Sedation practice standard

March 2026

Dental Council
Te Kaunihera Tiaki Niho

Standards Framework

The Dental Council (the "Council") is legally required to set standards of clinical competence, cultural competence and ethical conduct to be observed by all registered oral health practitioners ("practitioners"). This means that compliance to the Council's standards by practitioners is mandatory.

The Council has established a Standards Framework which defines the ethical principles, professional standards and practice standards that all practitioners must meet.

There are five ethical principles that practitioners must adhere to at all times.

Practitioners must:

- Put patients' interests first.
- Ensure safe practice.
- Communicate effectively.
- Provide good care.
- Maintain public trust and confidence.

Each of the five ethical principles is supported by a number of professional standards which articulate what a practitioner must do to ensure they achieve the ethical principles.

The professional standards are, in turn, supported by practice standards which relate to specific areas of practice that require more detailed standards to enable practitioners to meet the professional standards and ethical principles.

A copy of the Standards Framework is available on the Dental Council's website.

Purpose

The purpose of the Sedation practice standard is to set minimum standards for the practice of **minimal and moderate sedation**[1] in dentistry.

Sedation is offered to dental patients with the aim of reducing anxiety, improving comfort and the patient's ability to tolerate dental procedures.

The Sedation practice standard applies when:

- a practitioner administers a sedative drug/s
- a patient takes a "one-off" sedative drug that the patient self-administers.

The Sedation practice standard does not apply when a practitioner proceeds with treatment for a patient who has taken or received a sedative drug prescribed by another health practitioner as part of the patient's long-term health care.

The Sedation practice standard **does not** regulate practice intended to induce **deep sedation** or loss of consciousness (**general anaesthesia**)[1], where a specialist anaesthetist is required to administer the sedation or general anaesthesia and continuously monitor the patient until recovery.

[1] The terms minimal sedation, moderate sedation, deep sedation and general anaesthesia are defined on pages 9-10.

Compliance

Practitioners in the sedation team have a legal responsibility to meet the standards contained in this practice standard, and must be able to demonstrate this to the Council.

Practitioners must ensure that:

- their own clinical practices for sedation meet the standards; and
- the practice[2] environment is suitable for sedation and meets the standards.

The standards set by the Council are minimum standards which are used by the Council, the public of New Zealand, competence review committees, professional conduct committees, the Health and Disability Commissioner, the Health Practitioners Disciplinary Tribunal and the courts, to measure the competence, performance and conduct of practitioners.

A failure to meet the Council's standards and adhere to the ethical principles could result in Council involvement and may impact on the practitioner's practice.

Sometimes factors outside of a practitioner's control may affect whether, or how, they can meet the standards. In such circumstances, practitioners are expected to adhere to the ethical principles, demonstrate insight and use their professional judgement to determine appropriate behaviour.

Practitioners must be able to justify their behaviour when this is contrary to the standards and document their reasons.

The Council's *Medical emergencies in dental practice* practice standard and *Informed consent* practice standard must be read in conjunction with the *Sedation practice standard*.

[2] The "practice" is defined as all settings in which registered oral health practitioners perform activities associated with their scope of practice.

Standards for sedation

1	You must assess your patient to determine whether you can provide safe sedation for them and refer appropriately if you cannot.
2	You must provide patients with the information they need or request, in a way they can understand, to enable their informed consent for sedation and the planned dental treatment, before being sedated.
3	You must provide patients with comprehensive and understandable pre-operative instructions, both verbal and written, before the sedation appointment.
4	You must use only sedation techniques in which you have been formally trained and are competent.
5	You must administer only drugs for which you have gained an understanding of their pharmacokinetics and pharmacodynamics through formal education. Note: Formal education and training are defined in Part III of this practice standard.
6	You must use drugs in a manner that is unlikely to cause loss of consciousness, and/or impair ventilatory or cardiovascular function.
7	You must comply with the Misuse of Drugs Regulations 1977, which includes: a. Safe systems for prescribing, administration, and documentation of controlled drugs b. Secure storage of controlled drugs c. A controlled drug register.
8	You must ensure that the treatment and recovery areas are appropriately sized, configured and equipped for the sedation technique being used, to facilitate safe sedation and recovery - including management of sedation-related complications.
9	You must have ready access to the following in the treatment and recovery areas to prevent, identify and manage medical emergencies or sedation-related complications: a. Equipment that is age appropriate for your practice and fully operational. b. Emergency drugs that are easy to administer and are not beyond their expiry date. Specific requirements are defined in the tables on pages 18 & 19.
10	You must meet the specified requirements for sedation team members applicable to the intended level of sedation and delivery method, as defined in the tables on pages 20 & 21.
11	You must monitor the patient, appropriately for the intended level of sedation, throughout the sedation and recovery periods.
12	You must use capnography to monitor the patient when providing an intended level of moderate sedation.

13	You must use oxygen appropriately for patients during the sedation and recovery periods.
14	You must if you are the sedationist, ensure: a. The person monitoring the patient throughout the recovery period has NZRC CORE immediate (or equivalent) resuscitation training. b. A practitioner with the required training in monitoring a sedated patient (as per the table below standard 17), and NZRC CORE immediate (or equivalent) resuscitation training remains on the premises throughout the recovery period. c. The patient's suitability for discharge is assessed by a registered health practitioner who has received training in monitoring of sedated patients to meet competencies defined in Appendix D.
15	You must be able to identify and manage sedation-related complications, appropriate for your role in the sedation team.
16	You must have written procedures for managing sedation-related complications where the role of each sedation team member is clearly documented and practised annually.
	Monitoring of compliance to standards 17 and 18 from August 2027 recertification confirmation and declaration cycle.
17	You must meet the training requirements defined in the table below standard 17, relevant to your sedation practice.
18	*Monitoring of compliance to standard 18 from August 2027 recertification confirmation and declaration cycle.* 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 all sedation case records. c. Reflection on your annual sedation case load, complications and unexpected outcomes, documenting this reflection, and discussing this with your professional peer.
19	For those administering sedation and monitoring sedated patients – You must complete NZRC CORE immediate (or equivalent) resuscitation training every two years that includes scenario training relevant to the management of sedation-related complications.
20	You must keep accurate and contemporaneous sedation records as part of the patient record when sedation is provided or considered.

Sedation guidance

Guidance does not form part of the practice standards but describes actions and behaviours that can enable practice standards to be met.

Throughout the document, the sedation standards are referenced above the relevant guidance.

Example

1	Practice standard
Guidance	
> Actions and behaviours that can enable practice standards to be met	

Contents

Introduction to guidance

The guidance is a practitioner resource and describes actions and behaviours that support them to meet the practice standard. The guidance reflects current sedation knowledge and accepted good practice in healthcare settings.

The guidance is presented in four parts:

I: Preparation for sedation

II: Providing sedation

III: Education and training

IV: Documentation.

There will be times where alternatives are more appropriate to meet the practice standard, for instance when respecting patients' and staff cultural needs.

Duty of patient care

The Health and Disability Commissioner Code of Rights provides that every consumer has the right to have services provided with reasonable care and skill[3] that comply with legal, professional, ethical, and other relevant standards[4].

In accordance with the ethical principles of the standards framework, practitioners have a responsibility to put their patients' interests first, and to protect those interests by practising safely and providing good care. Safe practice is of heightened importance in this practice area as the risks associated with sedation are significant.

Practitioners within the clinical team for sedation must ensure they are appropriately educated and skilled in this practice area, and that patient safety is their primary consideration.

Within the oral health team, administration of sedation falls within the scope of practice of a dentist or dental specialist, if appropriately trained. Other members of the dental team can also perform procedures within their scope of practice on a sedated patient. Monitoring of a sedated patient can be performed by any oral health practitioner or unregistered assistant who has completed the defined monitoring training.

Definitions[5]

Minimal sedation: A drug-induced state of diminished anxiety, during which patients **are conscious** and respond purposefully to **verbal commands or light tactile stimulation**.

- Features of minimal sedation include maintenance of airway patency and reflexes, as well as ventilatory and cardiovascular function, although there may be some reduction in cognition and physical dexterity.

Moderate sedation: A drug induced state of **depressed consciousness** during which patients retain the ability to **respond purposefully to verbal commands and tactile stimulation.**

- Features of moderate sedation include maintenance of airway patency and reflexes, as well as ventilation and cardiovascular function. However minimal interventions to maintain airway patency, spontaneous ventilation or cardiovascular function may be required. Moderate sedation offers a margin of safety that is wide enough to render loss of consciousness unlikely.

[3] Right 4(1) Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights Regulations 1996.

[4] Right 4(2) Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights Regulations 1996.

[5] PG09(G) Guideline on procedural sedation 2023.

Deep sedation is a drug-induced state of **depressed consciousness** during which patients are **not easily roused and may respond only to noxious stimulation***.

- Features of deep sedation may be difficult to distinguish from general anaesthesia and include impaired ability to maintain an airway, inadequate spontaneous ventilation and/or impaired cardiovascular function. Deep sedation can readily and rapidly progress to general anaesthesia with onset of unconsciousness and inability to maintain an airway.

General anaesthesia is a drug-induced **loss of consciousness** during which patients are not able to be woken, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired*.

* Outside of dentistry practice.

Principles of safe sedation

The transition from complete consciousness through the various levels of sedation to general anaesthesia is a continuum, and not a set of discrete, well-defined stages. It is accompanied by increasing depression of the central nervous system and other physiological systems, which if not effectively monitored and managed may progress to poor outcomes.

The response of an individual patient to sedatives is not always predictable and, at times, it can be difficult to define the end-point of the target state.

Therefore, for safe and effective sedation practice it is essential that:

- practitioners can assess the combined impacts of the patient, sedation and dental procedure to determine a safe sedation plan
- practitioners complete formal education and training[6] to gain the necessary knowledge and skills to safely and competently provide sedation; and maintain competence
- practitioners use only those techniques and drugs for sedation in which they are formally educated and trained
- the drugs used for minimal and moderate sedation have a margin of safety that is wide enough to make deep sedation or general anaesthesia unlikely
- practitioners only use oral sedation for an intended level of minimal sedation, limited to a single oral dose and single drug
- practitioners providing sedation can identify sedation–related complications and appropriately manage the patient.

Sedation techniques and drugs

Sedation may be achieved by a wide variety of drugs and techniques and may accompany techniques for pain management such as local anaesthetic.

Within the continuum of minimal through to moderate sedation a variety of techniques and drugs may be used. The Sedation practice standard is not a manual on practical sedation techniques. No one technique, drug, or combination of drugs, is suitable for all patients; and individual patients may need different sedation techniques and drugs at different times.

[6] Refer to Part III of the practice standard.

Acknowledgements

The Sedation practice standard is founded on different sources including the Australian and New Zealand College of Anaesthetists guidelines PG09(G) the New Zealand Dental Association's Code of Practice, the Australian Dental Association's policy statement, and other international guidelines and standards. It has been developed with advice from dental specialists and dentists providing sedation at minimal and moderate levels, and an anaesthetist. Training positions were informed by the New Zealand Society for Sedation in Dentistry and BDS academic staff from the Faculty of Dentistry, University of Otago. Pharmacy Council New Zealand offered expert advice on the management of controlled drugs.

Part I: Preparation for sedation

Risk assessment

1 You must assess your patient to determine whether you can provide safe sedation for them and refer appropriately if you cannot.

Guidance

- Explore relevant anxiety and pain management techniques with the patient, to ensure all options are considered. Behavioural management, local analgesia or general anaesthesia may be suitable alternative options to sedation.
- Risk assessment involves:
  - Careful review of the patient's medical, physiological and behavioural status.
  - Understanding the complexity and length of the proposed dental procedure.
  - Understanding sedation technique options and alternatives.
  - Evaluation of the environment including equipment, staffing and accessibility of emergency support.

  A sedation risk framework is available as Appendix A.
- Perform a thorough patient assessment before the planned sedation and record your findings, ideally at a separate appointment.
- Refer to the American Society of Anesthesiologists' (ASA) Physical Status Classification System (Appendix B) and record the ASA status of the patient. Normally ASA I or ASA II patients are considered suitable for outpatient sedation in the community. There may be times where an ASA III patient is suitable, but this is dependent on the education, training and experience of the practitioner providing the sedation, the appropriateness of the clinical environment, and access to emergency care.
- 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). This is particularly relevant for infants, children and young people, where there are marked differences in treatment requirements for different age groups.[7]
- For children under 3 years of age, sedation to be provided by a paediatric dental specialist or an anaesthetist.
- 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. General anaesthesia may be more appropriate in higher risk scenarios.
- When your abilities and experience in sedation or the environment are not appropriate for the patient, referral is the safest and most suitable option for care.
- Record and/or update the medical history at the sedation appointment.

[7] ANZCA PG07 may be helpful guidance for pre-sedation consultation and patient preparation.

Informed consent

2 You must provide patients with the information they need or request, in a way they can understand, to enable their informed consent for sedation and the planned dental treatment, before being sedated.

Guidance

- Fully explain the risks and benefits of the method of sedation proposed as the most suitable in the patient's circumstance. Read the Council's *Informed consent* practice standard in conjunction with the *Sedation practice* standard.
- Fully explain the planned dental treatment. Before sedation, inform the patient and their carers of any possible changes to the planned dental treatment during the period of sedation.
- Patients who are already sedated cannot be considered able to make valid decisions and give informed consent.
- Confirm the patient's understanding of the sedation information and provide them with an opportunity for discussion.
- Record the patient's informed consent for sedation, the planned dental treatment and any changes to the plan, in writing.

Pre-operative instructions

3 You must provide patients with comprehensive and understandable pre-operative instructions, both verbal and written, before the sedation appointment.

Guidance

- Include information on the following:
  - Pre-sedation fasting protocol. Noting the specific requirements for patients taking GLP-1 receptor agonists and dual GLP-1/GIP receptor co-agonists.[8]
  - Recovery:
    - What the patient might expect during recovery from the sedation.
    - The need for the patient to arrange an escort[9]- a responsible adult to accompany the patient home and care for the patient for the time specified by the practitioner who administered the sedation.

[8] ANZCA GLP fasting guidance, ANZCA PG07- Pre-aeasthesia consultation.

[9] An escort is not normally required for adult patients who have received nitrous oxide sedation.

- Advice on the need to avoid activities that might place the patient or others at risk of injury or disadvantage.
- After-hours contact details for emergency advice and services.
- Care advice e.g. pain-relief medication.

- Allow the patient time to read the pre-operative instructions, preferably at the assessment appointment, confirm their understanding of the information, and provide them with the opportunity to ask any questions.
- Confirm the patient's compliance with the pre-operative instructions, and that a suitable escort and transportation have been arranged, before starting sedation.

Part II: Providing sedation

Sedation techniques and drugs

4 You must use only sedation techniques in which you have been formally trained and are competent.

5 You must administer only drugs for which you have gained an understanding of their pharmacokinetics and pharmacodynamics through formal education.

Note: Formal education and training are defined in Part III of this practice standard.

6 You must use drugs in a manner that is unlikely to cause loss of consciousness, and/or impair ventilatory or cardiovascular function.

Guidance

- Know the physiological effects of the drugs you use and be aware of potential adverse effects and drug interactions with prescribed and non-prescribed medications, which may influence the impact of the sedative drug(s).
- Know the time of onset, time to peak effect, and duration of action for each drug you use; related to the administration technique used.
- The ease of administration of a sedative does not necessarily reflect the degree of safety associated with it.
- 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.
- For this reason, **use oral sedation (limited to a single dose and single drug) only for an intended level of minimal sedation**.
- 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.**
- Reliable venous access is desirable, however when it is not practical, consideration may be given to proceeding without venous access for procedures under minimal oral sedation. Nonetheless, for deeper levels of sedation venous access is essential.
- Understand the relevance of a drug's therapeutic index on the margin of safety that exists for its use.

Management of Controlled Drugs

7 You must comply with Misuse of Drugs Regulations 1977, which includes:

a. Safe systems for prescribing, administration, and documentation of controlled drugs
b. Secure storage of controlled drugs
c. A controlled drugs register.

- Controlled drugs are substances that are tightly controlled because they may be abused or cause addiction.
- Control applies to the way the substance is manufactured, used, handled, stored, and distributed.[10]
- Ensure a safe system for prescribing, administration, and documentation of controlled drugs (see Appendix E).
- Record practice specific processes for safe management of controlled drugs in a policies and procedures manual which is updated annually.
- Remain knowledgeable about controlled medicine prescribing rules for dentists within New Zealand.[11]
- Keep Class A and Class B controlled drugs, and most Class C controlled drugs in a secure cupboard or compartment, as required by the Misuse of Drugs Regulations 1977 (see Appendix E).
- Keep a controlled drugs register in accordance with the requirements of the Misuse of Drugs Regulations 1977 if you hold or dispense controlled drugs.
- Keep the register in a secure place, in a neat and tidy manner with indelible marking.
- Record all movements (including transport to off-site clinics) of controlled drugs into the register within one business day of movement or use. In addition to the register, update the patient records with detailed information of controlled drugs administered, as soon as possible.
- Keep the register for 10 years after the last entry of a transaction is made into it.[12]
- Undertake a half yearly stock-take of controlled drugs at the close of business on 30 June and 31 December every year.

[10] Misuse of Drugs Regulations 1977 available here: https://www.legislation.govt.nz/regulation/public/1977/0037/latest/DLM54840.html

[11] Ministry of Health advice available here: https://www.health.govt.nz/regulation-legislation/medicines-control/controlled-drugs

[12] Health (Retention of Health Information) Regulations 1996.

Environment for sedation

8 You must ensure that the treatment and recovery areas are appropriately sized, configured and equipped for the sedation technique being used, to facilitate safe sedation and recovery - including management of sedation-related complications.

