Marie Mackay
Chief Executive
Dental Council of New Zealand
PO Box 10-448
Wellington 6140
New Zealand

Sent via e-mail to: consultations@dcnz.org.nz

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New Zealand
Dental Assoc.

NZDA House,195 Main Highway
Ellerslie, Auckland 1051
PO Box 28084
Remuera, Auckland 1541
New Zealand
tel. +64 9 579 8001

Submission from NZDA relating to the Proposed Draft Sedation Practice Standard 2026

Kia ora Marie and Team @ DCNZ,

Thank you for calling for submissions about relating to the proposed draft Sedation Practice Standard 2026. The New Zealand Dental Association (NZDA) has membership comprising more than 95% of registered dentists and dental specialists in Aotearoa New Zealand and thanks the Dental Council of New Zealand for the opportunity to comment.

The Dental Council of New Zealand (DCNZ) has released a draft updated Sedation practice standard for consultation, with submissions closing 18 February 2026 [1]. The review, conducted by a group of subject matter experts, proposes significant changes to the 2017 standard [2] and draws heavily on the Australian and New Zealand College of Anaesthetists (ANZCA) PG09(G) Guideline on procedural sedation 2023 [3], the UK Intercollegiate Advisory Committee on Sedation in Dentistry (IACSD) standards [4], and the Scottish Dental Clinical Effectiveness Programme (SDCEP) guidance [5]. This critique examines the proposed changes, acknowledging the Council's statutory duty to protect the public under the Health Practitioners Competence Assurance Act 2003, while considering the practical implications for dental practitioners, particularly regarding compliance burden and access to care.

Strengths of the Proposed Standard

NZDA submits that several proposed changes represent welcome and well-considered improvements. The broadening of Standard 1 from patient assessment to a comprehensive risk assessment framework, encompassing patient, procedural, environmental, and technique factors, aligns with the ANZCA PG09(G) approach [3] and represents a more sophisticated model for clinical decision-making. The accompanying risk assessment framework in Appendix A provides a practical, structured tool that should genuinely assist practitioners.

The introduction of Standard 7, addressing controlled drug management, fills an important regulatory gap. Given that Class B and C controlled substances including fentanyl, ketamine, and benzodiazepines are used in dental sedation, codifying the requirements of the Misuse of Drugs Regulations 1977 within the practice standard is appropriate and provides clarity [1]. Similarly, consolidating emergency drugs and equipment requirements within Standard 9 is a sensible practical measure.

The updated sedation level definitions, aligned with ANZCA PG09(G) [3], enhance consistency across the wider Australasian healthcare sector. The inclusion of methoxyflurane as an inhalational agent, with appropriate cautions regarding malignant hyperthermia screening [6,7], demonstrates that the standard is responsive to evolving clinical practice.

The change in resuscitation training from NZRC CORE Advanced to NZRC CORE Immediate for sedation providers is pragmatic. As the consultation document notes, the additional Advanced-level content (trauma management, manual defibrillation, and advanced rhythm identification) has limited relevance in dental sedation settings. Importantly, standardising the requirement across the entire sedation team enables joint

scenario training in the practice environment, which is likely to yield greater safety benefits than individual team members completing different courses separately.

Areas of Concern

NZDA has identified several areas of concern that it wishes to draw to the attention of DCNZ. It is hoped that DCNZ will amend the proposed practice standard to address these concerns. Doing so will maintain the contemporary nature of the proposed new standard, maintain high practitioner standards, high patient safety, and minimise compliance burden.

Team staffing and access implications. The revised team requirements in Standard 10, requiring a three-member team for multiple doses and/or multiple drugs regardless of intended sedation level, represent a significant operational change. While the rationale—that multiple drugs or doses increase the likelihood of moderate sedation endpoints—is sound, the practical impact warrants careful consideration. New Zealand faces well-documented dental workforce shortages, particularly in rural and regional areas [8]. For sole or small-practice operators offering sedation services in these communities, the additional staffing requirement may be prohibitive, potentially reducing access to sedation services for populations that already experience oral health inequities [9]. The Council should consider whether transitional provisions or rural practice exemptions might mitigate unintended reductions in service availability.

Oral sedation restrictions. The firm guidance that oral sedation should be limited to a single dose of a single drug for minimal sedation only, with an instruction to stop and reschedule rather than administer a second dose, is conservative. While the rationale regarding unpredictable responses with non-titratable routes is clinically valid, this position may be more restrictive than necessary for experienced sedationists treating patients with known tolerance. The UK IACSD standards [4] and SDCEP guidance [5] adopt a more nuanced approach, permitting incremental oral dosing in certain circumstances with appropriate safeguards. A more proportionate position might allow experienced practitioners to exercise clinical judgement within defined parameters while maintaining a sound safety profile.

Recertification burden (Standard 18). The proposed annual recertification requirements, including maintenance of a sedation case log, annual reflection, and mandatory peer review discussions, are philosophically sound as quality improvement measures. However, the cumulative administrative burden should not be underestimated. Practitioners already manage recertification requirements across multiple practice standards, and the addition of a sedation-specific component with detailed case recording and formal peer review adds considerable overhead. Monitoring of compliance from August 2027 provides a reasonable lead-in period, but the Council should clarify the expected granularity of case records and what constitutes an acceptable “professional peer” discussion, particularly for practitioners in isolated settings where peer sedationists may be scarce.

Training pathway complexity. The graduated training framework in Standard 17 introduces multiple tiers based on patient age, sedation technique, and drug delivery method. While the risk-based rationale is logical, the resulting matrix of requirements (Appendix F) is complex. The distinction between formal training, structured mentorship, observation, and strong recommendations for familiarisation could benefit from further clarification to ensure practitioners can readily determine which pathway applies to their intended scope of sedation practice.

Recovery and discharge (Standard 14). Allowing a registered health practitioner other than the sedationist to assess discharge suitability is a pragmatic change that improves workflow. However, the standard should more clearly delineate the minimum training and competence required of the person conducting the discharge assessment, beyond simply having “received training in monitoring of sedated patients,” to ensure patient safety is not compromised.

Conclusion

The proposed updated Sedation practice standard represents a considered and largely well-evidenced revision that enhances patient safety through improved risk assessment, international alignment, and structured ongoing competence requirements. However, the Council should give further attention to the

cumulative compliance burden on practitioners, the potential access-to-care implications of revised team staffing requirements in smaller and rural practices, and the complexity of the training pathways matrix. Achieving the right balance between robust public protection and proportionate regulation will be critical to ensuring that the standard enhances, rather than inadvertently restricts, the availability of safe sedation services across New Zealand.

References

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Kind regards,

Dr Mo Amso Chief Executive

New Zealand Dental Assoc.
NZDA House Building 1, 195 Main Highway, Ellerslie, Auckland 1051
PO Box 28084, Remuera, Auckland 1541, New Zealand
T: +64 9 579 8001 W: NZDA.org.nz
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