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Page 2: About your submission

**Q1**

First name

Frances

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**Q2**

Last name

Ruddiman

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**Q4**

**Registered oral health practitioner**

In what capacity are you making this submission?

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**Q5**

**Respondent skipped this question**

Company/organisation name

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Page 3: About your submission

**Q6**

**Dental specialist**

What is your profession?

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**Q7**

Please enter your Dental Council Person ID, if applicable

DD4957

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Page 4: Q1 - Sedation practice standard

**Q8**

**Agree**

Do you agree/disagree with the updated draft Sedation practice standard?

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**Q9**

**Respondent skipped this question**

If you disagree, please tell us why:

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Page 5: Q2 - Sedation practice standard

**Q10**

**Yes, more clarification or guidance needed**

Are there any areas of the proposed Sedation practice standard you feel require further clarification or guidance?

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**Q11**

If yes, please tell us which areas and why:

I would like to comment on some of the proposed changes.

1. Resuscitation training requirements: I support the move to make it easier for the team to complete their resuscitation together, preferably in the clinical environment. However I also see the benefits of the person administering sedation being able to complete the more advanced training. Currently the NZ Resus Council does not allow split training, but I think there would be benefit to the DCNZ petitioning them to change this. This would allow the entire team to complete the intermediate training including clinical scenarios in the morning, and then the people offering sedation could stay on and complete the advanced training in the afternoon. This is a "best of both worlds" situation that is not currently permitted by the Jesus council.

2. Recertification: I agree it is important that sedation learning aims are including in the PDP however I strongly disagree with the requirement of 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". This is an ongoing running audit that will be onerous and time consuming. All of this information is recorded within the patient file but I disagree on the need to have a separate log. Not even anaesthetists have to have a running log. Given the low rate of complications with sedation delivered well in the dental setting - it seems more logical that instead the focus should be on reflecting on the cases that did have complications to identify learning outcomes from that.

3. Oral sedation with intended minimal level of sedation. The guidance quotes that "Techniques that do not allow the drug to be titrated to effect, for example, the oral or transmucosal administration of sedative drugs, can result in a less predictable response than when a drug is administered intravenously or via inhalation". Because the response can be so varied, I think that even when oral midazolam is given it should be a requirement that the same monitoring is in effect e.g. capnography should be mandated for oral midazolam administration

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Page 6: Q3 - Sedation practice standard

**Q12**

Do you have any further comments on the proposed Sedation practice standard?

I am pleased to see that methoxyflurane is included in the new standard. As a periodontist I find it can be a very valuable adjunct for certain patients when performing SPT. The method of delivery via the pentrox inhaler works remarkably well in this situation and I support its inclusion in the standard.

I agree with the specified requirements for number of sedation team members as defined in the tables and do not think (as some have proposed) that a third team member solely monitoring the patient is necessary. As we work in the mouth and around the head, both team members are able to continuously monitor the patients consciousness and ventilation and a third person would add too much cost and likely make the procedure unaccessible to the patient, without significantly adding any additional safety for the patient.

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