# MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

Suite 100, 600 East Amite Street • Jackson, Mississippi 39201-2801 • (601) 944-9622 • www.msbde.state.ms.us

## ADVANCED ANESTHESIA PERMIT
## ON-SITE INSPECTION FORM

Instructions for completing on-site inspection and evaluation form:

- Prior to evaluation, review criteria and guidelines for Advanced Anesthesia Permit.
- Each evaluator shall complete this form independently by checking the appropriate answer box to the corresponding questions or filling in a blank space. A separate form shall be used for each practitioner applying for an Advanced Anesthesia Permit.
- ***IMPORTANT:*** **Answer each question.**
- ***IMPORTANT:*** **Sign evaluation form.**

| Name of Practitioner Evaluated: | Location Inspected: | |
|---|---|---|
| Examiner(s) Present: | Time of Evaluation: | Date of Evaluation: |

| **OFFICE FACILITIES AND EQUIPMENT** | | | |
|---|---|---|---|
| 1. | *Operating Theater* | Yes | No |
| | a. Is the operating theater large enough to accommodate the patient on an operating chair or table? | ☐ | ☐ |
| | b. Does the operating theater permit an operating team to freely move about the patient? | ☐ | ☐ |
| 2. | *Operating Chair or Table* | Yes | No |
| | a. Does the operating chair or table permit the patient to be positioned so the operating team can maintain the airway? | ☐ | ☐ |
| | b. Does the operating chair or table permit the team to alter the patient's position quickly in an emergency? | ☐ | ☐ |
| | c. Does the operating chair or table provide a firm platform for the management of cardiopulmonary resuscitation? | ☐ | ☐ |
| 3. | *Lighting System* | Yes | No |
| | a. Does the lighting system permit evaluation of the patient's skin and mucosal color? | ☐ | ☐ |
| | b. Is there backup/auxiliary lighting? | ☐ | ☐ |
| | c. Is the backup lighting of sufficient intensity to permit completion of any operation underway at the time of a general power failure? | ☐ | ☐ |

| | | Yes | No |
|---|---|---|---|
| 4. | *Suction Equipment* | | |
| | a. Does the suction equipment permit aspiration of the oral and pharyngeal cavities? | ☐ | ☐ |
| | b. Is there an emergency backup medical suction device? | ☐ | ☐ |
| 5. | *Oxygen Delivery System* | Yes | No |
| | a. Does the oxygen delivery system have adequate full-face masks and appropriate connectors? | ☐ | ☐ |
| | b. Is it capable of delivering oxygen to the patient under positive pressure? | ☐ | ☐ |
| | c. Is there an adequate backup oxygen delivery system? | ☐ | ☐ |
| 6. | *Recovery Area (Recovery Area may be the Operating Theater)* | Yes | No |
| | a. Does the recovery area have positive pressure oxygen available? | ☐ | ☐ |
| | b. Does the recovery area have adequate suction available? | ☐ | ☐ |
| | c. Does the recovery area have adequate lighting? | ☐ | ☐ |
| | d. Does the recovery area have adequate electrical outlets available? | ☐ | ☐ |
| | e. Can the patient be observed by a member of staff at all times during the recovery period? | ☐ | ☐ |
| | f. Is there a pulse oximeter? | ☐ | ☐ |
| 7. | *Monitors (with Backup Battery Source)* | Yes | No |
| | a. Is there a stethoscope? | ☐ | ☐ |
| | b. Is there a defibrillator or AED? | ☐ | ☐ |
| | c. Is there a blood pressure monitoring device and backup blood pressure measuring device? | ☐ | ☐ |
| | d. Is there a pulse oximeter? | ☐ | ☐ |
| | e. Is there a capnograph? | ☐ | ☐ |
| | f. Is there a pretracheal stethoscope? | ☐ | ☐ |
| | g. Is there an electrocardiographic monitoring unit? | ☐ | ☐ |
| | h. Is there a body temperature measuring device? | ☐ | ☐ |

| 8. | *Ancillary Equipment* | Yes | No |
|---|---|---|---|
| | a. Are there oropharyngeal and nasopharyngeal airways? | ☐ | ☐ |
| | b. Is there adequate equipment for the establishment of an intravenous infusion? | ☐ | ☐ |
| | Class I Permit specific requirements: | | |
| | a. Is there a working laryngoscope complete with multiple blades, backup batteries, and backup bulbs? | ☐ | ☐ |
| | b. Are there Magill forceps? | ☐ | ☐ |
| | c. Are there endotracheal, tonsillar or pharyngeal type suction tips adaptable to all office outlets? | ☐ | ☐ |
| | d. Are there Supra-Glottic Airway Adjuncts? (e.g., Laryngeal Mask Airway, King LT, Combi-Tube, Etc.) | ☐ | ☐ |
| | e. Are there endotracheal tubes and appropriate connectors? | ☐ | ☐ |
| | f. Is there equipment capable of performing needle or percutaneous cricothyroidotomy or tracheostomy for emergency oxygenation? | ☐ | ☐ |