Guidance

Treatment and recovery areas

- Have treatment and recovery areas that are large enough to accommodate the clinical team and equipment required for providing sedation, monitoring and emergency management.
- Have the following in the treatment and recovery areas when providing sedation by any technique:
  - An operating table, trolley or chair which can be readily tilted into a horizontal or head-down position.
  - Adequate floor space for ease of movement.
  - Adequate suction and room lighting, and an alternative means of supplying both in the event of a power failure.
- The patient's recovery can occur either in the treatment area or in a dedicated recovery area.
- Maintain adequate access throughout the facility to allow the patient to be moved easily and safely from the treatment area to the recovery area, if these are in different locations; and adequate access for emergency services.

Specialised equipment for inhalational sedation

- When inhalational agents such as nitrous oxide or methoxyflurane[13] are being used to provide sedation, consider the risks of chronic exposure.
- Satisfy the following special requirements:
  - Capacity for administration of 100% oxygen.
- Use equipment for nitrous oxide/oxygen sedation that meets the following specifications:
  - A patient breathing circuit of lightweight construction and low resistance to normal gas flows.
  - A non-return valve to prevent re-breathing, and a reservoir bag.
  - An anti-hypoxic device which cuts off nitrous oxide flow in the event of an oxygen supply failure, and opens the system to allow the patient to breathe room air.
  - A low gas-flow alarm.

[13] The short half-life and mode of administration may limit the suitability of methoxyflurane within dental practice.

- A minimum oxygen flow of 2.5 litres/minute with a maximum flow of 10 litres/minute of nitrous oxide, or have a reserve supply of oxygen readily available, with associated equipment for its use.
- An appropriate method for scavenging of expired gases in the room.

➢ Service nitrous oxide/oxygen equipment according to manufacturer's recommendations, at least annually.

➢ Maintain and service any piped gas system according to appropriate standards, at least annually. Use point-of-care cylinders where possible.

➢ Check the equipment and the associated system for gas delivery is working properly before administering sedation.

9

You must have ready access to the following in the treatment and recovery areas to prevent, identify and manage medical emergencies or sedation-related complications:

a. Equipment that is age appropriate for your practice and fully operational.
b. Emergency drugs that are easy to administer and are not beyond their expiry date.

Requirements listed in table below.

Equipment:

- Oxygen cylinder, regulator and associated equipment suitable for delivering high flow oxygen
- Bag mask device with oxygen reservoir
- Basic and advanced airway adjuncts - oropharyngeal and supraglottic airway devices
- Equipment for gaining and securing IV access, drawing up and administering medicines
- Spacer device to deliver Salbutamol
- A pulse oximeter
- An automated device for measuring blood pressure
- Automated external defibrillator (AED)
- A device to measure the partial pressure of CO2 from the airway (capnography) is required only for an intended level of moderate sedation.

Emergency drugs:

- Oxygen
- Glyceryl trinitrate
- Aspirin
- Adrenaline (1:1,000)

- Salbutamol
- Glucose
- Appropriate antagonist (reversal drug) for sedative being administered
- Dextrose 10%
- Glucagon
- Normal saline
- Hydrocortisone injection.

When nitrous oxide sedation is used the practitioner is required to comply with the Dental Council's standard on medical emergencies (refer *Medical emergencies practice standard*, standards 6 & 7).

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.

Clinical team for sedation

10 You must meet the specified requirements for sedation team members applicable to the intended level of sedation and delivery method, as defined in the tables below.

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 health practitioner or unregistered assistant who has completed the defined monitoring training as per Appendix D.

For sedation using a single dose of a single oral agent for intended minimal level of sedation OR inhalational sedation

The following scenarios are acceptable:

	Team Member 1	Team Member 2
Scenario 1	The **'operator-sedationist':** – Administers the sedation and performs the dental treatment. – Must be a dentist or dental specialist who is appropriately educated and trained in sedation.[14] – Must have NZRC CORE immediate (or equivalent) resuscitation training.[15]	The **'1st assistant':** – Primarily monitors the patient throughout the dental treatment and may assist in the dental treatment. – Must, at minimum, have received education and training in monitoring of sedated patients. – May be a non-registered team member, for example, a chairside assistant. – Must have NZRC CORE immediate (or equivalent) resuscitation training.[14]
Scenario 2	The **'sedationist':** – Administers the sedation and monitors the patient throughout the dental treatment. – Must be a dental or medical practitioner who is appropriately educated and trained in sedation.[13]	The **'operator':** – The oral health practitioner who performs the dental treatment. – Must have NZRC CORE immediate (or equivalent) resuscitation training.

[14] Refer to Part III of the practice standard.

[15] New Zealand Resuscitation Council (NZRC) Certificate of Resuscitation and Emergency Care (CORE).

	– Must have NZRC CORE immediate (or equivalent) resuscitation training.[14]	

For sedation using multiple agents or multiple doses, OR sedation administered intravenously OR intended moderate level of sedation

A three-member team is required. A minimum of two team members must be present in the treatment area throughout the sedation period in which the dental treatment is performed. A third team member must be immediately available to assist, when required.

The following scenarios are acceptable:

	Team member 1	Team member 2	Team member 3 (when required)
Scenario 1	The **'operator-sedationist':** – Administers the sedation and performs the dental treatment. – Must be a dentist or dental specialist appropriately educated and trained in sedation. [13] – Must have NZRC CORE immediate (or equivalent) resuscitation training. [14]	The **'1st assistant':** – Primarily monitors the patient throughout the dental treatment and may assist in the dental treatment. – Must, at minimum, have received education and training in monitoring of sedated patients.[13] – Must have NZRC CORE immediate (or equivalent) resuscitation training.[14]	The **'2nd assistant':** – Assists the other team members. – Must have NZRC CORE immediate (or equivalent) resuscitation training.
Scenario 2	The **'sedationist':** – Administers the sedation and monitors the patient throughout the dental treatment. – Must be a dental or medical practitioner appropriately educated and trained, in sedation.[13] – Must have NZRC CORE immediate (or equivalent) resuscitation training.[14]	The **'operator':** – The oral health practitioner who performs the dental treatment. – Must have NZRC CORE immediate (or equivalent) resuscitation training. [14]	The **'2nd assistant':** – Assists the other team members. – Must have NZRC CORE immediate (or equivalent) resuscitation training.

The '1st assistant' and '2nd assistant' may be non-registered team members, for example, a chairside assistant.

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.

Monitoring

11 You must monitor the patient, appropriately for the intended level of sedation, throughout the sedation and recovery periods.

12 You must use capnography to monitor the patient when providing an intended level of moderate sedation.

Guidance

- Monitoring of the patient is to be performed by a member of the sedation team who has received formal education and training in monitoring the sedated patient[16].
- Observe the patient's level of consciousness, and rate and depth of breathing, directly and continuously.
- Communicate regularly with the patient during the period of sedation and recovery to confirm the patient's ability to respond to verbal commands which is an indicator of a state of minimal or moderate sedation.
- If methoxyflurane is used careful screening for malignant hyperthermia and close monitoring for early warning signs of raised temperature and muscle pain is required.
- 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.

For all techniques and drugs administered for an intended level of minimal and moderate sedation, excluding inhalational sedation

- 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.
- Continuously measure oxygen saturation of the blood using a pulse oximeter which alarms when certain set limits are exceeded.

[16] Refer to Part III of the practice standard.

Use of oxygen

13 You must use oxygen appropriately for patients during the sedation and recovery periods.

Guidance

- Have the knowledge and skills to appropriately deliver oxygen to sedated patients.
- Consider the routine use of supplemental oxygen for patients from the commencement of sedation, through to readiness for discharge, particularly for:
  - patients with relevant medical conditions
  - when multiple drug techniques are used
  - when moderate sedation is intended.
- Have a positive-pressure oxygen delivery system immediately available for use, for the purposes of supplemental oxygen and correction of hypoxaemia, during the periods of sedation and recovery; and a back-up supply of oxygen immediately available.
- Check the oxygen delivery system is fully functional before the start of the sedation procedure.

Recovery and discharge

14

You must if you are the sedationist, ensure:

a. The person monitoring the patient throughout the recovery period has a NZRC CORE immediate (or equivalent) resuscitation training

b. A practitioner with the required training in monitoring a sedated patient (as per the table below standard 17), and NZRC CORE immediate (or equivalent) resuscitation training remains on the premises throughout the recovery period

c. The patient's suitability for discharge is assessed by a registered health practitioner who has received training in monitoring of sedated patients to meet competencies defined in Appendix D.

Guidance

- Sedated patients are vulnerable; respect and always protect the patient's personal boundaries. This includes creating an environment where opportunities for a breach of the patient's personal boundaries are minimised.
- During recovery of children under 3 years of age, immediate access to a person with expertise in dealing with children may be advisable.
- Use the following criteria, at minimum, to determine the suitability of the patient for discharge:
  - The patient is fully awake.
  - Blood pressure and heart rate are within normal limits for that patient.
  - Respiratory status is not compromised as patient can breathe deeply and cough freely.
  - The patient has returned to a pre-sedation level of activity.
- Discharge the patient into the care of a responsible adult to accompany the patient home and care for the patient for the time specified by the practitioner who administered the sedation.
- Provide the patient and escort with verbal and written instructions for the care and safety of the sedated patient, including emergency contact(s) information.
- Confirm the escort's understanding of the patient care instructions, and their agreement and capability to care for the patient as described.
- The patient's safety is the primary objective. In the event the escort does not arrive, make alternative arrangements to ensure the safety of the patient in the post sedation period.
- **Dental assistants are not registered health practitioners and cannot discharge patients** even if they have undertaken sedation monitoring training.

Sedation-related complications

15 You must be able to identify and manage sedation-related complications, appropriate for your role in the sedation team.

16 You must have written procedures for managing sedation-related complications where the role of each sedation team member is clearly documented and practised annually.

Guidance

- Sedation-related complications may present as:
  - Loss of consciousness
  - Loss of airway protection
  - Respiratory depression
  - Adverse drug reaction
  - Apnoea
  - Cardiovascular instability.
- These risks underpin the need for an emergency plan to be prepared and ready for immediate action if deeper than intended levels of sedation occur.
- Assure yourself that all members of the sedation team responsible for monitoring the patient can identify sedation-related complications.
- When you are the 'sedationist' or 'operator-sedationist' and sedation-related complications are identified:
  - Stop dental treatment and direct all members of the sedation team to devote their entire attention to the medical care and continued monitoring of the patient.
  - Primary focus in emergency management of a sedation complication is maintaining an open airway, encouraging adequate breathing, supplementing oxygen as required. If these actions are not successful then implement a rescue plan which may include IV administration of a suitable reversal drug/s.
  - Be prepared to use resuscitation techniques, if required.
- Request emergency medical services assistance as soon as you feel unable to manage the situation, and/or the patient is unresponsive to early management strategies.
- Include transfer and evacuation procedures as part of the sedation-related management protocols.
- Rehearse the procedures as a team, at minimum of six-monthly intervals, and document the rehearsals undertaken. Confirm each team member's understanding of their role in the event of sedation-related complications.
- Debrief with the clinical team following unexpected or complicated sedation outcomes.

Part III: Education and training

Sedation training requirements

Monitoring of compliance to standards 17 and 18 from August 2027 recertification confirmation and declaration cycle.

17 You must meet the training requirements defined in the table below, relevant to your sedation practice.

18 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 all sedation case records.

c. Reflection on your annual sedation case load, complications and unexpected outcomes, documenting this reflection, and discussing this with your professional peer.

Sedation training requirements to meet standard 17:

Sedation for children younger than 3 years

Paediatric dental specialist only[17]	Paediatric dental specialist training, that included sedation training.

Sedation for children between 3 and 6 years

Inhalation sedation (single technique)	No additional sedation training mandated beyond the qualification leading to dentist registration. A strong recommendation for familiarisation with the equipment, process and the environmental impact through observation in a practice where this sedation technique is used.
All other sedation techniques	Formal sedation training[18] to meet competencies described in Appendix C.

Sedation for patients over 6 years of age

Inhalation sedation (single technique)	No additional sedation training mandated beyond dentist degree.

[17] Or anaesthetist.

[18] 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). Dental specialists training may have embedded formal sedation training – if not, additional training will be required.

	A strong recommendation for familiarisation with the equipment, process and the environmental impact through observation in a practice where this sedation technique is used.
Minimal sedation (single oral dose of single drug)	Formal sedation training[17] to attain competencies described in Appendix D OR Observation and a structured mentorship[19] with a sedationist[20] experienced in the same technique to attain the competencies described in Appendix D.
Minimal sedation (multiple drugs or intravenous) And Moderate sedation (incl. multiple drugs/doses via any method)	Formal sedation training[17] to meet competencies described in Appendix C.
Use of advanced sedation delivery and monitoring tools e.g. Target Controlled Infusion and processed EEG monitoring	Advanced training course. Same learning outcomes as per Appendix C but specifically targeted to the IV anaesthetic agents and advanced techniques used. This training may only be undertaken by experienced sedationists with demonstrated safe and effective sedation outcomes.
Monitoring only	
Monitoring only	Formal sedation training to meet competencies described in Appendix D.

Guidance

- The University of Otago Bachelor of Dental Surgery provides foundational sedation knowledge. Additional clinical experience is required before administering sedation. Clinical experience can include observation, structured mentorship with an experienced sedationist, or additional formal training. The level of training is defined in the table below standards 17 and 18.
- Practitioners who have completed training are responsible for determining whether it has enabled them to meet the competencies defined in Appendices C and/or D.
- Maintenance of competence is important, particularly when sedation is not frequently provided. Undertake refresher training if you have not remained contemporary with sedation practice.
- In the sedation-specific component of your annual recertification programme, identify your own ongoing learning needs through reflection and self-review.
    - Include sedation learning aims and professional development activities into your development plan.

[19] A structured mentorship is an organised, active partnership where mentors and mentees work together to learn, apply the learning, and track progress to achieve the agreed objectives, which is to attain the competencies described in Appendix D.

[20] An experienced sedationist are current in their sedation practice, self-assess as compliant with the standards in the Sedation practice standard, and no sedation limitations placed on their practice.

- Professional development activities might include refresher training in sedation and monitoring. Resuscitation training as the only learning activity will be insufficient to maintain your sedation knowledge over time.

- 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. Focus on what worked well, unexpected outcomes, complications, and changes you can make to improve sedation outcomes.

➢ When a non-registered team member is responsible for monitoring the sedated patient, the dentist or dental specialist in the sedation team is responsible for ensuring the non-registered team member has received formal education and training to monitor sedated patients.

19

For those administering sedation and monitoring sedated patients –

You must complete NZRC CORE immediate (or equivalent) resuscitation training every two years that includes scenario training relevant to the management of sedation-related complications.

A summary of the training and ongoing competence requirements is provided in Appendix F.

Part IV: Documentation

Sedation records

20 You must keep accurate and contemporaneous sedation records as part of the patient record when sedation is provided or considered.

Guidance

- Read the Council's *Patient records and privacy of health information practice standard* in conjunction with the Sedation practice standard.
- Include the following in the sedation records:
  - Initial assessment findings.
  - The patient's written informed consent.
  - Pre-operative and post-operative instructions.
  - Names of sedation team members.
  - Techniques and drugs used for sedation with their batch number.
  - Time of drug administration, time(s) at which further doses of the drug(s) were administered, time of cessation.
  - Monitoring records - including regular written records of pulse rate, oxygen saturation, end tidal CO_2, respiratory rate and blood pressure, through the sedation and recovery period.
  - Details of any sedation-related complications.
  - Details of effectiveness of sedation, including if intended level of sedation was achieved and patient tolerance.
  - Duration of recovery period.
  - Discharge details.

Appendices

Dental Council
Te Kaunihera Tiaki Niho

Appendix A: Sedation risk assessment framework[21]

The patient	**General** • ASA classification (morbidity increases sedation complexity) • Frailty • Previous sedation/GA history of complications • Behavioural challenges and ability to cooperate e.g. neurodiversity, cognitive impairment • Anxiety disorders and psychiatric illlness • Communication barriers • Social support for discharge and recovery • Recreational drug use.	**Specific** • Obstructive sleep apnoea (OSA) or reports of excessive, loud snoring from family • Anatomically difficult airways • Airway assessment - range of neck movement, and range of mouth opening • GLP-1 receptor agonist fasting risks[22] • Pregnancy • Morbid obesity • 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.	**Children** • Age less than 6 years increases risk of unplanned escalation of sedation • Former prematurity increases risk of sedation-related adverse events from infancy through to young adulthood • OSA – related to adeno-tonsillar hypertrophy.
The dental procedure	• Time the procedure is estimated to need • Painful stimulus • Complexity and requirement for patient to remain cooperative.		
The environment	• Rural or urban access to emergency support services • Availability of appropriately trained staff for monitoring and recovery • Appropriate space and equipment for sedation, monitoring, recovery and emergency management.		

[21] Adapted from PG09(G).

[22] Clinical-Practice-Recommendations-Periprocedural-GLP-1RA-use-Apr-2025.pdf

The sedation technique	• Methoxyflurane requires malignant hyperthermia risk assessment • Drugs used for sedation have varying margins of safety.

Appendix B: American Society of Anesthesiologists' (ASA) Classification of Physical Status[23]

ASA PS Classification	Definition	Examples, including, but not limited to:
ASA I	A normal healthy patient.	Healthy, non-smoking, no or minimal alcohol use.
ASA II	A patient with mild systemic disease.	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled diabetes/hypertension, mild lung disease.
ASA III	A patient with severe systemic disease.	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled diabetes or hypertension chronic obstructive pulmonary disease morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, end-stage renal disease undergoing regularly scheduled dialysis, premature infant PCA(post conceptual age) < 60 weeks, history (>3 months) of myocardial infarct , cerebrovascular accident , transient ischemic attack , or coronary artery disease/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life.	Examples include (but not limited to): recent (<3 months) myocardial infarct ,cerebrovascular accident ,transient ischemic attack , or coronary artery disease /stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction or ejection fraction, sepsis, disseminated vascular coagulation , acid reflux disease or end-stage renal disease not undergoing regularly scheduled dialysis.
ASA V	A moribund patient who is not expected to survive without the operation.	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction.
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes.	
* The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part).		

[23] From ASA PHYSICAL STATUS CLASSIFICATION SYSTEM Last approved by the ASA House of Delegates on October 15, 2014 https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system

Appendix C: Core competencies to provide sedation

A practitioner who is competent to provide sedation will:

Learning outcomes:

- The goals of sedation include guarding patient safety and wellbeing, reducing discomfort and pain, controlling anxiety and minimising psychological trauma, modifying behaviour and/or movement to facilitate completion of the procedure.
- The definitions of minimal, moderate, and deep sedation; and general anaesthesia.
- That the transition from complete consciousness through the various stages of sedation to general anaesthesia is a continuum, and not a set of discrete well-defined stages.
- The risks associated with sedation are proportional to the depth of the sedation.
- Multifactorial components to risk include patient, procedural, environmental and technique factors.
- The need to use drugs for minimal and moderate sedation with a margin of safety wide enough to make loss of consciousness, or impairment of ventilatory or cardiovascular function unlikely.
- The benefits of using a sedation technique that allows the drug(s) to be titrated to effect; and the risks associated with using a technique that doesn't allow this.
- Anatomy and physiology of the respiratory, cardiovascular and central nervous systems in relation to sedation.
- How to perform a patient assessment, focussing on medical and physical assessment, to identify risk factors for sedation and determine the most suitable form of anxiety and/or pain management for the patient's circumstance.
- The special considerations associated with providing sedative medication e.g. benzodiazepines for children and the older adult due to unpredictable susceptibility.
- Stratify patients according to risk and when to refer, based on consideration of assessment findings and a recognition of their capability to provide safe sedation.
- How to determine the suitability of and requirements for the targeted level of sedation which reflect the complexity of the procedure and patient.
- To communicate the risks of the sedation and gain written informed consent for sedation and the planned dental treatment before the sedation appointment.
- To provide the patient with relevant pre- and post-operative instructions; including those for fasting[24], when required, and management of the patient's own medication prior to sedation.
- How to risk assess the environment where sedation is undertaken, including equipment, services and staffing to safely provide sedation; for the sedation technique(s) being used.

[24] Including for GLP-1 receptor antagonists and dual GLP-1/GIP receptor co-agonists.

- The pharmacology of the drugs they use (including reversal drugs for the sedatives being taught):
    - Basis for selection, dosing and techniques for administration.
    - Time of onset, peak effect and duration; as related to the administration technique(s).
    - Potential adverse effects and drug interactions.
    - Therapeutic index.
- The synergistic and potentiation effects of drugs when used in combination.
- How to titrate drugs to effect, or administer drugs as bolus doses (if suitable for the technique being used).
- How to monitor the sedated patient - physical and physiological monitoring including central nervous system, respiratory and cardiovascular systems, and necessary equipment – appropriate for the technique(s) and drugs being used, and the intended level of sedation.
- How to prevent, identify and manage sedation-related complications, including when and how to use oxygen.
- When to initiate management or rescue plan, and call for help if required.
- When and how to use reversal drugs in the emergency management of sedation-related complications.
- How to assess a patient's suitability for discharge following sedation.

Be competent in:

- The knowledge and technique(s) they use and drug(s) they administer to provide sedation.
- Monitoring the sedated patient.
- Preventing, identifying and managing sedation-related complications.

Appendix D: Core competencies to monitor sedated patients and/or provide minimal sedation with single oral dose of single drug

A sedation-team member who is competent to monitor-only sedated patients will:

Learning outcomes:

- The definitions of minimal, moderate, and deep sedation; and general anaesthesia.
- That the transition from complete consciousness through the various stages of sedation to general anaesthesia is a continuum, and not a set of discrete well-defined stages.
- The risks associated with sedation.
- Anatomy and physiology of the respiratory, cardiovascular and central nervous systems in relation to sedation.
- How to monitor the sedated patient - physical and physiological monitoring including central nervous system, respiratory and cardiovascular systems, and necessary equipment – appropriate for the technique(s) and drugs being used, and the intended level of sedation.
- How to identify sedation-related complications; and when to advise the ‘sedationist’ or ‘operator-sedationist’ of any abnormalities or concerns and initiate or assist in the management of a medical emergency.
- How to assess a patient’s suitability for discharge following sedation.

Be competent in:

- Monitoring the sedated patient.
- If administering minimal sedation with single oral dose of single drug: Assessing suitability of this sedation technique for the patient, the duration, and nature of dental procedure.

Appendix E: Management requirements of controlled drugs

Controlled drugs are prescription medicines that are tightly controlled because they may be abused or cause addiction. Controls apply to the way the substance is manufactured, used, handled, stored, and distributed.

They are classified into class A, B or C according to risk level. Class A have a very high risk of harm[25]

Controlled drugs that could be used as part of sedation within dental practice include:

Class B: Fentanyl, Remifentanyl

Class C, Part 4: Ketamine

Class C, Part 5: Benzodiazepines, Zopiclone.*

Policies and Procedures

The policy and procedure for the storage of controlled drugs must include:

- Secure storage
- Controlled drugs register
- Stocktaking
- Prescribing

Secure Storage

All health care professionals in legal possession of controlled drugs have a professional duty of care to take all reasonable steps in maintaining safe custody of the controlled drugs.

- Controlled drugs are to be kept in a locked cupboard, or a locked compartment, that is constructed of metal or concrete or both, and that, in the case of a cupboard or compartment installed in a building after the commencement of these regulations, is of an approved type (cabinets/safes constructed with 10mm steel and bolt down holes for fixing).
- Ensure that the cupboard or compartment is securely fixed to, or is part of, the building.
- Ensure that the key to the cupboard or compartment is kept in a safe place when not in use.
- The controlled drug storage requirements are exempt for Class C drugs that are listed in part 5 of section 3 in the Misuse of Drugs Act (this includes benzodiazepines and zopiclone).*

A small amount of a controlled drug for providing sedation as part of your practice may be kept on hand in a clinical bag for ‘as required’ or use in another practice. Drugs of this nature need to be recorded and managed for safety, transparency and auditing purposes.

- The bag must be lockable, and only able to be opened by the person to whom the regulation applies. A digital combination lock is a convenient solution.
- When not in use, the bag must be kept out of sight from the public in a locked cupboard or vehicle.

