Oregon
Kate Brown, Governor

Board of Dentistry
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Portland, OR 97201-5837
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# MEETING NOTICE

## ANESTHESIA COMMITTEE

Oregon Board of Dentistry
ZOOM MEETING
https://us02web.zoom.us/j/81307536546?pwd=WmUrTlNsN3NlUHlEUTNXYzVvcmU0UT09
Dial-In Phone #: 1-253-215-8782 • Meeting ID: 813 0753 6546 • Passcode: 304686

March 18, 2022
**3:45 p.m. - 5:15 p.m.**

Committee Members:

Reza Sharifi, D.M.D., Chair
Sheena Kansal, D.D.S.
Julie Ann Smith, D.D.S., M.D., M.C.R.
Brandon Schwindt, D.M.D.
Mark Mutschler, D.D.S.
Michael Doherty, D.D.S.
Jay Wylam, D.M.D.
Normund Auzins, D.M.D.
Eric Downey, D.D.S.
Ryan Allred, D.M.D.

AGENDA

Call to Order Reza Sharifi, D.M.D., Chair

1. Review Minutes of November 28, 2018 Committee Meeting

- November 28, 2018 Minutes - **Attachment #1**

**Correspondence**

2. Review OBD January 2019 Anesthesia Survey. - **Attachment #2**

3. Review, discuss and make recommendations to the Board regarding proposed rule changes to OAR 818-026-0010 – Definitions– adding non-intramuscular to (6) and defining recovery. Board Recommendation on 8/20/21. Defining recovery is a Staff Recommendation.

Draft change to OAR 818-026-0010 – Definitions – **Attachment #3**

4. Review, discuss and make recommendations to the Board regarding proposed rule changes to OAR 818-026-0020 – Presumption of Degree of Central Nervous System Depression – adding language that more than one patient can be under Nitrous at one time. Dental Therapy Rules Oversight Committee Recommendation.

Draft change to OAR 818-026-0020 – Presumption of Degree of Central Nervous System Depression – **Attachment #4**

The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson, (971) 673-3200.

5. Minimal Sedation Permit Emergency Drugs – Dr. Smith Email

Draft changes to OAR 818-026-0050 – Minimal Sedation Permit - **Attachment #5**

6. Review, discuss and make recommendations to the Board regarding proposed rule changes to OAR 818-026-0055 – Dental Hygiene, Dental Therapy, and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation (Changes proposed from Dental Therapy Rules Oversight Committee).

Draft changes to OAR 818-026-0055 – Dental Hygiene, Dental Therapy, and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation - **Attachment #6**

7. Permit Application and Renewal – Dr. Huggins Email – **Attachment #7**

8. Review, discuss and make recommendations to the Board regarding proposed rule changes to OAR 818-026-0060 – Moderate Sedation Permit – adding prechordial/pretrachial stethoscope as a requirement. Staff Recommendation

Draft change to OAR 818-026-0060 – Moderate Sedation – **Attachment #8**

9. Review, discuss and make recommendations to the Board regarding proposed rule changes to OAR 818-026-0080 – Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia – adding language that more than one patient can be under Nitrous at one time. Dental Therapy Rules Oversight Committee Recommendation and Board Recommendation.

Draft change to OAR 818-026-0080 – Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia – **Attachment #9**

10. Review and discuss 10/2/19 Oregon Society of Anesthesiologists testimony submitted for rule changes effective 1/1/20 - **Attachment #10**

11. Review and discuss 10/11/19 American Society of Anesthesiologists testimony submitted for rule changes effective 1/1/20 - **Attachment #11**

12. Review and discuss OSOMS Anesthesia testimony submitted for rule changes effective 1/1/20 - **Attachment #12**

13. Review and discuss OAR 818-026-0065 – Deep Sedation and OAR 818-026-0070 – General Anesthesia Permit - **Attachment #13**

14. Review and discuss Federal Anesthesia Monitor Requirements - **Attachment #14**

Any Other Business

This meeting is being held remotely via Zoom. A request for accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.

**Oregon Board of Dentistry**
**Anesthesia Committee Meeting**

**Minutes**
**November 28, 2018**

| | |
|---|---|
| MEMBERS PRESENT: | Julie Ann Smith, D.D.S., M.D., M.C.R., Chair<br>Hai Pham, D.M.D.<br>Brandon Schwindt, D.M.D.<br>Norman Auzins, D.M.D.<br>Daniel Rawley, D.D.S.<br>Jay Wylam, D.M.D.<br>Eric Downey, D.D.S.<br>Ryan Allred, D.M.D.<br>Michael J. Doherty, D.D.S. |
| STAFF PRESENT: | Stephen Prisby, Executive Director<br>Daniel Blickenstaff, D.D.S., Dental Director/Chief Investigator<br>Teresa Haynes, Office Manager<br>Samantha VandeBerg, Office Specialist |
| ALSO PRESENT: | Lori Lindley, Sr. Assistant Attorney General |
| VISITORS PRESENT: | Jeff Kobernik, D.M.D.; Cassie Leone, ODA; Paul Brannen, D.M.D.; Rich McKinney, D.M.D. |

**Call to Order:** The meeting was called to order by Dr. Smith at 6:31 p.m.

## MINUTES

Dr. Schwindt moved and Dr. Auzins seconded that the minutes of the September 26, 2017 Anesthesia Committee meeting be approved as presented. The motion passed unanimously.

## CORRESPONDENCE

### Correspondence from Dr. Jeffery Kobernik, D.M.D.

Dr. Kobernik submitted a letter to the committee in regards to the current requirements for the recovery of patients by anesthesia providers traveling to other offices. He requests that the Anesthesia Committee review more appropriate parameters for monitoring patient recovery that are representative of current practice seen in oral surgery offices and those practitioners who do not report to the Board (i.e. Physician Anesthesiologists & CRNAs).

### New Opioid Guidelines – Oregon Health Authority (OHA)

On October 25, 2018, the Oregon Health Authority released the Oregon Acute Opioid Prescribing Guidelines in an effort to help clinicians working in surgical, dental, primary care, emergency and urgent care settings make evidence-based prescribing decisions when treating pain. In general, the guidelines advise against using opioids as the first-line therapy for mild to

moderate pain. If opioids are deemed appropriate and likely effective for the patient, the guidelines emphasize the following principles:

- Evaluate the patient.
- Assess history of long-term opioid use or substance use disorder.
- Check the Prescription Drug Monitoring Program, which tracks prescribed controlled substances such as opioids and benzodiazepines.
- Provide patient education.
- Prescribe the lowest effective dose of short-acting opioids for no more than three days in most cases and no more than seven days in cases of more severe acute pain.
- Provide follow-up and reassess pain, healing and function.
- Implement, monitor and document pain management practices to ensure care safety and quality.

**OAR 818-026-0060 – Continuing Education - Dentists**

Dr. Auzins moved and Dr. Doherty seconded that the Committee recommend the Board send OAR 818-021-0060(5) – Continuing Education (Dentists) to the Rules and Oversight Committee requiring dentists to complete a one hour pain management course every third renewal cycle. The motion passed unanimously.

In addition, Dr. Schwindt moved and Dr. Doherty seconded that the Committee recommend the Board send OAR 818-021-0060(6) – Continuing Education (Dentists) to the Rules and Oversight Committee to consider reducing the infection control requirement from two hours to one. The motion passed unanimously.

**818-021-0060**
**Continuing Education — Dentists**
(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.
(3) Continuing education includes:
(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course includes an examination and the dentist passes the examination.
(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.

(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.
(5) All dentists licensed by the Oregon Board of Dentistry will complete**, every third renewal cycle,** a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority. **The implementation of this requirement will be effective January 1, 2020.** All applicants ~~or licensees~~ shall complete this requirement ~~by January 1, 2010 or~~ within ~~24 months of~~ the first renewal **cycle** of the dentist's license**, and every third renewal cycle thereafter**.
(6) At least ~~2~~ **(1)** hour~~s~~ of continuing education must be related to infection control. ~~(Effective January 1, 2015.)~~

## OAR 818-026-0010(6) – Definitions

Dr. Doherty moved and Dr. Auzins seconded that the Committee recommend that the Board send OAR 818-026-0010(6) to the Rules Oversight Committee as presented. The motion passed unanimously.

**818-026-0010(6)**
**Definitions**
(6) "Minimal Sedation" means minimally depressed level of consciousness, produced by non-intravenous pharmacological methods, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use**, can be achieved by incremental dosing**. Nitrous oxide/oxygen may be used in combination with a single non-intravenous pharmacological method in minimal sedation. **Maintenance of minimal sedation can be achieved through supplemental dosing.**
(7) "Nitrous Oxide Sedation" means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.
(8) "Maximum recommended dose" (MRD) means maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored use.
(9) "Incremental Dosing" means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).
(10) "Supplemental Dosing" means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is 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 total aggregate dose must not exceed 1.5x the MRD on the day of treatment.
(11) "Enteral Route" means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.
(12) "Parenteral Route" means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.
(13) American Society of Anesthesiologists (ASA) Patient Physical Status Classification System.
(a) ASA I "A normal healthy patient".
(b) ASA II "A patient with mild systemic disease".
(c) ASA III "A patient with severe systemic disease".
(d) ASA IV "A patient with severe systemic disease that is a constant threat to life".
(e) ASA V "A moribund patient who is not expected to survive without the operation".
(f) ASA VI "A declared brain-dead patient whose organs are being removed for donor

## Anesthesia Monitors

The Committee reviewed the current rule and recommends that it be taken out of OAR 818-026-0030(4) and add it to each permit level with specific anesthesia monitor requirements depending on the level of sedation. Based on the discussion the Committee directed staff and Dr. Smith to come up with language to present to the Board.

**818-026-0030 – Requirement for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor**

Requirement for Anesthesia Permit~~, Standards and Qualifications of an Anesthesia Monitor~~

(1) A permit holder who administers sedation shall assure that drugs, drug dosages, and/or techniques used to produce sedation shall carry a margin of safety wide enough to prevent unintended deeper levels of sedation.

(2) No licensee shall induce central nervous system sedation or general anesthesia without first having obtained a permit under these rules for the level of anesthesia being induced.

(3) A licensee may be granted a permit to administer sedation or general anesthesia with documentation of training/education and/or competency in the permit category for which the licensee is applying by any one the following:

(a) Initial training/education in the permit category for which the applicant is applying shall be completed no more than two years immediately prior to application for sedation or general anesthesia permit; or

(b) If greater than two years but less than five years since completion of initial training/education, an applicant must document completion of all continuing education that would have been required for that anesthesia/permit category during that five year period following initial training; or

(c) If greater than two years but less than five years since completion of initial training/education, immediately prior to application for sedation or general anesthesia permit, current competency or experience must be documented by completion of a comprehensive review course approved by the Board in the permit category to which the applicant is applying and must consist of at least one-half (50%) of the hours required by rule for Nitrous Oxide, Minimal Sedation, Moderate Sedation and General Anesthesia Permits. Deep Sedation and General Anesthesia Permits will require at least 120 hours of general anesthesia training.

