



Defense Health Agency

PROCEDURAL INSTRUCTION

NUMBER 6410.01

May 4, 2021

DAD-MA

SUBJECT: Dental Sedation Medical Management

References: See Enclosure 1

1. **PURPOSE.** This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (s), establishes Defense Health Agency's (DHA) procedures to establish a multidisciplinary approach to dental patient care guided by evidence-based clinical practice guidelines (CPGs) for dental sedation pathways. Army, Navy, and Air Force current Service policies concerning dental personnel conducting sedation were considered during the creation of this DHA-PI to ensure the unity of the respective CPGs. The requirements and guidance contained herein represent the standard of care for dentists providing anxiolysis, sedation, and anesthesia as supported by multiple national profession-governing organizations. The purpose of this DHA-PI is to establish the responsibilities for the oversight, quality assurance, and treatment protocols to be observed by dental personnel involved in the administration of anxiolysis, sedation, and anesthesia in all military medical treatment facilities (MTFs) and dental treatment facilities (DTFs). This instruction is not applicable to care delivered within the specialty of Anesthesiology, the practice of Certified Registered Nurse Anesthetists, sedation of mechanically ventilated patients in intensive care settings, or sedation by any other medical specialties; this instruction only applies to dentists and dental specialists (e.g., oral & maxillofacial surgeons, periodontists, pediatric dentists, endodontists, and comprehensive dentists). This DHA-PI outlines DHA procedures to:

a. Establish a comprehensive and standardized sedation management practice in order to provide high-quality and safe care for dental patients treated by privileged dental providers in all MTFs and DTFs.

b. Educate clinicians on the effective dental and oral and maxillofacial surgery (OMS) services management and the associated evidence-based practices.

c. Provide tools, through the Corporate Dental System, Military Health System (MHS) GENESIS, and legacy Electronic Health Records (EHRs), to assist clinicians in evidence-based and patient-centered Sedation Medical Management.

2. APPLICABILITY. This DHA-PI applies to the DHA, DHA Components (activities under the authority, direction, and control of DHA), Military Departments (MILDEPS), and the following personnel: assigned or attached active duty and reserve members, members of the Commissioned Corps of the Public Health Service, government civilians, contractors (when required by the terms of the applicable contract), and other personnel assigned in temporary or permanent duties at DHA, DHA Components, and DHA field activities (remote locations).

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (c) through (s), that the Services and all certified Markets, Small Market and Stand-Alone Medical Treatment Facility Organization (SSO), and Defense Health Agency Regions (DHARs) will implement this DHA-PI in the MTF/DTFs in order to standardize the sedation of dental patients by privileged dental providers in the MHS.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosures 3-6.

6. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director (DAD), Medical Affairs (MA). When Activities are unable to comply with this instruction, the activity may request a waiver that must include justification, to include an analysis of the risk associated with not granting the waiver. The activity director or senior leader will submit the waiver request through their supervisory chain to DAD-MA to determine if the waiver may be granted by the DHA Director or designee.

7. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the Internet from the Health.mil site at: <https://health.mil/Reference-Center/Policies> and is also available to authorized users from the DHA SharePoint site at: <https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx>.

8. EFFECTIVE DATE. This DHA-PI:
 - a. Is effective upon signature.

 - b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (c).

9. FORMS. DHA forms referenced in this document can be found at https://info.health.mil/cos/admin/DHA_Forms_Management/Lists/DHA%20Forms%20Management/AllItems.aspx#

- a. DHA Form 193, Dental Sedation Record
- b. DHA Form 195, Informed Consent Sedation and Anesthesia
- c. DHA Form 196, Minimal Sedation Procedure Sheet
- d. DHA Form 197, Pre-anesthetic Assessment
- e. DHA Form 198, Immediate Pre-procedural Assessment

/S/
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Enclosures

- 1. References
- 2. Responsibilities
- 3. Dental Use of Nitrous Oxide Instruction
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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs (ASD (HA)),” September 30, 2013, as amended
- (b) DoD Directive 5136.13, “Defense Health Agency (DHA),” September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, “Publication System,” August 24, 2018
- (d) Committee on Quality Management and Departmental Administration Standard and Guidelines, “Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia,” October 13, 1999, as amended
- (e) Ad Hoc Committee on Credentialing Standard and Guidelines “Granting Privileges for Administration of Moderate Sedation to Practitioners Who Are Not Anesthesia Professionals” October 25, 2005, as amended
- (f) American Dental Association Guidelines, “Guidelines for the Use of Sedation and General Anesthesia by Dentists” October, 2016
- (g) American Dental Association Guidelines, “Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students,” October, 2016
- (h) American Academy of Pediatric Dentistry Reference Manual “Use of Nitrous Oxide for Pediatric Dental Patients,” 2018
- (i) American Academy of Pediatric Dentistry Reference Manual, “Policy on Minimizing Occupational Health Hazards Associated with Nitrous Oxide,” 2018
- (j) CDC The National Institute for Occupational Safety and Health (NIOSH) Publication 94-100, “Controlling Exposures to Nitrous Oxide during Anesthetic Administration,” 1994
- (k) United States Department of Labor Guidelines, “Occupational Safety and Health Administration on Anesthetic Gases: Guidelines for Workplace Exposures,” July 20, 1999, as amended
- (l) United Federal Criteria 4-510-01, “Design: Military Medical Facilities,” May 1, 2016
- (m) The Joint Commission. Environment of Care and Life Safety: Oral Health Topics: Nitrous Oxide, (2018)
- (n) Best Practices for Nitrous Oxide-Oxygen Use. American Dental Association (2019).
- (o) American Academy of Periodontology Report, “American Academy of Periodontology Statement on the Use of Moderate Sedation by Periodontists,” April, 2013
- (p) American Association of Oral and Maxillofacial Surgeons Guide, “Parameters of Care: American Association of Oral and Maxillofacial Surgeons Clinical Practice Guidelines for Oral and Maxillofacial Surgery, Sixth Edition 2017,” 1992, as amended
- (q) American Association of Oral and Maxillofacial Surgeons White Paper, “Office-Based Anesthesia Provided by the Oral and Maxillofacial Surgeon,” 2016
- (r) DHA-Procedures Manual 6025.13 “Clinical Quality Management in the Military Health System,” August 29, 2019
- (s) DoD Instruction 6025.13, “Medical Quality Assurance and Clinical Quality Management in the Military Health System,” February 17, 2011, as amended

ENCLOSURE 2
RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA, will:
 - a. Support the MILDEPS, Markets, SSO, DHARs, and MTF/DTFs by identifying standard clinical processes, requirements, and assigning a collaborative resolution for the dental enterprise in the MHS.
 - b. Exercise authority, as outlined in Reference (b), over DHA-aligned MTF/DTFs.
 - c. Assign responsibility for tracking compliance with the standard processes and criteria outlined in this DHA-PI to the DAD-MA.

2. DAD-MA, DHA. The DAD-MA, DHA will ensure:
 - a. Markets, SSO, and DHARs assign responsibilities to implement this DHA-PI.
 - b. Ensure compliance, tailored to meet individual facility capabilities, with guidance outlined in this DHA-PI.

3. CHIEF, DENTAL CLINICAL MANAGEMENT TEAM (D-CMT), DHA. The Chief, D-CMT, DHA, will:
 - a. Drive clinical improvements in sedation management through CPGs which will standardize practice across the MHS.
 - b. In partnership with Clinical Quality Management and in accordance with References (r) and (s), strive to eliminate preventable sedation-related adverse events in the MHS.

4. CHIEF, DENTAL OPERATIONS SUPPORT BRANCH, DHA. The Chief, Dental Operations Support Branch, DHA will:
 - a. Promulgate this DHA-PI and ensure dissemination to the MILDEPs and Market, SSO, DHAR leadership in the MHS.
 - b. Upon request by Market/SSO/DHAR leadership, provide educational and training support through webinars to support requirements and ensure a clear understanding of the DHA-PI in the MTF/DTFs.

c. As needed, provide a review and analysis of the overall compliance of this DHA-PI to DAD-MA.

5. DIRECTOR, PHARMACY OPERATIONS DIVISION, DHA. The Director, Pharmacy Operations Division will:

a. Inform as needed Chief, D-CMT, DHA of any enterprise mitigation strategies implemented in response to shortages of medications utilized for sedation that may affect dental procedures.

b. Provide guidance as requested by Chief, D-CMT, DHA on the dental management of controlled substances.

c. Work as needed with Chief, D-CMT, DHA and Chief, Patient Safety, DHA to provide solutions that improve patient safety in dental sedation procedures.

6. SECRETARIES OF THE MILDEPS. The Secretaries of the MILDEPS will ensure MTFs and DTFs outside the continental United States comply with this DHA-PI.

7. MARKET, SSO, AND DHAR DIRECTORS. The Market, SSO, and DHAR Directors will:

a. Assure personnel are trained as described within and report compliance upon request.

b. Ensure systematic credentials authentication and competency assessment for all healthcare personnel. This includes verification of all licensure, certification, Ongoing Professional Practice Evaluation/Focused Professional Practice Evaluation registration, specific training, and other relevant documents required for the administration of sedation agents.

c. Provide feedback from the MHS Controlled Substance Prescriber Profile, as deemed appropriate, to the privileged provider whose sedation practices appear to be outside this DHA-PI. This will serve as a routine mechanism of peer review.

d. Engage Market, SSO, or DHAR Dental Lead and/or Chief of Dental Operations, and staff at the MTF/DTF level in continuous quality improvement regarding sedation management, reporting priorities, and progress on selected measures as needed.

e. Report information to DHA through Market Dental Lead or Chief, Dental Operations (Market-level), Direct Support Organizations, or designated appointees as appropriate.

8. MARKET, SSO, AND DHAR DENTAL LEAD AND/OR CHIEF, DENTAL OPERATIONS (MARKET-LEVEL). The Market, SSO, and DHAR Dental Lead and/or Chief, Dental Operations (Market-level) will:

a. Ensure the widest dissemination of this DHA-PI and future updates to the MTF/DTFs in the market.

b. Report issues in achieving compliance of this DHA-PI to the Chief, DHA D-CMT.

9. MTF/DTF DIRECTORS. The MTF/DTF Directors will:

a. Oversee the implementation of this DHA-PI and ensure privileged dental providers are informed and understand the requirements.

b. Appoint a Sedation Consultant (e.g., a dentist privileged in sedation) to facilitate the implementation of this instruction. Responsibilities include: informing providers of the DHA-PI, overseeing and reporting compliance, and collaborating with key stakeholders (e.g., Market Dental Lead, and Specialty Consultants) to rectify issues related to the administration of sedation in dental patients.

c. Ensure the OMS and dental clinics providing sedation are equipped with the resources required for safe sedation (e.g., personnel, training, and equipment).

d. Ensure overall compliance of this DHA-PI.

10. DEPARTMENT/CLINIC CHIEF. The Department/Clinic Chief will ensure:

a. That the standards and guidelines outlined in this DHA-PI are applied to privileged dental providers who administer, by any route, medications or pharmacologic agents to a dental patient which result in a state of sedation or general anesthesia (GA).

b. That when the level of sedation extends to the next deeper level, the standards as outlined in Enclosures 3 through 6 (including staff, training, and equipment) are applied for that deeper level of sedation or GA.

c. That the selection of appropriate procedures is the responsibility of the privileged dental provider and be based upon:

(1) Scope of services: The ability of the organization to support the proposed procedure through adequate, competent support staff, appropriate procedural environment, availability of adequate medications, supplies, and equipment;

(2) The patient's medical, anesthetic, and drug history;

(3) The patient's physical status according to the American Society of Anesthesiologists (ASA) classification system; and

(4) The risks/benefits of the procedure/test.

d. That dental providers and support staff practice patient safety at all times and are familiar with this DHA-PI as outlined in Enclosures 3 through 6 in the performance of anxiolysis, sedation, and anesthesia.

e. All adverse events and patterns of adverse events associated with sedation or anesthesia are reported, evaluated, and defined in order to develop improved processes and ensure patient safety.

11. MTF/DTF QUALITY CONTROL OFFICER. The MTF or DTF Quality Control Officer will ensure:

a. All departments conducting sedations and/or GA have a system to review and document. This review will encompass three main components:

(1) Appropriate record review which includes the following:

- (a) Pre-sedation evaluation completed.
- (b) Patient meets scope/criteria for type of sedation/anesthesia selected.
- (c) ASA physical classification documented.
- (d) Written consent present in the record.
- (e) Intraoperative vital signs adequately monitored according to aforementioned requirements.
- (f) Intentional plane of sedation achieved and maintained.
- (g) Postoperative vital signs adequately monitored.
- (h) Discharge criteria met prior to patient leaving department.

(2) Controlled substance review will be recorded in the patient's record. The local pharmacy department may keep the controlled substance inventory as appropriate. This review, at a minimum, will include the following:

- (a) Amount of controlled medication dispensed to the patient.
- (b) Amount of controlled medication used for the patient during the procedure.
- (c) Amount of controlled medication wasted or returned to stock.

(3) Equipment maintenance review with documentation of manufacturer-recommended maintenance requirements of monitors. The local biomedical engineering team or equivalent may maintain equipment maintenance/calibration records.

b. Each department perform at least a quarterly review of their sedation and GA practice. This review must include a representative sampling of each provider's sedation cases. Any adverse trends found in the Ongoing Professional Practice Evaluation/Focused Professional Practice Evaluation and/or additional performance reviews will be reported, when appropriate, to local credentials committee and the privileging authority (e.g., Director of Dental Clinical Services, Dental Commander, or Director of Dental Services).

12. DENTIST AND DENTAL SPECIALIST. A dentist and dental specialist working in MTF/DTFs in the MHS must comply with procedures detailed in this DHA-PI.

ENCLOSURE 3

DENTAL USE OF NITROUS OXIDE (N₂O) INSTRUCTION

1. OVERVIEW. This DHA-PI addresses the administration of Nitrous Oxide (N₂O) by privileged dental providers in MTF/DTFs. N₂O is typically delivered through a nasal hood breathing circuit to provide minimal sedation. Although cognitive function and coordination may be impaired, ventilation and cardiovascular functions are unaffected. The use of other pharmacologic agent in addition to N₂O/oxygen will require application of the moderate sedation standards.

a. N₂O used at greater than 50 percent concentration is considered moderate sedation. Combining an oral sedative medication with N₂O at 50 percent concentration or less is considered moderate sedation. Providers using N₂O in either manner listed above must follow moderate sedation guidelines and must be privileged in moderate sedation.

b. Educational requirements must be in accordance with Reference (g) as stated in this Enclosure.

c. Inhalation sedation providers utilizing N₂O must have the training, skills, and equipment to identify and safely manage a level of sedation deeper than the intended level until either assistance arrives or the patient returns to the intended level of consciousness.

d. Standard forms must be used for administrative procedures supporting sedation with N₂O by dental providers. The suggested form for N₂O consent and administration is DHA Form 196, Minimal Sedation Procedure Sheet. Alternatively, documentation may be in the EHR if all of the requirements for documentation in this enclosure are fulfilled.

e. Pediatric dentists may use the American Association of Pediatric Dentistry Sedation Record in agreement with national specialty standards.

2. DENTAL PERSONNEL. Dental personnel must follow the responsibilities outlined below during administration of N₂O.

a. Provider. Operating provider, privileged at the intended level of sedation, who directs the sedation and performs the procedure. The provider must:

(1) Remain in the treatment room until the completion of the procedure and the patient has recovered from the sedation and can be left in the care of a trained assistant to continue monitoring until release criteria are met.

(2) Maintain responsibility for the patient's welfare and be readily available until the patient is discharged from the clinic.

(3) Facilitate the management of the sedative agent and equipment if using portable tanks.

(4) Diagnose and treat emergencies related to the administration of N₂O sedation.

(5) Provide appropriate documentation to the credentials coordinator or privileging authority for initial request or renewal of privileges.

b. Chairside Assistant. Technician or dental assistant will assist the sedation provider with the operative procedure.

c. Dental Commanders or Directors of Dental Services. Dental Commanders or Directors of Dental Services will:

(1) Ensure N₂O inhalation sedation services utilizing N₂O provided by dentists in MTF/DTFs comply with national professional standards of care as outlined herein.

(2) Ensure N₂O inhalation sedation providers utilizing N₂O have required training, adequate experience in sedation, and an understanding of the requirements of this DHA-PI.

d. Credentials Coordinator. The Credentials Coordinator or privileging authority will ensure providers utilizing N₂O have the required credentials/training and maintain required documentation.

3. N₂O SEDATION QUALIFICATIONS

a. A minimum of two individuals (e.g., the provider and the dental assistant), each appropriately trained, are required for N₂O administration during the procedure. Each individual must have the appropriate credentials, skills, and training in accordance with this DHA-PI. After the procedure and N₂O administration is complete, only one of the individuals must remain with the patient until discharged from the clinic.

b. The dental provider must demonstrate competency by remaining current in a DHA-approved Basic Life Support (BLS) certification. The dental provider must additionally demonstrate competency through one or more of the following:

(1) Training in minimal sedation consistent with that prescribed in the current edition of Reference (r).

(2) Comprehensive training in moderate sedation that satisfies the requirements described in the Moderate Sedation section of Reference (g).

(3) An advanced education program accredited by the Commission on Dental Accreditation (CODA) that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines.

c. If appropriate, previously trained dental providers requiring current clinical proficiency may fulfill proficiency through a refresher training. The refresher training can be conducted under the supervision of a qualified practitioner and/or through an ADA Continuing Education Recognition Program that is designed to meet their specific instructional needs.

4. PERSONNEL AND EQUIPMENT REQUIREMENTS FOR AREAS ADMINISTERING N₂O

a. Personnel. The dental provider should have at least one additional person trained in DHA-approved BLS or the equivalent during the procedure. This may be the chairside assistant.

b. Equipment. The equipment must be checked for proper operation, maintenance, and disinfected per the manufacturer's standards.

(1) N₂O/oxygen equipment: A pre-procedural check of equipment must be conducted prior to use and documented using the DHA Form 196, Minimal Sedation Procedure Sheet. This includes inspecting the system components including the reservoir bag for cracks, wear, and tears. Pressure connections should be checked for leaks when a delivery system is turned on and each time a tank is changed. N₂O/oxygen equipment must:

(a) Have the capacity for delivering 100 percent, and never less than 30 percent, oxygen concentration at a flow rate appropriate to the patient. However, the concentration of N₂O should not typically exceed 50 percent for minimal sedation.

(b) Contain a fail-safe mechanism to shut off N₂O flow if oxygen pressure falls below threshold.

(c) Contain a scavenging system to minimize room air contamination and occupational risk.

(d) Display dosage of N₂O (e.g., percent N₂O/oxygen and/or flow rate and total flow of gases delivered).

(2) Other requirements:

(a) Ability to measure continuous pulse oximetry.

(b) A means of determining blood pressure.

(c) A functional source of oxygen. Piped oxygen is preferred but an oxygen cylinder may be used if adequate supply.

(d) A means of delivering positive pressure ventilation (e.g., bag, valve, mask).

(e) Suction equipment.

(f) A reliable means of two-way communication to summon help if required. Personnel should be familiar with activating emergency response/Code Blue team in their facility.

5. PATIENT MANAGEMENT FOR N₂O ADMINISTRATION

a. Pre-procedure. Preparation of the patient is the responsibility of the privileged dental provider and should include:

(1) History and evaluation, to include:

- (a) Allergies and previous allergic or adverse drug reactions.
- (b) Current medications.
- (c) Relevant diseases and physical/neurological impairment.
- (d) Previous experience with sedation or anesthesia.
- (e) Snoring, obstructive sleep apnea, and mouth breathing.
- (f) Recent illness (e.g., sinus congestion, cough, sore throat, fever).
- (g) Medical condition requiring a medical consultation.

(2) Pre-operative evaluation and preparation, to include:

- (a) Pre-operative dietary restrictions as indicated in Reference (f);
- (b) Pre-operative verbal and/or written instructions;
- (c) Informed consent from the patient or the patient's legally authorized representative in the case of a minor or an adult who lacks capacity. DHA Form 196, Minimal Sedation Procedure Sheet is the approved consent form. If unavailable, consent may be documented on an equivalent EHR or local MTF/DTF-approved form;
- (d) Pre-sedation summary to include age, weight in kilograms, blood pressure, heart rate, respiratory rate, oxygen saturation, and ASA classification.

b. Intra-procedure and post-procedure

(1) Intraoperative monitoring and documentation:

(a) At the dental provider's direction, an appropriately trained individual must remain in the operatory to monitor the patient until they meet the discharge criteria.

(b) Continual clinical observation of the patient's responsiveness (e.g., level of awareness), color, and respirations must be performed throughout the procedure. Spoken responses provide an indication that the patient is breathing per Reference (f). Relaxed or tired patients on N₂O can drift off to sleep. When this occurs, the team must awaken the patient, lower the level of the N₂O, and continue to assess responsiveness.

(c) No additional monitoring is required unless the status of the patient changes, at which point blood pressure monitoring, continuous pulse oximetry and oxygen saturation, and respiratory confirmation are required.

(d) Documentation in the patient's record must include indication for use of N₂O/oxygen inhalation, N₂O dosage (e.g., percent N₂O/oxygen and flow rate), duration of the procedures, and post treatment oxygenation procedure.

(2) Recovery and discharge.

(a) The dental operatory may be used for recovery. Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.

(b) The dental provider or appropriately trained clinical staff must monitor the patient during recovery and until the patient is ready to be discharged from the clinic.

(c) The dental provider must determine and document the level of consciousness, oxygenation, ventilation, and circulation are satisfactory prior to discharge.

(d) Patients are provided with post-sedation verbal or written discharge instructions that address activity level or limitations, dietary restrictions, medication instructions, safe use, storage, and disposal of opioids when prescribed, and include a 24-hour phone number where help can be obtained in case of complications.

(e) An adult escort is required only for a patient who is a minor, or an adult who is lacking capacity.

6. OCCUPATIONAL SAFETY AND HEALTH. The goal is to maintain the lowest practical levels of N₂O in the environment while using N₂O. Adherence to the following recommendations below can help minimize occupational exposure to N₂O. To limit occupational exposure, dental personnel:

- a. Must use scavenging systems that remove N₂O during the patient's exhalation.
- b. Where possible, use exhaust systems which adequately vent scavenged air and gases to the outside of the building and away from fresh air intake vents.
- c. Use, where possible, outdoor air for dental operatory ventilation.
- d. Must regularly inspect and maintain the N₂O/oxygen delivery equipment according to the manufacturer's instructions.
- e. Must select a properly-fitted mask size for each patient.
- f. Should encourage patients to minimize talking and mouth breathing during N₂O administration.
- g. Should use high volume dental suction and rubber dam, when possible and practical, during N₂O administration.
- h. Must administer 100 percent oxygen to the patient for at least 5 minutes after terminating N₂O administration.

7. COMPETENCY ASSESSMENT AND MAINTENANCE. The competency of privileged dental providers is evaluated through the credentialing process and does not require re-certification.

ENCLOSURE 4

MINIMAL SEDATION/ANXIOLYSIS INSTRUCTION

1. OVERVIEW. This DHA-PI addresses the administration of minimal sedation services by trained and privileged dental providers in MTF/DTFs. Per the ASA and ADA, “minimal sedation (anxiolysis) is a drug-induced state intended to facilitate a procedure, during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, ventilator, and cardiovascular functions are unaffected.” An example of minimal sedation is a single, orally administered sedative (e.g. pre-procedure triazolam) or analgesic medication administered in doses appropriate for the unsupervised treatment of procedure-related anxiety or pain. There are patients who will respond to a drug dose typically associated with anxiolysis with a physiologic response of moderate sedation or deeper. If so, the level of care delivered to such patients must reflect the actual sedation level achieved rather than the primary level intended. These standards for conduct are congruent with Reference (f).

a. Educational requirements and clinical practices must be in accordance with Reference (g).

b. Minimal sedation providers must have the training, skills, drugs, and equipment to identify and manage a level of sedation deeper than the one intended until either assistance arrives (emergency medical service) or the patient returns to the intended level of consciousness without airway or cardiovascular complications. Minimally sedated children can quickly become moderately sedated in spite of the intended level of minimal sedation. Consequently, the use of enteral techniques for minimal sedation in children under 12 will be limited to residency-trained pediatric dentists and OMS providers with current Pediatric Advanced Life Support (PALS) certification (or the DHA-approved equivalent) and privileged in moderate sedation.

c. The decision to use minimal sedation rests entirely with the privileged dental provider. Examples warranting minimal sedation include (but are not limited to) significant avoidance behavior, visible anxiety or discomfort with dental treatment, and a history of diagnosed or suspected post-traumatic stress disorder with chronic pain management difficulties.

d. Minimal sedation may be achieved by the administration of a drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose. The administration of enteral drugs exceeding the maximum recommended dose during a single appointment is considered moderate sedation and those guidelines must apply. If more than one enteral drug is administered to achieve the desired sedation effect, the guidelines for moderate sedation apply. If an enteral or parenteral drug is combined with N₂O, the guidelines for moderate sedation apply.

e. Standard forms must be used for administrative procedures supporting provision of minimal sedation by dental providers in DHA facilities. The approved consent form for minimal

sedation is DHA Form 195, Informed Consent Sedation and Anesthesia. Alternatively, a local MTF/DTF-approved form may be used or documentation in the EHR as long as the requirements for documentation in this enclosure are fulfilled.

2. DENTAL PERSONNEL. Dental personnel must follow the responsibilities outlined below during administration of minimal sedation.

a. Minimal Sedation Provider. Operating provider, privileged at the intended level of sedation, who directs or administers the minimal sedation and performs the procedure. The provider must:

(1) Remain in the dental treatment room during active dental treatment to monitor the patient continuously until discharge criteria are met. Minimal sedation providers may direct an appropriately trained individual who is competent with monitoring techniques and equipment to perform this function after active treatment is completed.

(2) Maintain responsibility for the patient's welfare and be readily available in the clinic until the patient is discharged.

(3) Manage the sedative agent, ensure adequacy of the facility and staff, diagnose and treat emergencies related to the administration of minimal sedation, and provide the equipment, drugs, and protocols for patient rescue.

(4) Provide appropriate documentation to the credentials coordinator or privileging authority for initial request or renewal of privileges.

b. Chairside Assistant. A technician or dental assistant will assist the minimal sedation provider with the operative procedure.

c. Dental Commanders or Directors of Dental Services. Dental Commanders or Directors of Dental Services will:

(1) Ensure enteral sedation services provided by dental providers comply with national professional standards of care as outlined in this instruction.

(2) Ensure minimal sedation providers have required training, adequate experience in sedation, and an understanding of the requirements of this DHA-PI.

(3) Maintain appropriate documentation for dental assistants in the training file.

d. Credentials Coordinator. The credentials coordinator or privileging authority will ensure minimal sedation providers have the required credentials/training and maintain required documentation.

e. Dental Sedation Officer. A dentist who directs quarterly audits of at least 10 percent of all minimal sedation records. When the privileged dental provider is also the Dental Sedation Officer, the Dental Director will designate an alternate dentist who is also privileged in minimal sedation administration to conduct the audit. If not practicable, then a licensed dentist may perform this administrative function. Self-auditing is not authorized.

3. MINIMAL SEDATION QUALIFICATIONS

a. To be privileged in minimal sedation, the dentist must demonstrate competency by successfully completing one of the following:

(1) Training in minimal sedation consistent with that prescribed in Reference (g) at the time that training was commenced.

(2) An advanced education program accredited by CODA that affords comprehensive and appropriate training necessary to administer and manage minimal sedation.

(3) Comprehensive training in moderate sedation that satisfies the requirements described in the Moderate Sedation section of Reference (g) at the time training was commenced.

b. Furthermore, the dentist privileged in minimal sedation must maintain:

(1) Appropriate license, privileges, and credentials.

(2) Current certification in DHA-approved BLS or the equivalent.

c. Prior to assisting with minimal sedation, dental assistants/technicians will be competent in the following:

(1) DHA-approved BLS or the equivalent.

(2) Code Blue procedures and emergency equipment familiarity.

4. EQUIPMENT REQUIREMENTS FOR AREAS CONDUCTING MINIMAL SEDATION.

The location where minimal sedation/anxiolysis is conducted must have the following items readily available:

a. Pulse oximetry for non-invasive monitoring of oxygen saturation.

b. A means of determining blood pressure.

c. Supplemental oxygen delivery system.

d. The following emergency equipment, at a minimum, must be immediately available.

(1) Equipment to provide positive pressure ventilation with supplemental oxygen.

(2) Automated External Defibrillator (AED) or manual defibrillator.

(3) Suction equipment.

(4) A reliable means of two-way communication to call for help. Personnel must be familiar with activating the emergency response system and the Code Blue team in their facility.

5. PATIENT MANAGEMENT

a. Pre-procedure. Preparation of the patient is the responsibility of the privileged dental provider and must include:

(1) Patient Evaluation/Medical History. Providers must be familiar with pertinent aspects of the patient's medical history including:

(a) Past diseases and/or abnormalities of major organ systems.

(b) Previous adverse experiences with sedation or anesthesia.

(c) Current medications and drug allergies.

(d) History of tobacco, alcohol, or substance abuse.

(2) Patient Counseling. Before the sedation/procedure commences, patients or their legal authorized representative in the case of a minor or adult lacking capacity, will be informed of, and give informed consent for the administration of sedation. Risks and benefits associated with the planned procedure or test, alternative anesthetic options, and risks of both the procedure and the anesthetic plan, must be discussed with the patient or legally authorized representative and documented on the approved DHA Form 195, Informed Consent Sedation and Anesthesia.

(3) Pre-sedation Fasting. Nothing-by-mouth (NPO) requirements will be determined by the privileged dental provider and on a case-by-case basis using current guidelines.

(4) Documentation

(a) Peri-procedural plan of care;

(b) Consent for the procedure and anesthetic before administration of the sedative on an appropriate consent form; and

(c) Pre-sedation summary to include: age, height, weight, blood pressure, heart rate, respiratory rate, and ASA physical status classification. Documentation must be recorded in the patient's record.

(d) Pregnancy status will be documented for all patients whose sex is female, who are of childbearing age, are premenopausal, and who have not had a total hysterectomy. This may be obtained through laboratory or point-of-care testing (e.g., human chorionic gonadotropin (hCG) hormone). Alternatively, after being educated on the risks of sedation/anesthesia during pregnancy, the patient may elect to answer pertinent questions by the treating provider in lieu of a pregnancy test; this decision should be documented in the record.

b. Intra-procedure

(1) Patients will be visually monitored for ventilation (e.g., chest excursions) continually. Level of consciousness will be assessed continually (e.g., responsiveness to verbal commands) throughout the procedure. The provider should utilize monitoring equipment (e.g., pretracheal or precordial stethoscope, pulse oximetry, blood pressure monitoring, temperature monitoring, or cardiac telemetry/electrocardiogram (ECG)) as deemed necessary for the care of the individual patient.

(2) At least one additional person current in BLS certification must be present in addition to the provider during the procedure. This may be the chairside dental assistant/technician.

(3) The intra-procedural recording of monitored parameters for anxiolysis in the patient record must include the name and dosage of the anxiolytic drug administered, time administered, and the route of administration.

(4) If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure and manage the patient appropriately until the patient returns to the intended level of sedation.

c. Post-procedure

(1) Record post-procedural recording of monitored parameters for anxiolysis (e.g., level of consciousness) and post-procedural vital signs.

(2) Discharge once the following criteria are met:

(a) Ability of patient, parent/legally authorized representative, or escort, to verbalize understanding of discharge instructions (if appropriate).

(b) Adequate analgesia.

(c) Adequate control of nausea and/or vomiting.

(d) Return to baseline or near baseline mental status.

(e) Patients are provided with post-sedation verbal or written discharge instructions that address activity level or limitations, dietary restrictions, medication instructions, and include a 24-hour phone number where help can be obtained in case of complications.

(3) An adult escort is required for the patient. The adult escort must understand the post-procedure and post-sedation instructions.

(4) At least one member of the dental treatment team (e.g., dental provider or dental assistant/technician) should directly observe the patient until discharged to a responsible adult.

6. COMPETENCY ASSESSMENT AND MAINTENANCE. Privileged providers' competency is evaluated through the credentialing process and does not require re-certification.

ENCLOSURE 5

MODERATE SEDATION/ANALGESIA INSTRUCTION

1. OVERVIEW. This procedural instruction addresses the administration of moderate sedation services by trained and privileged dental providers in DHA facilities. According to the ASA and the ADA, “moderate sedation/analgesia (“conscious sedation”) is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.” Of note, ketamine is an agent that induces a dissociative state during which patients will not usually respond to verbal commands. However, because no interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is usually maintained. Dissociative sedation induced by usual sedative doses of Ketamine (0.5-1 mg/kg intravenous (IV) or 2-2.5 mg/kg intramuscular, and repeated as needed to maintain dissociation) will be considered equivalent to moderate sedation/analgesia. These guidelines are in congruence with national professional standards as outlined in References (f), (g), (o), (p), and (q).

a. Moderate sedation/analgesia will be a core privilege for oral and maxillofacial surgeons, pediatric dentists, periodontists, and a supplemental privilege for general dentists and other dental specialists who attained the necessary education and training.

b. Moderate sedation providers must have the training, skills, drugs, and equipment to identify and manage a level of sedation deeper than the one intended until either assistance arrives (emergency medical service) or the patient returns to the intended level of consciousness without airway or cardiovascular complications.

c. Standard forms must be used for administrative procedures supporting moderate sedation administered by dental providers in DHA facilities. Approved forms for use in moderate sedation include the following: DHA Form 193, Dental Sedation Record; DHA Form 195, Informed Consent Sedation and Anesthesia; DHA Form 197, Pre-anesthetic Assessment; and DHA Form 198, Immediate Pre-procedural Assessment. If the forms are unavailable, local MTF/DTF-approved forms may be used or documentation may be in the EHR as long as all of the requirements for documentation in this enclosure are fulfilled.

2. DENTAL PERSONNEL. Dental personnel must follow the responsibilities outlined below during administration of moderate sedation.

a. Moderate Sedation Provider. Operating provider, privileged at level of sedation intended, directs or administers the moderate sedation and performs the procedure. The provider must:

(1) Remain in the dental treatment room to monitor the patient until the patient meets discharge criteria or recovers to a minimally sedated level. Once the patient recovers to a minimally sedated level, the provider may direct a qualified auxiliary (e.g., recovery assistant) to continue monitoring the patient until discharged from the facility to their escort.

(2) Maintain responsibility for the patient's welfare and be readily available until the patient is discharged from the clinic.

(3) Manage the sedative agents; ensure adequacy of the facility and staff, diagnose and treat emergencies related to the administration of moderate sedation, and provide the equipment, drugs, and protocols for patient rescue.

(4) Provide appropriate documentation to the credentials coordinator or privileging authority for initial request or renewal of moderate sedation privileges.

b. Chairside Dental Assistant & Monitor. A chairside dental assistant or dental technician will assist the provider with the operative procedure. The monitor will continuously assess and record the patient's physiological and psychological status. If the chairside dental assistant or dental technician is trained and competent as a monitor, he/she may serve as the monitor. Reference the following section for qualifications.

c. Recovery Assistant. The recovery assistant will assist in the recovery of the patient in an appropriately designated recovery area which may be the procedure room. The monitor may be the recovery assistant.

d. Dental Commanders or Directors of Dental Services. Dental Commanders or Directors of Dental Services will:

(1) Ensure moderate sedation services provided by dental providers comply with national professional standards of care as outlined in this document.

(2) Ensure moderate sedation providers have required training, adequate experience in sedation, and an understanding of the requirements of this procedural instruction.

(3) Maintain appropriate documentation for initial and refresher training for assistants and monitors in the training file.

e. Credentials Coordinator. The credentials coordinator or privileging authority will ensure moderate sedation providers have the required credentials/training and maintain required documentation in the provider's credentials file.

f. Dental Sedation Officer. A dentist, who is privileged in moderate sedation, will direct quarterly audits of at least 10 percent of all moderate sedation records. These audits will be conducted only by other providers who are privileged in moderate sedation. If not practicable, then a licensed dentist may perform this administrative function. Self-auditing is not authorized.

3. MODERATE SEDATION QUALIFICATIONS.

a. The dental provider and monitor must be present during the procedure. Upon completion of the dental procedure, either the provider or a qualified individual (e.g., trained dental assistant/technician) must remain with the patient for continual monitoring during the recovery phase. Each individual must have the appropriate credentials, skills, and training in accordance with national professional standards as outlined in References (f) and (g).

b. Moderate sedation providers must be current in the following credentials:

(1) A DHA-approved BLS or the equivalent.

(2) A DHA-approved Advanced Cardiac Life Support (ACLS) or Advanced Life Support (ALS) or equivalent if managing a patient 13 years or older.

(3) A DHA-approved PALS or equivalent if managing a patient 12 years or younger.

(4) A Neonatal Resuscitation Program (NRP) training if managing a patient 30 days or younger.

c. In accordance with Reference (g), moderate sedation providers must demonstrate competency by successfully completing one of the following:

(1) An advanced education program accredited by the CODA that affords comprehensive and appropriate training necessary to administer and manage moderate sedation (includes CODA-accredited residencies in oral and maxillofacial surgery, periodontics, and pediatric dentistry).

(2) Comprehensive training in moderate sedation that satisfies the requirements described in the Moderate Sedation section of Reference (g) at the time training was commenced. The course must include:

(a) A minimum of 60 hours of instruction plus administration of sedation for at least 20 individually managed patients.

(b) Certification of competence in moderate sedation techniques and in rescuing patients from a deeper level of sedation than intended (including managing the airway, obtaining intravascular or intraosseous access, and administering reversal medications).

d. The monitor, who may be a nurse, certified corpsman, surgical technician, dental assistant/technician, or other credentialed moderate sedation provider, is responsible for continuously assessing and recording the patient's physiological and psychological status. The monitor may obtain IV access and administer medications ordered by the provider and only under the direct supervision of the provider. The monitor, if not a licensed dental provider, must demonstrate competency through the following:

(1) Current DHA-approved BLS certification or the equivalent.

(2) Training which includes a standardized written test with a minimum passing score of 80 percent every 2 years. This training will be portable to another MTF/DTF in the case of permanent change of station as long as the originating certification is on file. Various resources and methods may be used to test competency in the following:

(a) Sedation medications and reversal agents.

(b) Management of the sedated patient and patient responses to sedation.

(c) Proper perioperative monitoring of patients, physiologic norms, and basic knowledge of monitoring equipment functions.

(d) Medical emergency preparedness and response training.

(e) Crash cart familiarity training.

(f) Recognition of apnea and airway obstruction.

(3) ACLS, ALS, or the DHA-approved equivalent is strongly recommended for personnel who are serving as monitors for moderate sedation for patients 13 years of age and older.

(4) PALS or the DHA-approved equivalent is strongly recommended for personnel who are serving as monitors for moderate sedation for patients 12 years of age and younger.

(5) Documented demonstration of the safe monitoring of five moderate sedation/analgesia cases under supervision.

e. The sedation team (e.g., providers and monitors) will conduct and document emergency response drills at least quarterly to ensure continued competency with airway management and other potential emergency events.

4. EQUIPMENT REQUIREMENTS FOR AREAS CONDUCTING MODERATE SEDATION.

The location where moderate sedation/analgesia is conducted, as well as the location where the patient is recovered, will each have the following items:

a. A functional source of oxygen. Piped oxygen is preferred but an oxygen cylinder may be used if adequate supply and replacement tanks are immediately available. Cylinder oxygen will be readily available in case of pipeline failure.

b. A means of delivering positive pressure ventilation (e.g., bag, valve, mask).

- c. Suction and appropriately sized suction catheters.
- d. Continuous pulse oximetry for non-invasive monitoring of oxygen saturation.
- e. Continuous capnography for monitoring respiratory status.
- f. Automated blood pressure determination.
- g. Continuous ECG or cardiac telemetry monitoring.
- h. Airway management equipment.
- i. A method for measuring body temperature.
- j. A reliable means of two-way communication to summon help if required.
- k. Additionally, there must be an immediately available emergency cart with equipment appropriate for the patient's age and size to include:
 - (1) AED or defibrillator.
 - (2) ACLS/PALS/NRP emergency drugs as age appropriate.
 - (3) Advanced airway equipment.
 - (4) IV solutions/supplies.
- l. Reversal agents for selected medications (e.g., primarily opioids and benzodiazepines), if applicable. These must be immediately available.

5. PATIENT MANAGEMENT FOR MODERATE SEDATION. When under moderate sedation, the patient will have both the provider and monitor present during the procedure and one person (e.g., provider, monitor, or qualified auxiliary) during the recovery phase. The patient will be directly observed after sedation is commenced and until the patient is discharged from the clinic. When active treatment concludes and the patient recovers to a minimally sedated level, the provider may direct the monitor or qualified auxiliary to remain as the direct observer and monitor the patient until discharged from the clinic to their escort.

a. Pre-procedure. Preparation of the patient is the responsibility of the privileged provider and will include:

(1) Patient evaluation

(a) Appropriate pre-procedure evaluation of the patient's medical history and physical examination reduces the risk of adverse outcomes.

(b) Providers administering moderate sedation/analgesia must be familiar with pertinent aspects of the patient's medical history including:

1. Past disease and abnormalities of major organ systems including recent illnesses that may compromise the airway.
2. Previous adverse experience with sedation or anesthesia.
3. Current medications and drug allergies.
4. Time and nature of last oral intake.
5. History of tobacco, alcohol, or substance abuse.

(c) Providers should consider seeking medical consultation prior to the procedure when the patient's preexisting medical condition may be associated with an increased risk of morbidity or mortality or when the patient requires medical optimization prior to sedation. In the cases of severely compromised or medically unstable patients (e.g., ASA status IV or V, anticipated difficult airway, severe obstructive pulmonary disease, coronary artery disease, or congestive heart failure) or if it is likely that sedation to the point of unresponsiveness will be necessary to obtain adequate conditions, consultation with and deferment to an anesthesiologist is encouraged.

(d) Patients presenting for moderate sedation/analgesia undergo a physical examination by an appropriately privileged provider which includes:

1. Auscultation of the heart and lungs.
2. Evaluation of the airway to identify factors that may be associated with difficulty in airway management (see Enclosure 7).
3. Pre-procedural laboratory testing will not be routine; instead, it is guided by patient's underlying medical conditions and the likelihood that results will change the sedation management plan.
4. Medical conditions placing the patient at increased risk should be optimized prior to elective procedures.

(2) Patient Counseling. Before the sedation/procedure commences, patients or their legally authorized representative in the case of a minor or adult lacking capacity will be informed and provide written informed consent for the administration of moderate sedation/analgesia. Risks and benefits associated with the planned procedure, sedation, and alternative anesthetic options, will be discussed with the patient or legally authorized representative and documented appropriately.

(3) Pre-sedation Fasting. Pre-operative preparation of the patient will include counseling

and review of fasting guidelines and protocol. Patients undergoing moderate sedation/analgesia for elective procedures must not drink liquids or eat solid foods for an ample period of time to allow for gastric emptying before their procedure (see Enclosure 7 for fasting guidelines). In an urgent or emergent circumstance where NPO protocol cannot be adhered to, the risk of injury due to aspiration must be weighed against the benefit of proceeding with the procedure. This assessment must be documented in the patient's health record.

(4) Documentation.

(a) Peri-procedure plan of care.

(b) Pre-sedation evaluation, past medical history, and previous sedation outcomes must be documented within 30 days of the procedural sedation on DHA Form 197, Pre-anesthetic Assessment or the equivalent EHR.

(c) Written consent for the procedure and sedation must be documented. DHA Form 195, Informed Consent Sedation and Anesthesia is the approved consent form for sedation. If unavailable, local MTF/DTF-approved forms or the EHR may alternatively be used for written consent.

(d) Immediate pre-sedation update/summary to include airway exam, age, height, weight, body mass index, blood oxygen saturation by pulse oximetry on room air, blood pressure, heart rate, respiratory rate, temperature, ASA classification, and allergies must be documented on DHA Form 198, Immediate Pre-procedural Assessment or equivalent EHR prior to beginning sedation.

(e) Pregnancy status will be documented for all patients whose sex is female, who are of childbearing age, are premenopausal, and who have not had a total hysterectomy. This may be obtained through laboratory or point-of-care testing (e.g., hCG hormone). Alternatively, after being educated on the risks of sedation/anesthesia during pregnancy, the patient may elect to answer pertinent questions by the treating provider in lieu of a pregnancy test; this decision should be documented in the record.

(f) All intra-procedural and post-procedural sedation data which is required in this Enclosure must be documented on DHA Form 193, Dental Sedation Record or in the equivalent EHR.

(5) The monitoring equipment, anesthesia delivery systems, and oxygen delivery systems must be checked prior to the initiation of sedation.

(6) A time-out procedure will be performed prior to sedation administration which includes verification of the patient's full name, date of birth, correct procedure, correct anesthetic plan, and correct site. This must be documented in the record.

b. Intra-Procedure

(1) Level of Consciousness. Response of the patient to commands during procedures performed with moderate sedation/analgesia is an indicator of their level of consciousness. Monitoring a patient's response to verbal commands is routine, except with pediatric patients or those having a procedure or test that prevents a verbal response. The ability to give a "thumbs up" or other indication of consciousness in response to verbal or tactile sensation is valuable in this patient population and suggests the patient will be able to maintain their airway. The level of consciousness will be documented at least every 5 minutes. The following are suggested (but not mandatory) descriptors from the modified Wilson scale:

- (a) Oriented (e.g., eyes may be closed but respond appropriately to questions).
- (b) Drowsy (e.g., eyes may be closed, arousable only to command).
- (c) Arousable (e.g., arousable to mild physical stimulation such as light ear lobe tug).
- (d) Unarousable to mild physical stimulation.

(2) Pulmonary Ventilation and Oxygenation. The primary cause of morbidity associated with moderate sedation/analgesia is drug induced respiratory depression. Monitoring of ventilatory function and oxygenation will be achieved by the following monitors:

- (a) Continuous observation of spontaneous respiratory activity (recorded every 15 minutes).
- (b) Auscultation of breath sounds (e.g., using a pretracheal or precordial stethoscope) may be used if direct observation of respiratory activity is unable to be accomplished;
- (c) Continuous pulse oximetry (recorded every 15 minutes).
- (d) Continuous waveform capnography.

(3) Hemodynamics

(a) Sedative and analgesic agents may diminish autonomic compensation for hypovolemia and surgical stress. Early detection of change in a patient's heart rate and blood pressure may enable quicker intervention and reduce the risk of cardiovascular collapse.

- (b) Required hemodynamic monitoring includes:
 - 1. Blood pressure readings recorded at 5 minute intervals during the procedure.
 - 2. Continuous ECG or cardiac telemetry monitoring (recorded every 15 minutes).
 - 3. Continuous heart rate readings recorded at 5 minute intervals.

(4) Recording of Monitored Parameters

(a) Simultaneous recording of patient's level of consciousness, respiratory function, and hemodynamics will be documented on DHA Form 193, Dental Sedation Record or an equivalent electronic document.

(b) The following must be recorded:

1. Type, amount, dosage of medication, and fluid administered along with time of administration.

2. Vital signs, ventilation, capnography, and oxygenation status at the intervals prescribed in paragraphs 5b(1), 5b(2)(a), 5b(2)(c), and 5b(3)(b) of this enclosure.

3. Level of consciousness.

4. Rate of supplemental oxygen.

5. Any emergency interventions.

(5) If the patient enters a deeper level of sedation than the provider is qualified to provide, the provider must stop the procedure and manage the patient appropriately until the patient returns to the intended level of sedation.

c. Post-procedure. Patients receiving moderate sedation/analgesia will be monitored until discharge criteria are fully met. Duration of monitoring must be individualized depending on the level of sedation accomplished, condition of the patient, and nature of intervention for which the moderate sedation/analgesia was administered. Patients will be monitored after moderate sedation/analgesia, and recovery will be appropriately documented in the patient's record. Oxygenation should be monitored until patients are no longer at risk for hypoxemia. Ventilation and circulation will be monitored at regular intervals no greater than 15 minutes and until patients are suitable for discharge. The patient will be directly observed and released when discharge criteria is met. Utilization of a standing order to discharge the patient when the below criteria are met is permissible as long as the name of the provider accepting responsibility for discharge is documented in the patient record:

(1) Predetermined objective criteria, which may include either the use of an Aldrete, modified-Aldrete Score, Post-Anesthesia Discharge Scoring System (PADSS), modified PADSS, or equivalent.

(2) Stable respiratory status and the ability to maintain a patent airway.

(3) An adult escort is present who understands the post-procedure and post-sedation instructions. The escort will assume the care, transportation, and monitoring of patient at home and be able to report complications.

(4) Satisfactory pain management and control of nausea.

(5) Patients are provided with post-sedation written discharge instructions that address post-procedure diet, medications, and activities, and include a 24-hour telephone number where help can be obtained in the event of a complication or emergency.

6. COMPETENCY ASSESSMENT AND MAINTENANCE

a. Providers. Maintenance of credentials in moderate sedation/analgesia is dependent upon proficiency and active practice.

(1) Oral and maxillofacial surgeons, periodontists, and pediatric dentists will have moderate sedation as a core privilege and maintained as such by the routine credentials renewal process.

(2) General dentists or specialists (other than oral and maxillofacial surgeons, periodontists, and pediatric dentists) may have supplemental privileges in moderate sedation/analgesia; those with supplemental privileges may provide sufficient evidence of active practice by showing proof of one of the following:

(a) Administering or directly supervising (in official teaching capacity) at least 24 cases during the previous 2 years.

(b) Demonstrating safe practice in which the dental provider simultaneously performs both the moderate sedation and the dental procedure under the supervision of a fully credentialed moderate sedation provider. This should be documented via memorandum in the training file and signed by the evaluating provider.

(3) If supplemental privileges in moderate sedation/analgesia have lapsed for 2 years or less, the following must be accomplished under supervision of a fully credentialed provider (instructor) for privilege renewal:

(a) Eight hours of review/instruction including patient management and related aspects of moderate sedation/analgesia;

(b) Five cases successfully managed under the supervision of the instructor; and

(c) A letter from the instructor (after completion of the above criteria) which recommends renewal of privileges to the credentials committee.

(4) If supplemental credentials for general dentists (or specialists other than oral and maxillofacial surgeons, periodontists, and pediatric dentists) in moderate sedation/analgesia have lapsed more than 2 years, a comprehensive course of instruction involving 60 hours of instruction and completion of 20 supervised cases must be completed prior to reinstatement of privileges. This is in congruence with Reference (g).

b. Monitors and recovery assistants. Recertification is required annually. Recertification requires documentation of safe monitoring of 12 sedations during the past year or re-completion of the initial certification requirements as noted above.

ENCLOSURE 6

DEEP SEDATION AND GENERAL ANESTHESIA (GA) INSTRUCTION

1. OVERVIEW

a. Oral and maxillofacial surgeons throughout all jurisdictions in the United States are trained, licensed, credentialed, and privileged to provide deep sedation and GA to patients in both an operating room environment and outpatient setting utilizing the Anesthesia Team Model. Deep sedation and GA are core privileges for OMS providers.

b. The only dental providers permitted to administer deep sedation or GA in MTF/DTFs are oral and maxillofacial surgeons privileged in deep sedation/GA and OMS residents or OMS providers operating under the appropriate level of supervision of an OMS provider privileged in deep sedation/GA.

c. Educational requirements and clinical practices are in accordance with American Association of Oral and Maxillofacial Surgeons Parameters of Care and Reference (f). Educational requirements for OMS residencies are dictated by the ADA CODA.

d. OMS deep sedation/GA providers must have the training, skills, drugs, and equipment to identify and manage a level of sedation deeper than the one intended until the patient returns to the intended level of consciousness without airway or cardiovascular complications. They must be able to manage patients who enter a state of GA.

e. Standard forms must be used for administrative procedures supporting deep sedation/GA administered by dental providers in DHA facilities. Approved forms for use in deep sedation/GA sedation are DHA Form 193, Dental Sedation Record; DHA Form 195, Informed Consent Sedation and Anesthesia; DHA Form 197, Pre-anesthetic Assessment; and DHA Form 198, Immediate Pre-procedural Assessment. If unavailable, local MTF/DTF-approved forms may be used or documentation may be in the EHR as long as all of the requirements for documentation in this enclosure are fulfilled

2. DENTAL PERSONNEL

a. Dental Commanders or Directors of Dental Services. Dental Commanders or Directors of Dental Services will:

(1) Ensure sedation and analgesia services provided in MTF/DTFs by dental providers comply with the standards of care outlined herein.

(2) Ensure OMS deep sedation/GA providers have required training, adequate experience in sedation, and an understanding of the requirements of this DHA-PI.

(3) Maintain appropriate documentation for initial and refresher training for deep sedation monitors in the training file.

b. Deep Sedation and GA Providers

(1) Must maintain responsibility for the patient's welfare and be readily available until the patient is discharged from the clinic.

(2) Must remain in the treatment room until the patient is recovered sufficiently from the sedation/anesthesia and can be left in the care of a monitor or recovery assistant to continue monitoring until discharge criteria are met.

(3) Must manage the sedative/anesthetic agents; ensure adequacy of the facility and staff; diagnose and treat emergencies related to the administration of deep sedation and GA; and provide the equipment, drugs, and protocols for patient rescue;

(4) Must maintain required credentials, training, and records of sedation procedures.

(5) Must provide appropriate documentation to the appropriate privileging authority for renewal of core privileges.

c. Credentials Coordinator. The credentials coordinator or privileging authority will ensure OMS deep sedation and GA providers have the required credentials/training and maintain the required documentation.

d. Dental Sedation Officer. The Dental Sedation Officer or Privileging Authority Sedation Officer directs quarterly audits of at least 10 percent of all deep sedation/GA records. While it is preferable for OMS providers to conduct these audits, any dental or medical provider privileged in moderate sedation may conduct these audits in locations with a single oral and maxillofacial surgeon. If not practicable, then a licensed dentist may perform this administrative function. Self-auditing is not authorized.

e. Anesthesia Team. The anesthesia team model requires a minimum of three appropriately trained individuals. Each individual must have the appropriate credentials, skills, and training in accordance with national professional standards as outlined in References (f), (g), (p), and (q). When GA is employed, a privileged GA provider (e.g., an oral and maxillofacial surgeon, certified registered nurse anesthetist, or anesthesiologist) will be dedicated to the administration of the anesthesia while the oral and maxillofacial surgeon performs the procedure.

(1) OMS Deep Sedation Provider. Directs the sedation/anesthetic, performs the procedure, and administers medications or directs (and directly observes) the administration of medications for deep sedation.

(2) Monitor. Observes the patient and documents vital signs and physiologic parameters for the deep sedation. The monitor is not required for general anesthetic cases since a provider dedicated to the anesthetic is required. See the following section for qualifications.

- (3) Dental Assistant/Technician. Assists with the operative procedure.

3. DEEP SEDATION AND GA QUALIFICATIONS

- a. OMS deep sedation/GA providers must be current in the following credentials:

- (1) Certificate of graduation from an OMS residency program accredited by the ADA CODA.

- (2) A current, active, valid, and unrestricted dental license from a United States jurisdiction.

- (3) ACLS certification or the DHA-approved equivalent (e.g., American Red Cross ALS).

- (4) BLS Healthcare Provider Course certification or the DHA-approved equivalent (e.g., American Red Cross BLS).

- (5) PALS certification or the DHA-approved equivalent for providers engaged in anesthesia for pediatric patients 12 and younger.

- (6) NRP certification for providers engaged in anesthesia for neonates (less than 30 days old).

- b. The monitor, who may be a nurse, certified corpsman, surgical technician, dental assistant/technician, or other credentialed moderate sedation provider, is responsible for continuously monitoring and recording the patient's physiological and psychological status during deep sedation. The monitor may assist the practitioner with minor ancillary interruptible tasks of short duration but may not be the chairside assistant/technician. The monitor may obtain IV access and may administer medications ordered by the provider under the direct supervision of the provider. The monitor, if not a provider, must demonstrate competence for certification by the following:

- (1) DHA-approved BLS Healthcare Provider Course certification or equivalent.

- (2) Training which includes a standardized written test with a minimum passing score of 80 percent every 2 years. This training will be portable to another MTF/DTF in the case of permanent change of station as long as the originating certification is on file. Various resources and methods may be used to test competency in the following:

- (a) Sedation medications and reversal agents.

- (b) Management of the sedated/anesthetic patient and patient responses to sedation.

(c) Proper perioperative monitoring of patients, physiologic norms, and basic functions of monitoring equipment.

(d) Medical emergency preparedness and response training.

(e) Crash cart familiarity training.

(f) Recognition of apnea and airway obstruction.

(3) ACLS or the DHA-approved equivalent, PALS or the DHA-approved equivalent (only if treating pediatric patients age 12 years and younger), and the American Association of Oral and Maxillofacial Surgeons Dental Anesthesia Assistant National Certification Examination completion are highly recommended for dental or surgical assistants/technicians who will be serving as anesthesia monitors during deep sedation.

(4) Documented demonstration of the safe monitoring of five deep sedation cases under supervision.

c. The OMS and the entire sedation team will conduct and document emergency response drills at least quarterly to ensure continued competency with airway management and other potential emergency events.

4. EQUIPMENT REQUIREMENTS FOR AREAS CONDUCTING DEEP SEDATION AND GA

a. A functional source of oxygen. Piped oxygen is preferred but an oxygen cylinder may be used if adequate supply and replacement tanks are immediately available. Cylinder oxygen will be readily available in case of pipeline failure.

b. A means of delivering positive pressure ventilation (e.g., bag, valve, mask).

c. Suction and appropriately sized suction catheters.

d. Continuous pulse oximetry for non-invasive monitoring of oxygen saturation.

e. Continuous capnography for monitoring respiratory status will be used in all sites.

f. Automated blood pressure determination.

g. Continuous ECG or cardiac telemetry monitoring.

h. Airway management equipment.

i. A method of measuring body temperature.

j. A reliable means of two-way communication to summon help if required.

k. Additionally, there must be a readily available emergency cart with equipment appropriate for the patient's age and size to include:

- (1) AED or defibrillator;
- (2) ACLS/PALS/NRP emergency drugs as age appropriate;
- (3) Advanced airway equipment; and
- (4) IV solutions/supplies.

l. Reversal agents for selected medications (primarily opioids and benzodiazepines), if applicable.

m. Sites that stock malignant hyperthermia (MH) triggering anesthetics such as volatile inhalational anesthetics or depolarizing muscle relaxants must:

- (1) Stock dantrolene within the treatment facility, preferably in the clinic or department.
- (2) Have immediate access to dantrolene initial dosing guidelines.
- (3) Have immediate access to the MH guidelines and telephone hotline for Malignant Hyperthermia Association of the United States (MHAUS) (1-800-MH-HYPER or 1-800-644-9737).

n. Sites that stock nondepolarizing muscle relaxants should stock a means of reversal, such as:

- (1) Sugammadex.
- (2) The appropriate anticholinesterase, which should be given following an anticholinergic medication to prevent bradycardia/asystole.

5. PATIENT MANAGEMENT FOR DEEP SEDATION/GA. While under deep sedation or GA, the patient will have at least three people in attendance. For procedures involving deep sedation, the OMS deep sedation provider, the monitor, and the dental/surgical assistant/technician are required to be in attendance. For procedures involving general anesthesia, the general anesthesia provider, the surgeon, and a dental/surgical assistant/technician are required to be in attendance. A minimum of one person is required to be in attendance during recovery until discharge. The patient will be directly observed after sedation/anesthesia is commenced. When active treatment concludes and the patient recovers to a minimally altered level of sedation, the

provider may direct a qualified auxiliary (recovery assistant) to continue monitoring the patient until discharged from the facility to their escort. The recovery assistant requirements are the same as the monitor requirements listed above.

a. Pre-procedure. Preparation of the patient is the responsibility of the privileged provider and will include:

(1) Patient evaluation.

(a) Appropriate pre-procedure evaluation of the patient's medical history and physical examination reduces the risk of adverse outcomes.

(b) Providers administering deep sedation/analgesia and GA must be familiar with pertinent aspects of the patient's medical history including:

1. Past disease and abnormalities of major organ systems including recent illnesses that may compromise the airway.

2. Previous adverse experience with sedation or anesthesia.

3. Current medications and drug allergies.

4. Time and nature of last oral intake.

5. History of tobacco, alcohol, or substance abuse.

(c) Providers should consider seeking medical consultation/referral prior to the procedure when it is believed that the patient's preexisting medical condition may be associated with an increased risk of morbidity or mortality.

(d) Physical Examination. Patients presenting for deep sedation/analgesia or GA must undergo a physical examination by an appropriately privileged provider which includes:

1. Auscultation of the heart and lungs.

2. Evaluation of the airway to identify factors that may be associated with difficulty in airway management.

3. Pre-procedural laboratory testing will not be routine; instead, it is guided by patient's underlying medical conditions and the likelihood results will change the sedation management plan.

4. Medical conditions placing the patient at increased risk should be optimized prior to elective procedures.

(2) Patient Counseling. Before the sedation/procedure commences, patients or their legally authorized representative in the case of a minor or an adult lacking capacity will be informed and provide written informed consent for the administration of deep sedation/analgesia or GA. Risks and benefits associated with the planned procedure, sedation, and alternative anesthetic options, will be discussed with the patient or legally authorized representative and documented appropriately.

(3) Pre-sedation Fasting. Pre-operative preparation of the patient will include counseling and review of fasting guidelines and protocol. Patients undergoing deep sedation/analgesia or GA for elective procedures must not drink liquids or eat solid foods for an ample period of time to allow for gastric emptying before their procedure. In an urgent or emergent circumstance where NPO protocol cannot be adhered to, the risk of injury due to aspiration must be weighed against the benefit of proceeding with the procedure. This assessment must be documented in the patient's health record.

(4) Documentation

(a) Peri-procedure plan of care.

(b) Pre-sedation evaluation, past medical history, and previous sedation outcomes must be documented within 30 days of the procedural sedation on DHA Form 197, Pre-anesthetic Assessment or the equivalent electronic health record.

(c) Written consent for the procedure and sedation must be documented. DHA Form 195, Informed Consent Sedation and Anesthesia is the approved consent form for sedation. Local MTF/DTF-approved forms or the electronic health record may alternatively be used for written consent.

(d) Immediate pre-sedation update/summary to include airway exam, age, height, weight, body mass index, blood oxygen saturation by pulse oximetry on room air, blood pressure, heart rate, respiratory rate, temperature, ASA classification, and allergies must be documented on DHA Form 198, Immediate Pre-procedural Assessment or equivalent electronic health record prior to beginning sedation.

(e) Pregnancy status will be documented for all patients whose sex is female, who are of childbearing age, are premenopausal, and who have not had a total hysterectomy. This may be obtained through laboratory or point-of-care testing (e.g., hCG hormone). Alternatively, after being educated on the risks of sedation/anesthesia during pregnancy, the patient may elect to answer pertinent questions by the treating provider in lieu of a pregnancy test; this decision must be documented in the record.

(f) All intra-procedural and post-procedural sedation data which is required in this Enclosure must be documented on DHA Form 193, Dental Sedation Record or in the equivalent EHR.

(5) The monitoring equipment, anesthesia delivery systems, and oxygen delivery

systems must be checked prior to the initiation of sedation.

(6) A time-out procedure will be performed prior to initiation of sedation which includes verification of the patient's full name, date of birth, correct procedure, correct anesthetic plan, and correct site.

b. Intra-Procedure

(1) Intravenous access. In selected circumstances, deep sedation or GA may be utilized without establishing an indwelling IV line. These selected circumstances may include very brief procedures or periods of time which, for example, may occur in some patients, or the establishment of IV access after deep sedation has been induced because of poor patient cooperation.

(2) Level of Consciousness. Response of patient to commands during procedures performed with deep sedation/analgesia is an indicator of their level of consciousness. Monitoring a patient's response to verbal commands is routine, except with pediatric patients or those having a procedure or test that prevents a verbal response. The level of consciousness will be documented at least every 5 minutes. The following are suggested (but not mandatory) descriptors from the modified Wilson scale:

(a) Oriented (e.g., eyes may be closed but respond appropriately to questions).

