ADVANCED ANESTHESIA PERMIT
CLASS 2: 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.
- ***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?		

4.	*Suction Equipment*	Yes	No
	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?		
	I. Is there a glucometer?		
	J. Was monitoring equipment checked and calibrated in accordance with the manufacturer's recommendations and documented on a yearly basis?		

8.	*Ancillary Equipment*	Yes	No
	a. Are there oropharyngeal and nasopharyngeal airways?		
	b. Is there adequate equipment for the establishment of an intravenous infusion?		
9.	*Staffing*		
	Please list all staff names and credentials (BLS, ACLS, PALS, Other)		

10.	*Record review (♦audit of ten (10) charts with AAP)*	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. ♦♦ Electrocardiograph documentation (pre-op, intra-op, post-op)		
	j. ♦♦ Pulse oximeter documentation (pre-op, intra-op, post-op)		
	k. ♦♦ Blood pressure and vital sign documentation (pre-op, intra-op, post-op)		
	l. ♦♦♦ Ventilation documentation (capnography, precordial or pretracheal stethoscope)		
	m. Record of vitals every five (5) minutes		
	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)		

♦ 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*	Exp. Date	Yes	No
	a. Controlled Substance Perpetual Inventory Log (Receipt, Admin, Destruction)	---		
	b. Anticonvulsant Name:			
	c. Antiemetic(s) Name:			
	d. Antihistamine Name:			
	e. Beta adrenergic antagonist Name:			
	f. Bronchodilator (inhaled) Name:			
	g. Corticosteroid(s) Name:			
	h. Aspirin			
	i. Atropine			
	j. Dextrose / Glucose (IV or oral gel)			
	k. Epinephrine 0.1mg/mL (1:10,000), 10mL			
	l. Epinephrine (IM) 1mg/mL (1:1000) or autoinjector preferred			
	m. Intravenous fluids & Administration Set			
	n. Lidocanie, cardiac			
	o. Magnesium Sulfate (IV)			
	p. Nitroglycerin			
	q. Oxygen Supply (Source and backup delivery systems)			
	r. Reversals: Flumazenil and naloxone			

12.	*Continued Proficiency*	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. Acceptable written protocols and/or standards of care for managing complications/emergencies including at a minimum:		
	• Local anesthetic systemic toxicity or overdose		
	• Allergic reaction or anaphylaxis		
	• Convulsion or seizure		
	• Epinephrine overdose or adverse cardiovascular reaction		
	• Bronchospasm or acute asthma exacerbation		
	• Emesis and suspected aspiration		
	• Laryngospasm or acute upper-airway obstruction		
	• Angina pectoris		
	• Suspected myocardial infarction or acute coronary syndrome		
	• Hypotension or shock		
	c. Acceptable written protocols and/or standards of care for transfer of patient to tertiary care facility		

EVALUATOR'S RECOMMENDATIONS

Facility Inspection

Consult and chart review with:

Type: Class 2

☐ 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:

Scenario 1: Local Anesthetic Systemic Toxicity

Clinical stem

During an inferior alveolar nerve block with 4% articaine with 1:100,000 epinephrine, the patient reports a metallic taste, ringing in the ears, and dizziness. Within 60 seconds, the patient becomes agitated, speech becomes slurred, and muscle twitching begins.

The patient is becoming confused and is developing muscle twitching. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop the local anesthetic injection immediately.
□ Stop dental treatment and remove instruments and materials from the oral cavity.
□ Recognize suspected local anesthetic systemic toxicity, or LAST.
□ Call for help and assign specific responsibilities to staff members.
□ Direct a team member to call 911.
□ Tell EMS: “Suspected local anesthetic systemic toxicity following a dental local anesthetic injection.”
□ Assess airway, breathing, circulation, and level of consciousness.
□ Provide 100% oxygen.
□ Prepare suction and a bag-mask ventilation device.
□ Support ventilation if respirations become inadequate.
□ Monitor oxygen saturation, heart rate, blood pressure, respiratory rate, and cardiac rhythm if available.
□ Protect the patient from injury if seizure activity develops.
□ Do not place anything in the patient’s mouth during a seizure.
□ Treat persistent seizure activity with a benzodiazepine according to the provider’s training and emergency protocol.
□ Do not administer additional local anesthetic.
□ Obtain the AED and prepare for cardiovascular deterioration or cardiac arrest.
□ Retrieve the LAST rescue kit and administer 20% lipid emulsion promptly for significant or progressive LAST when it is available and within the provider’s training and protocol.
□ Recognize that LAST resuscitation differs from standard ACLS and that large doses of epinephrine should be avoided.
□ If lipid emulsion is not immediately available, recognize that early EMS activation, oxygenation, ventilation, monitoring, and rapid transfer are especially important.
□ Continue monitoring and reassessment until EMS assumes care.

Key knowledge point

Rapid neurologic or cardiovascular symptoms may occur even below the maximum recommended local anesthetic dose, particularly following intravascular injection or rapid systemic absorption. Early warning signs may include metallic taste, tinnitus, circumoral numbness, dizziness, agitation, confusion, slurred speech, or muscle twitching. Severe toxicity may progress to seizures, hypotension, dysrhythmias, or cardiac arrest. ASRA recommends calling for help, securing the airway, suppressing seizures, and considering early 20% lipid emulsion therapy.

Pass standard

Pass if the provider recognizes suspected LAST, stops the injection, activates EMS, supports oxygenation and ventilation, manages seizure risk, avoids additional local anesthetic, retrieves or identifies lipid emulsion therapy, and prepares for cardiovascular deterioration.

Needs remediation if the provider continues injecting, fails to recognize LAST, delays EMS despite progressive symptoms, fails to provide airway or ventilation support, or does not recognize the role of 20% lipid emulsion.

Scenario 2: Allergic Reaction or Anaphylaxis

Clinical stem

A 45-year-old patient with a prosthetic heart valve receives 2 grams of oral amoxicillin in the office for infective endocarditis prophylaxis. Approximately 45 minutes later, the patient develops widespread hives on the neck and chest. Within minutes, the patient begins wheezing, reports throat tightness, becomes anxious, and the blood pressure decreases to 82/40 mmHg.

The patient has hives, wheezing, throat tightness, and hypotension. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop treatment immediately and clear the oral cavity.
□ Recognize systemic anaphylaxis based on skin findings combined with respiratory involvement and hypotension.
□ Call for help and assign specific responsibilities to staff members.
□ Direct a team member to call 911 immediately.
□ Tell EMS: “Suspected anaphylaxis with airway symptoms, wheezing, and hypotension following oral antibiotic administration.”
□ Administer epinephrine immediately as the first-line treatment.
□ Administer adult epinephrine 0.3 to 0.5 mg IM using the 1 mg/mL concentration into the mid-anterolateral thigh.
□ Do not delay epinephrine while attempting IV access or administering antihistamines, corticosteroids, or albuterol.
□ Position the hypotensive patient supine with the legs elevated if tolerated and not otherwise contraindicated.
□ Do not allow the hypotensive patient to sit, stand, or walk suddenly.
□ Assess airway, breathing, circulation, and level of consciousness.
□ Provide 100% oxygen.
□ Prepare suction and a bag-mask ventilation device.
□ Support ventilation with positive-pressure ventilation if respirations are inadequate.
□ Establish IV access if available and within the provider’s training.
□ Administer rapid isotonic crystalloid fluids for persistent hypotension when appropriate.
□ Repeat IM epinephrine if symptoms persist or worsen according to the office emergency protocol or cognitive aid.

□ Administer albuterol for persistent bronchospasm as an adjunct after epinephrine.
□ Administer an antihistamine or corticosteroid only as a secondary medication after epinephrine.
□ Recognize that worsening upper-airway edema may make airway management increasingly difficult.
□ Prepare advanced airway equipment without delaying epinephrine, oxygenation, ventilation, or EMS activation.
□ Obtain the AED and prepare for cardiovascular collapse.
□ Continue monitoring and reassessment until EMS assumes care.

Key knowledge point

Anaphylaxis is a clinical diagnosis. Hives alone may represent a limited allergic reaction, but hives combined with wheezing, throat tightness, or hypotension indicates systemic anaphylaxis. IM epinephrine in the mid-outer thigh is the first-line treatment and should not be delayed. Antihistamines, corticosteroids, and inhaled bronchodilators are adjuncts and do not replace epinephrine.

Pass standard

Pass if the provider recognizes anaphylaxis, administers IM epinephrine promptly, activates EMS, supports airway, oxygenation, and ventilation, positions the patient appropriately, treats hypotension with IV fluids when available, and uses secondary medications only after epinephrine.

Needs remediation if the provider delays epinephrine, treats only with an antihistamine, corticosteroid, or inhaler, allows the hypotensive patient to sit or stand, fails to activate EMS, or does not support the airway and breathing.

Scenario 3: Convulsion or Seizure

Clinical stem

During a routine restorative procedure, the patient suddenly becomes unresponsive, the eyes roll upward, and the body stiffens. This is followed by generalized rhythmic tonic-clonic movement of the arms and legs.

The patient is actively seizing in the dental chair. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop dental treatment immediately.
□ Remove instruments, handpieces, materials, and fluids from the oral cavity when it is safe to do so.
□ Call for help and assign specific responsibilities to staff members.
□ Protect the patient from injury by supporting or padding the head and preventing contact with hard surfaces.
□ Position the dental chair to reduce the risk of falling.
□ Do not forcefully restrain the patient.
□ Do not place fingers, bite blocks, tongue blades, instruments, or any other object into the patient’s mouth.
□ Time the seizure from its onset.

□ Provide oxygen as safely as possible.
□ Prepare suction and a bag-mask ventilation device.
□ Support the airway and ventilation once the movements permit or sooner if ventilation can be provided safely.
□ Assess airway, breathing, circulation, and level of consciousness after the active movements stop.
□ Monitor oxygen saturation, pulse, blood pressure, respiratory rate, and cardiac rhythm if available.
□ Activate EMS if the seizure lasts 5 minutes or longer.
□ Activate EMS if seizures repeat without recovery of consciousness.
□ Activate EMS if the patient has respiratory compromise, significant injury, persistent altered consciousness, a first-time seizure, pregnancy, suspected poisoning, or another concerning condition.
□ Identify benzodiazepine rescue therapy for a prolonged seizure or status epilepticus when available and permitted.
□ After the seizure stops, place the patient in a lateral or recovery position when feasible.
□ Suction secretions as needed.
□ Reassess airway, breathing, circulation, neurologic status, and recovery of consciousness.
□ Obtain the AED and prepare for deterioration.
□ Continue monitoring until the patient has fully recovered or EMS assumes care.

Key knowledge point

Most isolated generalized seizures stop within a few minutes. Initial treatment is supportive: stop treatment, remove hazards, protect the patient, avoid placing anything in the mouth, provide oxygen, prepare to support ventilation, and time the event. A seizure lasting 5 minutes or longer, repeated seizures without recovery, respiratory compromise, significant injury, or a first-time seizure requires EMS activation and consideration of benzodiazepine rescue therapy.

Pass standard

Pass if the provider stops treatment, clears the oral cavity when safe, protects the patient, avoids placing objects in the mouth, avoids forceful restraint, supports oxygenation and ventilation, times the seizure, recognizes EMS criteria, and identifies benzodiazepine rescue therapy for a prolonged seizure.

Needs remediation if the provider attempts to place an object in the mouth, forcefully restrains the patient, fails to protect the patient from injury, fails to support airway or breathing, or does not recognize prolonged seizure activity as an emergency.

Scenario 4: Epinephrine Overdose or Adverse Cardiovascular Reaction

Clinical stem

During a restorative procedure, the patient receives several cartridges of local anesthetic containing epinephrine. Shortly after the most recent injection, the patient becomes anxious and tremulous and reports a pounding

headache and forceful heartbeat. The heart rate is 148 beats per minute, and the blood pressure is 208/112 mmHg. The patient remains conscious but reports mild chest pressure.

The patient has severe hypertension, tachycardia, palpitations, and chest pressure immediately after the injection. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop the local anesthetic injection immediately.
□ Stop dental treatment and remove instruments and materials from the oral cavity.
□ Recognize a suspected epinephrine overdose, intravascular injection, or severe sympathomimetic cardiovascular reaction.
□ Call for help and assign specific responsibilities to staff members.
□ Reassure the patient and minimize stimulation.
□ Position the conscious patient comfortably, generally semi-reclined if breathing adequately.
□ Assess airway, breathing, circulation, mental status, and chest symptoms.
□ Monitor blood pressure, heart rate, respiratory rate, oxygen saturation, and cardiac rhythm if available.
□ Do not administer additional epinephrine or local anesthetic containing a vasoconstrictor.
□ Provide oxygen if the patient is hypoxemic, dyspneic, or clinically unstable.
□ Activate EMS because the patient has severe vital-sign abnormalities and chest pressure.
□ Tell EMS: “Suspected severe cardiovascular reaction following epinephrine-containing local anesthetic, with marked hypertension, tachycardia, and chest pressure.”
□ Obtain the AED and prepare for dysrhythmia, myocardial ischemia, or cardiac arrest.
□ Do not dismiss the symptoms as anxiety without performing a complete assessment.
□ Do not attempt aggressive blood-pressure reduction with medications outside the provider’s training, permit level, or established emergency protocol.
□ Continue monitoring and reassessment until EMS assumes care.