(d) An applicant for sedation or general anesthesia permit whose completion of initial training/education is greater than five years immediately prior to application, may be granted a sedation or general anesthesia permit by submitting documentation of the requested permit level from another state or jurisdiction where the applicant is also licensed to practice dentistry or dental hygiene, and provides documentation of the completion of at least 25 cases in the requested level of sedation or general anesthesia in the 12 months immediately preceding application; or

(e) Demonstration of current competency to the satisfaction of the Board that the applicant possesses adequate sedation or general anesthesia skill to safely deliver sedation or general anesthesia services to the public.

~~(4) Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained in monitoring patient vital signs, and be competent in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. (The term "competent" as used in these rules means displaying special skill or knowledge derived from training and experience.)~~

**(4)**~~(5)~~ A licensee holding a nitrous or minimal sedation permit, shall at all times maintain a current BLS for Health Care Providers certificate or its equivalent.

**(5)**~~(6)~~ A licensee holding an anesthesia permit for moderate sedation, deep sedation or general anesthesia at all times maintains a current BLS for Health Care Providers certificate or its equivalent, and a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated. If a licensee permit holder sedates only patients under the age of 12, only PALS is required. If a licensee permit holder sedates only patients age 12 and older, only ACLS is required. If a licensee permit holder sedates patients

younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. For licensees with a moderate sedation permit only, successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" at least every two years may be substituted for ACLS, but not for PALS.

**(6)**~~(7)~~ Advanced Cardiac Life Support (ACLS) and or Pediatric Advanced Life Support (PALS) do not serve as a substitute for Health Care Provider Basic Life Support (BLS).

**(7)** ~~(8)~~ When a dentist utilizes a single oral agent to achieve anxiolysis only, no anesthesia permit is required.

**(8)** ~~(9)~~ The applicant for an anesthesia permit must pay the appropriate permit fee, submit a completed Board-approved application and consent to an office evaluation.

**(9)** ~~(10)~~ Permits shall be issued to coincide with the applicant's licensing period.

**818-026-0040 - Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Permit**

Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Permit

Nitrous Oxide Sedation.

(1) The Board shall issue a Nitrous Oxide Permit to an applicant who:

(a) Is either a licensed dentist or licensed hygienist in the State of Oregon;

(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and

(c) Has completed a training course of at least 14 hours of instruction in the use of nitrous oxide from a dental school or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association, or as a postgraduate.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow delivery of appropriate care in an emergency situation;

(b) An operating table or chair which permits the patient to be positioned so that the patient's airway can be maintained, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system; and

(g) Sphygmomanometer and stethoscope and/or automatic blood pressure cuff.

(3) Before inducing nitrous oxide sedation, a permit holder shall:

(a) Evaluate the patient;

(b) Give instruction to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;

(c) Certify that the patient is an appropriate candidate for nitrous oxide sedation; and

(d) Obtain informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(4) If a patient chronically takes a medication which can have sedative side effects, including, but not limited to, a narcotic or benzodiazepine, the practitioner shall determine if the additive sedative effect of nitrous oxide would put the patient into a level of sedation deeper than nitrous oxide. If the practitioner determines it is possible that providing nitrous oxide to such a patient would result in minimal sedation, a minimal sedation permit would be required.

(5) A patient under nitrous oxide sedation shall be visually monitored by the permit holder or by an anesthesia monitor at all times. The patient shall be monitored as to response to verbal stimulation, oral mucosal color and preoperative and postoperative vital signs.

(6) The permit holder or anesthesia monitor shall record the patient's condition. The record must include documentation of all medications administered with dosages, time intervals and route of administration.

**(7) Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)**

**(8)**~~(7)~~ The person administering the nitrous oxide sedation may leave the immediate area after initiating the administration of nitrous oxide sedation only if a qualified anesthesia monitor is continuously observing the patient.

**(9)**~~(8)~~ The permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(b) The patient can talk and respond coherently to verbal questioning;

(c) The patient can sit up unaided or without assistance;

(d) The patient can ambulate with minimal assistance; and

(e) The patient does not have nausea, vomiting or dizziness.

**(10)**~~(9)~~ The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.

**(11)**~~(10)~~ Permit renewal. In order to renew a Nitrous Oxide Permit, the permit holder must provide proof of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Nitrous Oxide Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, nitrous oxide, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060 and 818-021-0070.

## OAR 818-026-0050 – Minimal Sedation

Dr. Auzins moved and Dr. Doherty seconded that the Committee recommend that the Board send OAR 818-026-0050 to the Rules Oversight Committee as amended. The motion passed unanimously.

**818-026-0050**
Minimal Sedation Permit
Minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a Minimal Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and

(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or

(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and

(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;

(c) Certify that the patient is an appropriate candidate for minimal sedation; and

(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(4) No permit holder shall have more than one person under minimal sedation at the same time.

(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.

(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. **The record must include documentation of all medications administered with dosages, time intervals and route of administration.** The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.

**(7) Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)**

**(8)**~~(7)~~ The patient shall be monitored as follows:

(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, **pulse oximetry** and respiration shall be monitored and documented **every fifteen minutes,** if they can reasonably be obtained.

(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

**(9)**~~(8)~~ The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.

**(10)**~~(9)~~ Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

**818-026-0060**
**Moderate Sedation Permit**

Moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue or renew a Moderate Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, either maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated; and

(c) Satisfies one of the following criteria:

(A) Completion of a comprehensive training program in enteral and/or parenteral sedation that satisfies the requirements described in Part V of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced.

(i) Enteral Moderate Sedation requires a minimum of 24 hours of instruction plus management of at least 10 dental patient experiences by the enteral and/or enteral-nitrous oxide/oxygen route.

(ii) Parenteral Moderate Sedation requires a minimum of 60 hours of instruction plus management of at least 20 dental patients by the intravenous route.

(B) Completion of an ADA accredited postdoctoral training program (e.g., general practice residency) which affords comprehensive and appropriate training necessary to administer and manage parenteral sedation, commensurate with these Guidelines.

(C) In lieu of these requirements, the Board may accept equivalent training or experience in moderate sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, oral and nasopharyngeal airways, larynageal mask airways, intravenous fluid administration equipment, automated external defibrillator (AED); and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) No permit holder shall have more than one person under moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.

(4) During the administration of moderate sedation, and at all times while the patient is under moderate sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist permit holder performing the dental procedures.

(5) Before inducing moderate sedation, a dentist permit holder who induces moderate sedation shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for moderate sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and

(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(6) A patient under moderate sedation shall be visually monitored at all times, including the recovery phase. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.

**(7) Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, and a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support Certificate, whichever is appropriate for the patient being sedated. If a licensee permit holder sedates only patients under the age of 12, only PALS is required. If a licensee permit holder sedates only patients age 12 and older, only ACLS is required. If a licensee permit holder sedates patients younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. Anesthesia monitors shall be competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)**

**(8)**(7) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring using pulse oximetry, and End-tidal CO2 monitors. Patients with cardiovascular disease shall have continuous electrocardiograph (ECG) monitoring. The patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 15 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under moderate sedation shall be continuously monitored and shall not be left alone while under sedation;

(b) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from moderate sedation.

**(9)**~~(8)~~ A dentist permit holder shall not release a patient who has undergone moderate sedation except to the care of a responsible third party.

(a) When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.

**(10)**~~(9)~~ The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

**(11)**~~(10)~~ A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

**(12)**~~(11)~~ After adequate training, an assistant, when directed by a dentist permit holder, may dispense oral medications that have been prepared by the dentist permit holder for oral administration to a patient under direct supervision. Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may introduce additional anesthetic agents into an infusion line under the direct supervision of a dentist permit holder.

**(13)**~~(12)~~ Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; Successful completion of a board approved course on minimal/moderate sedation at least every two years may be substituted for ACLS, but not for PALS; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or PALS certification or successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021- 0060.

**818-026-0065**
**Deep Sedation Permit**

Deep sedation, moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue a Deep Sedation Permit to a licensee who holds a Class 3 Permit on or before July 1, 2010 who:
(a) Is a licensed dentist in Oregon; and
(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) No permit holder shall have more than one person under deep sedation, moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.

(4) During the administration of deep sedation, and at all times while the patient is under deep sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist permit holder performing the dental procedures.

(5) Before inducing deep sedation, a dentist permit holder who induces deep sedation shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for deep sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and

(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(6) A patient under deep sedation shall be visually monitored at all times, including the recovery phase. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.

**(7) Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, and a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support Certificate, whichever is appropriate for the patient being sedated. If a licensee permit holder sedates only patients under the age of 12, only PALS is required. If a licensee permit holder sedates only patients age 12 and older, only ACLS is required. If a licensee permit holder sedates patients younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. Anesthesia monitors shall be competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)**

**(8)**(7) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's heart rhythm shall be continuously monitored and the patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 5 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under deep sedation shall be continuously monitored;

(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.

(c) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from deep sedation.

**(9)**~~(8)~~ A dentist permit holder shall not release a patient who has undergone deep sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.

**(10)**~~(9)~~ The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

**(11)**~~(10)~~ A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

**(12)**~~(11)~~ Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may administer oral sedative agents calculated by a dentist permit holder or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist

**(13)**~~(12)~~ Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

**818-026-0070**
**General Anesthesia Permit**

General anesthesia, deep sedation, moderate sedation, minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a General Anesthesia Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated, and

(c) Satisfies one of the following criteria:

(A) Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students consisting of a minimum of 2 years of a postgraduate anesthesia residency at the time training was commenced.

(B) Completion of any ADA accredited postdoctoral training program, including but not limited to Oral and Maxillofacial Surgery, which affords comprehensive and appropriate training necessary to administer and manage general anesthesia, commensurate with these Guidelines.

(C) In lieu of these requirements, the Board may accept equivalent training or experience in general anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least three individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for treatment of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics, antihypertensives and anticonvulsants.

(3) No permit holder shall have more than one person under general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation at the same time.

(4) During the administration of deep sedation or general anesthesia, and at all times while the patient is under deep sedation or general anesthesia, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory in addition to the dentist permit holder performing the dental procedures.

(5) Before inducing deep sedation or general anesthesia the dentist permit holder who induces deep sedation or general anesthesia shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for general anesthesia or deep sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and

(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(6) A patient under deep sedation or general anesthesia shall be visually monitored at all times, including recovery phase. A dentist permit holder who induces deep sedation or general anesthesia or anesthesia monitor trained in monitoring patients under deep sedation or general anesthesia shall monitor and record the patient's condition on a contemporaneous record.

**(7) Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, and a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support Certificate, whichever is appropriate for the patient being sedated. If a licensee permit holder sedates only patients under the age of 12, only PALS is required. If a licensee permit holder sedates only patients age 12 and older, only ACLS is required. If a licensee permit holder sedates patients younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. Anesthesia monitors shall be competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)**

**(8)**(7) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring of their heart rate, heart rhythm, oxygen saturation levels and respiration using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's blood pressure, heart rate and oxygen saturation shall be assessed every five minutes, and shall be contemporaneously documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. The person administering the anesthesia and the person monitoring the patient may not leave the patient while the patient is under deep sedation or general anesthesia;

(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.

(c) During the recovery phase, the patient must be monitored, including the use of pulse oximetry, by an individual trained to monitor patients recovering from general anesthesia.

**(9)**~~(8)~~ A dentist permit holder shall not release a patient who has undergone deep sedation or general anesthesia except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.

**(10)**~~(9)~~ The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have nausea or vomiting and has minimal dizziness.

**(11)**~~(10)~~ A discharge entry shall be made in the patient's record by the dentist permit holder indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

**(12)**~~(11)~~ Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may introduce additional anesthetic agents to an infusion line under the direct visual supervision of a dentist permit holder.

**(13)**~~(12)~~ Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

## OAR 818-026-0080 Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia

Dr. Auzins moved and Dr. Rawley seconded that the Committee recommend that the Board send OAR 818-026-0080 to the Rules Oversight Committee as amended. The motion passed unanimously.

**818-026-0080**
**Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia**

(1) A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the Oregon Board of Medical Examiners, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.

(2) A dentist who does not hold a Nitrous Oxide Permit for nitrous oxide sedation may perform dental procedures on a patient who receives nitrous oxide induced by an Oregon licensed dental hygienist holding a Nitrous Oxide Permit.

(3) A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall maintain a current BLS for Healthcare Providers certificate, or its equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.

(4) A dentist, a dental hygienist or an Expanded Function Dental Assistant (EFDA) who performs procedures on a patient who is receiving anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit or a CRNA shall not schedule or treat patients for non emergent care during the period of time of the sedation procedure.
(5) Once anesthetized, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(6) The qualified anesthesia provider who induces moderate sedation, deep sedation or general anesthesia shall monitor the patient~~'s condition the patient is discharged~~ **until easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred the patient may be monitored by a qualified anesthesia monitor until discharge criteria is met. The patient's dental record shall document** the patient's condition at discharge ~~in the patient's dental record~~ as required by the rules applicable to the level of anesthesia being induced. ~~The~~ **A copy of the** anesthesia record shall be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures.
**(7) No qualified provider shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery.**
**(8)**~~(7)~~ A dentist who intends to use the services of a qualified anesthesia provider as described in section 1 above, shall notify the Board in writing of his/her intent. Such notification need only be submitted once every licensing period.

**Recommendations from the Anesthesia Office Evaluation Safety Workgroup - July 31, 2018 Meeting**

The Committee reviewed the Anesthesia Office Evaluation Safety Workgroups recommendations. The Committee directed staff to survey licensees on which emergency drugs they have in their offices, how often they check to make sure the drugs have not expired, if they hold emergency drills, and if so how often, if they utilize a qualified provider and if so, do they run emergency drills with the qualified provider.

1. Add an Attestation Form to renewal forms for those that have any level of anesthesia permit, with the form also indicating that the drugs kept for emergency management have not expired.
2. A reminder at the time of renewal that every office should hold quarterly emergency drills and the Board would give a brief outline of what should be covered in those drills.
3. A quiz be added to renewal forms for those that have a moderate, deep and general anesthesia permit.
4. That those that utilize a qualified provider per OAR 818-026-0080, attest that they hold emergency drills annually with that provider.
5. A recommendation that OAR 818-026-0080 be reviewed closer to highlight that no two patients can be sedated at any time, and that there be proper protocol and hand off to a qualified anesthesia monitor, if the qualified provider will no longer be required to monitor the patient until criteria for discharge met.
6. Review and update lists of drugs an office should have relevant to the anesthesia permit they hold and also of those the qualified provider has.

Dr. Auzins moved and Dr. Schwindt seconded that the Board implement a quiz as part of the renewal process for a sedation or general anesthesia permit. The Committee recommends that quiz be electronic and available at the time of renewing a licensee's dental license online. The motion passed unanimously.

The Workgroup compiled the following sample quiz to potentially be included as part of the anesthesia permit renewal process every third renewal cycle for licensees holding a moderate sedation, deep sedation or general anesthesia permit:

Sample Quiz: Moderate, deep, general anesthesia

**DPA rules**

1) You provide moderate sedation or deeper to a population of patients aged 8 to 65. Which of the following certifications is required?
    a. ACLS only
    b. PALS and ACLS
    c. BLS only
    d. ACLS, PALS, and BLS

2) You have 4 operatories. How many patients can you have under either nitrous, minimal sedation, or moderate sedation at one time?
    a. 1
    b. 2
    c. 3
    d. 4
3) During the administration of moderate or deeper levels of sedation, the minimum number of people who must be in the operatory besides the dentist permit holder performing the procedure include:
    a. One dental assistant
    b. One BLS provider
    c. One anesthesia monitor and one BLS provider
    d. One BLS certified anesthesia monitor

**Pre-anesthesia evaluation**

1) All of the following findings on airway exam suggest a possible increased risk for a difficult airway EXCEPT:
    a. Mallampati class 3 or 4
    b. BMI > 35 kg/$m^2$
    c. Thyromental distance of 6.5 cm
    d. Maximal interincisal opening < 30 mm
2) Which of the following disease states is most likely to be a contraindication to in-office moderate or deeper levels of sedation, even assuming adequate treatment is in place?
    a. Obstructive sleep apnea
    b. Asthma
    c. Diabetes Mellitus
    d. Seizure disorder
3) All of the following patients are healthy 15 year olds who present for moderate sedation. Which patient is appropriately prepared for moderate sedation?
    a. Sally—last meal was chicken fingers 4 hours ago
    b. Jonathan—last meal was a skim latte 2 hours ago
    c. Katie—last meal was a cup of apple juice 4 hours ago
    d. Mark—last meal was a donut 30 minutes ago

**Monitoring**

1) During what levels of sedation is ETCO2 monitoring required?
    a. Moderate sedation
    b. Deep sedation or General anesthesia only
    c. Moderate, deep, and general anesthesia
    d. General anesthesia only
2) Who can monitor a patient during recovery who has undergone moderate sedation?
    a. The patient's parents
    b. The front desk receptionist
    c. The patient may be left alone once the procedure is complete
    d. An individual trained to perform monitoring
3) Which of the following medications, if administered after sedation, will alter how long you plan to monitor the patient?
    a. Romazicon
    b. Ketorolac

c. Acetaminophen
d. Dexamethasone

**Management of emergencies**

1) Your patient is a healthy 15 year old with no personal or family history of anesthesia complications. During the course of sedation, your patient coughs and begins to desaturate. A crowing sound is heard from the throat. You identify laryngospasm and attempt positive pressure ventilation, which is unsuccessful. The oxygen saturation is 84%. Of the following, what drug would you select as your next step in treatment?
    a. Albuterol
    b. Hydrocortisone
    c. Succinylcholine
    d. Epinephrine
2) Your 59 year old patient under sedation begins obstructing his airway and he begins to desaturate. You attempt bag valve mask ventilation with both an oral airway and a nasal airway, but are still unable to ventilate. His preop saturation was 99% and now it is 83%. He is unconscious and has a pulse, but is not breathing. The next airway adjunct you might try is:
    a. Needle cricothyroidotomy
    b. Wait until he wakes up
    c. Supraglottic airway
    d. Tracheostomy
3) In the current ACLS algorithm for adult cardiac arrest, the drug that may be administered in addition to Epinephrine is:
    a. Lidocaine
    b. Vasopressin
    c. Adenosine
    d. Amiodarone

Dr. Auzins moved and Dr. Rawley seconded to move the anesthesia quiz to the Board for further review. The motion passed unanimously.

**OTHER BUSINESS**

Nothing to report.

The meeting adjourned at 9:15 p.m.

Oregon
Kate Brown, Governor

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**TO:** OBD Board Members

**FROM:** Stephen Prisby, Executive Director

**DATE:** February 5, 2019

**SUBJECT:** OBD January 2019 Anesthesia Survey

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The OBD created an anesthesia survey based on the recommendations from our Anesthesia Office Evaluation Workgroup, and fine-tuned further with input from our Anesthesia Committee. The survey sought to gather information from our licensees on whether they utilize a qualified outside provider to sedate their patients along with questions regarding emergency drugs and emergency drills.

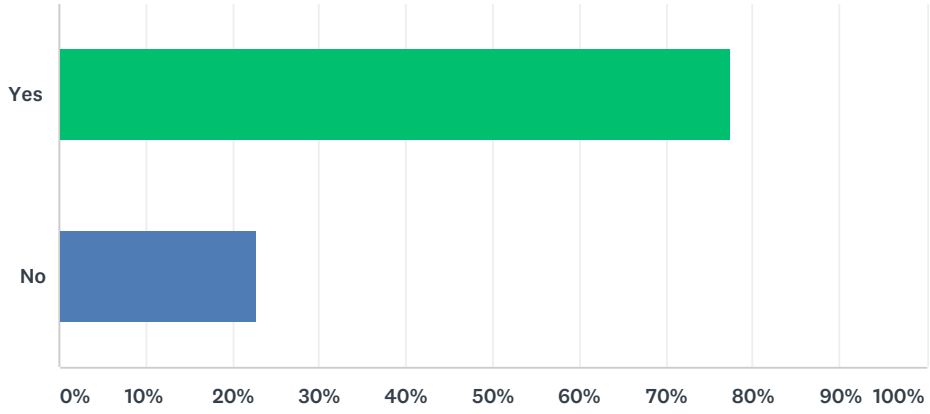
The survey was sent to 3078 dentists that the Board had email addresses on. The board sent the survey out on January 14 and closed the survey on January 22.

The response was very good with 644 surveys completed, which is almost a 21% response rate. The survey results are attached and yield many interesting data points which you will be discussing at the Board meeting. The survey was intended to be high level view of sedation practices, and is limited. Nevertheless, as instructed the staff executed this survey, it yielded a solid response and we are encouraged by the information we have from it.

It also communicates to our Licensees that the Board continues to focus on safe sedation practices in Oregon and there will be on-going dialogue and work on this issue.

# Q1 Does your office/clinic administer any level of sedation/anesthesia (excluding local) to patients?

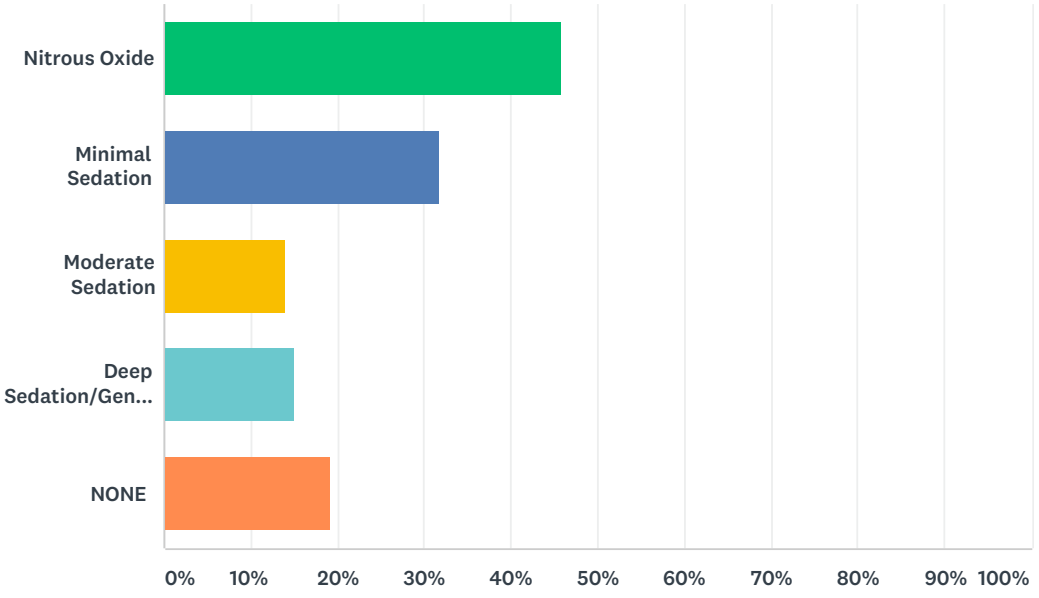
Answered: 644 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 77.33% | 498 |
| No | 22.83% | 147 |
| Total Respondents: 644 | | |

# Q2 What level of anesthesia is provided in your office/clinic? (Choose the highest level provided)

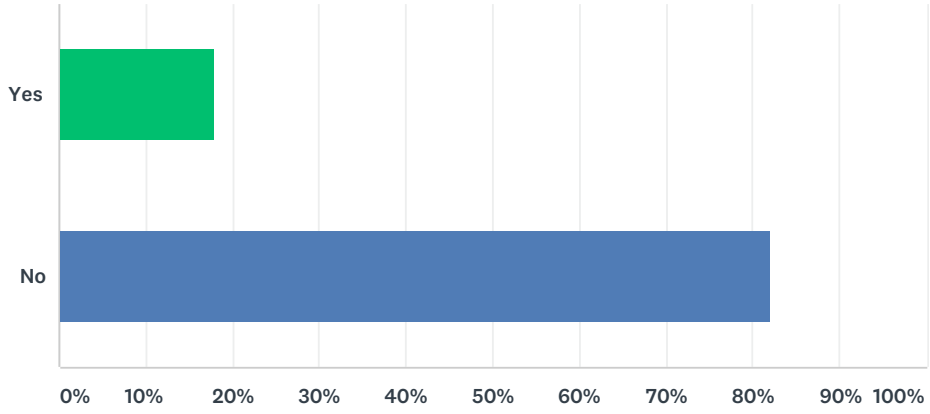
Answered: 644 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Nitrous Oxide | 45.81% | 295 |
| Minimal Sedation | 31.83% | 205 |
| Moderate Sedation | 13.98% | 90 |
| Deep Sedation/General Anesthesia | 15.06% | 97 |
| NONE | 19.25% | 124 |
| Total Respondents: 644 | | |

# Q3 Does your office/clinic utilize a qualified provider to induce sedation/anesthesia (like a Dental Anesthesiologist, CRNA)?

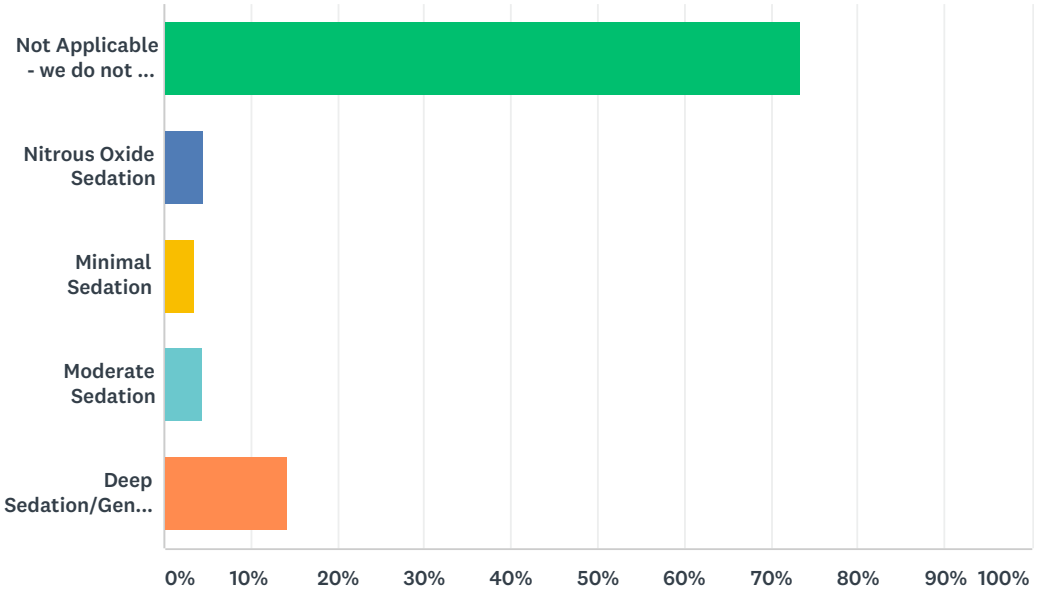
Answered: 644 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 18.01% | 116 |
| No | 81.99% | 528 |
| TOTAL | | 644 |

# Q4 If your office/clinic uses a qualified provider to induce sedation/anesthesia, what is the highest level of sedation provided?

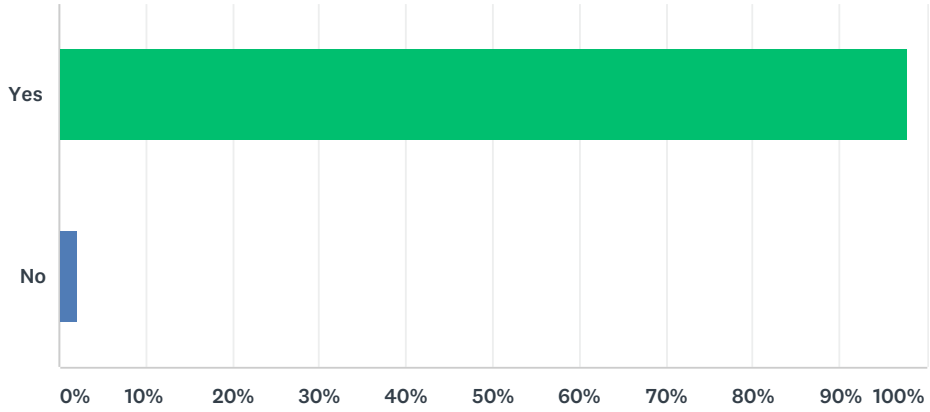
Answered: 644 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Not Applicable - we do not use a qualified provider | 73.45% | 473 |
| Nitrous Oxide Sedation | 4.50% | 29 |
| Minimal Sedation | 3.57% | 23 |
| Moderate Sedation | 4.35% | 28 |
| Deep Sedation/General Anesthesia | 14.13% | 91 |
| TOTAL | | 644 |

# Q5 Are emergency drugs in office/clinic checked regularly to see if they have expired?

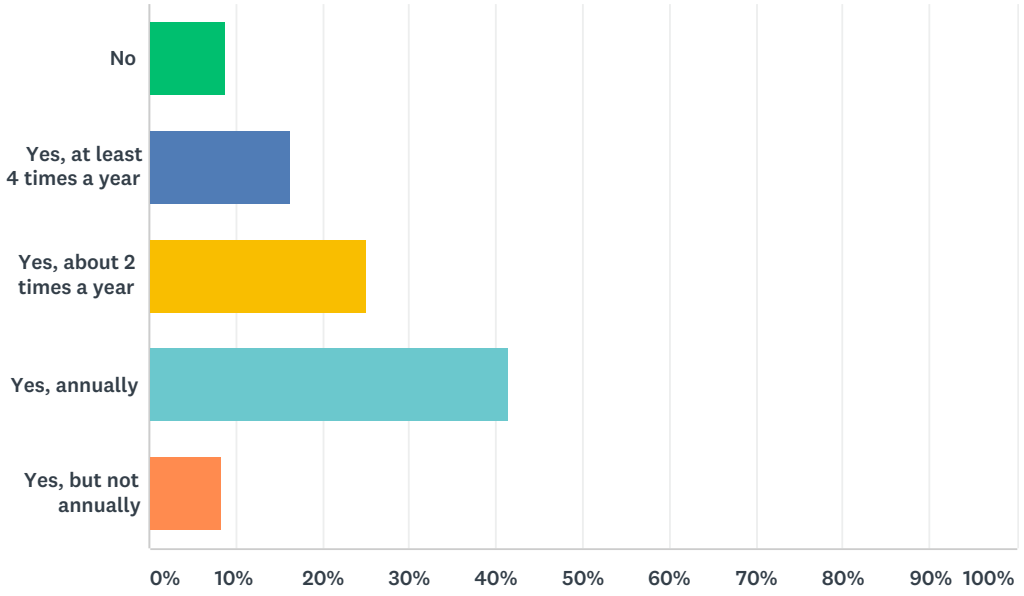
Answered: 644 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 97.98% | 631 |
| No | 2.02% | 13 |
| TOTAL | | 644 |

# Q6 Does your office/clinic conduct emergency drills, regarding patient medical emergencies?

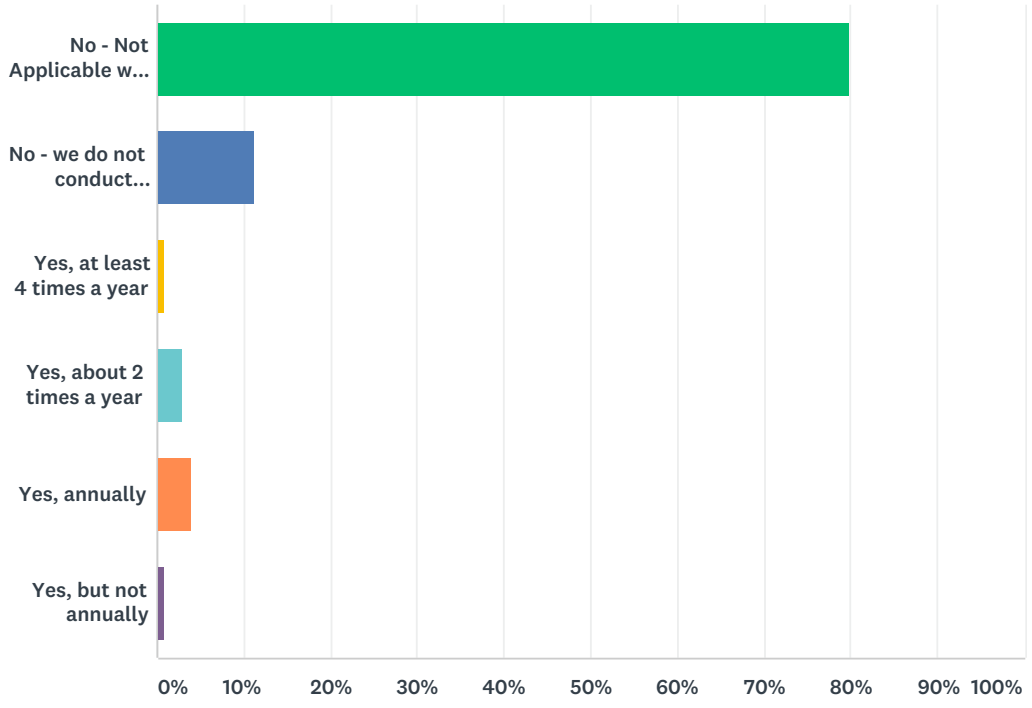
Answered: 644 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| No | 8.70% | 56 |
| Yes, at least 4 times a year | 16.30% | 105 |
| Yes, about 2 times a year | 25.16% | 162 |
| Yes, annually | 41.46% | 267 |
| Yes, but not annually | 8.39% | 54 |
| TOTAL | | 644 |

# Q7 If your office/clinic utilizes an outside qualified provider for sedation/anesthesia services, do you conduct patient emergency medical emergency drills with that provider?

Answered: 644 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| No - Not Applicable we do not use an outside qualified provider for sedation/anesthesia services. | 79.97% | 515 |
| No - we do not conduct emergency drills with outside qualified provider(s). | 11.34% | 73 |
| Yes, at least 4 times a year | 0.78% | 5 |
| Yes, about 2 times a year | 2.95% | 19 |
| Yes, annually | 4.04% | 26 |
| Yes, but not annually | 0.93% | 6 |
| TOTAL | | 644 |

| | |
|---|---|
| **From:** | CARTER Bernie * OBD |
| **To:** | NYE Ingrid * OBD; PRISBY Stephen *OBD; ROBINSON Haley * OBD |
| **Cc:** | SMORRA Angela * OBD |
| **Subject:** | RE: Suggestion for rule review/revision by anesthesia committee |
| **Date:** | Wednesday, May 12, 2021 1:42:12 PM |

Hi Ingrid,
This issue just came up in an “ask the Board” question recently to which I responded.

First, I do not believe the DPA defines “recovery.” That phase of sedation needs to be determined. My definition is that the patient has had all of the optative procedures performed ( whether surgical or non-surgical and sedated) and completed, and then enters a phase of “therapy” when the discharge criteria have not been yet achieved for the patient. That phase of treatment is the period of recovery. Since Dr. Sharifi is our OMS BD member, I would suggest he determine a recommended definition for “recovery” for the Board to be submitted for rule change.

Consider, discharge criteria can be met, with the sedation medications still having an effect on a patient. An example is a patient who has had Valium for sedation, can be discharged when the criteria have been met, but the Valium can affect the patient, even unconsciously, for up to about 48 hrs. This is one reason Navy pilots could not fly for a week after receiving Valium, even after receiving normal local dental anesthetic.

I believe all levels of sedation imply, or so state, that a second patient may start to be sedated only when the first patient is in recovery. (The analogy in the hospital is when the patient leaves the operating room, and goes to recovery. The patient stays in “recovery” until discharge criteria have been met.).

Thanks,
Bernie

---

**From:** NYE Ingrid * OBD <ingrid.nye@oregondentistry.org>
**Sent:** Wednesday, May 12, 2021 12:47 PM
**To:** PRISBY Stephen *OBD <Stephen.PRISBY@oregondentistry.org>; ROBINSON Haley * OBD <Haley.Robinson@oregondentistry.org>
**Cc:** CARTER Bernie * OBD <bernie.carter@oregondentistry.org>; SMORRA Angela * OBD <Angela.Smorra@oregondentistry.org>
**Subject:** Suggestion for rule review/revision by anesthesia committee

Please see the highlighted rule below (emphasis mine):

**818-026-0020**
**Presumption of Degree of Central Nervous System Depression**

(1) In any hearing where a question exists as to the degree of central nervous system depression a licensee has induced (i.e., general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation), the Board may base its findings on, among other things, the types, dosages and routes of administration of drugs administered to the patient and what result can reasonably be expected

from those drugs in those dosages and routes administered in a patient of that physical and psychological status.

(2) The following drugs are conclusively presumed to produce general anesthesia and may only be used by a licensee holding a General Anesthesia Permit:

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

(b) Alkylphenols — propofol (Diprivan) including precursors or derivatives;

(c) Neuroleptic agents;

(d) Dissociative agents — ketamine;

(e) Etomidate; and

(f) Volatile inhalational agents.

(3) No permit holder shall have more than one person under any form of sedation or general anesthesia at the same time **exclusive of recovery**.

(4) A licensee that does not hold a Moderate, Deep Sedation or General Anesthesia Permit may not administer, for purpose of anxiolysis or sedation, Benzodiazepines or narcotics in children under 6 years of age.

(5) A licensee must ensure a written emergency response protocol is in place for all patients undergoing nitrous oxide, minimal sedation, moderate sedation, deep sedation or general anesthesia.

**Statutory/Other Authority:** ORS 679 & 680
**Statutes/Other Implemented:** ORS 679.250(7) & 679.250(10)
**History:**
OBD 2-2018, amend filed 10/04/2018, effective 01/01/2019
OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16
OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13
OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10
OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05
OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03
OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99
OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98

The rules for Minimal Sedation, Moderate Sedation, Deep Sedation, and General Anesthesia all have a similar, but not identical rule.

Minimal 818-026-0050(4): “No permit holder shall have more than one person under minimal sedation at the same time”.
Moderate 818-026-0060(3): “No permit holder shall have more than one person under moderate sedation, minimal sedation, or nitrous oxide sedation at the same time”.
Deep 818-026-0065(3): “No permit holder shall have more than one person under deep sedation, moderate sedation, minimal sedation, or nitrous oxide sedation at the same time”.
General 818-026-0070(3): “No permit holder shall have more than one person under general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation at the same time”.

I suggest:

1. Nitrous oxide should have a similar rule for consistency and clarity. Suggested language: "No permit hold shall have more than one person under nitrous oxide sedation at the same time".
2. The wording of either 818-026-0020(3), *or* all of the individual rules for each type of sedation, should be changed to reflect whether or not the Board wants to include or exclude patients in recovery. 818-026-0020(3) makes it sounds like patients in recovery (as long as they are properly monitored, of course) would *not* be counted as a patient under sedation. The other rules do not have this same language, which would make it hard for a permit holder to figure out whether or not they can sedate a patient while a previously sedated patient is still in recovery.
3. Another option would be to strike all of the rules in the individual sedation sections, as they are redundant to 818-026-0020(3).

Thoughts?

*Ingrid Nye*

Examination & Licensing Manager
Pronouns: she, her, hers

OREGON BOARD OF DENTISTRY
1500 S.W. 1ST AVENUE, SUITE #770
PORTLAND, OR 97201
PHONE: 971-673-3200
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www.Oregon.gov/Dentistry

**IMPORTANT NOTICE ABOUT COVID-19/NOVEL CORONAVIRUS:** At this time, the Oregon Board of Dentistry (OBD) intends to remain fully operational, with OBD staff reporting to work. However, the OBD anticipates the possibility that individual staff members may abruptly be absent from work and unable to respond to email, possibly for long periods of time, due to a quarantine after exposure to COVID-19, an illness, or a need to care for a family member. **Please allow 1-2 business days for a response to your email**. If you have not received a response, please email information@oregondentistry.org or call 971-673-3200 and any available OBD staff member will respond. Thank you for your patience.

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EXAMINATION & LICENSING MANAGER CURRENT OFFICE HOURS: MONDAY – THURSDAY, 6:00AM – 4:30PM.
OBD TELEPHONE HOURS: MONDAY – FRIDAY, 7:30AM – 4:00PM.

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https://www.surveymonkey.com/r/OBDSurveyLink

**818-026-0010**
**Definitions**

As used in these rules:

(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.

(2) "Anxiolysis" means the diminution or elimination of anxiety.

(3) “General Anesthesia” means 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.

(4) “Deep Sedation” means 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.

(5) “Moderate Sedation” means a 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.

(6) “Minimal Sedation” means minimally depressed level of consciousness, produced by non-intravenous **and/or non-intramuscular** pharmacological methods, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous pharmacological method in minimal sedation.

(7) “Nitrous Oxide Sedation” means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(8) “Maximum recommended dose” (MRD) means maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored use.

(9) “Incremental Dosing” means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

(10) “Supplemental Dosing” means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is 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 total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

(11) “Enteral Route” means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.

(12) “Parenteral Route” means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.

(13) American Society of Anesthesiologists (ASA) Patient Physical Status Classification System.

(a) ASA I “A normal healthy patient”.

(b) ASA II “A patient with mild systemic disease”.

(c) ASA III “A patient with severe systemic disease”.

(d) ASA IV “A patient with severe systemic disease that is a constant threat to life”.

(e) ASA V “A moribund patient who is not expected to survive without the operation”.

(f) ASA VI “A declared brain-dead patient whose organs are being removed for donor purposes".

**(14) “Recovery” means the patient has had all operative procedures performed (surgical or non-surgical and sedated) and completed, and then enters a phase of therapy when the discharge criteria have not been yet achieved for the patient.**

**818-026-0020**
**Presumption of Degree of Central Nervous System Depression**

(1) In any hearing where a question exists as to the degree of central nervous system depression a licensee has induced (i.e., general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation), the Board may base its findings on, among other things, the types, dosages and routes of administration of drugs administered to the patient and what result can reasonably be expected from those drugs in those dosages and routes administered in a patient of that physical and psychological status.

(2) The following drugs are conclusively presumed to produce general anesthesia and may only be used by a licensee holding a General Anesthesia Permit:

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

(b) Alkylphenols — propofol (Diprivan) including precursors or derivatives;

(c) Neuroleptic agents;

(d) Dissociative agents — ketamine;

(e) Etomidate; and

(f) Volatile inhalational agents.

(3) No permit holder shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery**, except under Nitrous Oxide sedation**.

(4) A licensee that does not hold a Moderate, Deep Sedation or General Anesthesia Permit may not administer, for purpose of anxiolysis or sedation, Benzodiazepines or narcotics in children under 6 years of age.

(5) A licensee must ensure a written emergency response protocol is in place for all patients undergoing nitrous oxide, minimal sedation, moderate sedation, deep sedation or general anesthesia.

## Teresa Haynes

**From:** Stephen Prisby
**Sent:** Tuesday, May 28, 2019 8:05 AM
**To:** Julie Ann Smith D.D.S., M.D.
**Cc:** Amy Fine D.M.D.; Teresa Haynes; Hai Pham; Reza Sharifi, D.M.D.
**Subject:** RE: Proposed rules back to anesthesia committee

Thank you Dr. Smith,

We are adding your suggestions to a draft Anesthesia Committee Meeting agenda.

Stephen

-----Original Message-----
From: Julie Ann [mailto:surgeonchick@hotmail.com]
Sent: Sunday, May 26, 2019 9:04 AM
To: Teresa Haynes <Teresa.Haynes@state.or.us>; Hai Pham <haithanhpham@gmail.com>; Stephen Prisby <Stephen.Prisby@state.or.us>; Reza Sharifi, D.M.D. <rezajsharifi@gmail.com>
Cc: Amy Fine D.M.D. <afinedmd@gmail.com>
Subject: Re: Proposed rules back to anesthesia committee

Forgot to mention I'd like this added to the agenda: for nitrous and minimal sedation, I think we should look at the emergency drugs we require and decide if they make sense for the level of permit. I don't remember where we are with the proposed rule change for nitrous. {818-026-0040(2)(h)}. I feel like most people with a minimal sedation permit don't have the background to properly administer vasopressors, antihypertensives (unless you count sublingual nitroglycerin or nitrous oxide), or any other intravenous emergency medication.

Sent from my iPhone

> On May 26, 2019, at 8:57 AM, Julie Ann <surgeonchick@hotmail.com> wrote:
>
> Hi. The Licensing Standards, etc committee referred back to anesthesia committee the proposed changes to moderate, deep, and general anesthesia that address level of training and certification for anesthesia monitors for those levels of anesthesia. Some requirements for the anesthesia monitor that should be considered include:
> Demonstration of competence in recognition and initial management of an obstructed airway including use of bag valve mask, jaw thrust, head tilt and chin lift.
> Competency in basic understanding of data derived from EKG, ETCO2, blood pressure, and pulse oximetry. Not sure how specific to get, but they should be able to recognize significant ekg changes like PVC's, ventricular tachycardia, ventricular fibrillation (or just ventricular ectopy in general), asystole, tachycardia and bradycardia in general. Should recognize decreased ventilation rate from etco2, hypertension and hypotension, and oxygen desaturation.
> Competency in assessing discharge criteria using Aldrete score, or a similar tool.
> An attestation could be part of renewal.
> For general anesthesia, I think their assistant should be DAANCE or CALAMOS certified (I have to look up the calamos training because I don't remember what it entails).
> Let me know what you guys think. If you can add this to the agenda for the next anesthesia meeting, that would be great. Thank you!
>
> Sent from my iPhone

**818-026-0050**
**Minimal Sedation Permit**

Minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a Minimal Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and

(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or

(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and

(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;

(c) Certify that the patient is an appropriate candidate for minimal sedation; and

(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(4) No permit holder shall have more than one person under minimal sedation at the same time.

(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.

(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.

(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)

(8) The patient shall be monitored as follows:

(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, pulse oximetry and respiration shall be monitored and documented every fifteen minutes, if they can reasonably be obtained.

(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(9) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.

(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.

(11) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

**818-026-0055**
**Dental Hygiene, Dental Therapy and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation**
(1) Under indirect supervision, dental hygiene procedures may be performed for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding a Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; or
(c) If a dental hygienist with a nitrous oxide permit administers nitrous oxide sedation to a patient and then performs authorized procedures on the patient, an anesthesia monitor is not required to be present during the time the patient is sedated unless the permit holder leaves the patient.
(d) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with **Board rules.**
(2) Under indirect supervision, a dental assistant may perform those procedures for which the dental assistant holds the appropriate certification for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with **Board rules.**
**(3) Under indirect supervision, a dental therapist may perform procedures for which they hold the appropriate license for a patient who is under nitrous oxide or minimal sedation under the following conditions:**
**(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;**
**(b) The permit holder, or an anesthesia monitor, monitors the patient; and**
**(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with Board rules.**

**Leslee S. Huggins, DDS, MS, FAAPD**
1240 Hansen Ave S.
Salem, OR 97302
drlesleehuggins@gmail.com
401.575.1322

RECEIVED
JAN 02 2020
Oregon Board
of Dentistry

December 27, 2019

Oregon Board of Dentistry
Attn: Anesthesia Committee
1500 SW 1st Ave Suite 770
Portland, OR 97201

**(via CERTIFIED MAIL)**

Re: Request for Sedation Permit Rules Review

Dear Anesthesia Committee:

Recently I applied for a moderate sedation permit and discovered (what I feel are) discrepancies in the BOARD LAWS that should be reviewed in the interest of the public. Most notably the discrepancies are in terms of a new applicant versus a renewal applicant as well as clarity for, or perhaps the lack of, proper credit for this work in other jurisdictions. I initially attempted to bring these issues to the attention of the Oregon Board of Dentistry and was advised that I should submit my concerns to the Anesthesia Committee.

As a board-certified Pediatric Dentist who has practiced continuously for 24 years in numerous jurisdictions, the last five here in Oregon, the inconsistent position the rules present to applicants is a concern. (I recognize that each jurisdiction is different with regards to permitting for various levels of sedation.) I've practiced in TX, NC, RI, CT, MA, NH, and CA as both a private practitioner and as US Naval officer. Out of all my experiences, I find OR presents a unique scenario and I would like to request a review of the following areas regarding the rules for a Moderate Sedation Permit. Specifically:

**818-026-0060 (C) Permit Application (initial permit)**

> In lieu of the requirements, the Board may accept equivalent training or experience in moderate sedation anesthesia.

According to what I can find, there is ***not*** *a definition of exactly what this is*. Therefore, having met all of the other stated requirements for a candidate for whom "training was completed more than 5 years ago", I was very surprised to learn that my *completion of over 400 hours of direct patient care in residency at UNC-CH combined with 100 cases after residency was* ***not*** *considered equivalent training or experience because it had been 13 years since last performing moderate sedation cases.*

As there is no time limit specified in the Rules and I feel my experience and certifications were more than sufficient, I requested clarification. The Board responded: "As it has been 13 years since you performed moderate sedation and you don't have a license/permit to administer moderate sedation (or equivalent) in another state, your only option would be to redo your original training in moderate sedation and then apply for a permit on the basis of that training. For the enteral permit, you would need to complete a comprehensive training program that includes a minimum of 24 hours of instruction plus management of at least 10 dental patient experiences by the enteral and /or enteral-nitrous oxide/oxygen route."

This statement of requirement appears to be undocumented in the current rules. It is also at odds with the rule for a practitioner merely renewing a license (below). Respectfully, I would also add that it does not adequately consider the applicants full experience and background.

**818-026-0060 (12) Permit renewal.**

> According to this, a dentist can renew a moderate sedation permit 10 years after the original application was approved *without performing **any** moderate sedation cases (**as no proof of completed cases is required) since the permit was obtained.*

Thus, the rules allow a practitioner who receives a sedation permit immediately upon completion of the training outlined above, and then performs ***NO*** cases after that, to simply renew their permit every 10 years without proof of proficiency (or even competency). Further, should they decide after 20 years to start doing sedation cases, can do so without any requirement being levied that they regain currency or demonstrate proficiency in this discipline. Yet a practitioner with over 500 cases since their completion of training cannot obtain a permit to perform the same procedures. Personally this appears to be a very inconsistent position and professionally presents a tremendous concern to me in terms of public safety as I think it would to the public were they aware. At the very least, I would suggest that renewal of a sedation permit should require documented demonstration of its use and continued proficiency with the required knowledge.

In summary, these two requirements—initial application and renewal—appear to not have equal requirements and therefore carry a different potential risk to the public. In the best interest of the public we serve, I respectfully request a review and remedy of these rules.

Please feel free to contact me with any questions or concerns. Thank you for your time.

Regards,

Leslee S. Huggins MSS

Leslee S. Huggins, DDS, MS, FAAPD
Pediatric Dentist
Oral Health Member, Oregon Medicaid Advisory Committee

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Please consider the environment before printing this e-mail.

**From:** CARTER Bernie * OBD <bernie.carter@oregondentistry.org>
**Sent:** Tuesday, March 23, 2021 9:40 AM
**To:** NYE Ingrid * OBD <ingrid.nye@oregondentistry.org>
**Cc:** Reza Sharifi <rezajsharifidmdfacs@gmail.com>
**Subject:** RE: Moderate Sedation Permit Application - Judd Larson - D11308

Good morning Ingrid,
**818-026-0060**
**Moderate Sedation Permit**
Moderate sedation, minimal sedation, and nitrous oxide sedation.

Paragraph (2) of the rule states:
(2) The following facilities, equipment and drugs **shall be on site and available** for immediate use during the procedures and during recovery:
(h) Sphygmomanometer**, precordial/pretracheal** stethoscope, capnograph, pulse oximeter, oral and nasopharyngeal airways, larynageal mask airways, intravenous fluid administration equipment, automated external defibrillator (AED)…

My **interpretation is that the precordial/pretracheal stethoscope is not required to be used**, but is **required to be present** for immediate use during the procedure and during recovery.

I would think somewhere in the Licensee's application he would mention the prechordal stethoscope so that the Board knows he is aware of the equipment. In the **equipment present part of the application,** the said equipment should be listed as being in the operatory (for immediate use is presumed). If the equipment it is not listed in that application section, it is a violation and I would not approve the application.

Although not required, I use the equipment, and I am sure Dr. Sharifi uses the equipment, since the prechorial/pretrachael stethoscope provides the vital signs monitoring of breathing (respiration monitoring required per paragraph (8)(a)) vs end tidal CO2 (required per paragraph (8)(a)), which measures something different than breathing. Obviously you want to make sure the patient is still breathing when the procedure is being completed. This is current state of the art compliance, and some would interpret standard of care compliance currently. Dr. Sharifi may very well, as I do also , consider the said equipment standard of care and state of the art.

For all intent and purposes, my opinion is for the Board to consider a rule change changing the prechordial/pretrachael stethoscope in paragraph (2)(h)to required, and place in paragraph (8)(a).
Thanks,
Bernie

Thank you,

**818-026-0060**
**Moderate Sedation Permit**

Moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue or renew a Moderate Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, either maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated; and

(c) Satisfies one of the following criteria:

(A) Completion of a comprehensive training program in enteral and/or parenteral sedation that satisfies the requirements described in Part V of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced.

(i) Enteral Moderate Sedation requires a minimum of 24 hours of instruction plus management of at least 10 dental patient experiences by the enteral and/or enteral-nitrous oxide/oxygen route.

(ii) Parenteral Moderate Sedation requires a minimum of 60 hours of instruction plus management of at least 20 dental patients by the intravenous route.

(B) Completion of an ADA accredited postdoctoral training program (e.g., general practice residency) which affords comprehensive and appropriate training necessary to administer and manage parenteral sedation, commensurate with these Guidelines.

(C) In lieu of these requirements, the Board may accept equivalent training or experience in moderate sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, ~~precordial/pretracheal stethoscope,~~ capnograph, pulse oximeter, oral and nasopharyngeal airways, larynageal mask airways, intravenous fluid administration equipment, automated external defibrillator (AED); and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) No permit holder shall have more than one person under moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.

(4) During the administration of moderate sedation, and at all times while the patient is under moderate sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist permit holder performing the dental procedures.

(5) Before inducing moderate sedation, a dentist permit holder who induces moderate sedation shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for moderate sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and

(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient’s record.

(6) A patient under moderate sedation shall be visually monitored at all times, including the recovery phase. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.

(7) Persons serving as anesthesia monitors for moderate sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)

(8) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring using pulse oximetry, and End-tidal CO2 monitors. Patients with cardiovascular disease shall have continuous electrocardiograph (ECG) monitoring. The patient's blood pressure, heart rate, and respiration shall be recorded **and monitored using a precordial/pretracheal stethoscope,** at regular intervals but at least every 15 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under moderate sedation shall be continuously monitored and shall not be left alone while under sedation;

(b) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from moderate sedation.

(9) A dentist permit holder shall not release a patient who has undergone moderate sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.

(10) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(11) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(12) After adequate training, an assistant, when directed by a dentist permit holder, may dispense oral medications that have been prepared by the dentist permit holder for oral administration to a patient under direct supervision. Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may introduce additional anesthetic agents into an infusion line under the direct supervision of a dentist permit holder.

(13) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; Successful completion of a board approved course on minimal/moderate sedation at least every two years may be substituted for ACLS, but not for PALS; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training

taken to maintain current ACLS or PALS certification or successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

At the December 8, 2021 Dental Therapy Rules Oversight (DTRO) Committee Meeting this rule was discussed and that Committee recommended the Board move it to the Anesthesia Committee for further review and discussion. At its February 25, 2022 Board Meeting, the Board moved the rule to the Anesthesia Committee. Specifically, the DTRO Committee wanted the Anesthesia Committee to take into consideration allowing more than one patient to be sedated with Nitrous Oxide at any time, due to the safe nature of it and its application.

**818-026-0080**
**Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia**

(1) A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the Oregon Board of Medical Examiners, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.
(2) A dentist who does not hold a Nitrous Oxide Permit for nitrous oxide sedation may perform dental procedures on a patient who receives nitrous oxide induced by an Oregon licensed dental hygienist holding a Nitrous Oxide Permit.
(3) A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall maintain a current BLS for Healthcare Providers certificate, or its equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.
(4) A dentist~~, a dental hygienist or an Expanded Function Dental Assistant (EFDA)~~ who performs procedures on a patient who is receiving anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit or a CRNA shall not schedule or treat patients for non emergent care during the period of time of the sedation procedure.
(5) Once anesthetized, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(6) The qualified anesthesia provider who induces moderate sedation, deep sedation or general anesthesia shall monitor the patient until easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred the patient may be monitored by a qualified anesthesia monitor until discharge criteria is met. The patient's dental record shall document the patient's condition at discharge as required by the rules applicable to the level of anesthesia being induced. A copy of the anesthesia record shall be maintained in the patient's

dental record and is the responsibility of the dentist who is performing the dental procedures.

(7) No qualified provider shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery**, except under Nitrous Oxide sedation.**

(8) A dentist who intends to use the services of a qualified anesthesia provider as described in section 1 above, shall notify the Board in writing of ~~her or his~~ **their** intent. Such notification need only be submitted once every licensing period.

Oregon Society of Anesthesiologists

October 2nd, 2019

Dr. Fine and members of the Oregon Board of Dentistry-

On behalf of the Oregon Society of Anesthesiologists (OSA), I would like would like to express our society's concern about proposed changes to 818-026-0065 (Deep Sedation Permit) and 818-026-0070 (General Anesthesia).

As physician anesthesiologists, we truly appreciate your efforts to enhance minimal requirements for anesthesia monitors involved with deep sedation and general anesthesia cases. Along with our national society, the American Society of Anesthesiologists (ASA, asahq.com), I encourage the Board of Dentistry to further amend the proposed language within 818-026-0065 and 818-026-0070 to reflect the 2019 American Academy of Pediatric Dentistry (AAPD) and American Academy of Pediatrics (AAP) "Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures." At a minimum, the proposed language defining an anesthesia monitor should be amended to mean a qualified anesthesia provider as defined in the CMS Conditions of Participation at 42 C.F.R. § 482.52(a).

Briefly, the ASA, American Society of Dentist Anesthesiologists, the Society for Pediatric Anesthesia, and the Society for Pediatric Sedation endorse the AAP/AAPD guidelines. These guidelines recommend that at least two individuals with specific training and credentials should be present with a pediatric patient undergoing deep sedation/general anesthesia for dental treatment in a dental facility or hospital/surgicenter. Specifically, the guidelines clarify that a separate qualified anesthesia professional (a physician anesthesiologist, a certified registered nurse anesthetist, a dentist anesthesiologist or a second oral surgeon) must administer the anesthesia and/or sedation and monitor the patient.

We appreciate the time you have taken to consider our concerns.

Sincerely,
Seth Palesch, MD

President, Oregon Society of Anesthesiologists

American Society of Anesthesiologists™

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905 16th Street N.W. | Washington, D.C. 20006 | (202) 289-2222

October 11, 2019

Amy B. Fine, DMD, President
Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

[Submitted via Email: stephen.prisby@state.org.us]

**Re: Notice of Proposed Rulemaking**

Dear Dr. Fine,

The American Society of Anesthesiologists (ASA) appreciates the opportunity to comment on the Oregon Board of Dentistry's proposed amendments to the Oregon Administrative Rules. On behalf of ASA, I am writing to express concern regarding proposed changes to 818-026-0065 (Deep Sedation Permit) and 818-026-0070 (General Anesthesia).

ASA is a more than 53,000 member educational, research, and advocacy organization dedicated to improving the medical care of patients and raising standards in the science and art of anesthesiology. Since its founding in 1905, the ASA's achievements have made it the leading voice and the foremost expert in American medicine on matters of patient safety in the perioperative environment and pain medicine.

On behalf of ASA, I encourage the Board of Dentistry to further amend the proposed language[1] within 818-026-0065 and 818-026-0070 to reflect the 2019 American Academy of Pediatric Dentistry (AAPD) and American Academy of Pediatrics (AAP) "Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures". [2]

ASA appreciates the Board of Dentistry's efforts to enhance minimal requirements for anesthesia monitors involved with deep sedation and general anesthesia cases. In recent years, a number of pediatric deaths have been reported in dental offices. Subsequently, numerous states and dental organizations have enhanced their sedation and anesthesia requirements/guidelines. Most recently the AAP, in conjunction with the AAPD, released a clinical report on their updated "Guidelines for Monitoring and Management of Pediatric Patients Before, During and After Sedation for Diagnostic and Therapeutic

[1] (7) Persons serving as anesthesia monitors for general anesthesia in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)

[2] Coté CJ, Wilson S. American Academy of Pediatric Dentistry, American Academy of Pediatrics. Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures. Pediatr Dent 2019;41(4):E26-E52.

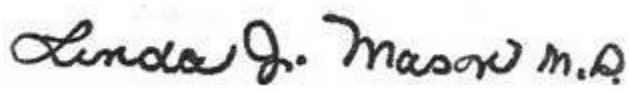
Procedures." In a joint statement,[3] ASA, the Society for Pediatric Anesthesia, the American Society of Dentist Anesthesiologists, and the Society for Pediatric Sedation endorsed the AAP/AAPD guidelines.

The guidelines – updated from 2016 – recommend that at least two individuals with specific training and credentials should be present with a pediatric patient undergoing deep sedation/general anesthesia for dental treatment in a dental facility or hospital/surgicenter. Further, the guidelines clarify that a separate qualified anesthesia professional who is one of the following: a physician anesthesiologist, a certified registered nurse anesthetist, a dentist anesthesiologist or a second oral surgeon – must administer the anesthesia and/or sedation and monitor the patient in a dental facility. Additional providers with advanced training in perioperative care and airway management skills may fill this vital role in preventing sedation-related morbidity and mortality in a hospital or surgicenter setting.

ASA policy offers a wealth of guidance for anesthesia administration in a variety of settings.[4,5,6,7] A common recommendation within our policy is that a designated individual, other than the individual performing the procedure, should be present to monitor the patient throughout procedures performed with sedation. During deep sedation and/or general anesthesia, this individual should have no other responsibilities – thus ensuring singular focus on the anesthetized patient's safety. Critically important for the patient's safety is that the individual monitoring the anesthetized patient be competent to fully understand and apply the clinical information they are receiving.

On behalf of ASA, I thank you for your consideration of this very important issue. Should you have any questions, please feel free to contact Jason Hansen, M.S., J.D., Director of State Affairs, at j.hansen@asahq.org.

Sincerely,



Linda J. Mason, M.D., FASA
President

[3] Anesthesia Health Care Groups Join American Academy of Pediatrics in Endorsement of Guidelines for Deep Sedation and Anesthesia During Dental Procedures. Available at: https://www.asahq.org/advocacy-and-asapac/advocacy-topics/ofØce-based-anesthesiaand-dental-anesthesia/joint-statement-pediatric-dental-sedation

[4] ASA Statement on Nonoperating Room Anesthetizing Locations. *Available at*: https://www.asahq.org/standards-and-guidelines/statement-on-nonoperating-room-anesthetizing-locations

[5] ASA Statement on Sedation & Anesthesia Administration in Dental Office-Based Settings. *Available at*: https://www.asahq.org/standards-and-guidelines/statement-on-sedation--anesthesia-administration-in-dental-officebased-settings

[6] ASA Guidelines for Office-Based Anesthesia. *Available at*: https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia

[7] ASA Standards for Basic Anesthetic Monitoring. *Available at*: https://www.asahq.org/standards-and-guidelines/standards-for-basic-anesthetic-monitoring

OREGON SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS

October 23, 2019

Amy B. Fine, DMD, President
Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

Submitted via Email: stephen.prisby@state.org.us

Dr. Fine and members of the Oregon Board of Dentistry,

I am writing on behalf of the Oregon Society of Oral & Maxillofacial Surgeons in response to letters submitted by Dr. Linda Mason and Dr. Seth Palesch. We support the proposed language within 818-026-0065 and 818-026-0070. We also encourage input and recommendations from our medical colleagues if they are based on sound evidence and data to implement policies that would improve patient safety. Both letters reference a recently published "Joint Statement on Pediatric Dental Sedation." The recommendations from the Joint Statement were also incorporated into the recently published "Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures" by the American Academy of Pediatrics(AAP). The AAP's guidelines are comprehensive and relevant for the vast majority of healthcare providers who require sedation in order to treat a pediatric patient. For over 60 years, Oral and Maxillofacial Surgeons have developed an anesthesia team concept providing safe, cost-effective, and accessible anesthesia services with an unparalleled safety record. Our guidelines satisfy the safety concerns addressed in the AAP's publication.

Of the AAP's 15-page document, our anesthesia team model is almost indistinguishable from that of our Pediatric colleagues. There is ONE difference that appears to have been singled out by Drs. Mason and Palesch. Our model requires at least three team members to monitor the patient through audible means at all times and visual means when possible. One team member, the anesthesia assistant, has the sole responsibility to monitor the patient visually and audibly without interruption. The team is trained to communicate throughout the surgery such that should any change of a vital sign, pulse oximetry, electrocardiogram, end tidal CO2 reading, or audible and visual changes from the upper airway or chest wall movement, the surgeon can immediately stop to assess the patient's status and respond accordingly. During our Oral & Maxillofacial Surgery training, we develop the skills to operate while

keeping a keen level of situational awareness regarding the anesthesia status of our patients. Proper patient selection as well as procedure selection is paramount to the successful anesthesia delivery and another reason for our unparalleled safety record. This anesthesia team model is reserved for less complicated procedures with low anticipated blood loss and relatively healthy patients.

According to the AAP's report, it "was developed through a collaborative effort of the American Academy of Pediatrics and the American Academy of Pediatric Dentistry to offer pediatric providers updated information and guidance in delivering safe sedation to children" (Pediatrics Vol 143, 6, JUN 2019). The purpose of this report was to unify guidelines for sedation by medical and dental practitioners. It also set out to clarify monitoring modalities, "particularly regarding continuous expired carbon dioxide measurement. "Furthermore, this report sought to serve as an update from the medical and dental literature as well as to suggest methods to improve safety and outcomes. These guidelines suggest that there "must be an independent anesthesia provider(observer) whose sole responsibility is to administer drugs and constantly observe the patient's vital signs, depth of sedation, airway patency, and adequacy of ventilation." This observer must be PALS certified and capable of managing any airway, ventilatory, or cardiovascular emergency event. In summary, the observer is referring to either an Anesthesiologist (physician or dentist), CRNA, or an Oral & Maxillofacial Surgeon. The guidelines also state that the practitioner performing a procedure must be trained in PALS and capable of providing "skilled assistance" to the independent observer with the rescue of a child. The overall guidelines are replete with merits, and the language adopted makes a lot of sense for many dental and medical providers, but there are challenges to consider every scenario within every subspecialty of medicine and dentistry, specifically Oral & Maxillofacial Surgery. Our combined training in both anesthesia and surgery sets us apart from virtually every other specialty.

The collaborative efforts of the two referenced reports did not include Oral & Maxillofacial Surgeons. Furthermore, the "Joint Statement on Pediatric Dental Sedation" is very critical of the Oral Surgeon anesthesia team model. Even though this team model consists of one Oral Surgeon, one Dental Anesthesia monitor, and one surgical assistant, the Joint Statement continues to use terms like "single provider/operator" model, as if the other two or more healthcare providers are not in the room.

The Joint Statement is highly critical of dental assistants having "virtually no hands-on or formal medical training, cannot administer drugs, cannot establish venous access and cannot reliably provide definitive airway assistants." With our certified dental anesthesia assistants in the state or Oregon, I beg to differ. I can only wonder how familiar Drs. Mason and Palesch are with the progressive strides we've made in Oregon regarding anesthesia. Our certified anesthesia dental assistants can administer drugs under direct supervision. They are capable of starting IVs if they've taken the required phlebotomy training. The "Joint Statement" is a flawed document in many respects, and it is unfortunate that it references "continued tragic outcomes" that were "directly related to a different treatment paradigm from that recommended by the AAP." The document insinuates that the Oral Surgeon model is responsible for these tragic outcomes when in fact a review of recent incidents will show that many of the adverse events occurred not in oral and maxillofacial surgery offices, but in facilities with lesser trained provider or in many cases situations involving a separate physician anesthesiologist or dental anesthetist.

These incidents are tragic, no matter where they occur, and no matter who provided the service. However, to advocate for unnecessary changes without sound data or scientific evidence is irresponsible

and could unnecessarily limit access to care for patients that are in need of these important services. Patient safety has been and continues to be paramount to our specialty. Our long history of providing necessary office-based anesthesia has been proven to be safe, and these false claims being made that our model is unsafe or detrimental to pediatric patients simply is not true.

Furthermore, if one were to critically review the "Joint Statement on Pediatric Dental Sedation," a paltry 19 references are cited to make such claims. 7 citations refer to position papers, whereas 2 of them are opinion pieces. One reference is the AAOMS website describing the DAANCE program, and 7 more are either case reports or articles from media sources describing tragic outcomes. Only 2 references contain analysis of some primary data. Lee et al, Pediatric Anesthesia; 2013;23(8):741-746 referenced 42 pediatric deaths associated with patients having general anesthesia or sedation for a dental procedure. Of the 42 deaths, 25 of them occurred when the anesthesia provider was either a general or pediatric dentist, 8 occurred with an Oral Surgeon, and 7 occurred with an itinerant anesthesiologist. In addition, none of the citations were added to the document for the 2019 revision, meaning the recommended change to personnel was made with no new evidence being presented.

More recent data regarding pediatric deaths in the dental office, specifically from studies conducted in California and Texas, do not show a disproportionately high mortality with the Oral Surgeon anesthesia team model compared to that of the itinerant, independent observer model. I am not sure why the Joint Statement takes great lengths to erroneously criticize the oral surgeon anesthesia team model, but it certainly was not based on credible evidence. I would urge the Board of Dentistry to examine our state's own morbidity and mortality data and am confident that the results will show our anesthesia delivery model as safe and effective.

We applaud the measures the Oregon Board of Dentistry has taken to continually address safety concerns by maintaining a robust anesthesia committee and by creating the recent anesthesia work group. Pediatric dentistry is represented not only on the Board itself, but also on the anesthesia committee and work group. To my knowledge, the Oregon pediatric dental community has not raised concerns in agreement with the ASA or the OSA regarding this one difference.

I thank you for your consideration in this manner and can assure the board that Oregon oral surgeons will continue to support and participate in your programs to promote safe practices within the entire dental community.

Very Respectfully,

Normund K. Auzins, D.D.S
President, Oregon Society of Oral & Maxillofacial Surgeons
Board Certified Oral & Maxillofacial Surgeon

**818-026-0065**
**Deep Sedation Permit**

Deep sedation, moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue a Deep Sedation Permit to a licensee who holds a Class 3 Permit on or before July 1, 2010 who:

(a) Is a licensed dentist in Oregon; and

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) No permit holder shall have more than one person under deep sedation, moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.

(4) During the administration of deep sedation, and at all times while the patient is under deep sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist permit holder performing the dental procedures.

(5) Before inducing deep sedation, a dentist permit holder who induces deep sedation shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for deep sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and

(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient’s record.

(6) A patient under deep sedation shall be visually monitored at all times, including the recovery phase. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.

(7) Persons serving as anesthesia monitors for deep sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)

(8) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's heart rhythm shall be continuously monitored and the patient’s blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 5 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under deep sedation shall be continuously monitored;

(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.

(c) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from deep sedation.

(9) A dentist permit holder shall not release a patient who has undergone deep sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.

(10) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(11) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(12) Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may administer oral sedative agents calculated by a dentist permit holder or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist.

(13) Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

**818-026-0070**
**General Anesthesia Permit**

General anesthesia, deep sedation, moderate sedation, minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a General Anesthesia Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated, and

(c) Satisfies one of the following criteria:

(A) Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students consisting of a minimum of 2 years of a postgraduate anesthesia residency at the time training was commenced.

(B) Completion of any ADA accredited postdoctoral training program, including but not limited to Oral and Maxillofacial Surgery, which affords comprehensive and appropriate training necessary to administer and manage general anesthesia, commensurate with these Guidelines.

(C) In lieu of these requirements, the Board may accept equivalent training or experience in general anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least three individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for treatment of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics, antihypertensives and anticonvulsants.

(3) No permit holder shall have more than one person under general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation at the same time.

(4) During the administration of deep sedation or general anesthesia, and at all times while the patient is under deep sedation or general anesthesia, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory in addition to the dentist permit holder performing the dental procedures.

(5) Before inducing deep sedation or general anesthesia the dentist permit holder who induces deep sedation or general anesthesia shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for general anesthesia or deep sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and

(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient’s record.

(6) A patient under deep sedation or general anesthesia shall be visually monitored at all times, including recovery phase. A dentist permit holder who induces deep sedation or general anesthesia or anesthesia monitor trained in monitoring patients under deep sedation or general anesthesia shall monitor and record the patient's condition on a contemporaneous record.

(7) Persons serving as anesthesia monitors for general anesthesia in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)

(8) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring of their heart rate, heart rhythm, oxygen saturation levels and respiration using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's blood pressure, heart rate and oxygen saturation shall be

assessed every five minutes, and shall be contemporaneously documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. The person administering the anesthesia and the person monitoring the patient may not leave the patient while the patient is under deep sedation or general anesthesia;

(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.

(c) During the recovery phase, the patient must be monitored, including the use of pulse oximetry, by an individual trained to monitor patients recovering from general anesthesia.

(9) A dentist permit holder shall not release a patient who has undergone deep sedation or general anesthesia except to the care of a responsible third party. When a reversal agent is administered, the dentist permit holder shall document justification for its use and how the recovery plan was altered.

(10) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have nausea or vomiting and has minimal dizziness.

(11) A discharge entry shall be made in the patient's record by the dentist permit holder indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(12) Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may introduce additional anesthetic agents to an infusion line under the direct visual supervision of a dentist permit holder.

(13) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

# 42 CFR § 410.69 - Services of a certified registered nurse anesthetist or an anesthesiologist's assistant: Basic rule and definitions.

CFR

## § 410.69 Services of a certified registered nurse anesthetist or an anesthesiologist's assistant: Basic rule and definitions.

**(a)** ***Basic rule.*** Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist or an anesthesiologist's assistant who is legally authorized to perform the services by the State in which the services are furnished.

**(b)** ***Definitions.*** For purposes of this part -

*Anesthesia and related care* means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished.

*Anesthesiologist's assistant* means a person who -

**(1)** Works under the direction of an anesthesiologist;

**(2)** Is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on nonphysician anesthetists; and

**(3)** Is a graduate of a medical school-based anesthesiologist's assistant educational program that -

**(A)** Is accredited by the Committee on Allied Health Education and Accreditation; and

**(B)** Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

*Anesthetist* includes both an anesthesiologist's assistant and a certified registered nurse anesthetist.

*Certified registered nurse anesthetist* means a registered nurse who:

Is licensed as a registered professional nurse by the State in which the nurse practices;

Meets any licensure requirements the State imposes with respect to non-physician anesthetists;

Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs, or such other accreditation organization as may be designated by the Secretary; and

**(4)** Meets the following criteria:

**(i)** Has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary; or

**(ii)** Is a graduate of a program described in paragraph (3) of this definition and within 24 months after that graduation meets the requirements of paragraph (4)(i) of this definition.

[57 FR 33896, July 31, 1992, as amended at 77 FR 69363, Nov. 16, 2012]

# 42 CFR § 482.52 - Condition of participation: Anesthesia services.

CFR

## § 482.52 Condition of participation: Anesthesia services.

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

**(a)** ***Standard: Organization and staffing.*** The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by -

**(1)** A qualified anesthesiologist;

**(2)** A doctor of medicine or osteopathy (other than an anesthesiologist);

**(3)** A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;

**(4)** A certified registered nurse anesthetist (CRNA), as defined in § 410.69 (b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or

**(5)** An anesthesiologist's assistant, as defined in § 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.

**(b)** ***Standard: Delivery of services.*** Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of preanesthesia and post anesthesia responsibilities. The policies must ensure that the following are provided for each patient:

**(1)** A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery or a procedure requiring anesthesia services.

**(2)** An intraoperative anesthesia record.

**(3)** A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.

**(c)** ***Standard: State exemption.***

**(1)** A hospital may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.

**(2)** The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time, and are effective upon submission.

[51 FR 22042, June 17, 1986, as amended at 57 FR 33900, July 31, 1992; 66 FR 56769, Nov. 13, 2001; 71 FR 68694, Nov. 27, 2006; 72 FR 66934, Nov. 27, 2007]