Submission on: Consultation on an updated sedation practice standard.

Dr. Chris Waalkens.
Periodontist,
[redacted]

In putting in the submission, I do so from the point of view of a practitioner who uses oral sedation (minimal sedation). My comments should not be applied to the use of IV sedation.

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

I disagree with this proposal. In most situations the second member of the clinical team will be the dental assistant (DA). The reason I disagree with this proposal is that in the case of minimal sedation, I do not see why a DA who is the second team member can not leave the surgery for a couple of minutes to do something like get a piece of equipment etc. It would be more reasonable for the proposal to state that the second team member "must be within call of the sedation area".

Under point 8 in the Draft proposals for sedation, the scenarios for the team members states that the second team member involved in minimal sedation should have received training in the monitoring of sedated patients. I presume that this refers to in-house training in emergency procedures relating to sedation, and not something like the NZRC CORE level 5 course. I feel that a NZRC CORE level 5 course is not needed for a DA who is the second team member. This course is difficult. I am concerned that it would be beyond the ability of many DA's to pass this course. I think it would be reasonable that the second team member should have done a basic CPR course. In my view, the second team member should be there to take instruction from the team leader (registered dentist) and does not need a high level of training.

Please see point 5 below about the relative safety of minimal (oral sedation) as this relates to the lack on need for the second team member to need formal training..

I feel that the proposal relating to the second team member should be changed as follows:

That the second team member has to be within call of the treatment area and does not have to be in the treatment area at all times..

The requirement for formal training of the second team member should be removed. The second team member should be there to support the dental practitioner. The registered dental practitioner who is administering and monitoring the sedation should be responsible for briefing the second team member on emergency procedures related to sedation. This should be done every 6 months.

The second team member should have done a basic CPR course.

Q2. Do you agree/disagree with the proposed formal education requirement to provide sedation and monitoring only of sedation patients (proposal 2 & 3). If you disagree, please explain why.

I disagree with this. The guidelines say that a non registered member of the team who is involved in the monitoring of sedation must have the appropriate training. In my surgery, my DA applies the cuff to measure and record blood pressure. She also places the pulse oximeter on the patients finger. She has no formal training. Her only training in sedation is what I have given her over the 10 years that she has worked with me. In doing these tasks, she is involved in the monitoring of sedation, even though I take complete responsibility for the monitoring of the sedation. Under the draft proposals, she would need "formal training" to do these tasks. I do not feel that she needs such training for the oral sedation that I use..

For the purpose of minimal sedation, I agree that it is appropriate that the person in charge of the procedure (in most situations this would mean the dentist or dental specialist) should be adequately trained and have formal education in providing and monitoring sedated patients. As mentioned above while the second team member should receive in-house instruction in emergency procedures, I do not feel that the second person (usually DA) should require formal education in either providing or monitoring sedation but is there purely to help in whatever way the person in charge of the sedation requests.

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

I agree with these core competencies.

Q4. Do you agree with the proposal to have scenario training relevant to the management of sedation related complications, incorporated into the NZRC CORE advance recession patient training every 2 years (proposal 5)? If you disagree, please detail why.

I strongly agree that the NZRC CORE course (either 4 or 5) that dental practitioners who provide sedation have to do should have the specific training relevant to the management of sedation related complications incorporated into these courses. The only reason that I did a NZRC level 5 course is to be able to use sedation in practice. While I found the course to be very good, there was almost nothing taught about sedation specific emergencies in these courses. This is something that we need, and it needs to be repeated every 2 years.

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

I feel that aspects of these regulations are excessive for practitioners carrying out minimal sedation. Most of the drugs used in minimal sedation are drugs that medical practitioners will prescribe to their patients to help them go to sleep at nights. Other people take these on aeroplanes when they travel long haul. In neither of these situations are a patients blood pressure, heart rate and oxygen saturations etc monitored. These drugs are considered very

safe drugs. There are no requirements for medical practitioners to have 2 trained team members watch over a person who has taken these drugs either to help them go to sleep at night in their own home or to help them sleep on their overseas trip. Furthermore I suspect many patients (particularly those on long haul flights) will have consumed alcohol before taking their sedation.

If formal training for those using sedation is to be imposed on dental practitioners, who will run the courses? Currently there is very little on offer. Before the DCNZ brings in regulations such as these they need to make sure that there is some structure in place to provide these courses.

I can appreciate that the purpose of these regulations is all about safety however are there problems with safety for cases involving use of minimal sedation, or are these regulations being brought in because of some vague speculation that there might be problems? I have been using minimal sedation for over 30 years. I know lots of other practitioners who are doing the same. I have never heard of one incident where a practitioner has had a patient who has had any problems when using oral sedation. I suspect the number of incidents is very low – if there are any.

Considering the relative safety of oral sedation why are we having all these regulations imposed upon us? Is it because of having to meet standards developed overseas? If it is, then we should remember that not everything that happens overseas is correct and we should be able to make our own laws and guidelines without having to follow overseas trends.