[25] Section 3A Classification of drugs Misuse of Drugs Act 1975 No 116 (as at 12 April 2024), Public Act 3A Classification of drugs – New Zealand Legislation

- Another team member needs to witness the stocking of the bag from the controlled drug stock and record an entry in the controlled drug register.

Controlled drugs register

A controlled drug register records all transactions and includes a running balance of the controlled drugs.

The controlled drug register must be:

- Kept in a neat and orderly manner (legibly and indelibly) in a secure place.
- Kept for a period of ten years[26] following the date of the last entry made in it.

All movements of a controlled drug, including those in the clinical bag, must be recorded in the register no later than the next business day following the day on which that transaction took place.

In addition to the register, update the patient records with detailed information of controlled drugs administered, as soon as possible.

Any mistake in any entry may be corrected by a marginal note or footnote giving the correct particulars and containing, as part of the note, the date on which the note is written (and initials of the person making the entry).

The following details are required for each transaction in a controlled drug register:

- Date of transaction, for example, receipt, administration, stock take or destruction of the medicine.
- Name and address of person from whom received; or name of patient; or name and address of person supplied; or form from which or into which the CD was made; or declaration 'physical stocktaking'.
- Prescription number; or order number; or time of administration or destruction of medicine.
- Number in.
- Number out.
- Balance.
- Name of authority/prescriber.
- Received, issued, dispensed, or administered by.
- Initials/signature of person making entry or checking balance (preferably two signatures). It is recommended that controlled drug administration be witnessed wherever possible – this means seeing the drugs being received, issued, dispensed, administered or destroyed and signing as a witness.

Stocktaking

- Balances shall be undertaken six monthly (at the close of business on 30 June and 31 December in every year[27]) and at the time of obtaining new stock.

[26] Health (Retention of Health Information) Regulations 1996.

[27] Regulation 43 of Misuse of Drugs Regulations 1977 https://www.legislation.govt.nz/regulation/public/1977/0037/latest/DLM55968.html

- The stock record, and explanation of variations must be entered on the page of the controlled drug register relating to the controlled drug.
- There must be a system for checking the expiry dates of all controlled drugs stored in a practice (including clinical/doctors' bags and/or emergency bags).
- The practice must have a process for the identification and witnessed destruction/disposal of expired controlled drugs and these actions must be documented in the controlled drug register.
- Records must be retained for a period of 4 years[28] following the date of the last entry.

Controlled Drug Prescriptions

- Controlled drug prescription pads and forms must be kept secure, usually in the controlled drugs cabinet or a locked cupboard.
- The practice needs a system for notifying relevant authorities if controlled drugs prescriptions are found to be missing.
- Dentist prescribers (refer **Controlled drugs | Ministry of Health NZ**)
- The maximum period of supply is no greater than a quantity sufficient for use for a period of:
    - 1 month for Class A controlled drugs.
    - 1 month for Class A, Class B and Class C controlled opioids.
    - 3 months for Class B and Class C non-opioid controlled drugs (dispensed at up to 1-monthly intervals as specified by prescriber).
    - Every prescription for a controlled drug must be handwritten and signed physically by the prescriber 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).
    - Details required on each prescription, including prescriptions generated using an approved electronic system include:
        - The date.
        - The name and address of the patient.
        - Name of the medicine.
        - The dose and frequency.
        - The prescriber's name and address.
        - Include the words "for dental treatment only".

[28] Regulation 42 Retention of records Misuse of Drugs Regulations 1977. https://www.legislation.govt.nz/act/public/1975/0116/latest/whole.html

Appendix F: Summary of sedated related training requirements

	Initial training for those new to sedation, or adopting a new technique or sedative drug	NZRC CORE Immediate resuscitation training, incl sedation-related scenario training every two years[29]	Record of your sedation cases over last year, reflection and review annually with your professional peer	Six monthly emergency practice/rehearsal by sedation team
Sedation for children younger than 3 years				
Paediatric dental specialist only[30]	Paediatric dental specialist training that included sedation training.	✓	✓	✓
Sedation for children between 3 and 6 years				
Inhalation sedation (single technique)	No additional sedation training mandated beyond the qualification leading to dentist registration.A strong recommendation for familiarisation with the equipment, process and the environmental impact through observation in a practice where this sedation technique is used.	✓	✓	✓
All other sedation techniques	Formal sedation training to attain competencies described in Appendix C.	✓	✓	✓
Sedation for patients over 6 years of age				
Inhalation sedation (single technique)	No additional sedation training mandated beyond the qualification leading to registration as a dentist. A strong recommendation for familiarisation with the equipment, process and environmental impact through observation in a practice where this sedation technique is used.	✓	✓	✓
Minimal sedation (single oral dose of single drug)	Formal sedation training to attain competencies described in Appendix D. OR	✓	✓	✓

[29] Initially with sedation training, and two-yearly refresher. Ideally, sedation-related scenario training completed with normal sedation team.

[30] Or anaesthetist.

	Observation and a structured mentorship[31] with a sedationist[32] experienced in the same technique to attain the competencies described in Appendix D.			
Minimal sedation (multiple drugs or intravenous) and Moderate sedation (incl. multiple drugs/doses via any method)	Formal sedation training to meet competencies described in Appendix C.	✓	✓	✓
Use of advanced sedation delivery and monitoring tools e.g. Target Controlled Infusion and processed EEG monitoring	Advanced training course. Same learning outcomes as per Appendix C but specifically targeted to the IV anaesthetic agents and advanced techniques used. This training may only be undertaken by experienced sedationists, with demonstrated safe and effective sedation outcomes.	✓	✓	✓
Monitoring only				
Monitoring only	Formal sedation training to meet competencies described in Appendix D.	✓	N/A	✓

[31] A structured mentorship is an organised, active partnership where mentors and mentees work together to learn, apply the learning, and track progress to achieve the agreed objectives, which is to attain the competencies described in Appendix D.

[32] An experienced sedationist are current in their sedation practice, self-assess as compliant with the standards in the Sedation practice standard, and no sedation limitations placed on their practice.