Sedation Consultation. Response from the New Zealand Society of Periodontology.

Q1. Do you agree/disagree with the updated draft Sedation practice standard? If you disagree, please detail why.

Overall we agree with the updated draft sedation practice standard. It appears to find the balance between patient safety and compliance. Sedation in the dental setting is a powerful tool in increasing patients access to care (reducing anxiety), and we do not want to make it too challenging for clinicians to provide it, as this reduces the numbers providing, and increases the costs to provide.

The increased focus on risk assessment as opposed to patient assessment acknowledges the combined impact of the environment, procedure, as well as patient clinical and patient behavioural risks.

Including sedation learning aims in our professional development plan with reflection enhances patient safety. However, we strongly disagree with the submission of an annual record of all sedation cases for audit with details on the effectiveness of sedation including if the intended level of sedation was achieved, patient tolerance, and sedation related complications. The amount of compliance is enormous as some of us would have sedation cases several times per week, if not on a daily basis. The financial cost for this is indeed out of proportion to maintenance or enhancement of competence. The wording of maintaining a caselog in the PG09 document is quite different to the dental council wanting to see a list of all of the sedation cases with full patient details. Submitting the list could also be considered a breach of patient privacy?

We strongly agree to the more pragmatic approach to the required staffing capability for recovery and discharge of the sedated patient.

We agree that the dental team being able to do their resuscitation training together is a positive move, especially when it can be completed within the clinical environment. This means we agree with the move to decrease the sedationist's training to the intermediate level – especially as very few will have access to manual defibrillation within their practice. However we would also like to suggest that if someone did want to still complete the advanced training but have the advantage of doing training with their team as well, the NZ Resus Council should allow split training e.g. the whole team does intermediate in the morning, and then the sedationists could stay on to do the advanced components in the afternoon. This would allow a higher degree of training for the responsible seditionist but also allow for the benefit of the team scenario training.

Q2. 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.

The two-person vs 3-person team requirement. Why is the route of administration the driving factor in choosing the sedation team, rather than the drug. Eg. Midazolam IV is much easier to control than oral midazolam (where patients' response to the drug can be varied, delayed) and in IV sedation, a reversal agent is easily administered.

For sedation using a single dose of a single oral agent for intended **minimal level of sedation**, a two person team consisting of operator/sedationist and dental assistant is rightly considered adequate. However, the “guidance” for sedation records (Part IV) includes "regular written records of pulse rate, oxygen saturation, end tidal CO2, respiratory rate and blood pressure, through the sedation and recovery period”. Whilst monitoring this data can be achieved with a two person team who are also occupied with patient treatment, writing down the data (at an undefined “regular” interval) is not achievable. This really should only apply to intravenous sedation, when a three person team is mandatory.

Q3. Do you have any further comments on the proposed Sedation practice standard?

Six-monthly sedation training is very frequent. We suggest annually, because there is also the resuscitation training bi-annually which according to the document is also supposed to be aimed at working together as a team.

Standard 14 – practitioner who performs the dental treatment, should be changed to “who performs the sedation” as sometimes the dental treatment provider is not the sedationist and shouldn’t be responsible for the sedation treatment.

Also, does the person who assess suitability for discharge have to be ‘registered health professional’ or can they be a DA who has received training in monitoring of sedated patients.

18th Feb 2026