| 9. | *Record review (ǂaudit of five (5) charts)* | Yes | No |
|---|---|---|---|
| | Are the following records maintained? | | |
| | a. An adequate medical history of the patient | | |
| | b. Preoperative, postoperative and informed consent form | | |
| | c. Indication for sedation or general anesthesia | | |
| | d. A pre-procedural check of equipment for each administration of sedation | | |
| | e. Time-oriented anesthetic record including preoperative evaluation, recovery and discharge condition | | |
| | f. An adequate physical evaluation of the patient (including airway evaluation) | | |
| | g. ASA Classification | | |
| | h. NPO status | | |
| | i. ǂǂ Electrocardiograph documentation (pre-op, intra-op, post-op) | | |
| | j. ǂ Pulse oximeter documentation (pre-op, intra-op, post-op) | | |
| | k. ǂǂ Blood pressure and vital sign documentation (pre-op, intra-op, post-op) | | |
| | l. Record of vitals every five (5) minutes | | |
| | m. ǂǂǂ Ventilation documentation (capnography, precordial or pretracheal stethoscope) | | |
| | n. Medications given, including dosage, time intervals and the route and site of administration | | |
| | o. Type and size of IV catheter (if applicable) | | |
| | p. Length of the procedure | | |
| | q. Documentation of recovery criteria (scoring system or narrative) | | |
| | r. Documentation of discharge criteria, time of discharge, including name of escort (scoring system or narrative) | | |
| | s. Acceptable written protocols and/or standards of care for managing complications/emergencies | | |
| | t. Acceptable written protocols and/or standards of care for transfer of patient to tertiary care facility | | |

ǂ First time facility review must demonstrate how these criteria will be accomplished

ǂǂ Pre-op vital signs including blood pressure, pulse rate, respiration rate, and blood oxygen saturation must be obtained unless invalidated by the patient, procedure or equipment.

ǂǂǂ End-tidal $CO_2$ unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation should be monitored by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.

| 10. | *Drugs* | Yes | No |
|---|---|---|---|
| | a. Proper documentation of controlled substances that includes a perpetual inventory log showing the receipt, administration, dispensing, and destruction of controlled substances | | |
| | b. Anticonvulsant drug available<br>Name of drug: | | |
| | c. Antiemetic(s) drug available<br>Name of drug: | | |
| | d. Antihistamine drug available<br>Name of drug: | | |
| | e. Aspirin available | | |
| | f. Beta adrenergic antagonist drug available<br>Name of drug: | | |
| | g. Bronchodilator (inhaled) available<br>Name of drug: | | |
| | h. Corticosteroid(s) available<br>Name of drug: | | |
| | i. Dextrose available | | |
| | j. Epinephrine available | | |
| | k. Intravenous fluids available | | |
| | l. Magnesium available | | |
| | m. Nitroglycerin available | | |
| | n. Oxygen available | | |
| | o. Flumazenil and naloxone available | | |
| | p. Sterile water for injection available | | |
| | Class I Permit specific requirements: | | |
| | a. Adenosine available | | |
| | b. Amiodarone available | | |
| | c. Dantrolene available<br>(If triggering agents may be used) | | |
| | d. Lidocaine, cardiac available | | |
| | e. Succinylcholine or Rocuronium available | | |
| | f. Vasopressor(s), other than epinephrine available<br>Name of drug: | | |

# *EVALUATOR'S RECOMMENDATIONS*

On-site Inspection

Type: ☐ Class 1 ☐ Class 2

| | |
|---|---|
| ☐ Pass | Successful completion of the onsite evaluation |
| ☐ Conditional Approval | Failure to have appropriate drugs or equipment, proper documentation of controlled substances, or proper record keeping. Applicant must submit proof of correction before permit is issued. |
| ☐ Category 1 Failure | Deficiency in knowledge NOT directly related to the management of general anesthesia or anesthetic emergencies or urgencies. Applicant must review the appropriate subject matter and schedule a subsequent evaluation. |
| ☐ Category 2 Failure | Deficiency in knowledge directly related to the management of general anesthesia or anesthetic emergencies or urgencies. Applicant must complete Board approved remedial continuing education in the subject matter identified by the evaluators. Applicant shall not provide any form of sedation or general anesthesia during this time. |

## DEFICIENCIES

(Additional sheets may be attached if necessary.)

The provider ☐ [was] ☐ [was not] provided with the opportunity to correct the deficiency.

The provider was not provided with an opportunity to correct the deficiency because:

- ☐ Committed intentionally.
- ☐ Not correctable within a reasonable period of time as determined by the agency.
- ☐ Evidence of a pattern of noncompliance.
- ☐ A risk to any person, the public health, safety or welfare or the environment.

Signature of Evaluator: Printed Name: