

## Dentistry for Chickens Proposed Sedation Practice Standards feedback

Do you agree/disagree with the updated draft Sedation practice standard? If you disagree, please detail why?

Area	Issue	Suggested change
<p><b>Part I, Point 1, Page 12:</b>  <i>Perform a thorough patient assessment at a separate appointment before the planned sedation appointment, and record your findings.</i></p>	<p>The wording stipulates a requirement for a separate consultation appointment before every sedation. In some cases, patients may book an appointment for emergency treatment where they receive fasting requirements at the time of booking earlier in the day. A sedation assessment would be conducted as part of the initial dental assessment and the patient may receive treatment under sedation on the spot.</p>	<p>To sufficiently allow for emergency treatment, we suggest removing “at a separate appointment” as to read:  <i>Perform a thorough patient assessment before the planned sedation appointment and record your findings.</i></p>
<p><b>Part II, Page 15:</b>  <i>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.</i></p>	<p>This section can be read to preclude the use of limited oral sedation as a pre-medication for IV sedation in particularly nervous or needle-phobic patients. If oral sedation is precluded in use as a pre-medication, those patients would need to unnecessarily receive treatment under GA instead when oral and IV would otherwise suffice.</p>	<p>Add an additional point within the guidance that permits the use of oral sedation as a pre-medication for titrated forms of sedations.</p>
<p><b>Part II, Point 10, page 21:</b>            This feedback relates to scenario 2, 2<sup>nd</sup> assistant’ on page 21.   <i>Must have NZRC CORE immediate (or equivalent) resuscitation training.</i></p>	<p>Scenario 2 is one where the primary operator is not also the sedationist. This scenario largely plays out as dentists or specialist with minimal sedation requirements bringing in an external sedationist to provide the sedation services to their patients in their rooms. NZRC CORE Immediate is a Sedation Standard</p>	<p>We strongly recommend removing or amending this requirement to keep it in line with the requirements per the Medical Emergencies Practice Standards for non-sedation assistants.             Having an experienced sedationist with appropriate resuscitation training, focused</p>

	<p>requirement, not a general requirement for all dental assistants so there is a high likelihood that the Dental Assistant present would not have received that specific certification and instead received standard resuscitation training per the requirements under the Medical Emergencies Practice Standards.</p> <p>This clause places a significant and likely unpalatable burden on clinics wanting to bring in an external sedationist for irregular sedations, and the sedationist themselves who must ensure compliance with the standard including checking that the staff of an external practice have received the required certification.</p>	<p>solely on the sedation competent of treatment, and a second operator with the same level of training should be more than sufficient to manage a medical emergency.</p> <p>Note: Reducing the requirements for sedationist and operator-sedationist in scenario 1 to Immediate instead of Advanced is a very welcomed change, especially to allow the team to conduct training together within the practice.</p>
<p><b>Part III, Point 18, Page 26:</b>  <i>a. Sedation learning aims in your professional development plan, and the related educational activities to achieve this.</i>  <i>b. 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.</i></p>	<p>Both of these points don't seem to sufficiently consider experienced practitioners with a high volume of sedations.</p> <ol style="list-style-type: none"> <li>a. An experienced practitioner is likely to have limited opportunity for new learning of techniques and drugs they are already experienced in and practice regularly.</li> <li>b. A consolidated annual record of all sedation cases is unrealistic for practitioners conducting potentially hundreds of sedations per year. The information collection proposed is fine within the patient file, the issue is that a consolidated record of all cases would be a huge and unnecessary administrative burden for providers who are maintaining</li> </ol>	<p>We suggest the following:</p> <ol style="list-style-type: none"> <li>a. Reword to focus on maintaining competence in sedation techniques, and related activities to achieve that. This provides enough scope for sedationists with regular cases to meet the standard through maintaining a case load and through points b and c, without creating a requirement for new unnecessary or irrelevant formal learning.</li> <li>b. Keep the information collection requirement to be part of the record keeping requirements within a patient file and require a record of a sample of cases as a percentage of overall case load (we suggest 10%) with a minimum number of</li> </ol>

	the highest levels of competency through frequent sedation practice.	cases (we suggest 20) that the provider records and reflects on specifically as part of their annual recertification to maintain and prove competency.
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**Are there any areas of the proposed Sedation practice standard you feel require further clarification or guidance? If yes, please tell us which areas and why.**

Area	Clarification required	Rationale
<p><b>Part II, point 4 and 4, Page 15:</b>  <i>You must use only sedation techniques in which you have been formally trained and are competent.</i></p> <p><b>And part III:</b>  <i>Formal sedation training is defined as a documented learning programme with specified aims and learning outcomes that enables the attainment of the Council-defined competencies for providing sedation and monitoring, and assesses achievement of these (competencies as per Appendices C and/or D).</i></p>	An appendix list of drugs covered by this Standard, and the minimum acceptable formal qualification required for each drug.	While the scope of the Standard is clear in Purpose section on page 2, other than Nitrous Oxide, the Standard leaves to interpretation the types of drugs covered by the Standard and what the formal qualification required for those drugs would be. That uncertainty currently exists in practice and makes ensuring compliance with the Standard difficult. If the Council has determined that certain formal training is required for specific drugs, the Council should provide a list of such training to allow providers and practices to ensure that they meet the Standard.
<p><b>Part II, Point 9, Page 18:</b>  <i>Oxygen cylinder, regulator and associated equipment suitable for delivering high flow oxygen</i></p>	Define “high flow oxygen”.	The current wording leaves “high flow oxygen” to interpretation and given this is a required equipment list, it is prudent that an unambiguous, measurable, minimum flow rate standard is set so practices can ensure compliance.
<p><b>Part II, Point 11, Page 22:</b></p>	Define “appropriate intervals” and “regular”	The current wording leaves “appropriate intervals” and “regular” to interpretation. The

*Measure the blood pressure and heart rate by automated means, at the appropriate intervals.*

**And part IV, Point 20, Page 29:**

*Monitoring records - including regular written records of pulse rate, oxygen saturation, end tidal CO<sub>2</sub>, respiratory rate and blood pressure, through the sedation and recovery period.*

Sedation Society typically recommends 10 minutes but as this is the Standard, it is prudent that an unambiguous minimum interval is set so practices can ensure compliance.