3 August 2016

SUBMISSION TO DCNZ REGARDING SEDATION PRACTICE STANDARD

Dear Marie,

I wish to make the following points in my submission for the new practice standard for sedation.

Q1. Proposal 1.

I agree with the team proposal for minimal sedation.

I disagree with the proposal for moderate sedation. This is on the basis that the continuum between minimal and moderate sedation means that in reality that it is highly unlikely that a patient will only ever have minimal sedation, and the staffing requirements should be the same for both minimal and moderate sedation, excluding Nitrous Oxide sedation.

Also to have 3 team members always present for all moderate sedation is unnecessary 'overkill' of staffing, and also very boring for the dedicated monitoring staff member. I suggest that this be revised to a 3rd staff member being 'immediately available' to assist in the event that increased monitoring is needed, at the discretion of the sedationist. This would enable a third person such as a receptionist or extra chairside assistant to be on the premises, but not have to be in the treatment room the whole time. For example, I do IV sedation sessions that are 4-6 hours long. To have a dedicated extra staff member present for this time would be mind- numbingly boring and also unnecessary. If 'immediately available' was acceptable, then my receptionist would be available to 'assist as a priority' at any time necessary during the session.

Q2. Proposals 2and 3.

I agree with the proposals. I feel the NZSSD IV sedation course including mentor observation of 3 sedation cases, and the passing of the online Safe Sedation Training course is adequate training for IV sedation.

SST is an ASA approved CE course for all sedationists, and is an on line excellent resource. It has been written by Telmage Egan an anaesthetist from the University of Utah, and the content is modified 2 yearly to comply with the two yearly update requirement.

Here is a quote from an attendee of the IV sedation course July 30/31 2016 who wished to remain anonymous:-

"The SST online course is an excellent way to start learning about sedation. It goes through several scenarios when the user must troubleshoot the problem from the material that has just been taught. The material is excellent, and it will supplement (not replace) the material that has been taught during the course and also real world clinical situations and supervision."

A course for 'monitoring' could be developed, and run by NZSSD or a third party provider. SST is also promoted for nurses in the USA.

Q3. Proposal 4.

I agree.

Q4. Proposal 5.

Agree in part. Agree that a 2 yearly recertification be introduced.

After recent discussions with some paramedic trainers, I propose that the Dental resuscitation should be 'Modular' Advanced rather than 'core', as the medical trauma management component of the core course isn't relevant to sedation management. This would enable a Dental Specific, team related simulation course to be developed which would be directly applicable to dental sedation. This could be run by a third party provider.

Q6. Other areas.

The NZDA code of practice was developed to specifically introduce Capnography over the next 5 years. The DCNZ standard has not adopted this recommendation, which I find disappointing. It is hinted at on page 16, section 8 with reference to "cardiorespiratory" status monitoring, however I feel the DCNZ standard has come up short by not adopting the same approach to Capnography as NZDA. My recommendation would be to add this into the practice standard. Firstly, this would be adopting 'best practice' and secondly, this would create consistency between the two documents and organisations. There is no argument to suggest that capnography doesn't provide a vastly superior monitoring by early/instant detection of inadequate ventilation due to respiratory depression, so please include a requirement for capnography to become mandatory by 2020 to support this. This also supports the NZSSD in our stance, as well as NZDA, and in many ways if capnography isn't added/included to back up this stance, it actually undermines both organisations.

In the second paragraph of Section 2. The sedation practice standard it states that the standard applies if a practitioner proceeds with treatment, knowing at the time of appointment, that the patient as self-administered a sedative drug or drugs that the practitioner has not prescribed or recommended.

If a dentist was not qualified and set up to do sedation, then a patient who turned up self-medicated would not be able to be treated by that dentist, as the dentist would not comply with the standard for treating a sedated patient. I am not sure whether this in the intention of the practice standard?

If the treating dentist is qualified to do sedation, then they would be able to monitor the sedation and comply with the standard.

My point is, that a non- complying dentist would have to decline treatment in this situation, and I am not sure whether this was intentional. If it is intentional, then I agree with the proposal.

Your sincerely,

Graham Shaw. B.D.S.

President NZSSD.