(b) Drowsy (e.g., eyes may be closed, arousable only to command).

(c) Arousable (e.g., arousable to mild physical stimulation such as light ear lobe tug);
and

(d) Unarousable to mild physical stimulation.

(3) Pulmonary Ventilation and Oxygenation. The primary cause of morbidity associated with deep sedation/analgesia is drug induced respiratory depression. Monitoring of ventilatory function and oxygenation will be achieved by the following monitors:

(a) Continuous observation of spontaneous respiratory activity (recorded every 15 minutes).

(b) Auscultation of breath sounds (e.g., using a pretracheal or precordial stethoscope) may be used if direct observation of respiratory activity is unable to be accomplished.

(c) Continuous pulse oximetry (recorded every 15 minutes).

(d) Continuous waveform capnography.

(4) Hemodynamics

(a) Sedative and analgesic agents may diminish autonomic compensation for hypovolemia and surgical stress. Early detection of change in a patient's heart rate and blood pressure may enable quicker intervention and reduce the risk of cardiovascular collapse.

(b) Required hemodynamic monitoring includes:

1. Blood pressure readings recorded at 5 minute intervals during the procedure;
2. Continuous ECG or cardiac telemetry monitoring (recorded every 15 minutes).
3. Continuous heart rate readings recorded at 5 minute intervals.

(5) Recording of monitored parameters

(a) Simultaneous recording of patient's level of consciousness, respiratory function, and hemodynamics will be documented DHA Form 193, Dental Sedation Record or an equivalent electronic document. Such recording confirms that the practitioner caring for the patient is aware of changes in a patient's condition.

(b) The following must be recorded:

1. Type, amount, dosage of medication and fluid administered, and time of administration.
2. Vital signs, ventilation, capnography, and oxygenation status at the intervals prescribed above.
3. Level of consciousness.
4. Rate of supplemental oxygen.
5. End-tidal anesthetic gas concentration (if utilized).
6. Body temperature monitoring which must be accomplished whenever triggering agents associated with MH are administered (note: continuous body temperature monitoring should be available but not necessarily used for deep sedation cases).
7. Any emergency interventions.

c. Post-procedure. Patients receiving deep sedation/analgesia or GA will be monitored until appropriate discharge criteria are satisfied. Duration of monitoring must be individualized depending on the level of sedation accomplished, condition of the patient, and nature of intervention for which the deep sedation/analgesia was administered. Patients will be monitored after deep sedation/analgesia and GA, and recovery will be appropriately documented in the patient's record. The patient will not be left unattended and will not be released until the

following criteria are met (utilization of a standing order to discharge the patient when the below criteria are met is permissible as long as the name of the provider accepting responsibility for discharge is documented in the patient record):

- (1) Predetermined objective criteria. Such criteria may include either the use of an Aldrete, modified-Aldrete Score, PADSS, modified PADSS, or equivalent.
- (2) Stable respiratory status and the ability to maintain a patent airway.
- (3) An adult escort is present who understands the post-procedure and post-sedation instructions. The escort will assume the care, transportation, and monitoring of patient at home and be able to report complications;
- (4) Satisfactory pain management and control of nausea.
- (5) Patients are provided with post-sedation verbal or written discharge instructions that address activity level or limitations, dietary restrictions, medication instructions, safe use, storage, and disposal of opioids when prescribed, and include a 24-hour phone number where help can be obtained in case of complications.

6. COMPETENCY ASSESSMENT AND MAINTENANCE

- a. Providers. Oral and maxillofacial surgeons will have deep sedation/analgesia and GA as core privileges and will demonstrate active practice through the routine credentials renewal process.
- b. Monitors and Recovery Assistants. Recertification is required annually. Recertification requires documentation of safe monitoring of 12 sedations during the past year or re-completion of the initial certification requirements as noted above.

ENCLOSURE 7

SUPPLEMENTAL INFORMATION

1. ASA PHYSICAL STATUS CLASSIFICATIONS

Classification	Definition	Examples, including but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, *ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or *ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	
*The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)		

2. NPO GUIDELINES FOR MODERATE SEDATION, DEEP SEDATION, AND GA. Gastric contents and pH may be influenced by many factors including anxiety, pain, abnormal autonomic function (diabetes), pregnancy, and mechanical obstruction. These guidelines do not guarantee complete gastric emptying has occurred. Unless contraindicated, pediatric patients should be offered clear liquids until 2-3 hours before anesthesia to minimize dehydration.

Ingested Material	Minimum Fasting Period
Clear liquids*	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal**	6 hours
Fatty meal	8 hours

*Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee.

***Examples of light meal include toast and clear liquids. Meals that include fried or fatty foods or meat may prolong gastric emptying time. Additional fasting time (e.g., 8 or more hours) may be needed in these cases.*

3. FACTORS ASSOCIATED WITH THE DIFFICULT AIRWAY

a. History

- (1) Previous problems with anesthesia or sedation.
- (2) Stridor, snoring, or sleep apnea.
- (3) Dysmorphic facial structure (e.g., Pierre-Robin syndrome, craniofacial syndromes, or Down syndrome).
- (4) Advanced rheumatoid arthritis.
- (5) Temporomandibular joint disease.
- (6) Prior airway surgery.

b. Physical Examination

- (1) Habitus-Significant obesity (especially involving the neck and facial structures).
- (2) Head and neck-short neck, limited neck extension, previous cervical fusion, decreased thyro-mandible distance (e.g., less than three finger breadths in an adult), neck mass, cervical disease or trauma, tracheal deviation. Mallampati Classification (class III and IV may indicate a more challenging airway):
 - (a) Class I: Soft palate, uvula, fauces, pillars visible.
 - (b) Class II: Soft palate, uvula, fauces visible.
 - (c) Class III: Soft palate, base of uvula visible.
 - (d) Class IV: Only hard palate visible.
- (3) Trismus (less than 3 cm in an adult), edentulous, protruding incisors, loose, or crowned teeth, high-arched palate, macroglossia, tonsillar hypertrophy, previous pharyngeal flap, nonvisible uvula.
- (4) Mandible/occlusion-Micrognathia, retrognathia, trismus, significant malocclusion.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ACLS	Advanced Cardiac Life Support
ADA	American Dental Association
AED	Automated External Defibrillator
ALS	Advanced Life Support
ASA	American Society of Anesthesiologists
BLS	Basic Life Support
CODA	Commission on Dental Accreditation (of the American Dental Association)
CPG	Clinical Practice Guideline
DAD	Deputy Assistant Director
D-CMT	Dental Clinical Management Team
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
DHAR	Defense Health Agency Region
DTF	Dental Treatment Facility
ECG	Electrocardiogram
EHR	Electronic Health Record
GA	general anesthesia
hCG	human chorionic gonadotropin
IV	Intravenous
MA	Medical Affairs
MHAUS	Malignant Hyperthermia Association of the United States
MH	Malignant Hyperthermia
MHS	Military Health System
MILDEPS	Military Departments
MTF	Military Medical Treatment Facility
N ₂ O	Nitrous Oxide
NPO	Nothing-by-mouth
NRP	Neonatal Resuscitation Program
OMS	Oral and Maxillofacial Surgery
PADSS	Post-Anesthesia Discharge Scoring System
PALS	Pediatric Advanced Life Support

SSO

Small Market and Stand-Alone Medical Treatment Facility Organization

PART II. DEFINITIONS

assistant. An assistant is the member of the procedure/surgical team who assists with the treatment procedures per the training and competencies possessed by the individual. The assistant may be responsible for the recording of vital signs as directed by the practitioner. Assistants in areas providing sedation will be qualified members of the sedation/anesthesia team.

deep sedation. Deep sedation is 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. Normal cardiovascular function is usually maintained. The only dental providers who are credentialed and privileged to administer deep sedation are oral and maxillofacial surgeons.

general anesthesia. General anesthesia is 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. The only dental providers who are privileged and credentialed to administer general anesthesia are oral and maxillofacial surgeons.

minimal sedation/anxiolysis. Minimal sedation or anxiolysis is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

moderate sedation. Moderate sedation is 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. Normal cardiovascular function is usually maintained.

monitor. A monitor is the member of the sedation/anesthesia team responsible for the direct observation and assessment of the patient's vital signs as prescribed in the standards for each level of sedation or anesthesia. Please see Enclosures 5 and 6 for monitor responsibilities and qualifications according to level of sedation.

N₂O sedation. N₂O, usually delivered through nasal hood breathing circuit, and usually at no more than 50 percent with or without local anesthetic, to provide minimal sedation (anxiolysis), a state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. The use of other pharmacologic agents in addition to nitrous oxide/oxygen will require application of the moderate sedation standards.

pharmacology. The above listed levels of sedation can all be achieved irrespective of either the route of administration or the specific pharmacological agent used. Utilization of certain sedation and anesthetic induction medications noted for narrow therapeutic windows, including barbiturates, etomidate, and propofol are limited to those providers credentialed in deep sedation or general anesthesia. Fully credentialed oral and maxillofacial surgeons may use the above drugs following moderate or deep sedation guidelines and is dependent on the patient response to the titrated medication.

provider. A provider is a privileged licensed professional in the MHS and specifically refers to licensed dentists in this DHA-PI. The privileged dental provider will not perform sedation or anesthesia beyond the level allowed by their privileges.