Q1. Do you agree/disagree with the proposed clinical team for sedation (proposal 1)? If you disagree, please detail why.

- minimal and moderate sedation should have the same conditions
- it is sufficient to have a minimum of two staff members in the room and a third person available when appropriate. The sedationist and clinician should be competent to assess the expected risk factors and complexity of the case in order to make this call.

Q2. Do you agree/disagree with the proposed formal education requirements to provide sedation and for monitoring-only of sedated patients (proposals 2&3)? If you disagree, please detail why.

Agree with this proposal.

Q3. Do you agree with the proposed core competencies for providing sedation and monitoring-only of a sedated patient (proposal 4 and appendices B & C of the draft practice standard)? If you disagree, please detail why.

Agree with this proposal

Q4. Do you agree with the proposal to have scenario training relevant to the management of sedation-related complications, incorporated into the NZRC CORE Advanced resuscitation training every two years (proposal 5)? If you disagree, please detail why.

Yes I agree with this proposal. Many practitioners are competent to administer and monitor sedation but are not fully confident about recognising or dealing with complication. However as this is not evident in the NZRC training at the moment I believe that there may be other educators who may be able to provide the same level of resuscitation training with more relevant scenario training. I would support a proposal that equivalence to the NZRC Core Intermediate resuscitation training should be the required standard.

Q5. Do you have any concern with other areas of the draft practice standard, not already expressed?

- There are several other scenarios that could be given more guidance. The scenario of the sedation administering the drugs and leaving the room for another operator e.g.hygieinist and assistant to monitor. They are often available next door. I believe it should be mandatory for the sedationist to be in the same room and to monitor.
- The introduction clarifies that the standard applies when a practitioner proceeds with treatment knowing at the time of appointment, that the patient has self-administered a sedative drug or drugs that the practitioner has not prescribed or recommended. This new Standard will give many clinicians an opportunity to reflect on safe practice for these patients. Guidance on the requirements and best practice for this situation, including a requirement for monitoring or not, should be emphasised in the document. This situation includes patients that present for treatment with a hygienist having self administered prior to the appointment. The document does not clarify if this operator needs to be trained in administration of sedation, or if it is mandatory to have a clinician trained in sedation on site. Also clarification around the level of training required for this operator
- In the same situation above will a dentists or hygienist need to refuse treatment to a patient who arrives having self administered if they have no sedation training?

- More detail around the difference between minimal and moderate sedation
- What is the age guidance of a responsible adult. 14, 15, 16?
- Capnography should become mandatory if we are to be serious about patient safety. My understanding is that capnography will require continuous monitoring and it is in this instance that a third monitoring-only assistant will be required.
- Monitoring training credentials should be mandatory when training programmes become available.