MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

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ADVANCED ANESTHESIA PERMIT
CLASS 3: FACILITY INSPECTION FORM

Instructions for completing facility 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 for stabilization and emergence of any operation 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*		
	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)*		
	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)*		
	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?	☐	☐
	h. Is there a body temperature measuring device?	☐	☐

8.	*Staffing*		
	Please list all staff names and credentials (BLS, ACLS, PALS, Other)		
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

9.	*Record review (♦audit of ten (10) charts)*	Yes	No
	Are the following records maintained?		
	a. An adequate medical history of the patient	☐	☐
	b. Preoperative and postoperative instructions and informed consent forms	☐	☐
	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. ♦♦ Pulse oximeter documentation (pre-op, intra-op, post-op)	☐	☐
	j. ♦♦ Blood pressure and vital sign documentation (pre-op, intra-op, post-op)	☐	☐
	k. Record of vitals every five (5) minutes	☐	☐
	l. ♦♦♦ Ventilation documentation (capnography, precordial or pretracheal stethoscope)	☐	☐
	m. Medications given, including dosage, time intervals and the route and site of administration	☐	☐
	n. Length of the procedure	☐	☐
	o. Documentation of recovery criteria (scoring system or narrative)	☐	☐
	p. Documentation of discharge criteria, time of discharge, including name of escort (scoring system or narrative)	☐	☐
	q. Acceptable written protocols and/or standards of care for managing complications/emergencies	☐	☐
	r. Acceptable written protocols and/or standards of care for transfer of patient to tertiary care facility	☐	☐

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

♦♦ 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.

♦♦♦ 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.

11.	*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. Antiemetic(s) drug available Name of drug:		
	c. Antihistamine drug available Name of drug:		
	d. Aspirin available		
	e. Bronchodilator (inhaled) available Name of drug:		
	f. Sugar containing products		
	g. Epinephrine available		
	h. Nitroglycerin available		
	i. Oxygen available		
	j. Flumazenil and naloxone available		

12.	*Renewal Applicants Only – Continued Competency*	Yes	No
	a. Did the permit holder show documentation of emergency management training in the form of drills or simulation involving their staff on a quarterly basis?		
	b. Was monitoring equipment checked and calibrated in accordance with the manufacturer's recommendations and documented on a yearly basis?		

EVALUATOR'S RECOMMENDATIONS

Facility Inspection

Type: Class 3

☐ Pass	Pass: Successful completion of the onsite evaluation.
☐ Conditional Approval	For failing to have appropriate drugs or equipment, proper documentation of controlled substances, or proper record keeping. The provider must submit proof of correcting the deficiencies before full approval is issued.
☐ Not Pass	This category is reserved for deficiencies that are judged to potentially be a patient safety concern. The provider will be notified by the board of necessary corrective action. Until that corrective action is taken, the provider shall not allow the provision of any form of sedation or general anesthesia in his/her dental facility.

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(s): Printed Name:

Signature of Evaluator(s): Printed Name: