and management of sedation/anesthesia related emergencies. Literature clearly documents that emergency management improves as the entire team is trained as opposed to only the doctor.

The SBDE require level 2, 3, 4 providers who desire to sedate/anesthetize children under 8 years of age to document specific training in the management of this age group of patients.

The SBDE require level 2, 3, 4 providers who desire to sedate/anesthetize high-risk adults (75 years of age and older, ASA 3 or 4, obese - BMI greater than or equal to 30) to document specific training in the management of this group of patients. Each of the major events in this case series involved a child less than 8 years or a high-risk adult.

The SBDE mandate that offices where portable providers function have basic ventilation equipment on-site. Two of the six major events involved a portable provider who attempted to manage an emergency without ventilation equipment.

The SBDE mandate the use of capnography and a precordial stethoscope for level 2, 3 and 4 sedation. Of all the potential recommendations discussed by the BRP, this was the only one that did not garner almost immediate and unanimous support. The recommendation passed but with clear reservation by several members. Valid concerns were raised regarding applicability in level 2 and 3 sedation. Literature support for the use of capnography or a precordial stethoscope in deep sedation is well accepted, but is controversial in moderate sedation. Further consideration and study of the issue is needed by an ongoing committee of the board.

Administrative recommendations:

The SBDE continue to utilize an independent panel of expert sedation/anesthesia providers to advise the Board. This BRP was given only a short period of time to accomplish their assigned task. An ongoing group can continue to discuss and more fully evaluate ideas based on evolving scientific literature that may allow improved patient safety.

The SBDE make public de-identified sedation related major events and mishaps. If other state dental boards would do the same, a much larger pool of information would be available with which to draw better conclusions.

The Texas Legislature make an effort to encourage other state legislatures to share de-identified sedation/anesthesia data publicly. If a majority of states would participate, a much more scientifically valid pool of data would be available for study. This would include both accident data and non-accident data.
The SBDE collect data regarding sedations performed by Texas dentists. (non-accident data)

The SBDE create a system to evaluate and approve sedation/anesthesia continuing education programs.

The SBDE mandate that the sedation record for a dental procedure be a required part of the dental record, even if the sedation provider is a non-dentist.

Administrative suggestions:

The SBDE consider creation of a required online sedation/anesthesia rules examination.

The SBDE consider encouraging or mandating that dentists use a preoperative sedation checklist.

The SBDE consider including more detail in the SBDE rules regarding appropriate pre-operative evaluation and an acceptable sedation/anesthesia record.
A dentist shall maintain and annually update written policies and procedures for responding to emergency situations.

**Source Note:** The provisions of this §108.15 adopted to be effective December 25, 2016, 41 TexReg 9932
DISCUSSION MATERIALS – SUNSET COMMISSION DECISIONS
JANUARY 25, 2017, ANESTHESIA COMMITTEE MEETING

There are no management recommendations related to sedation/anesthesia in the Sunset Commission Decisions. However, the Anesthesia Committee and the Board may look to the Sunset Commission Decisions to discuss or act in anticipation of potential statuary changes.

Recommendation 3.1:

1. For Level 2-4 permit holders, require training on pre-procedural patient evaluation, including the evaluation of the patient’s airway and ASA, ongoing monitoring of sedation and anesthesia, and management of emergencies.

2. For Level 2-4 permit holders, requiring additional training for the treatment of pediatric and/or high-risk patients, including advanced didactic and clinical training.

Recommendation 3.2:

1. Require written emergency action plans
   - For Level 2-4 permit holders, the plan must include ACLS rescue protocols and advanced airway management techniques

   - For Level 2-4 permit holders treating pediatric patients, the plan must include PALS and advanced airway management techniques
New Issue 4

1. Establish minimum emergency preparedness standards including:
   
   o Adequate unexpired supply of drugs and agents
   
   o AED immediately available
   
   o Periodic equipment inspections
   
   o Equipment readiness log
Modification to Recommendation 3.1- (Statutory) Adopt Rec. 3.1, which clarifies that the Dental Board has authority to regulate and inspect all methods of anesthesia when performed in a dental office, but modify the recommendation to include the following as statutory changes.

- Define “pediatric” as patients ages 0-12.
- Define "high risk patient" as patients with an American Society of Anesthesiologists rating of Level 3 or 4 or older than 75.
- Require an annual permit for each of the 4 different levels of anesthesia, defined based on the depth of the intended procedure to alter the patient's mental status and the method of drug delivery.
  - Level 1: Minimal Sedation
  - Level 2: Moderate Sedation (Enteral)
  - Level 3: Moderate Sedation (Parenteral)
  - Level 4: Deep Sedation or General Anesthesia
- Require the board to develop rules establishing minimum standards for training, education, and other standards for different permit levels. For level 2 - 4 permit holders, education/training requirements must include training on pre-procedural patient evaluation including the evaluation of the patient’s airway and physical status as currently defined by the ASA, ongoing monitoring of sedation and anesthesia, and management of emergencies.
- Require Level 2-4 permit holders to provide proof of additional training for the treatment of pediatric and/or high risk patients including advanced didactic and clinical training requirements. Dentists would not be allowed to treat pediatric and/or high-risk patients without proof of specialized education.
- Allow the board to establish additional limitations on the administration of anesthesia on pediatric and/or high risk patients.
- Allow the board to conduct pre-permit, random, and compliance inspections.
- Require the board to determine an appropriate risk-based inspection schedule for on-site inspections of dental offices of dentists with a Level 2, 3 or 4 permit.
- Allow the board to stagger inspections as long as all relevant offices are inspected at least once every 5 years.
- Allow the board to determine education and training requirements for
inspectors.

- Require the board to maintain records of inspections.

**Submitted by Senator Charles Schwertner**

**Fiscal Impact:**
The Board estimated that the original recommendation would require 3 FTEs, the costs of which would be offset by increased fees. Only requiring inspections of Level 2-4 should reduce this significantly.

**Background & Purpose**

The Sunset staff recommendation would allow the board to conduct routine, non-complaint based inspections of offices in which dentists perform any type of anesthesia, not just enteral. As a management action, the board would also be required to adopt rules to support a risk-based inspection schedule.

This modification adds statutory definitions for pediatric and high risk patients and ensures the Board is cognizant of the unique needs and elevated risks of these populations when developing training and education requirements for anesthesia permit holders.

This modification codifies the annual permitting process for dentists performing dental sedation/anesthesia, and requires the Board to establish enhanced training and education requirements for Level 2-4 permit holders who administer sedation or anesthesia on pediatric or high risk patients. These changes will ensure dental anesthesia is performed in a safe setting with special consideration for the unique needs and risks of pediatric and high risk patients.

This modification also requires the board to establish minimum standards related to education and training for level 2-4 anesthesia permit holders along with additional training requirements to administer anesthesia on pediatric and high risk patients.

This modification also changes the Sunset recommendation to only require inspections for level 2-4 permit holders instead of inspections of all permit holders. This will focus the Boards inspections on the higher levels of sedation permit holders.
**Dental Board**

*Modification to Recommendation 3.2- (Statutory)* Require dentists holding an anesthesia permit to maintain and update written emergency action plans as a statutory instead of a management recommendation. Additionally:

- Level 2-4 sedation/anesthesia permit holders' emergency plans must include current Advanced Cardiac Life Support (ACLS) rescue protocols and advanced airway management techniques.
- For Level 2-4 sedation/anesthesia permit holders treating pediatric patients emergency management plans must include current Pediatric Advanced Cardiac Life Support (PALS) rescue protocols and advanced airway management techniques.

**Submitted by Senator Charles Schwertner**

**Fiscal Impact:**

None

**Background & Purpose**

This modification ensures the requirement to have an emergency action plan is in statute instead of Sunset staff's recommendation to be a management action. This will make certain this is an ongoing requirement.

This modification also requires that written emergency action plans for level 2-4 permit holders include protocols and techniques on how to treat patients in emergency settings and how to treat children in emergency settings.
Dental Board

New Issue 4- (Statutory) Require the board to develop rules establishing minimum emergency preparedness standards necessary prior to administering sedation/anesthesia including requirements related to:

- Having an adequate, unexpired supply of necessary drugs and anesthetic agents;
- Having an onsite automated external defibrillator (AED) immediately available;
- Periodic equipment inspections in a manner and on a schedule determined by the Board; and
- Maintenance and retention of an equipment readiness log that shall be made available to the Board upon request and to Board staff during inspections.

Submitted by Senator Charles Schwertner

Fiscal Impact:
None

Background & Purpose

New Issue 4 adds requirements for the Board to develop rules for emergency preparedness related to the availability of life saving drugs and equipment for anesthesia along with maintenance and inspections of anesthesia equipment. These requirements will ensure dentists performing anesthesia are adhering to the best practices of emergency preparedness.

This new issue would also require an equipment readiness log to certify that all emergency preparedness standards have been met.
### Dental Board

*New Issue 5- (Statutory)* Amend Board's statute to include the following portability requirements:

- Define "portability" as the ability of a permit holder to provide permitted anesthesia services in a location other than a facility or satellite facility, consistent with the definition in rule.
- Require the board to establish in rule requirements and methods for a dental sedation and anesthesia permit holder to obtain a portability permit.
- Require the board to establish advanced didactic and clinical training requirements necessary for a portability permit, with consideration for additional requirements for those using their portability permit to treat pediatric and/or high risk patients.

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**Submitted by Senator Charles Schwertner**

**Fiscal Impact:**

None

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**Background & Purpose**

There are currently no statutory requirements or guidelines related to portability of sedation/anesthesia permits.

New Issue 5 codifies portability permit requirements to ensure traveling dentists performing anesthesia have the proper training and that the Board makes rules based on best practices for treating anesthesia portably. These requirements will protect the public and provide a consistent level of anesthesia treatment across all patient treatment sites.
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
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. Section192(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).
6 Section 162.106(a), Texas Occupations Code.
7 Section 162.103, Texas Occupations Code.
(e) Standard of Care and Clinical Requirements. A dentist must maintain the minimum standard of care in the administration of sedation/anesthesia in accordance with rule 108.7, including but not limited to the following 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. Patients with significant medical considerations (ASA III, IV) require review of their current medical history, medication use, and NPO status, as well as documented verbal or written consultation with the patients’ primary care physician or consulting medical specialist.

This highlighted section of the new rules regarding ASA III, IV patients should not be included. The verbal or written consultations referenced are, and should be, at the discretion of the anesthesiologist as consultations are discretionary for other ASA classification patients. MD anesthesiologists have never practiced with this demand now or ever. This rule creates a standard of care that does not exist in medicine or dentistry.

Anesthesiologists are trained, qualified, and credentialed practitioners to make the decision as to necessity for outside consultations after making the initial assessment, the decision based on the anesthesiologists’ history and physical evaluation of the patient.

The anesthesiologist on the Board can give you insights as to how anesthesia is practiced in dentistry and in medicine as to standards of care. There is no valid justification to revamp this longstanding standard of care only in dentistry in Texas.
Frank E Ford DDS
President, TX Society of Dentist Anesthesiologists
To: Members of the Texas State Board of Dental Examiners

Dear Sirs,

Having both a teaching background and also the private practice of dental office-based general anesthesia in Texas for over 26 years, and after review of the proposed changes in Chapter 110 of the TSBDE Rules & Regulations posted on the Texas Register, I would like to offer my comments and observations.

Revising an entire chapter such as this, especially in time of much interest and scrutiny by both professionals and non-professionals, is a very daunting task and I respect and appreciate the Board’s efforts. However, my hopes are that these revisions go back to committee before a final draft is submitted. There are many discrepancies and inconsistencies that need to be addressed in order to create a complete and meaningful document. Although there are numerous recognizable areas that need revisiting, I would like to specifically address a few areas of concern which I hope will be reconsidered by the Board.

Of greatest concern is in the area of Patient Evaluation within all levels of anesthesia/sedation including nitrous oxide. As it reads in the proposed Rules 110.3-6, it is required with all patients with significant medical considerations (ASA III and IV) to have "documented verbal and written consultation the patient’s primary care physician or consulting medical specialist." Although a mandate such as this might look good to the uninformed public, it will have very little positive impact on anesthesia outcomes. In fact, including this language has more downside than potential upside:

1) medical consults are usually of little value because either the dentist doesn't ask the right questions, and/or the physician has no idea what the dentist attempting to do;

2) getting a medical consult is interpreted by the dentist as getting "clearance", or in other words, "permission" to proceed with the anesthesia. This gives the dentist a false sense of security and confidence, and a free pass from liability;

3) it will likely result in many dentist assigning a universal "ASA II" classification for all patients with a positive medical history in order to avoid the consult mandate;

4) requiring a medical consult for all patients with medical issues will not only drive up the cost of healthcare, but potentially limit patient access to care.

The language should read "may require documented verbal and written consultation the patient’s primary care physician or consulting medical specialist."

Secondly, the topic of capnography is widely recognized as the subject of debate in all corners of the anesthesia world. And although there is room for discussion when talking about the requirement for capnography at some levels, the use of capnography must not be a choice in others. For example, in Rule 110.6 Deep Sedation/General anesthesia (e) (3)(B)(vi), the use of both inspired agent analysis AND capnography should be mandatory whenever volatile agents are given. There are no options for this in the operating room or ambulatory surgical setting, and there should not be an option in the dental office. Capnography should also be a "must" in describing ventilation monitoring in the non-intubated general anesthesia technique (Rule 110.6(e)(4)(B)(ii)). The risks at that level of anesthesia are high and the electronic measuring of carbon dioxide is simple and noninvasive - simply the standard of care.
Lastly, for many reasons and especially in the current climate of concern in anesthesia for the pediatric patient, the monitoring of a pediatric patient undergoing deep sedation/general anesthesia must include the use of pulse oximetry, and the use of BOTH capnography and a precordial stethoscope (Rule 110.11(i)(4). There is little room for error in this population, and the vast majority of anesthesia mishaps can be universally traced to the respiratory issues of oxygenation/ventilation. Watching the chest rise, listening to breath sounds, and even observing the color of the lips and mucosa, are not necessarily useful in a pediatric patient who is under a blanket, sun glasses, rubber dam, and surrounded with a room filled with conversation, music/videos, hand pieces and suction. All those proposed modalities of monitoring are neutralized, and the capnography tracing may be the only warning sign of impending doom.

Please give these issues and the entire revision of Chapter 110 the appropriate time and scrutiny it deserves before making a final decision. The Board has a unique opportunity to make significant and wise improvements to this heavily regulated area of dentistry, and should read through it very carefully before adopting any changes.

Respectfully submitted,

Dr. Ron Redden

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December 19, 2016

Mr Tyler Vance
General Counsel
Texas State Board of Dental Examiners
333 Guadalupe Tower 3 Ste 800
Austin, Texas 78732
Via Email: rulecomments@tsbde.texas.gov

Re: 22 Texas Administrative Code §§110.1, concerning definitions; 110.2, concerning sedation/anesthesia permits; 110.3, concerning nitrous sedation; 110.4, concerning minimal sedation; 110.5, concerning moderate sedation; 110.6, concerning deep sedation; 110.9, concerning permit renewal; and new rule 110.11, concerning pediatric patients.

Dear Mr Vance:

The Texas Dental Association (TDA) is a professional association that represents over 9,000 dentists who are committed to delivering quality, comprehensive oral health services to all Texans.

The TDA appreciates the opportunity to comment on the Texas State Board of Dental Examiners (TSBDE) sedation/anesthesia rule proposals as published in the December 16, 2016, issue of the Texas Register.

The TDA’s comments are subject to reconsideration and revision by the TDA based upon analysis of any future sedation/anesthesia data publicly released by the TSBDE. Both the availability and analysis of such data are critical in determining the incidence and prevalence of dental patient complications related to dental sedation and anesthesia in Texas, and in identifying actions for further improvement in patient safety and outcomes.

The Association’s comments are detailed by specific rule section below.

110.1 Definitions
Anxiolytic – The TDA recommends removing the words “dangerous drug” from the proposed definition. Such emotionally charged language is inappropriate for rule construction. Alternatively, the TSBDE should consider the following definition for anxiolytic agent from Malamed, “drug(s) used in dentistry for anxiolysis – a minimally depressed level of consciousness that retains the patient’s ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal commands and that is produced by a pharmacologic or non-pharmacologic method or a combination thereof. Although cognitive function and coordination may be modestly impaired, ventilator and cardiovascular functions are unaffected.”

110.3 Nitrous Oxide/Oxygen Inhalation Sedation
(a)(2)(A) – Strike the words, “American Dental Association (ADA),” before the words, “Commission on Dental Accreditation (CODA).” CODA is a separate entity from the American Dental Association that develops and implements accreditation standards for dental education programs.
Proposed Amendments to 22 Texas Administrative Code Chapter 110 Sedation and Anesthesia
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What is meant by the phrase, “in person clinical experience?” Is this phrase intended to mean live patient training, simulators and/or other course participants as “patients?” Additionally, it is not clear whether the non-clinical experience hours may be completed on-line.

The 2016 revised American Dental Association’s (ADA) Guidelines for Teaching and Pain Control and Sedation to Dentists and Dental Students recommends a minimum number of didactic hours in addition to management of clinical dental cases for inhalation sedation courses. The TSBDE should consider emphasizing in rule language that education include a clinical component during which clinical competency in inhalation sedation technique is achieved as opposed to requiring a specific number of clinical case hours.

There is no scientifically validated number of training hours or live case experiences that will result in a permit holder’s proficiency. Emphasis should be placed on the quality of education. Arbitrarily increasing training hours and live case experiences will not, in and of itself, necessarily improve patient safety and could lead to a decrease in the availability of educational opportunities and/or dramatically raise the cost for educational programs. Further, inclusion of live cases inevitably limits the potential number of course participants due to supervisory requirements in the ADA guidelines as well as ADA Continuing Education Recognition Program accreditation standards.

(e)(1) – Requiring a Level 1 permit for the delivery of N2O/O2 inhalation sedation if medications for anxiolysis or analgesia have been administered to the patient by the dentist within 12 hours prior to the dental treatment seems unreasonable and arbitrary. Oral analgesics (non-narcotic and narcotic) are often necessary for pain relief prior to a dental visit during which N2O/O2 inhalation would be administered. Some of these drugs have a relatively short half-life and may actually increase the efficacy of local anesthetics used during dental care.

Patient selection remains the key to safe administration of N2O/O2 inhalation administration, and the dentist should be able to exercise their independent professional judgement in evaluating the patient and deciding if sedation is the correct approach.

(e)(2) – The TDA respectfully suggests that the proposed rule language be revised to use the word “should” instead of “shall” for medically stable individuals (ASA I, II), and that the word “may” be included for patients with significant medical considerations (ASA III, IV). These suggestions are consistent with the terms and clinical guidelines for patient evaluation in the ADA guidelines.

Mandating consultation with a patient’s primary care physician could potentially cause a delay in medically necessary dental treatment.

110.4 Minimal Sedation – Level 1
(a)(2)(A) – Strike the words, “American Dental Association (ADA),” before the words, “Commission on Dental Accreditation (CODA).” CODA is a separate entity from the American Dental Association that develops and implements accreditation standards for dental education programs.
(e)(1) Patient Evaluation – Patient history and evaluation should include “nothing by mouth” (NPO) status.

The TDA respectfully suggests that the proposed rule language be revised to use the word “should” instead of “shall” for medically stable individuals (ASA I, II), and that the word “may” be included for patients with significant medical considerations (ASA III, IV). These suggestions are consistent with the terms and clinical guidelines for patient evaluation in the ADA guidelines.4

Mandating consultation with a patient’s primary care physician could potentially cause a delay in medically necessary dental treatment.

110.5 Moderate Sedation – Levels 2 and 3
(a)(3)(A), (b)(3)(A) – Strike the words, “American Dental Association (ADA),” before the words, “Commission on Dental Accreditation (CODA).” CODA is a separate entity from the American Dental Association that develops and implements accreditation standards for dental education programs.

(4)(C)(ii) Monitoring – Keeping the word “or” in this rule section allows the dentist permit holder the ability to exercise their independent professional judgement in deciding whether end-tidal CO2 monitoring is necessary.

The TDA respectfully suggests that the proposed rule language be revised to use the word “should” instead of “shall” for medically stable individuals (ASA I, II), and that the word “may” be included for patients with significant medical considerations (ASA III, IV). These suggestions are consistent with the terms and clinical guidelines for patient evaluation in the ADA guidelines.4

Mandating consultation with a patient’s primary care physician could potentially cause a delay in medically necessary dental treatment.

(f)(1) Patient Evaluation – Patient history and evaluation should include “nothing by mouth” (NPO) status.

110.6 Deep Sedation or General Anesthesia – Level 4
(a)(3)(A) – Strike the words, “American Dental Association (ADA),” before the words, “Commission on Dental Accreditation (CODA).” CODA is a separate entity from the American Dental Association that develops and implements accreditation standards for dental education programs.

(B)(ii) Non-intubated patient – Keeping the word “or” in this rule section allows the dentist permit holder the ability to exercise their independent professional judgement in deciding whether end-tidal CO2 monitoring is necessary.

110.9 Sedation/General Anesthesia Permit Renewal
The TDA supports the TSBDE’s consideration of a permit holder’s disciplinary history in Texas and in other jurisdictions in its review of a permit renewal application. The TSBDE should only permit qualified and competent dentists to deliver sedation/anesthesia services in Texas.
110.11 Sedation/General Anesthesia of Pediatric Patients

(i)(1) Pediatric Standard of Care Monitoring – There does not appear to be a scientific basis for prohibiting dentists from administering nitrous oxide (N2O) concentration of greater than 50% during anesthesia/sedation without a Level 2 or higher sedation/anesthesia permit. This potential prohibition also conflicts with 22 Texas Administrative Code §110.3(e)(3)(C)(i) requiring a fail-safe system prohibiting the delivery of less than 30% oxygen. Further, this prohibition is also inconsistent with current American Academy of Pediatric Dentistry (AAPD) guidelines. AAPD guidelines state that nitrous oxide concentrations “should not routinely exceed 50 percent.” It is a reasonable guideline and emphasizes the word “should” instead of “shall.” It would be detrimental to patients and dentists if the TSBDE limited N2O concentrations so that an otherwise uneventful sedation procedure requiring a short period of administration of 55-60% N2O would be aborted simply on the basis that it does not comply with a rule. This approach is consistent with previous scientific studies of the safety of nitrous oxide in the pediatric population.

Also, the TDA has concerns about requiring electrocardiography (EKG) for monitoring pediatric patients under Level 2 moderate sedation. A well-monitored airway and evaluation of respiration/cardiac function through blood pressure, pulse oximetry, end-tidal CO2 or the use of a precordial/pretracheal stethoscope provides more clinically relevant information than can be obtained from an EKG at this level of sedation and thus meets a higher standard of patient care.

Automated External Defibrillators

The TDA supports requiring all sedation/anesthesia permit holders to have an onsite automated external defibrillator immediately available. Basic Life Support includes training in the use of an automated external defibrillator (AED) for cardiac emergencies. As a result, requiring permit holders to have an AED available when providing sedation/anesthesia to patients is consistent with the standard of care.

Thank you for considering the TDA’s views on these important issues.

Sincerely,

Rita M. Cammarata
President
Proposed Amendments to 22 Texas Administrative Code Chapter 110 Sedation and Anesthesia
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cc: Dr Steven J. Austin, Presiding Officer, Texas State Board of Dental Examiners
Ms Kelly Parker, Executive Director, Texas State Board of Dental Examiners
Ms Nycia Deal, Chief Legal Officer, Texas State Board of Dental Examiners

References
Tyler Vance  
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Re: 22 TAC Part 5 Chapters 104, 107, and 110  
State Board of Dental Examiners  
12.16.2016 Issue of Texas Register

Dear Mr. Vance:

The Texas Society of Anesthesiologists ("TSA") is the Texas component of the American Society of Anesthesiologists and counts among its members over 3,000 physicians who practice the medical specialty of anesthesiology in health care facilities throughout Texas, including dental practice sites.

The Texas Society of Anesthesiologists appreciates the opportunity to provide comments as the State Board of Dental Examiners reviews 22 TAC Chapter 104-Continuing Education, Chapter 107-Subchapter E-Data Reporting, and Chapter 110-Sedation and Anesthesia. TSA has consistently supported the Board’s efforts to improve patient safety in connection with the administration of anesthetic agents during dental procedures.

1. Regarding 22 TAC §104.6 the TSA defers comments per se on the requirements set forth by the TSBDE for Texas dentists. The TSA notes differences in education, experience and background amongst anesthesia providers but emphasizes that in areas of patient safety and sedation/analgesia, the standards should be robust enough to protect the patients undergoing procedures in dental offices and minimize complications related to sedation.

2. Concerning 22 TAC §107.400 the TSA respectfully recommends that under Section §107.400 (3) (A), as to the requirement of evaluation of the patient and determination of ASA status, patients for higher levels of sedation and general anesthesia should be evaluated preoperatively by a physician, consistent with standards required by ASCs and hospitals (or recent primary care physician evaluation).

3. Under Chapter §107.400, (3) (B), TSA suggests that reporting categories be modified to include an additional category of 6 (possibly 8) and under, between ages 6-13 and leaving the remainder as is (*this reflects some of the data accumulated by the Dental Blue Ribbon Panel on dental anesthesia/sedation safety showing the number of complications in smaller, preschool age children).
4. Under Chapter 110, 22 TAC §§110.1 Definitions, (3) TSA recommends changing the last word from "efficiently" to "safely".

5. Under Chapter 110, 22 TAC §§110.1 Definitions, new (25), TSA recommends deleting the last seven words of this section: "unless patient cooperation interferes or prohibits compliance". Compliance with data collection and reasonable standards are the norm and lack of patient cooperation could indicate over sedation, impaired status and need to modify or terminate sedation NOT persisting with procedure and sedation without monitoring and recording physiologic parameters.

6. Under Chapter 110, 22 TAC §§110.6, (e)(1) page 9869 it is recommended that "NPO status" be specifically delineated as to time and recorded with the additional comment that NPO status for lower levels of sedation be determined, since levels of sedation frequently change from that planned by the provider. TSA further recommends the addition of the following to the last statement, "and may require treatment at a location other than the dental office, such as a hospital or ambulatory surgery center."

7. In the same chapter and same page, Section (e) (2) (G), waiver of intravenous lines should always be documented in the record as to "Special Situations and Special Needs Patients".

8. Likewise continuing on the same page, Section (e) (4) (B) (ii), TSA strongly recommends that in those cases where volatile anesthetics are utilized with OR without intubation that capnography shall be mandatory.

9. TSA has suggested previously that the Board consider rules similar to those adopted by the Texas Medical Board for office-based anesthesia practice settings. Specifically, TSA believes the Board should authorize inspections and audits of dental facilities, including, but not limited to, equipment (particularly equipment utilized by portable providers), documentation, procedures, and personnel training. Currently, 22 TAC §110.2(b)(4) authorizes limited facility inspections prior to issuance of a sedation/anesthesia permit, which the current proposal would limit to general anesthesia permits. TSA believes the Board's approach is too restrictive, and respectfully recommends that the Board adopt rules similar to those of the Texas Medical Board as found in 22 TAC §§192.5 and 192.6. This action would be consistent with recent findings and recommendations of the report issued by the Blue Ribbon Panel on Dental Anesthesia/Sedation Safety.

Thank you for your consideration. Please advise if you have questions.

Sincerely,

Deborah M. Plagenhoef, M.D.
President
Texas Society of Anesthesiologists
(a) Pediatric patients include all patients under the age of thirteen (13) at the time of a dental treatment or procedure.

(b) Initial Requirement for Pediatric Sedation/General Anesthesia Privileges. A dentist may obtain pediatric privileges on a Level 1, Level 2, Level 3, or Level 4 sedation/general anesthesia permit by demonstrating compliance with one of the following requirements at the time the dentist renews or seeks a sedation/general anesthesia permit:

1. Completion of an advanced education program accredited by the Commission on Dental Accreditation that provided didactic and clinical education in pediatric sedation/general anesthesia;

2. Successful administration of sedation/general anesthesia to at least 20 (twenty) pediatric patients, in the six months preceding the date of initial application for a sedation/general anesthesia permit with pediatric privileges or the date of renewal application for a sedation/general anesthesia permit with initial application for pediatric privileges; or

3. Completion of an in-person board-approved education program of at least 24 (twenty-four) hours of training in pediatric sedation/general anesthesia. The board-approved education program shall include, at a minimum, the following 21 (twenty-one) hours of training:

   (A) A minimum of three hours of training in pharmacology;

   (B) A minimum of three hours of training in pre-procedure evaluation, patient selection, anatomy, and ASA classification;

   (C) A minimum of six hours of training in sedation/general anesthesia technique, monitoring, and equipment;

   (D) A minimum of six hours of training in emergency preparedness, including running scenarios and management of complications; and

   (E) A minimum of three hours of training in treating special needs pediatric patients.

(c) For the time period from September 1, 2017, through a dentist’s next sedation/general anesthesia permit renewal occurring prior to September 1, 2018, a dentist may sedate pediatric patients pursuant to the dentist’s underlying sedation/general anesthesia permit without demonstrating to the agency compliance with (b) above.

(d) If a dentist does not demonstrate compliance with (b) above at the time of the sedation/general anesthesia permit renewal occurring between September 1, 2017, and August 31, 2018, the dentist does not hold pediatric sedation privileges and may no longer sedate pediatric patients, as of the date of the dentist’s sedation/general anesthesia permit renewal.
(e) A dentist may seek pediatric sedation privileges at any time by completing an application and demonstrating compliance with (b) above and any other requirements.

(f) Continuing Education Requirements for Pediatric Sedation/General Anesthesia Privileges. In addition to continuing education required by other rules, a dentist who administers Level 1, 2, 3, or 4 sedation/general anesthesia to a pediatric patient must complete a minimum of eight hours of continuing education in pediatric sedation/general anesthesia every two years. This continuing education is in addition to continuing education required for license renewal, renewal of sedation/anesthesia permits, or any other continuing education requirement. BLS, ACLS, or PALS do not satisfy the continuing education requirement for renewal of sedation/general anesthesia permits under this section. A dentist must submit proof of compliance at the time of permit renewal.

(g) The initial training requirements in subsection (b) and the continuing education requirements in subsection (f) are subject to audit by the agency.

(h) Emergency Preparedness. In addition to the requirements of emergency preparedness in other sections of these rules, a dentist administering sedation/general anesthesia to a pediatric patient must be prepared to rescue a child from a deeper level of sedation than intended, and comply with the following requirements:

1. A dentist administering sedation to a pediatric patient must maintain current certification in Pediatric Advanced Life Support (PALS). A dentist delegating the administration of sedation to a pediatric patient must maintain current certification in PALS or Advanced Cardiac Life Support (ACLS). A dentist must submit proof of compliance at the time of permit renewal.

2. A dentist administering sedation to a pediatric patient or delegating the administration of sedation to a pediatric patient must maintain a protocol for immediate access to back-up emergency services, including, for nonhospital facilities a protocol for the immediate activation of the EMS system for life-threatening complications. The practitioners must be prepared to provide initial rescue for life-threatening complications.

3. A dentist administering sedation to a pediatric patient or delegating the administration of sedation to a pediatric patient must ensure that an emergency cart or kit is immediately accessible and contains the necessary age- and size-appropriate equipment and emergency drugs to resuscitate a non-breathing and unconscious child. The contents of the kit must allow for the provision of continuous life support while the pediatric patient is being transported to a medical/dental facility or to another area within the facility. All equipment and drugs must be checked and maintained on a scheduled basis.

   (A) An emergency cart or kit accompanying a pediatric sedation at Level 1 or 2 must include, at a minimum, the following components: oral and nasal airways, bag-valve-mask device, laryngeal mask airways or other supraglottic devices, face masks, blood pressure cuffs; and

   (B) An emergency cart or kit accompanying a pediatric sedation at Level 3 or 4 must include, at a minimum, the following components: oral and nasal airways, bag-valve-mask device, laryngeal mask airways or other supraglottic devices, laryngoscope blades, tracheal tubes, face masks, blood pressure cuffs, and intravenous catheters.

(i) Pediatric Standard of Care and Monitoring.

1. Nitrous oxide shall not be administered to a pediatric patient at a concentration of greater than 50% unless the person administering the nitrous oxide holds a Level 2 or higher sedation/general anesthesia permit and meets all other requirements of this rule.

2. Monitoring of a pediatric patient undergoing minimal sedation must include the use of pulse oximetry and precordial stethoscope.
(3) Monitoring of a pediatric patient undergoing moderate sedation must include the use of pulse oximetry, electrocardiography, and either capnography or a precordial/pretracheal stethoscope.

(4) Monitoring of a pediatric patient undergoing deep sedation/general anesthesia must include the use of pulse oximetry, electrocardiography, capnography and a precordial/pretracheal stethoscope.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on December 5, 2016

TRD-201606155

Kelly Parker
Executive Director
State Board of Dental Examiners

Earliest possible date of adoption: January 15, 2017

For further information, please call: (512) 475-0977
Application for TMB Designation of Continuing Medical Education as Medical Ethics or Professional Responsibility

Name of Provider Organization: ________________________________________________________

Contact Name and Title: _____________________________________________________________

Mailing Address: __________________________________________ City_________, TX ZIP_______

Telephone Number: ___________________________________________________________________

E-Mail Address: _____________________________________________________________________

Course Title: ___________________________ Number of Hours Requested for Approval ______

Accrediting Organization: ___________________________ Date of Accreditation: __________ Delivery Method: (online or lecture) _______________

Description of Course Content - (Please include a brief description and attach the course agenda with the portions devoted to medical ethics or professional responsibility identified):
_____________________________________________________________________________________
_____________________________________________________________________________________

Instructors Name(s)-( Attach CVs for all instructors): __________________________

Applications may be emailed to verifcic@tmb.state.tx.us, faxed to (512) 305-7009, or mailed to TMB PO Box 2029 Austin TX 78768-2029.

Please allow at least 30 days processing time.

You may be required to provide additional information and documentation to the board at the request of the Executive Director.

Ethics/Professional Responsibility courses are considered to be those that address the principles of proper professional conduct concerning the rights and duties of the physician, patients, and fellow practitioners, as well as the physician’s actions/relations concerning patients and their families.

Given the large amount of subject matter that meets the definition above, there may be some confusion as to what the board will approve. Please consider the following two clarifications:

1. Courses on how a physician should defend themselves once sued will not generally be accepted. That said, courses on how to avoid being sued by improving the physician’s practice in the areas of communication and disclosure will generally be accepted.

2. Courses that focus on personal values will generally not be accepted. (e.g.—abortion, assisted suicide)

For general information about CME, please see Board Rule 166.2.

Any approval granted will be valid for three years from the date of initial approval.
The information below is a non-exhaustive list of concepts the Anesthesia Committee may want to discuss as it considers how the Board may approve sedation/anesthesia CE courses to qualify for permit issuance and maintenance of competency.

- Determine what information is considered in written application process
  - Curriculum
  - Equipment
  - Description of use of live patients
  - Description of use of simulations
  - Description of use of groups
  - Course location
  - Instructor CVs
  - Instructor roster
  - Endorsement by societies
- Determine grounds for denial based on initial written application
- Determine appellate process, if any, for denial at any stage
- Determine role of staff vs. role of AC vs. role of full Board in review of course applications
  - Application submission
  - Initial review of application
  - Coordination of course review
  - Collection of information
  - Provisional approval
  - Final approval
- Determine whether in-person audit of courses is required
- Determine what information is evaluated if in-person audit is performed
- Determine which Board representatives conduct in-person audit of courses
- Determine grounds for denial based on in-person audit
- Determine whether course representative must appear at AC meeting or Board meeting to present course
- Determine whether courses must be “renewed” on set intervals
- Determine grounds to remove a course from approval list
- Determine tracking of course success through licensee incidents
- Determine timeframe for implementation of approval process
(a) Authority and purpose.

(1) Authority. In accordance with §559.053 of the Texas Pharmacy Act, (Chapters 551 - 566, and 568 - 569, Occupations Code), all pharmacists must complete and report 30 contact hours (3.0 CEUs) of approved continuing education obtained during the previous license period in order to renew their license to practice pharmacy.

(2) Purpose. The board recognizes that the fundamental purpose of continuing education is to maintain and enhance the professional competency of pharmacists licensed to practice in Texas, for the protection of the health and welfare of the citizens of Texas.

(b) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) ACPE--Accreditation Council for Pharmacy Education.

(2) Act--The Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Occupations Code.

(3) Approved programs--Live programs, home study, and other mediated instruction delivered by an approved provider or a program specified by the board and listed as an approved program in subsection (e) of this section.

(4) Approved provider--An individual, institution, organization, association, corporation, or agency that is approved by the board.

(5) Board--The Texas State Board of Pharmacy.

(6) Certificate of completion--A certificate or other official document presented to a participant upon the successful completion of an approved continuing education program.

(7) Contact hour--A unit of measure of educational credit which is equivalent to approximately 60 minutes of participation in an organized learning experience.

(8) Continuing education unit (CEU)--A unit of measure of education credit which is equivalent to 10 contact hours (i.e., one CEU = 10 contact hours).

(9) CPE Monitor--A collaborative service from the National Association of Boards of Pharmacy and ACPE that provides an electronic system for pharmacists to track their completed CPE credits.

(10) Credit hour--A unit of measurement for continuing education equal to 15 contact hours.

(11) Enduring Materials (Home Study)--Activities that are printed, recorded or computer assisted instructional materials that do not provide for direct interaction between faculty and participants.
(12) Initial license period--The time period between the date of issuance of a pharmacist's license and the next expiration date following the initial 30 day expiration date.

(13) License period--The time period between consecutive expiration dates of a license.

(14) Live programs--Activities that provide for direct interaction between faculty and participants and may include lectures, symposia, live teleconferences, workshops, etc.


(c) Methods for obtaining continuing education. A pharmacist may satisfy the continuing education requirements by either:

(1) successfully completing the number of continuing education hours necessary to renew a license as specified in subsection (a)(1) of this section;

(2) successfully completing during the preceding license period, one credit hour for each year of their license period, which is a part of the professional degree program in a college of pharmacy the professional degree program of which has been accredited by ACPE; or

(3) taking and passing the standardized pharmacy examination (NAPLEX) during the preceding license period, which shall be equivalent to the number of continuing education hours necessary to renew a license as specified in subsection (a)(1) of this section.

(d) Reporting Requirements.

(1) Renewal of a pharmacist license. To renew a license to practice pharmacy, a pharmacist must report on the renewal application completion of at least thirty contact hours (3.0 CEUs) of continuing education. The following is applicable to the reporting of continuing education contact hours.

(A) For renewals received after January 1, 2015, at least one contact hour (0.1 CEU) specified in paragraph (1) of this subsection shall be related to Texas pharmacy laws or rules.

(B) Any continuing education requirements which are imposed upon a pharmacist as a part of a board order or agreed board order shall be in addition to the requirements of this section.

(2) Failure to report completion of required continuing education. The following is applicable if a pharmacist fails to report completion of the required continuing education.

(A) The license of a pharmacist who fails to report completion of the required number of continuing education contact hours shall not be renewed and the pharmacist shall not be issued a renewal certificate for the license period until such time as the pharmacist successfully completes the required continuing education and reports the completion to the board.

(B) A pharmacist who practices pharmacy without a current renewal certificate is subject to all penalties of practicing pharmacy without a license including the delinquent fees specified in the Act, §559.003.

(3) Extension of time for reporting. A pharmacist who has had a physical disability, illness, or other extenuating circumstances which prohibits the pharmacist from obtaining continuing education credit during the preceding license period may be granted an extension of time to complete the continued education requirement. The following is applicable for this extension:

(A) The pharmacist shall submit a petition to the board with his/her license renewal application which contains:
(i) the name, address, and license number of the pharmacist;

(ii) a statement of the reason for the request for extension;

(iii) if the reason for the request for extension is health related, a statement from the attending physician(s) treating the pharmacist which includes the nature of the physical disability or illness and the dates the pharmacist was incapacitated; and

(iv) if the reason for the request for the extension is for other extenuating circumstances, a detailed explanation of the extenuating circumstances and if because of military deployment, documentation of the dates of the deployment.

(B) After review and approval of the petition, a pharmacist may be granted an extension of time to comply with the continuing education requirement which shall not exceed one license renewal period.

(C) An extension of time to complete continuing education credit does not relieve a pharmacist from the continuing education requirement during the current license period.

(D) If a petition for extension to the reporting period for continuing education is denied, the pharmacist shall:

(i) have 60 days to complete and report completion of the required continuing education requirements; and

(ii) be subject to the requirements of paragraph (2) of this subsection relating to failure to report completion of the required continuing education if the required continuing education is not completed and reported within the required 60-day time period.

(4) Exemptions from reporting requirements.

(A) All pharmacists licensed in Texas shall be exempt from the continuing education requirements during their initial license period.

(B) Pharmacists who are not actively practicing pharmacy shall be granted an exemption to the reporting requirements for continuing education provided the pharmacists submit a completed renewal application for each license period which states that they are not practicing pharmacy. Upon submission of the completed renewal application, the pharmacist shall be issued a renewal certificate which states that pharmacist is inactive. Pharmacists who wish to return to the practice of pharmacy after being exempted from the continuing education requirements as specified in this subparagraph must:

(i) notify the board of their intent to actively practice pharmacy;

(ii) pay the fee as specified in §295.9 of this title (relating to Inactive License); and

(iii) provide copies of completion certificates from approved continuing education programs as specified in subsection (e) of this section for 30 contact hours (3.0 CEUs). Approved continuing education earned within two years prior to the licensee applying for the return to active status may be applied toward the continuing education requirement for reactivation of the license but may not be counted toward subsequent renewal of the license.

(e) Approved Programs.

(1) Any program presented by an ACPE approved provider subject to the following conditions.

(A) Pharmacists may receive credit for the completion of the same ACPE course only once during a license period.
(B) Pharmacists who present approved ACPE continuing education programs may receive credit for the time expended during the actual presentation of the program. Pharmacists may receive credit for the same presentation only once during a license period.

(C) Proof of completion of an ACPE course shall contain the following information:

(i) name of the participant;

(ii) title and completion date of the program;

(iii) name of the approved provider sponsoring or cosponsoring the program;

(iv) number of contact hours and/or CEUs awarded;

(v) the assigned ACPE universal program number and a "P" designation indicating that the CE is targeted to pharmacists; and

(vi) either:

(I) a dated certifying signature of the approved provider and the official ACPE logo; or

(II) the CPE Monitor logo.

(2) Courses which are part of a professional degree program or an advanced pharmacy degree program offered by a college of pharmacy which has a professional degree program accredited by ACPE.

(A) Pharmacists may receive credit for the completion of the same course only once during a license period.

(B) Pharmacists who teach these courses may receive credit towards their continuing education, but such credit may be received only once for teaching the same course during a license period.

(3) Basic cardiopulmonary resuscitation (CPR) courses which lead to CPR certification by the American Red Cross or the American Heart Association or its equivalent shall be recognized as approved programs. Pharmacists may receive credit for one contact hour (0.1 CEU) towards their continuing education requirement for completion of a CPR course only once during a license period. Proof of completion of a CPR course shall be the certificate issued by the American Red Cross or the American Heart Association or its equivalent.

(4) Advanced cardiovascular life support courses (ACLS) or pediatric advanced life support (PALS) courses which lead to initial ACLS or PALS certification by the American Heart Association or its equivalent shall be recognized as approved programs. Pharmacists may receive credit for twelve contact hours (1.2 CEUs) towards their continuing education requirement for completion of an ACLS or PALS course only once during a license period. Proof of completion of an ACLS or PALS course shall be the certificate issued by the American Heart Association or its equivalent.

(5) Advanced cardiovascular life support courses (ACLS) or pediatric advanced life support (PALS) courses which lead to ACLS or PALS recertification by the American Heart Association or its equivalent shall be recognized as approved programs. Pharmacists may receive credit for four contact hours (0.4 CEUs) towards their continuing education requirement for completion of an ACLS or PALS recertification course only once during a license period. Proof of completion of an ACLS or PALS recertification course shall be the certificate issued by the American Heart Association or its equivalent.

(6) Attendance at Texas State Board of Pharmacy Board Meetings shall be recognized for continuing education credit as follows.

(A) Pharmacists shall receive credit for three contact hours (0.3 CEUs) towards their continuing education requirement for attending a full, public board business meeting in its entirety.
(B) A maximum of six contact hours (0.6 CEUs) are allowed for attendance at a board meeting during a license period.

(C) Proof of attendance for a complete board meeting shall be a certificate issued by the Texas State Board of Pharmacy.

(7) Participation in a Texas State Board of Pharmacy appointed Task Force shall be recognized for continuing education credit as follows.

(A) Pharmacists shall receive credit for three contact hours (0.3 CEUs) towards their continuing education requirement for participating in a Texas State Board of Pharmacy appointed Task Force.

(B) Proof of participation for a Task Force shall be a certificate issued by the Texas State Board of Pharmacy.

(8) Attendance at programs presented by the Texas State Board of Pharmacy or courses offered by the Texas State Board of Pharmacy as follows:

Cont'd...
(A) Pharmacists shall receive credit for the number of hours for the program or course as stated by the Texas State Board of Pharmacy.

(B) Proof of attendance at a program presented by the Texas State Board of Pharmacy or completion of a course offered by the Texas State Board of Pharmacy shall be a certificate issued by the Texas State Board of Pharmacy.

(9) Pharmacists shall receive credit toward their continuing education requirements for programs or courses approved by other state boards of pharmacy as follows:

(A) Pharmacists shall receive credit for the number of hours for the program or course as specified by the other state board of pharmacy.

(B) Proof of attendance at a program or course approved by another state board of pharmacy shall be a certificate or other documentation that indicates:

(i) name of the participant;

(ii) title and completion date of the program;

(iii) name of the approved provider sponsoring or cosponsoring the program;

(iv) number of contact hours and/or CEUs awarded;

(v) a dated certifying signature of the provider; and

(vi) documentation that the program is approved by the other state board of pharmacy.

(10) Completion of an Institute for Safe Medication Practices' (ISMP) Medication Safety Self Assessment for hospital pharmacies or for community/ambulatory pharmacies shall be recognized for continuing education credit as follows.

(A) Pharmacists shall receive credit for three contact hours (0.3 CEUs) towards their continuing education requirement for completion of an ISMP Medication Safety Self Assessment.

(B) Proof of completion of an ISMP Medication Safety Self Assessment shall be:

(i) a continuing education certificate provided by an ACPE approved provider for completion of an assessment; or

(ii) a document from ISMP showing completion of an assessment.

(11) Pharmacists shall receive credit for three contact hours (0.3 CEUs) toward their continuing education requirements for taking and successfully passing the initial Geriatric Pharmacy Practice certification.
(12) Pharmacist shall receive credit for three contact hours (0.3 CEUs) toward their continuing education requirements for taking and successfully passing an initial Board of Pharmaceutical Specialties certification examination administered by the Board of Pharmaceutical Specialties. Proof of successfully passing the examination shall be a certificate issued by the Board of Pharmaceutical Specialties.

(13) Programs approved by the American Medical Association (AMA) as Category 1 Continuing Medical Education (CME) and accredited by the Accreditation Council for Continuing Medical Education subject to the following conditions.

(A) Pharmacists may receive credit for the completion of the same CME course only once during a license period.

(B) Pharmacists who present approved CME programs may receive credit for the time expended during the actual presentation of the program. Pharmacists may receive credit for the same presentation only once during a license period.

(C) Proof of completion of a CME course shall contain the following information:

(i) name of the participant;

(ii) title and completion date of the program;

(iii) name of the approved provider sponsoring or cosponsoring the program;

(iv) number of contact hours and/or CEUs awarded; and

(v) a dated certifying signature of the approved provider.

(f) Retention of continuing education records and audit of records by the board.

(1) Retention of records. Pharmacists are required to maintain certificates of completion of approved continuing education for three years from the date of reporting the contact hours on a license renewal application. Such records may be maintained in hard copy or electronic format.

(2) Audit of records by the board. The board shall audit the records of pharmacists for verification of reported continuing education credit. The following is applicable for such audits.

(A) Upon written request, a pharmacist shall provide to the board documentation of proof for all continuing education contact hours reported during a specified license period(s). Failure to provide all requested records during the specified time period constitutes prima facie evidence of failure to keep and maintain records and shall subject the pharmacist to disciplinary action by the board.

(B) Credit for continuing education contact hours shall only be allowed for approved programs for which the pharmacist submits documentation of proof reflecting that the hours were completed during the specified license period(s). Any other reported hours shall be disallowed. A pharmacist who has received credit for continuing education contact hours disallowed during an audit shall be subject to disciplinary action.

(C) A pharmacist who submits false or fraudulent records to the board shall be subject to disciplinary action by the board.

Source Note: The provisions of this §295.8 adopted to be effective March 19, 1990, 15 TexReg 1234; amended
to be effective March 29, 1995, 20 TexReg 1889; amended to be effective March 25, 1999, 24 TexReg 203; amended to be effective January 3, 2000, 24 TexReg 12068; amended to be effective June 20, 2001, 26 TexReg 4513; amended to be effective December 19, 2001, 26 TexReg 10311; amended to be effective June 23, 2003, 28 TexReg 4639; amended to be effective March 10, 2005, 30 TexReg 1284; amended to be effective November 21, 2007, 32 TexReg 8310; amended to be effective December 14, 2008, 33 TexReg 10027; amended to be effective September 13, 2009, 34 TexReg 6113; amended to be effective March 10, 2011, 36 TexReg 1556; amended to be effective September 9, 2012, 37 TexReg 6938; amended to be effective March 17, 2013, 38 TexReg 1682
Additional Continuing Education Requirements

- Pharmacist preceptor
  - Initial requirements: Three hours of pharmacist preceptor training provided by an ACPE approved provider within the previous two years. The training shall be:
    - developed by a Texas college/school of pharmacy; or
    - approved by a committee comprised of the Texas college/schools of pharmacy or by the board.
  - Continuing requirements: Three hours of pharmacist preceptor training provided by an ACPE approved provider within the pharmacist’s current license renewal period. The training shall be:
    - developed by a Texas college/school of pharmacy; or
    - approved by a committee comprised of the Texas college/schools of pharmacy or by the board.
  - These hours may be applied towards the hours required for renewal of a license to practice pharmacy.

- Pharmacists engaged in sterile compounding
  - In order to renew a license to practice pharmacy, during the previous licensure period, a pharmacist engaged in sterile compounding shall complete a minimum of:
    - two hours of ACPE-accredited continuing education if the pharmacist is engaged in compounding low and medium risk sterile preparations, or
    - four hours of ACPE-accredited continuing education if the pharmacist is engaged in compounding high risk sterile preparations.
  - CE’s obtained for low, medium, and high risk sterile preparations must relate to one or more of the areas listed:
    - Aseptic technique, critical area contamination factors, environmental monitoring, structure and engineering controls related to facilities, equipment and supplies, sterile preparation calculations and terminology, sterile preparation compounding documentation, quality assurance procedures, aseptic preparation procedures including proper gowning and gloving technique, handling of hazardous drugs, if applicable, cleaning procedures, and general conduct in the clean room.
  - These hours may be applied towards the hours required for renewal of a license to practice pharmacy.

- Pharmacists engaged in the administration of immunizations or vaccinations under written protocol of a physician
  - Obtain 3 hours of continuing education every 2 years which are designed to maintain competency in the disease states, drugs, and administration of immunizations or vaccinations; and maintain current certification in the American Heart Association's Basic Cardiac Life Support for Health-Care Providers or its equivalent.
  - These hours may be applied towards the hours required for renewal of a license to practice pharmacy.

- Pharmacists engaged in the provision of drug therapy management under written protocol of a physician
  - Initial requirements: Six hours of continuing education related to drug therapy offered by an ACPE approved provider.
  - Continuing requirements: Six hours of continuing education related to drug therapy offered by an ACPE approved provider completed annually.
  - These hours may be applied towards the hours required for renewal of a license to practice pharmacy.
Continuing Medical Education for MDs/DOs

As a prerequisite for physician registration, practitioners are required to complete continuing medical education. Current requirements for physicians are summarized below. If you would like to review the current rule, these requirements are currently listed Board rule 166.2 available on our website at: http://www.tmb.state.tx.us/page/board-rules

Physicians need to complete at least 48 credits of continuing medical education every 24 months (24 month timeline is in relation to the biennial registration period, not the calendar year). At least half of these hours must be in formal, category I or 1A courses. A physician must report during registration if she or he has completed the required CME. However, newly licensed physicians are exempt from the CME requirement the first time they register.

Documentation of CME courses shall be made available to the Board upon request (See the Spring 97 Newsletter article “Board Initiates CME Audits” available in the TMB Bulletins), but should not be mailed with the registration payment. Random audits will be made to assure compliance.

Physician CME Requirements (per biennium)

24 Formal Category 1 or 1A hours:

- courses designated for AMA/PRA Category 1 credit by a CME sponsor accredited by ACCME (Accreditation Council for CME) or state medical society recognized by ACCME;
- approved for credit by American Academy of Family Physicians;
- designated for AOA Category 1-A credit; or
- approved by TMA based on standards established by AMA for its Physician's Recognition Award.

Medical Ethics and/or Professional Responsibility

- At least 2 of the formal hours must involve the study of medical ethics and/or professional responsibility. Professional responsibility includes but is not limited to courses in: Risk management, Domestic Abuse; or Child Abuse. Formal courses must be approved for ethics or professional responsibility credit by the accrediting agency. Also acceptable are the CME activities designated by the Texas Medical Board as Medical Ethics and/or Professional Responsibility requirements for registration but are not automatically acceptable for fulfillment of CME Ethics requirements for disciplinary orders.

24 Informal Hours:

- Composed of informal self study, attendance at hospital lectures
- or grand rounds not approved for formal CME or case conferences and shall be recorded in a manner easily transmitted to the board.

There is a maximum of 48 total excess credit hours that may be carried forward and a limit of two years from the date of the registration following the period during which the hours were earned. Excess hours are applied/reported according to their Category. See Board Rule 166.2 for additional information.

For Medical Ethics and/or Professional Responsibility CME Providers - Application for TMB Designation of CME as Medical Ethics or Professional Responsibility
For CME course listings contact:
Texas Medical Association: (512) 370-1300, (800) 880-1300
Texas Osteopathic Medical Association: (512) 708-8662, (800) 444-8662

Additional requirements:

Forensic examinations
Per Board rule 166.2(a)(4), a physician who performs forensic examinations on sexual assault survivors must have basic forensic evidence collection training or the equivalent education. A physician who completes a CME course in forensic evidence collection that meet the requirements described in the formal category above, or is approved or recognized by the Texas Board of Nursing, is considered to have the basic forensic evidence training required by the Health and Safety Code, §323.0045.

Tick-Borne Diseases
Per Board rule 166.2(a)(6), a physician whose practice includes the treatment of tick-borne diseases should complete CME in the treatment of tick-borne diseases that meet the requirements described in the formal category above.

EMS Medical Director (also known as Off-Line Medical Director)
Per Board rule 197.3(a)(17), an off-line medical director shall be required to complete the following educational requirements:
- within two years, either before or after initial notification to the board of holding the position as off-line medical director:
  - 12 hours of formal continuing medical education (CME) as defined under Board rule §166.2 (relating to Continuing Medical Education) in the area of EMS medical direction;
  - board certification in Emergency Medical Services by the American Board of Medical Specialties or a Certificate of Added Qualification in EMS by the American Osteopathic Association Bureau of Osteopathic Specialists; or
  - a DSHS approved EMS medical director course; and
- every two years after meeting the requirements of subparagraph (A) of this paragraph, one hour of formal CME in the area of EMS medical direction.

Additional information available at: http://www.tmb.state.tx.us/page/renewal-physician-EMS

Pain Management Clinics
Per Board rule 195.4(e), the medical director of a pain management clinic must, on an annual basis, ensure that all personnel (including the medical director) are properly licensed, and if applicable, trained to include 10 hours of continuing medical education (CME) related to pain management.

Additional information available at: http://www.tmb.state.tx.us/page/resources-cme-for-pain-management-clinic

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Board Certification
Per Board rule 166.2(c), a licensee shall be presumed to have complied with this section if in the preceding 36 months the licensee becomes board certified or recertified in a medical specialty and the medical specialty program meets the standards of the American Board of Medical Specialties, the American Medical Association, the Advisory Board for Osteopathic Specialists and Boards of Certification, or the American Osteopathic Association. This provision exempts the physician from all CME requirements, including the requirement involving the study of medical ethics and/or professional responsibility. This exemption is valid for a maximum of one registration.

Maintenance of Certification (MOC)
Per Board rule 166.2(d), a licensee shall be presumed to have complied with the formal and informal hours requirement of this section if the licensee:
- is meeting the Maintenance of Certification (MOC) program requirements set forth by a specialty or subspecialty member board of the ABMS or the Osteopathic Continuous Certification (OCC) program requirements set forth by the AOA, and
- the member board's MOC or OCC program mandates completion of CME credits that meet the minimum criteria set forth under the formal hours requirement.

PLEASE NOTE: This provision does not exempt the physician from the requirement for two credits involving the study of medical ethics and/or professional responsibility, as outlined on the page above.
Education - Continuing Nursing Education & Competency

The Board offers three different venues for Continuing Nursing Education. Select one of the links below for a complete listing of all our options.

Continuing Nursing Education / Continued Competency Offerings

| Webinars | Workshops | Online CNE |

Continuing Competency, including Continuing Nursing Education (CNE)

For questions regarding Continuing Competency, please review: **Continuing Competency FAQs**.

All nurses with an active Texas license are required to demonstrate continuing competency for relicensure. This aligns with the mission of the Board of Nursing (BON or Board) to protect and promote the welfare of the people of Texas by ensuring that each person holding a license as a nurse in the State of Texas is competent to practice safely.

In 1991, rules were adopted requiring nurses to complete 20 contact hours of continuing nursing education (CNE) every two years for relicensure. CNE is defined as programs beyond the basic nursing preparation that are designed to promote and enrich knowledge, improve skills, and develop attitudes for the enhancement of nursing practice, thus improving health care to the public [Board Rule 216.1(12)]. In 2009, rules were adopted to allow nurses to demonstrate competency through achievement of an approved national nursing certification in the nurse’s area of practice or completion of 20 contact hours of CNE. In 2010, the rules were changed requiring that the CNE be relevant to the nurse’s “area of practice.” “Area of practice” is defined as including any activity, assignment, or task performed by the nurse that utilizes nursing knowledge, judgement, or skills [Board Rule 216.1(4)]. Each nurse reactivating an inactive or delinquent license must also submit verification of 20 contact hours completed in the two years prior to reactivation, or have a current approved national nursing certification. If the nurse does not have a current area of practice, the nurse refers to the prior area of practice [Board Rule 216.1(4)].

**CNE Requirement**

One method to demonstrate compliance with the continuing competency requirements is to complete 20 contact hours of CNE in the nurse’s area of practice every two years coinciding with the nurse’s license renewal [Board Rule 216.3(a)]. A contact hour is defined as 60 minutes of a clock hour [Board Rule 216.1(11)]. The CNE hours must be earned within the two-year period immediately preceding the license renewal, beginning with the first day after the renewal month until the last day of the subsequent renewal. For example, if a nurse is required to renew the nursing license in December 2015 (his/her birth month), then the CNE hours must be earned between January 1, 2014 and December 31, 2015. Additional hours earned may not be carried over to the next renewal period.

**Mandatory CNE Requirements**

There are several mandatory continuing education requirements that nurses must meet. These requirements are detailed in this section. A nurse is required to retain continuing competency records for three licensure renewal cycles at a minimum [Board Rule 216.7 (c)].
Nursing Jurisprudence and Nursing Ethics. All licensed vocational nurses (LVNs), registered nurses (RNs), and advanced practice registered nurses (APRNs) are required to complete at least two contact hours of CNE in nursing jurisprudence and ethics prior to the end of each third two-year licensure renewal cycle for licensure cycles beginning on or after January 1, 2014. The course is required to contain information related to the Texas Nursing Practice Act, Texas BON Rules, Texas BON Position Statements, principles of nursing ethics, and professional boundaries [Board Rule 216.3(g)]. This course counts as part of the 20 required contact hours; however, certification cannot be used to fulfill this mandatory requirement [Board Rule 216.3(g)].

Older Adult or Geriatric Care. Any LVN, RN, or APRN whose practice includes the older adult or geriatric population is required to complete at least two contact hours in every licensure cycle beginning on or after January 1, 2014 [Board Rule 216.3(h)]. The content must include information relating to elder abuse, age-related memory changes and disease processes, including chronic conditions, and end of life issues [Board Rule 216.3(h)(1)]. A nurse may choose to complete more than one course in order to cover all content required in the rule.

Forensic Evidence Collection CNE. Effective September 1, 2013, nurses who perform a forensic exam on a sexual assault survivor must have completed basic forensic evidence collection training, or the equivalent education, prior to performing the examination [Board Rule 216.3(d)(1)]. This is a one-time requirement; therefore, nurses who perform forensics exams are encouraged to retain the certificate of course completion indefinitely.

Effective September 1, 2005, the NPA was amended, adding the CNE requirement: Forensic Evidence Collection in Continuing Education. This targeted CNE requirement applies to all nurses practicing in emergency department (ED) settings as their home unit, floating, contracted, or other duties that involve functioning in an ED setting or role. This is a one-time requirement per nurse effective September 1, 2006. Any nurse who is working in an ED setting must complete this requirement within two years of the initial date of the nurse’s employment in an ED setting [Board Rule 216.3(d)(2)]. There is no expiration date for this requirement under Texas Occupations Code Section 301.306 (NPA); thus, any nurse working in the ED must comply and maintain the course completion certificate indefinitely.

What CNE is Acceptable?

To count toward licensure renewal, a program must have been approved by one of the credentialing agencies recognized by the Board. The credentialing agencies have met nationally-predetermined criteria to approve programs and providers of CNE. The Board recognizes the following credentialing agencies and providers:

- American Association of Nurse Practitioners (AANP);
- American Association of Critical-Care Nurses (AACN);
- American Association of Nurse Anesthetists (AANA);
- American College of Nurse Midwives (ACNM);
- American Nurses Credentialing Center (ANCC);
- Category I Continuing Medical Education (for APRNs only);
- Colleges and Universities in the United States of America;
- Emergency Nurses Association (ENA);
- National Association for Practical Nurse Education and Service (NAPNES);
- National Association of Pediatric Nurse Practitioners (NAPNAP);
- National Federation of Licensed Practical Nurses (NFLPN); and
- Other State Boards of Nursing.

Some of these organizations, in turn, approve other CNE providers. For example, most of the state nursing associations such as the Texas Nurses Association (TNA), and many of the nursing specialty organizations are accredited through the ANCC to approve both individual CNE programs and also approve providers of CNE programs. Thus, these programs would be accepted. In addition, the Board also recognizes the Licensed Vocational Nurses Association of Texas (LVNAT) and the Texas League of Vocational Nurses (TLVN) as providers of CNE.

PLEASE NOTE: Successful completion of either initial or renewal courses such as Advanced Cardiac Life Support, Advanced Trauma Life Support, Pediatric Advanced Life Support, and other courses specific to specialty practice, may be counted for CNE credit, if a specific course meets requirements of Chapter 216. If you are asked for proof of continuing competency, please submit the course completion certificate that meets the Board’s CNE criteria [please see Board Rule 216.4]. Cards from these courses are not accepted for CNE.

Self-Paced/Online CNE Programs are acceptable for CNE credit if approved by one of the credentialing organizations recognized by the BON (provided they meet any other criteria specified in Chapter 216).
What Certifications are Acceptable?

One method to demonstrate compliance with the continuing competency requirements is to attain, maintain or renew an approved national nursing certification in the nurse’s area of practice [Board Rule 216.3(b)]. A certification must be in nursing and have the approval of a national certification accreditation agency recognized by the Board to qualify as continuing competency for licensure renewal. A national nursing certification that has been approved by the Accreditation Board for Specialty Nursing Certification (ABSN), that is attained, maintained or renewed during the licensure renewal cycle and is in the nurse’s area of practice, is acceptable to demonstrate the nurse’s continued competence.

The National Commission for Certifying Agencies (NCCA) is another certification accreditation agency; however, most of these certifications are not accepted since not all of their certifications have substantively equivalent requirements for nurses to demonstrate continuing competency. However, the American Association of Critical-Care Nurses – Certification Corporation (AACN-CC) and the National Certification Corporation (NCC) have certifications approved by NCCA and have specific certifications approved by the BON for nurses. The certifications accepted by the BON for RNs are:

- AACN-CC: Acute/Critical Care Nursing (CCRN),
- AACN-CC: Tele-ICU Acute/Critical Care Nursing (CCRN-E),
- AACN-CC: Acute/Critical Care Knowledge Professional (CCRN-K),
- AACN-CC: Progressive Care Nursing (PCCN), and
- AACN-CC: Nurse Manager and Leader (CNML).
- NCC: Inpatient Obstetric Nursing (RNC-OB),
- NCC: Maternal Newborn Nursing (RNC-MNN),
- NCC: Low Risk Neonatal Nursing (RNC-LRN), and
- NCC: Neonatal Intensive Care Nursing (RNC-NIC).

The National Association for Practical Nurse Education & Service, Inc. (NAPNES) offers two certifications for LVNs that have been approved by the Board for demonstration of LVN continuing competency: Pharmacology and Long-Term Care. The two certifications offered by the Developmental Disabilities Nurses Association have also been approved by the Board (one is for RNs and one for LVNs).

PLEASE NOTE: Certification cannot be used to meet the required two contact hours in Nursing Jurisprudence and Nursing Ethics that each nurse must complete prior to the end of each third two-year licensure renewal cycle. A certification meeting BON requirements, related to the older adult or geriatric population may be used to meet the older adult or geriatric care requirement instead of two contact hours.

Requirements for the Advanced Practice Registered Nurse (APRN)

A licensee who is licensed by the Board to practice as an Advanced Practice Registered Nurse (APRN) is required to obtain 20 contact hours of targeted continuing education in the advanced practice role and population focus area recognized by the Board or attain, maintain, or renew the national certification recognized by the Board as meeting the certification requirement for the APRN role and population focus area of licensure; this will satisfy the requirements to renew both the RN license and APRN licensure. The Board approves four broad categories of APRNs including Clinical Nurse Specialist (CNS), Nurse Midwife (CNM), Nurse Anesthetist (CRNA), and Nurse Practitioner (NP).

In addition to the 20 contact hours of continuing education in the advanced practice role and population focus area or renewal of the certification as specified, an APRN who has Prescriptive Authority must also complete at least five additional contact hours in pharmacotherapeutics within the preceding two years. APRNs that have prescriptive authority and prescribe controlled substances must complete at least three additional contact hours of continuing education related to prescribing controlled substances (this totals 28 contact hours for the APRN with prescriptive authority who prescribes controlled substances). Category I Continuing Medical Education (CME) contact hours will meet requirements for continuing competency for APRNs. Academic courses; program development and presentation; and authorship may be utilized to meet continuing competency requirements if they are targeted to the APRN role and population focus area for which they are licensed [Board Rule 216.3(c)].

**Academic courses; Program Development and Presentation; and Authorship**

**Academic courses** must be within the framework of a curriculum that leads to an academic degree in nursing or any academic course relevant to nursing practice [Board Rule 216.5(a)]. An academic course taken for credit may be used to meet BON continuing competency requirements if a grade of C or better
or “pass” on a pass/fail system is achieved. One academic semester hour is equal to 15 contact hours; one academic quarter hour is equal to 10 contact hours [Board Rule 216.1(1)]. Prerequisite courses, such as mathematics, government, anatomy, physiology, etc., cannot be counted to meet any part of the continuing competency requirements for a nurse [Board Rule 216.6(10)(A)].

Program Development and Presentation may be used to meet continuing competency requirements for licensure renewal when the program is approved by one of the credentialing agencies approved by the Board [Board Rule 216.5(b)]. The nurse who developed and/or presented the qualifying program may count the number of contact hours awarded by the credentialing agency or provider to the distinct activity [Board Rule 216.5(b)(2)].

Authorship of a developed and published manuscript may be used to meet continuing competency requirements for licensure renewal [Board Rule 216.5(c)]. One contact hour may be counted for each distinct publication [Board Rule 216.5(c)(2)].

Activities Not Acceptable for CNE Credit

The following activities are not acceptable for CNE credit:

- Basic CPR;
- In-service programs that provide specific information about the work setting’s philosophy, policies and procedures;
- On-the-job training and equipment demonstration;
- Refresher courses designed to update knowledge;
- Orientation programs designed to introduce employees to a specific work setting;
- Courses focusing on self-improvement, changes in attitude, self-therapy, self-awareness, weight loss, or yoga;
- Economic courses for financial gain, e.g., investments, retirement, preparing resumes and techniques for job interviews;
- Liberal Art courses in music, art, philosophy, etc., when unrelated to patient/client care; or
- Courses for lay people.

Auditing Process

The Board conducts random audits to determine compliance with the continuing competency requirements. Notice is e-mailed to the nurse’s email address on file or mailed to the last known address (if no e-mail is on record). This notice is sent 90 days prior to the renewal dates for nurses who are chosen randomly by computer. The email notification is sent by the BON service provider: e-Strategy Solutions. A nurse being audited will not be able to renew his/her license until adequate proof of continuing competency has been submitted and approved. Please allow up to ten (10) business days for review of the submitted audit. The nurse will receive an email at the address on file, notifying the nurse of the outcome of the audit, and whether any additional action is required by the nurse.

A nurse selected for a continuing competency audit may locate information and instructions to submit documentation of compliance with continuing competency requirements on the e-Strategy Solutions website at https://ce.esslearning.com. The nurse will log in using the nurse’s license number and date of birth.

Renewing of License

A nurse renewing the license will be asked if he/she has completed the required 20 hours of CNE within the previous two-year period or has a current national nursing certification and has complied with any targeted CNE requirements. Compliance with continuing competency requirements must be achieved prior to renewal of the nursing license. Continuing competency requirements may be achieved through completion of 20 contact hours or by attaining, maintaining, or renewing an approved national nursing certification in the nurse’s area of practice. Proof of compliance with continuing competency requirements must also be submitted to renew a delinquent license, reactivate a license from inactive status, or when petitioning the Board for reinstatement of a revoked or surrendered license. Each nurse is responsible for maintaining his/her own records of continuing competency compliance. In general, records should be kept for three renewal periods (six years). Evidence of completion of CNE for forensic evidence collection should be maintained indefinitely.

First Time Renewals

A nurse newly licensed in Texas either by examination or by endorsement from another state is exempt from the continuing competency requirement for the first licensure renewal. A nurse’s initial license
may be valid for a period ranging from six (6) to 29 months, depending on the licensee’s birth date. Following the first license renewal, the nurse must meet continuing competency requirements for the subsequent biannual renewal periods.

**Late Renewals**

A nurse whose license has expired will be required show proof of completion of 20 hours of CNE, including any targeted CNE requirements, or achievement, maintenance or renewal of an approved national nursing certification within the past two years. This applies whether the license is delinquent for one day or longer.

**Requirements for Advanced Practice Registered Nurse (APRN)**

A licensee who is authorized by the Board to practice as an Advanced Practice Registered Nurse (APRN) is required to obtain 20 contact hours of targeted continuing nursing education in the advanced practice role and population focus area recognized by the Board or attain, maintain, or renew the national certification recognized by the Board as meeting the certification requirement for the APRN role and population focus area of licensure; this will satisfy the requirements to renew both your RN license and APRN license. The Board approves four broad categories of APRNs including Clinical Nurse Specialist (CNS), Nurse Midwife (CNM), Nurse Anesthetist (CRNA), and Nurse Practitioner (NP). In addition to the 20 contact hours of continuing nursing education in the advanced practice role and population focus area or renewal of the certification as specified, an APRN who has Prescriptive Authority must also complete at least five additional contact hours in pharmacotherapeutics within the preceding two years. Category I Continuing Medical Education (CME) contact hours will meet requirements for continuing competency for APRNs. Academic courses may be utilized to meet continuing competency requirements if they are targeted to the APRN role and population focus area for which they are licensed.

**Inactive/Retired/Volunteer Retired Status**

A nurse who is no longer practicing nursing may place the license on inactive status prior to licensure expiration. Continuing education is not required as long as the nursing license is inactive. Should a nurse wish to reactivate the license to return to nursing practice and the nurse has been inactive (or delinquent or retired) for less than four years, the nurse must show proof of completion of 20 hours of CNE, or attainment, maintenance, or renewal of a national nursing certification within the two years prior to the request for reactivation. If the nurse has not practiced nursing in any jurisdiction (i.e. another state) for four or more years, in addition to the CNE hours, the nurse will be required to complete a nursing refresher or extensive orientation course.

A nurse may request “volunteer retired nurse” authorization [Section 301.261 of the Nursing Practice Act (NPA)]. Board Rule 216.3(e) requires a nurse who wishes to provide only voluntary charity care to obtain 10 hours of CNE for each two year authorization renewal cycle. An APRN authorized as a volunteer retired RN in a specific APRN role and population focus area may renew his/her volunteer retired advanced practice license through completion of 20 hours of continuing education targeted to the APRN’s role and population focus area.

**Where to Find CNE Offerings**

Many CNE offerings may be located on the internet. Local colleges, universities, nursing schools, or large hospitals may have a schedule of offerings or a mailing list. Many nursing journals contain a schedule of offerings. Professional nursing associations are another resource. In addition, the BON has a continuing education course catalog listing those education courses offered by Board staff: https://www.bon.texas.gov/catalog/.

**Forensic Evidence Collection CNE**

Effective September 1, 2005, the NPA was amended, adding the CNE requirement: Forensic Evidence Collection in Continuing Education. This targeted CNE requirement applies to all nurses practicing in emergency department (ED) settings as either their home unit, floating, contracted, or other duties that involve functioning in an ED setting or role. This is a one-time requirement per nurse effective September 1, 2006. There is no expiration date for this requirement under Texas Occupations Code Section 301.306 (NPA), thus any nurse working in the ED must comply and maintain the course completion certificate indefinitely.

Frequently asked questions on this targeted CNE may be viewed on the BON web page here.

*Please retain this informational material for a quick reference on continuing competency (CC). Feel free to copy it and share it with others. The rules specific to CC for nurses are located in 22 Tex. Admin. Code*
Chapter 216. A copy of the CC rules may be downloaded from the BON web site. Additional copies of this brochure may be obtained by downloading it from the Texas Board of Nursing’s web site located at www.bon.texas.gov. You may also send a stamped, self-addressed envelope to the Board’s office, 333 Guadalupe, Suite 3-460, Austin, Texas 78701, Attn: C.N.E.

(Revised 05/2015)

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Patients often require assistance even by painful stimulation. The ability to independently maintain anesthesia gastrointestinal (GI) tract or oral mucosa (i.e., oral, rectal, sublingual) may be inadequate. Cardiovascular function is usually maintained.

(7)(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.

(8)(7) Direct supervision--the dentist responsible for the sedation/general anesthesia procedure shall be physically present in the facility and shall be continuously aware of the patient's physical status and well-being.

(9)(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).

(10)(9) Facility--a location where a permit holder practices dentistry and/or provides sedation/general anesthesia services.

(11)(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.

(12)(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.

\((13)\) Immediately available--on-site in the facility and available for immediate use.

\((14)\) Incremental dosing--administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

\((15)\) Local anesthesia--the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

\((16)\) 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.

\((17)\) 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 under the age of thirteen (13) [aged twelve (12) or younger] should be avoided due to the risk of unobserved respiratory obstruction during the transport by untrained individuals.

\((18)\) 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.

\((19)\) Parenteral--the administration of pharmacological agents intravenously, intraosseously, intramuscularly, subcutaneously, submucosally, intranasally, or transdermally.

\((20)\) 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) Emergency operation of any variety (used to modify ASA I - ASA VI).

(21) Pediatric patient—a patient who is under the age of 13 at the time of a dental treatment or procedure.

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

(23) Protective reflexes—includes the ability to swallow and cough effectively.

(24) 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.]

(25) 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.

(26) 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.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on December 5, 2016

TRD-201606155

Kelly Parker
Executive Director
State Board of Dental Examiners

Earliest possible date of adoption: January 15, 2017

For further information, please call: (512) 475-0977
Preamble

(a) A dentist licensed under Chapter 101 of this title shall obtain a sedation/general anesthesia permit for the following sedation/general 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 sedation/general anesthesia 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) A dentist applying for a sedation/general anesthesia permit must meet the requirements of the highest permit level sought and all permit levels below the highest permit level sought.

(4) Prior to issuance of a sedation/general 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.

(5) An applicant for a sedation/general 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 shall not be approved.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.
TRD-201606155

Kelly Parker
Executive Director
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For further information, please call: (512) 475-0977
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TITLE 22 EXAMINING BOARDS
PART 5 STATE BOARD OF DENTAL EXAMINERS
CHAPTER 110 SEDATION AND ANESTHESIA
RULE §110.3 Nitrous Oxide/Oxygen Inhalation Sedation
ISSUE 12/16/2016
ACTIONS Proposed

Preamble

(a) Initial Application for Nitrous Oxide/Oxygen Inhalation Sedation. [Education and Professional Requirements] A dentist applying for a nitrous oxide/oxygen inhalation sedation permit shall demonstrate the following: [meet one of the following educational/professional criteria:]

1. current certification in Basic Life Support (BLS) for Healthcare Providers; and

2. [(f)] satisfactory completion of one of the following education programs:

   (A) an American Dental Association (ADA) Commission on Dental Accreditation (CODA) approved or recognized pre-doctoral dental or postdoctoral dental training program that affords comprehensive training administering and managing nitrous oxide/oxygen inhalation sedation, commensurate with the ADA’s Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or

   (B) 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 of at least four hours of in-person clinical experience in the administration and management of nitrous oxide, during which competency in inhalation sedation technique is achieved. Acceptable courses include those obtained from academic programs of instruction recognized by the 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). [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) Maintenance of Permit. A dentist must comply with the requirements of rule 110.9 to qualify for annual renewal of a nitrous oxide/oxygen inhalation sedation permit.

(c) Administration of Nitrous Oxide/Oxygen Inhalation Sedation to Pediatric Patients. A dentist shall comply with all requirements regarding the treatment of pediatric patients, including those described in rule 110.11. Additionally, 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) Delegation and Supervision Requirements. A dentist performing nitrous oxide/oxygen inhalation sedation must maintain the minimum standard of care, including, but not limited to the requirements outlined in (e) below, and in addition, shall:

1. 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.

2. 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

3. Not supervise a Certified Registered Nurse Anesthetist (CRNA) any level of sedation unless the dentist holds a permit issued by the board for the level of sedation to be administered during the dental procedure being performed.

(e) Standard of Care and Clinical Requirements. A dentist must maintain the minimum standard of care in the administration of sedation/anesthesia in accordance with rule 108.7, including but not limited to the following requirements:

1. Administration of Nitrous Oxide Following Anxiolysis or Analgesia. A dentist, who does not hold a Level 1 Minimal Sedation permit or higher, shall not administer nitrous oxide to a patient if the patient was treated with anxiolysis or analgesia administered by the dentist within the twelve hours prior to the dental treatment at which nitrous oxide will be administered.

2. 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 shall consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) require review of their current medical history and medication use, as well as documented verbal or written consultation with the patients’ primary care physician or consulting medical specialist.


   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 rules 108.7 and 108.8.


   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.

(5) 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.

(6) 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.

(E) The dentist’s record of the patient’s treatment shall include all records created by or for the sedation provider.

(7) 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.

(8) 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.
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.

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

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.

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.

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.]

[(f)(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.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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TITLE 22  EXAMINING BOARDS
PART 5  STATE BOARD OF DENTAL EXAMINERS
CHAPTER 110 SEDATION AND ANESTHESIA
RULE §110.4  Minimal Sedation - Level I
ISSUE  12/16/2016
ACTION  Proposed

Preamble  Texas Admin Code

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

(1) current certification in Basic Life Support (BLS) for Healthcare Providers; and

(2) satisfactory completion of one of the following education programs:

(A) an advanced education program accredited by the American Dental Association (ADA) Commission on
Dental Accreditation (CODA) that affords comprehensive training in administering and managing minimal
sedation, commensurate with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and
Dental Students; or

(B) a board-approved education program of at least sixteen (16) hours of didactic training and instruction in
which competency in enteral and/or combined inhalation-ental minimal sedation technique is demonstrated.
A board-approved education program shall include, at a minimum, the following components: training in
pharmacology; pre-procedure evaluation, patient selection, anatomy, and ASA classification; anesthesia
technique and monitoring, equipment, and emergency preparedness, including running scenarios and
management of complications; and managing special needs patients.

((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-ental 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 I
Minimal Sedation permit on June 1, 2011. A Texas licensed dentist whose permit is reclassified from an enteral
sedation permit to a Level I 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) Maintenance of Permit. A dentist must comply with the requirements of rule 110.9 to qualify for annual renewal of a Level 1 permit.

(c) Administration of Level 1 Sedation/Anesthesia to Pediatric Patients. A dentist shall comply with all requirements regarding the treatment of pediatric patients, including those described in rule 110.11. Additionally, 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) Delegation and Supervision Requirements. A dentist must maintain the minimum standard of care, including, but not limited to the requirements outlined in (e) below, and in addition, shall:

1. 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;

2. 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

3. not supervise a Certified Registered Nurse Anesthetist (CRNA) performing any level of sedation unless the dentist holds a permit issued by the board for the level of sedation to be administered during the dental procedure being performed.

(e) Standard of Care and Clinical Requirements. A dentist must maintain the minimum standard of care in the administration of sedation/anesthesia in accordance with rule 108.7, including, but not limited to the following requirements:

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 patients (ASA I, II), this shall consist of a review of the patients’ current medical history and medication use. Patients with significant medical considerations (ASA III, IV) require review of the patients’ current medical history and medication use, as well as documented verbal or written consultation with the patients’ 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 rules 108.7 and 108.8.

(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.

(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 preprocedurely, post-procedurely and intra-procedurely as necessary.

(5) Documentation.

(A) Documentation must be made in accordance with rules 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.

(D) The dentist’s record of the patient’s treatment shall include all records created by or for the sedation provider.

(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.

[(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 operator 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.]  

Cont'd...
(a) Initial Application Requirements for Level 2 Moderate Sedation (ental). A dentist applying for a Level 2 Moderate Sedation Permit shall demonstrate the following: [Education and Professional Requirements.]

(1) current certification in Basic Life Support (BLS) for Healthcare Providers;

(2) current certification in Advanced Cardiac Life Support (ACLS); and

(3) satisfactory completion of one of the following education programs:

(A) an advanced education program accredited by the American Dental Association (ADA) Commission on Dental Accreditation (CODA) that affords comprehensive and appropriate training in administering and managing enteral moderate sedation, commensurate with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or

(B) completion of a board-approved education program that includes a minimum of sixty (60) hours of didactic training and instruction, and satisfactory management of at least twenty (20) case experiences in moderate sedation. These twenty (20) case experiences must include at least ten 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. A board-approved education program shall include, at a minimum, the following components:

(i) Eight hours pharmacology;

(ii) 12 hours pre-procedure evaluation, patient selection, anatomy, and ASA classification;

(iii) Four hours anesthesia technique, monitoring, and equipment;

(iv) 12 hours inter-operative management and recognition of emergencies and complications;

(v) Six hours emergency preparedness, including running scenarios and management of complications; and

(vi) Four hours management of geriatric patients.

[(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) Initial Application Requirements for Level 3 Moderate Sedation (parenteral). A dentist applying for a Level 3 Moderate Sedation permit shall demonstrate the following:

(1) current certification in Basic Life Support (BLS) for Healthcare Providers;

(2) current certification in Advanced Cardiac Life Support (ACLS); and

(3) satisfactory completion of one of the following education programs:

(A) an advanced education program accredited by the ADA CODA that affords comprehensive and appropriate training in administering and managing parenteral moderate sedation, commensurate with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or

(B) an internship or residency that included intravenous moderate sedation training equivalent to that defined in this subsection; or

(C) a board-approved education program that 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. A board-approved education program shall include, at a minimum, the following components:

(i) Eight hours pharmacology;

(ii) 12 hours pre-procedure evaluation, patient selection, anatomy, and ASA classification;

(iii) Four hours anesthesia technique, monitoring, and equipment;

(iv) 12 hours inter-operative management and recognition of emergencies and complications;

(v) Six hours emergency preparedness, including running scenarios and management of complications; and

(vi) Four hours management of geriatric patients.

(c) Maintenance of Permit. A dentist must comply with the requirements of rule 110.9 to qualify for annual renewal of a Level 2 or Level 3 sedation/anesthesia permit.

(d) Administration of Level 2 or Level 3 Sedation/Anesthesia to Pediatric Patients. A dentist shall comply with all requirements regarding the treatment of pediatric patients, including those described in rule 110.11. Additionally 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.

(e) Delegation and Supervision Requirements. A dentist must maintain the minimum standard of care, including, but not limited to the requirements outlined in (f) below, and in addition shall:

(1) 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;

(2) 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

(3) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing any level of sedation unless the dentist holds a permit issued by the board for the level of sedation to be administered during the dental
procedure being performed.

(f) Standard of Care and Clinical Requirements. A dentist must maintain the minimum standard of care in the administration of sedation/anesthesia in accordance with rule 108.7, including but not limited to the following 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 shall consist of at least a review of the patient’s current medical history and medication use. Patients with significant medical considerations (ASA III, IV) require review of their current medical history and medication use, as well as documented verbal or written consultation with the patients’ primary care physician or consulting medical specialist.

(2) Pre-Procedural 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 rules 108.7 and 108.8 of this title.

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

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

(F) Pre-procedural 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.

(D)The dentist’s record of the patient’s treatment shall include all records created by or for the sedation provider.

(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.
**Texas Register**

TITLE 22  
EXAMINING BOARDS

PART 5  
STATE BOARD OF DENTAL EXAMINERS

CHAPTER 110  
SEDATION AND ANESTHESIA

RULE §110.6  
Deep Sedation or General Anesthesia - Level 4

ISSUE  
12/16/2016

ACTION  
Proposed

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**Preamble**

(a) **Initial Application Requirements for Level 4 Deep Sedation or General Anesthesia Permit.** A Dentist applying for a Level 4 Deep Sedation or General Anesthesia permit shall demonstrate the following: [Education and Professional Requirements.]

(1) **current certification in Basic Life Support (BLS) for Healthcare Providers:**

(2) **current certification in Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) course; and**

(3) **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 in administering and managing deep sedation or general anesthesia.**

([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) Maintenance of Permit. A dentist must comply with the requirements of rule 110.9 to qualify for annual renewal of a Level 4 sedation/general anesthesia permit.

(c) Administration of Level 4 Sedation/anesthesia to Pediatric Patients. A dentist shall comply with all requirements regarding the treatment of pediatric patients, including those described in rule 110.11. Additionally 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) Delegation and Supervision Requirements. A dentist must maintain the minimum standard of care, including, but not limited to the requirements outlined in (e) below, and in addition shall:

(1) 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;

(2) 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

(3) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing any level of sedation unless the dentist holds a permit issued by the board for the level of sedation to be administered during the dental procedure being performed.

(e) Standard of Care and Clinical Requirements. A dentist must maintain the minimum standard of care in the administration of sedation/anesthesia in accordance with rule 108.7, including but not limited to the following 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. Patients with significant medical considerations (ASA III, IV) require review of their current medical history, medication use, and NPO status, as well as documented verbal or written consultation with the patients’ 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 Special Situations 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

(ii) Two additional individuals who hold current certification 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.

(D) The dentist’s record of the patient’s treatment shall include all records created by or for the sedation provider.

(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 and 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.

(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.

[(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 caregiver 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 caregiver.]

[(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.]
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.

Cont'd...
(a) The Board shall renew a sedation/general anesthesia [anesthesia/sedation] permit annually if required fees are paid and the required emergency management training and continuing education requirements are satisfied. The Board shall consider disciplinary history in Texas and in other jurisdictions in its review of a sedation/general anesthesia permit renewal application. The Board shall not renew a sedation/general anesthesia [anesthesia/sedation] permit if, after notice and opportunity for hearing, the Board finds the permit holder has provided, or is likely to provide, sedation/general anesthesia [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) Emergency Management Training. To renew a sedation/general anesthesia permit, a dentist shall demonstrate maintenance of competency in emergency management. Specifically, a dentist must provide proof of the emergency management certification required of the dentist’s highest sedation/general anesthesia permit level, as follows:

(1) Nitrous Oxide/Oxygen Inhalation Sedation and Level 1 Minimal Sedation - current certification in Basic Life Support (BLS).

(2) Levels 2 and 3: Moderate Sedation - current certification in BLS and current certification in Advanced Cardiac Life Support (ACLS). A dentist who obtained pediatric privileges by meeting the requirements of rule 110.11(b)(1), may meet this requirement by maintaining current certification in BLS and current certification in Pediatric Advanced Life Support (PALS).

(3) Level 4: Deep Sedation/General Anesthesia - current certification in BLS and current certification in ACLS. A dentist who obtained pediatric privileges by meeting the requirements of rule 110.11(b)(1), may meet this requirement by maintaining current certification in BLS and current certification in Pediatric Advanced Life Support (PALS).

(d) Continuing Education. In addition to the continuing education required for renewal of dental licensure, a dentist seeking to renew a minimal sedation, moderate sedation, or deep sedation/general anesthesia permit must submit proof of completion of additional continuing education to maintain a sedation/anesthesia permit. A dentist shall, at a minimum, complete the following hours of continuing education every two years on the administration of or medical emergencies associated with the permitted level of sedation:

(1) Level 1: Minimal Sedation - twelve (12) hours, including eight hours of sedation/general anesthesia emergency preparedness training
(2) Levels 2 and 3: Moderate Sedation - twelve (12) hours, including eight hours of sedation/general anesthesia emergency preparedness training.

(3) Level 4: Deep Sedation/General Anesthesia - sixteen (16) hours, including eight hours of sedation/general anesthesia emergency preparedness training.

(e) The emergency management training and continuing education requirements required by this rule shall be in addition to any additional continuing education required to maintain dental licensure. ACLS, BLS, and Pediatric Advanced Life Support (PALS) courses may not be used to fulfill continuing education required for renewal of dental licensure or renewal of a sedation/anesthesia permit under this section.

(f) A licensee’s emergency management and continuing education is subject to audit in Board investigation and as described in rule 104.5.

(g) Continuing education courses must meet the provider endorsement requirements of rule 104.2.

[(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.]

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on December 5, 2016

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Kelly Parker

Executive Director

State Board of Dental Examiners

Earliest possible date of adoption: January 15, 2017

For further information, please call: (512) 475-0977
(a) Pediatric patients include all patients under the age of thirteen (13) at the time of a dental treatment or procedure.

(b) Initial Requirement for Pediatric Sedation/General Anesthesia Privileges. A dentist may obtain pediatric privileges on a Level 1, Level 2, Level 3, or Level 4 sedation/general anesthesia permit by demonstrating compliance with one of the following requirements at the time the dentist renews or seeks a sedation/general anesthesia permit:

(1) completion of an advanced education program accredited by the Commission on Dental Accreditation that provided didactic and clinical education in pediatric sedation/general anesthesia;

(2) successful administration of sedation/general anesthesia to at least 20 (twenty) pediatric patients, in the six months preceding the date of initial application for a sedation/general anesthesia permit with pediatric privileges or the date of renewal application for a sedation/general anesthesia permit with initial application for pediatric privileges; or

(3) completion of an in-person board-approved education program of at least 24 (twenty-four) hours of training in pediatric sedation/general anesthesia. The board-approved education program shall include, at a minimum, the following 21 (twenty-one) hours of training:

(A) A minimum of three hours of training in pharmacology;

(B) A minimum of three hours of training in pre-procedure evaluation, patient selection, anatomy, and ASA classification;

(C) A minimum of six hours of training in sedation/general anesthesia technique, monitoring, and equipment;

(D) A minimum of six hours of training in emergency preparedness, including running scenarios and management of complications; and

(E) A minimum of three hours of training in treating special needs pediatric patients.

(c) For the time period from September 1, 2017, through a dentist’s next sedation/general anesthesia permit renewal occurring prior to September 1, 2018, a dentist may sedate pediatric patients pursuant to the dentist’s underlying sedation/general anesthesia permit without demonstrating to the agency compliance with (b) above.

(d) If a dentist does not demonstrate compliance with (b) above at the time of the sedation/general anesthesia permit renewal occurring between September 1, 2017, and August 31, 2018, the dentist does not hold pediatric sedation privileges and may no longer sedate pediatric patients, as of the date of the dentist’s sedation/general anesthesia permit renewal.
(c) A dentist may seek pediatric sedation privileges at any time by completing an application and demonstrating compliance with (b) above and any other requirements.

(f) Continuing Education Requirements for Pediatric Sedation/General Anesthesia Privileges. In addition to continuing education required by other rules, a dentist who administers Level 1, 2, 3, or 4 sedation/general anesthesia to a pediatric patient must complete a minimum of eight hours of continuing education in pediatric sedation/general anesthesia every two years. This continuing education is in addition to continuing education required for license renewal, renewal of sedation/anesthesia permits, or any other continuing education requirement. BLS, ACLS, or PALS do not satisfy the continuing education requirement for renewal of sedation/general anesthesia permits under this section. A dentist must submit proof of compliance at the time of permit renewal.

(g) The initial training requirements in subsection (b) and the continuing education requirements in subsection (f) are subject to audit by the agency.

(h) Emergency Preparedness. In addition to the requirements of emergency preparedness in other sections of these rules, a dentist administering sedation/general anesthesia to a pediatric patient must be prepared to rescue a child from a deeper level of sedation than intended, and comply with the following requirements:

1. A dentist administering sedation to a pediatric patient must maintain current certification in Pediatric Advanced Life Support (PALS). A dentist delegating the administration of sedation to a pediatric patient must maintain current certification in PALS or Advanced Cardiac Life Support (ACLS). A dentist must submit proof of compliance at the time of permit renewal.

2. A dentist administering sedation to a pediatric patient or delegating the administration of sedation to a pediatric patient must maintain a protocol for immediate access to back-up emergency services, including, for nonhospital facilities a protocol for the immediate activation of the EMS system for life-threatening complications. The practitioners must be prepared to provide initial rescue for life-threatening complications.

3. A dentist administering sedation to a pediatric patient or delegating the administration of sedation to a pediatric patient must ensure that an emergency cart or kit is immediately accessible and contains the necessary age- and size-appropriate equipment and emergency drugs to resuscitate a non-breathing and unconscious child. The contents of the kit must allow for the provision of continuous life support while the pediatric patient is being transported to a medical/dental facility or to another area within the facility. All equipment and drugs must be checked and maintained on a scheduled basis.

(A) An emergency cart or kit accompanying a pediatric sedation at Level 1 or 2 must include, at a minimum, the following components: oral and nasal airways, bag-valve-mask device, laryngeal mask airways or other supraglottic devices, face masks, blood pressure cuffs; and

(B) An emergency cart or kit accompanying a pediatric sedation at Level 3 or 4 must include, at a minimum, the following components: oral and nasal airways, bag-valve-mask device, laryngeal mask airways or other supraglottic devices, laryngoscope blades, tracheal tubes, face masks, blood pressure cuffs, and intravenous catheters.

(i) Pediatric Standard of Care and Monitoring.

1. Nitrous oxide shall not be administered to a pediatric patient at a concentration of greater than 50% unless the person administering the nitrous oxide holds a Level 2 or higher sedation/general anesthesia permit and meets all other requirements of this rule.

2. Monitoring of a pediatric patient undergoing minimal sedation must include the use of pulse oximetry and precordial stethoscope.
(3) Monitoring of a pediatric patient undergoing moderate sedation must include the use of pulse oximetry, electrocardiography, and either capnography or a precordial/pretracheal stethoscope.

(4) Monitoring of a pediatric patient undergoing deep sedation/general anesthesia must include the use of pulse oximetry, electrocardiography, capnography and a precordial/pretracheal stethoscope.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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Kelly Parker

Executive Director

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