Dental Council
Te Kaunihera Tiaki Niho

30 March 2026

Tēnā koe,

On 7th January 2026 the Council issued a consultation on proposed updates to the Sedation practice standard (practice standard).

The Council is grateful for the constructive engagement, having received 108 submissions from a range of professional bodies and practitioners involved in sedation.

In addition to leveraging off the expertise and experience of the sedation review working group and the submissions, the Council was also guided by other comparable international guidelines. In particular, the Australia and New Zealand College of Anaesthetists Guideline on procedural sedation 2023 (ANZCA PG09(G)).

The Council was mindful of its duty to protect patient safety while not placing unnecessary barriers or compromising patient access to care.

The Council has considered all submitted feedback and has amended some aspects of the proposed practice standard in response. Other proposed changes were considered but not accepted with explanation detailed in Appendix 1.

The updated practice standard is available here.

Executive summary

There was general support for:

1. Aligning sedation definitions and key principles with the ANZCA PG09(G).
2. Introduction of a risk assessment framework.
3. New standard for addressing management of controlled drugs.
4. Changing to New Zealand Resuscitation Council CORE immediate (or equivalent) resuscitation training.
5. Limiting sedation to children under three years to specialist paediatric dentists or anaesthetists.

Changes made to the standards after considering the consultation feedback are:

1. *Standard 18 – recertification* was refined to be more outcome-focussed. The standard retains the intent of incorporating a recertification requirement for review of sedation practice with annual reflection on sedation load and outcomes – especially on unexpected outcomes.
2. *Standard 16 – Sedation-related complications.* Emergency management scenario training is required annually, not 6 monthly to better align with annual recertification requirements.

3. *Standard 14 – recovery and discharge* moves the responsibility from the treating oral health practitioner to the sedationist for ensuring the clinical team is appropriately trained for monitoring and discharge roles.

4. *Standard 10 – Clinical team for sedation* updated with clarity on whom within the dental team can perform various sedation activities, and who remains responsible for which aspects to the treatment provided.

5. *Standard 9* – Use the term *Emergency drugs* instead of *medicines* for consistency.

The guidance for standard 12 now includes a recommendation that capnography should be available when providing minimal sedation with a single oral dose of a drug, in case it is needed for monitoring an unintended moderate sedation.

Tables 2 and 3 in Appendix 1 contain the specific rewording, and a comprehensive list of all updates made to the practice standard.

The practice standard comes into effect immediately except for standards 17 and 18 where monitoring starts from August 2027.

Thank you for participating in the consultation process.

Ngā mihi nui,

Marie MacKay

Chief Executive

Appendix 1

Summary of feedback and changes made to practice standard

The feedback document is structured as follows:

Submissions summary

1. Recertification
2. Oral sedation
3. Monitoring
4. Methoxyflurane
5. Advanced sedation
6. Emergency drugs
7. NZRC Core Immediate (or equivalent) resuscitation training.

Changes made to the practice standard

Table 2: Changes to the standards

Table 3: Changes to guidance and appendices.

Submissions summary

A total of 108 submissions were received on the proposed changes to the Council's Sedation practice standard (practice standard). 103 submissions were from individual health practitioners and five from professional associations. 75 submissions from individual practitioners were in support of the New Zealand Sedation Society in Dentistry's (NZSSD) submission to the Council.

In addition to individual practitioners and dental practices, the New Zealand Society of Anaesthetists, New Zealand Dental Association, and New Zealand Society of Periodontology broadly supported the draft practice standard with few suggestions and areas for consideration.

The NZSSD raised six key areas of concern that required specific review.

The Council noted the following proposed changes were generally supported by submitters, with minor refinements suggested for some aspects:

- Alligning definitions of sedation with ANZCA PG09(G)
- Introduction of a risk assessment framework
- New standard 7 addressing management of controlled drugs
- NZRC Core Immediate resuscitation training
- Limiting sedation to children under three years to specialist paediatric dentists or anaesthetists.

Significant feedback and discussion was generated in the following areas.

1. Recertification

Concerns were raised about the new requirement (in standard 18) to maintain a sedation case log and undertake annual reflection with peer review.

The NZSSD supported the introduction of a formal sedation case log, which was also supported by their members who made submissions. Two professional organisations and multiple individuals raised concerns about the cumulative regulatory burden, logistics of maintaining a sedation case log, and completing annual self-reflection with professional peer review.

Outcome: Changes to standard 18 and guidance.

- Reduce the emphasis on maintaining a case log and increasing emphasis on high standard clinical records that enable practitioners to undertake an annual self-review/audit.
- Increase the emphasis on identification of unexpected outcomes when self–reviewing. Standard 18c updated to: 'Reflection on your annual sedation case load, complications and unexpected outcomes, documenting this reflection, and discussing this with your professional peer.'
- Maintain emphasis on peer review and annual reflection on sedation practice, but not require the professional peer to be a sedation provider.
- Encourage debrief as a sedation team, in particular with unexpected outcomes, and record these reflections in the patient record.

2. Oral sedation

The draft practice standard proposed that the training, equipment and staffing requirements are lifted to the moderate sedation requirements when minimal sedation is delivered with multiple doses of an oral drug or multiple drug types.

This approach to definitions and minimal sedation practice aligns with guidance in ANZCA PG09(G) and was endorsed by three professional organisations and individual submissions.

Other individual submitters raised concern about the potential impact of the increased requirements when minimal sedation is delivered with multiple doses of an oral drug or multiple drug types, especially around the three-member team and learning requirements.

The NZSSD raised multiple concerns about specific anxiolytics and benchmarking of the draft practice standard. These relate to the NZSSD's position that Midazolam and Triazolam should be reclassified as moderate sedation and that all benzodiazepine sedation requires increased staffing (three-person clinical team) and monitoring equipment (capnography).

The NZSSD recommended that the Council restricts the "Minimal Sedation" category to low-potency agents (Diazepam, similar agents) and nitrous oxide, that the Scenario 1 (two-person team) be restricted to nitrous oxide sedation, and that there should be a mandate for Scenario 2 (a three-person clinical team, dedicated monitor) for any agent where airway reflexes are not reliably preserved, ensuring compliance with ANZCA PG09(G) and preventing task saturation.

The NZSSD also raised concern about the need for 'off label' administration of oral Midazolam.

The Council considerations are summarised below.

Table 1: Summary of the Council's consideration on single dose, single drug oral sedation

Definitions	The draft practice standard's definitions for sedation describe levels of patient consciousness and responsiveness. This aligns with the approach taken by ANZCA PG09(G) and SAAD Guidance on Conscious Sedation for Dentistry 2026[1]. Specifying individual drugs within a definition in a regulatory standard carries risk. If drug availability or clinical approaches change, the standard becomes obsolete. For example, Triazolam referred to in the submission has been delisted from the New Zealand Pharmaceutical Schedule.
Risk proportionate approach	The draft Council practice standard and ANZCA PG09(G) take a risk proportionate approach to staffing by differentiating between minimal sedation delivered with a single dose of a single oral agent (or inhalation sedation), and minimal sedation achieved with multiple doses or multiple agents or intravenous administration. The same approach is proposed in the Dental Board of Australia's consultation position that non-sedation endorsed dentists can use a single dose of an oral anxiolytic to achieve minimal sedation without any additional training or other regulatory obligations.[2]
Safe practice	The NZSSD recommendation for a mandatory three-person clinical team for all benzodiazepine sedation reflects their concern about inadvertent over-sedation such that airway reflexes are not reliably preserved. There is a body of evidence and existing practice supporting benzodiazepines (including Midazolam) being orally administered to achieve a minimal sedation outcome.[3,4]
"Off label" prescribing	The Medicines Act 1981 allows authorised prescribers (dentists) to prescribe approved medicines for an unapproved use.[5] "Off label" use does not automatically mean the drug is unsafe to use, but a reflection of the license the medicine importer applied for, and is common practice within NZ healthcare. The provider has the responsibility to ensure all treatment meets ethical and professional standards. uz

Further detailed feedback on some of the NZSSD's international benchmarking and comparisons were shared directly with the society.

Outcome: No related changes to standard 10 (clinical team for sedation) and standard 17 (training requirements).

3. Monitoring

The NZSSD submission recommends that capnography monitoring be mandated for all Midazolam and Triazolam administrations, regardless of the intended depth or route of administration.

Capnography for moderate sedation is already mandatory within the current and draft Council practice standard. This is a higher level of sedation monitoring compared with other regulatory authorities and has been in place since the 2017 practice standard changes.

ANZCA PG09(G)[6] recommends capnography for moderate sedation achieved with either multiple doses or multiple agents or intravenous administration in ASA 1 and 2 patients, and mandates capnography for moderate sedation in ASA 3 & 4 patients. IACSD[7] and SCDEP[8] Conscious Sedation guidance does not recommend capnography for minimal and moderate dental sedation.

The Council recognised the importance of monitoring, the delayed onset of oral sedatives, limited value and use of reversal drugs for oral sedation in practice, and pulse oximetry lag in detecting latent respiratory depression.

The Council emphasises that should a sedation-related complication occur, the capability of sedationists and registered oral health practitioners exist through their NZRC Core Immediate training to effectively manage the airway.

Outcome: No change to standard 12.

- On balance, the Council does not consider requiring capnography for all minimal sedation with a single dose or single drug is risk-proportional.

Outcome: Change to guidance.

- A recommendation that capnography be available in the event of unintended moderate sedation for those providing minimal sedation with a single drug, single dose oral sedative has been included in the guidance for standard 12.

- Emphasise throughout the practice standard the primary importance of prioritising airway management in the event of compromised breathing.

4. Methoxyflurane

The NZSSD submission recommends that Methoxyflurane (Penthrox) is removed from the practice standard due to occupational and patient safety concerns, and that ANZCA does not recognise it as a sedation option.

Methoxyflurane is undergoing a revival across health practitioners, and under standing orders by non-registered first responders. Lower doses are available and occupational safety improved with activated carbon filter/chamber drug delivery systems. There is a growing body of evidence that supports its use as a safe alternative to nitrous oxide sedation in medical and dental care.[9,10,11,12,13]

ANZCA PG09(G) provides guidance for inhalational sedation with both nitrous oxide/oxygen and methoxyflurane (referenced 13 times), including within its sedation competencies.

While the levels of methoxyflurane use is unknown, submissions confirmed its use within NZ dental practices. Consistent with earlier approaches, promoting or restricting the use of specific medicines or techniques are contrary to the Council's regulatory approach.

The guidance within the Council's draft practice standard includes safety and risk considerations, and practitioners should use clinical judgement on the appropriateness of any treatment options offered.

Outcome: No change to the practice standard.

5. Advanced sedation

The Council noted that ANZCA opposes the training and use of propofol TCI and BIS processed EEG monitoring by non-anaesthetists. ANZCA considers that this training exceeds the scope of practice for dental sedation delivery and monitoring tools.

Advanced sedation has been offered within dental practices over 20 years. Additional advanced training is completed, and only experienced dentist sedationists can undertake this. The Council has no evidence of harm caused by these practitioners.

Outcome: No change to the practice standard.

6. Emergency drugs

The NZSSD submission recommends that the mandatory minimum emergency drug list for dental sedation providers include Adrenaline 1:10,000 for IV titration due to concern that stocking only Adrenaline 1:1,000 creates a risk of accidental intravenous administration during resuscitation. Consistency of terminology between medicines and emergency drugs was also suggested.

The proposed mandatory emergency drug list aligns with the New Zealand Resuscitation Council (NZRC) guidelines. Adult Advanced Life Support CPR algorithm which recommends 1ml of adrenaline is administered intravenously as either 1 ml of 1:1,000 or 10ml of 1:10,000. Guideline 11.5 – Medications in Adult Cardiac Arrest.

The NZSSD submission also recommended that the emergency drugs should specify glucagon IM and IV dextrose 10% or 50%. The updated NZRC guidance is cautious about the use of IM glucagon unless trained, and favours glucose over IV dextrose. A more detailed review is required.[14]

The medical emergencies practice standard is scheduled for review later in 2026 which will reconsider all the requirements.

The list of emergency drugs and equipment is a minimum requirement and does not preclude practices from stocking additional items based on their specific practice needs or preferences.

Outcome: Standard 9b was updated with the term *Emergency drugs* for consistency. No change to the list of emergency drugs required under standard 9.

7. NZRC Core Immediate (or equivalent) resuscitation training

While submitters generally supported the change for a move to NZRC Core Immediate (or equivalent), some submitters indicated a preference to continue with the NZRC Core Advance training while participating in the sedation scenario training with their team.

There were requests to explore with NZRC the ability to allow split training in the advanced course while enabling the sedationist to attend the sedation-related complications scenario training with their team undertaking the Core Immediate training. This matter falls outside the scope of the Council, but the sector could explore this with the NZRC and individual NZRC Core Immediate training providers.

Changes made to the practice standard

The tables below detail the changes made to the practice standard following consultation feedback.

Table 2: Changes to the standards

Standard 9 – Equipment and emergency drugs	Use the term *Emergency drugs* instead of *medicines* for consistency.
Standard 10 – Clinical team for sedation	Clarity on whom within the dental team can perform various sedation activities, and who remains responsible for which aspects to the treatment provided. Sedationist - administration of sedation falls within the scope of practice of a dentist or dental specialist, if appropriately trained as per Appendix C. The sedationist or operator-sedationist takes overall responsibility for the health and wellbeing of the patient while under sedation and takes the lead during management of any sedation related complication management. Operator - other members of the dental team can perform procedures within their scope of practice on a sedated patient. The operator remains accountable for the dental treatment. 1st or 2nd Assistant - monitoring of a sedated patient can be performed by any oral health practitioner or unregistered assistant who has completed the defined monitoring training as per Appendix D.
Standard 14 – Recovery and discharge	Within the clarity of sedation team roles under standard 10, the responsibility of recovery and discarge is changed to the the sedationist instead of the dental operator. Standard 14: You must if you are the sedationist, ~~practitioner who performs the dental treatment~~ ensure: a. The person monitoring the patient throughout the recovery period has NZRC CORE immediate (or equivelant) resuscitation training. b. A practitioner with the required training in monitoring a sedated patient (as per the table below standad 17) and NZRC CORE immediate (or equivelant) resuscitation training remains on the premises throughout recovery period. c. The patients suitability for discharge is assessed by a registered health practitoner who has received training in monitoring of sedated patients to meet competencies defined in Appendix C.
Standard 16 – Sedation-related complications	Align sedation team practise of emergency scenarios with recertification timeframes, being annually. You must have written procedures for managing sedation related complications where the role of each sedation team member is clearly documented and practised emergency scenarios ~~six monthly~~ annually.

Standard 18 – Recertification	Reworded with emphasis on documenetion and annual review of unexpected outcomes For those dentists/dental specialists administering sedation – You must include in your annual recertification programme a sedation-specific component that includes: a. Sedation learning aims in your professional development plan, and the related educational activities to achieve this. b. Annual review of sedation patient records ~~An annual record of all your sedation cases with details on the effectiveness of sedation, including if the intended level of sedation was achieved, patient tolerance, and any sedation-related complications.~~ c. Reflection on your annual sedation case load, <u>complications</u> and <u>unexpected</u> outcomes, documenting this reflection, and discussing this with your professional peer.

Table 3: Changes to guidance and appendices

Sedation definitions	Emphasised that deep sedation and general anaesthesia is outside of dentistry practice.
Acknowledgements	Update to New Zealand Society for Sedation in Dentistry.
Guidance for standard 1	Allowed more flexibility for pre-assessment not always completed at separate, planned appointments for example trauma or medical emergency. Perform a thorough patient assessment ~~at a separate appointment~~ before the planned sedation ~~appointment~~ and record your findings, <u>ideally at a separate appointment</u>. To better align with PG07, added increased emphasis on special consideration for young children, and added PG07 reference: Consider the age of the patient when determining the safety and suitability of the care you can provide as extremes of age may affect the sensitivity of the patient to the sedative(s). <u>This is particularly relevant for infants, children and young people, where there are marked differences in treatment requirements for different age groups</u>. Added specific reference to GA that may be more appropriate in complex risk scenarios If the patient's medical condition, age and/or results from the physical examination are of concern consult with the patient's general medical or specialist practitioner before any planned sedation. <u>General anaesthesia may be more appropriate in higher risk scenarios.</u>
Guidance for standard 3 – Pre-operative instructions	Gap perceived by submitters on fasting protocols <u>Noting the specific requirements for patients taking GLP-1 receptor agonists and dual GLP-1/GIP receptor co-agonists.</u> Inclusion of links to ANZCA guidance documents.

Guidance for standards 4-6 – Sedation techniques and drugs	To allow a more nuanced and pragmatic approach on the guidance to stop and reschedule treatment, rather than administering a second oral dose of sedative. Updated guidance: For this reason, use oral sedation (limited to a single dose and single drug) only for an intended level of minimal sedation. ~~Do not administer a second dose of oral sedation to achieve the desired sedation level – stop, review the alternatives when the patient can consent, and refer or reschedule with a new plan~~. If a second dose of oral sedation is required to achieve the desired sedation level, the staffing and equipment required for moderate level of sedation **become mandatory**.
Guidance for standard 7 – Management of controlled drugs	Add requirement for detailing the administration of controlled drugs into the patient records (in addition to the register). In addition to the register, update the patient records with detailed information of controlled drugs administered, as soon as possible.
Guidance for standard 8 – Environment for sedation	To align with international initiatives, supported in NZ, for decommissioning nitrous oxide for medical gas pipeline systems. ~~Install,~~ Maintain and service any piped gas system according to appropriate standards, at least annually. Use point-of-care cylinders where possible. Moved the guidance for scavenging methods to the nitrous oxide/oxygen specific equipment guidance.
Guidance for standard 9 – Environment for sedation	Added new guidance: The primary focus in emergency management of a sedation complication is maintaining an open airway, encouraging adequate breathing, and supplementing oxygen as required. See standards 15 and 16.
Guidance for standard 10 – Clinical team for sedation	Add new guidance: When administering minimal sedation using a single oral dose of single drug or inhalational sedation for children under 3 years of age – consider using a third person within the sedation team, ideally with expertise dealing with children.
Guidance for standards 11 & 12 – Monitoring	Added recognition that blood pressure monitoring may not always be possible, especially for young children. Measure the blood pressure and heart rate by automated means, at the appropriate intervals. Sometimes this may not be possible, especially for young children. Continue monitoring for purposeful response. Added recommendation on capnography: Capnography should be available when providing minimal sedation with a single oral dose of a single drug, in case it is needed for monitoring an unintended moderate sedation outcome.
Guidance for standard 14 – Recovery and discarge	Added new guidance to align with changes made to guidance in standard 10:

	During recovery of children under 3 years of age, immediate access to a person with expertise in dealing with children may be advisable. Recognition that not all patients are mobile. The patient has returned to a pre-sedation level of activity ~~and is able to walk independently~~. Reflecting that a suitable escort for discharge must always be a responsible adult. Discharge the patient into the care of ~~a suitable escort – usually~~ *a* responsible adult to accompany the patient home and care for the patient for the time specified by the practitioner who administered the sedation. Added guidance for absolutely clarity that a dental assistant cannot discharge the sedated patient even with sedation monitoring training. **Dental assistants are not registered health practitioners and cannot discharge patients** even if they have undertaken sedation monitoring training. The Council requested the first section of sentence be underlined or made bold.
Guidance for standards 15 & 16 – Sedation-related complications	Added new guidance: Debrief with the clinical team following unexpected or complicated sedation outcomes.
Education table standard 17 and Appendix F	Change terminology from *dentist degree* to *qualification leading to dentist registration*.
Guidance for standard 18 – Recertification	Updated guidance to offer greater flexibility. • ~~Maintain records of all your sedation cases in a format that enables you to review the effectiveness and outcomes of your sedation practice. Utilise the key information already captured in your patient records (refer to documentation guidance for standard 20). Record if the intended level of sedation was achieved, patient tolerance for the sedation, and any sedation-related complications.~~ Maintain clinical records of your sedation cases that enable you to annually review the effectiveness and outcomes of your sedation practice. Refer to clinical documentation guidance in standard 20. • Use your sedation records and feedback from your clinical team to annually self-review/audit your sedation practice with your professional peer~~, who is ideally another practitioner doing sedation~~. Focus on what worked well, unexpected outcomes, complications ~~if and where things went wrong~~, and changes you can make to improve sedation outcomes.
Guidance for standard 20 – Documentation	Added new guidance: Read the Council's *Patient records and privacy of health information practice standard* in conjunction with the *Sedation practice* standard.
Appendix A - Sedation risk assessment framework	Added:

	• Known chronic diseases such as cardiac, respiratory, severe gastro-oesophageal reflux, chronic aspiration, neuromuscular or metabolic and rare syndromes. • History of laryngospasm or presence of URTI. Changed terminology *immobile* to *cooperative.*
Appendices C & D	Changed headers from *Understand* and K*now,* to be grouped under *Learning outcomes*. Appendix C: added knowledge to first competency to better reflect learning outcomes: The *knowledge and* technique(s) they use and drug(s) they administer to provide sedation.
Appendix E – Management requirements of controlled drugs	Incorporate additional requirements for controlled drugs to be prescribed on a triplicate form (H572 or NZePS equivalent). Updated guidance: Every prescription for a controlled drug must be handwritten and signed physically by the prescriber ~~in his or her own handwriting~~ on a form approved by the Director-General of Health (currently a triplicate controlled drugs prescription form H572) or an electronically generated prescription from an approved system (such as the New Zealand electronic Prescription Service, NZePS) ~~(apart from prescriptions generated using an approved electronic system)~~. Added new guidance: In addition to the register, update the patient records with detailed information of controlled drugs administered, as soon as possible.

References

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