Key knowledge point

Brief palpitations, tremor, or anxiety may occur after epinephrine administration. However, severe hypertension, sustained tachycardia, chest discomfort, altered mental status, neurologic symptoms, or dysrhythmia requires immediate assessment and escalation. The provider should stop further epinephrine exposure, provide supportive care, monitor closely, and consider myocardial ischemia or another cardiovascular emergency.

Pass standard

Pass if the provider stops treatment and additional epinephrine administration, recognizes a significant cardiovascular reaction, assesses the patient for chest pain and instability, monitors appropriately, activates EMS, and prepares for deterioration.

Needs remediation if the provider administers additional epinephrine, continues dental treatment, dismisses the symptoms as anxiety without assessment, fails to monitor the patient, or delays EMS despite chest pain and severe vital-sign abnormalities.

Scenario 5: Bronchospasm or Acute Asthma Exacerbation

Clinical stem

A 28-year-old patient with a history of asthma develops coughing and expiratory wheezing during dental treatment. The patient reports chest tightness and difficulty breathing. The respiratory rate is 28 breaths per minute, oxygen saturation is 91%, and the patient is able to speak only in short phrases. The patient's albuterol inhaler is available.

The patient has wheezing, chest tightness, difficulty speaking, and decreasing oxygen saturation. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop dental treatment immediately.
□ Remove instruments and materials from the oral cavity.
□ Recognize acute bronchospasm or an asthma exacerbation.
□ Call for help and assign specific responsibilities to staff members.
□ Position the conscious patient upright or in the position that best facilitates breathing.
□ Assess airway, breathing, circulation, respiratory effort, ability to speak, and level of consciousness.
□ Administer the patient's prescribed rapid-acting bronchodilator or office albuterol.
□ Use a metered-dose inhaler with a spacer when available.
□ Provide supplemental oxygen and monitor oxygen saturation.
□ Reassess respiratory effort, breath sounds, respiratory rate, ability to speak, and oxygen saturation after treatment.
□ Repeat the rapid-acting bronchodilator according to the patient's asthma action plan, medication instructions, or office emergency protocol.
□ Activate EMS promptly because the patient has difficulty speaking and persistent hypoxemia.
□ Tell EMS: "Acute bronchospasm or severe asthma exacerbation with respiratory distress and oxygen saturation of 91%."
□ Prepare suction, a bag-mask ventilation device, airway equipment, and the AED.
□ Assist ventilation with a bag-mask device if respirations become inadequate.
□ Consider anaphylaxis if the patient also has hives, facial or airway swelling, hypotension, or recent exposure to a likely allergen.
□ Administer IM epinephrine promptly if anaphylaxis is suspected.
□ Recognize a silent or nearly silent chest, exhaustion, cyanosis, altered mental status, decreasing respiratory effort, or worsening hypoxemia as signs of impending respiratory failure.
□ Continue bronchodilator therapy, oxygenation, monitoring, and reassessment while awaiting EMS.

Key knowledge point

A rapid-acting inhaled bronchodilator is an essential initial treatment for acute bronchospasm. Difficulty speaking, hypoxemia, exhaustion, altered mental status, cyanosis, or minimal air movement indicates a severe or potentially life-threatening exacerbation.

Pass standard

Pass if the provider stops treatment, positions the patient appropriately, administers a rapid-acting bronchodilator, provides oxygen, reassesses the patient, recognizes severe respiratory distress, activates EMS, and prepares to support ventilation.

Needs remediation if the provider places a severely dyspneic conscious patient flat, delays bronchodilator treatment, fails to provide oxygen for hypoxemia, does not recognize signs of impending respiratory failure, or fails to prepare for assisted ventilation.

Scenario 6: Emesis and Suspected Aspiration

Clinical stem

During moderate sedation, the patient begins gagging and suddenly vomits a large amount of gastric material. The patient coughs weakly, and fluid is visible in the mouth. After initial suctioning, the patient continues coughing, oxygen saturation decreases from 98% to 88%, and coarse breath sounds are heard.

The patient has vomited and may have aspirated gastric contents. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop the procedure and discontinue administration of sedative or anesthetic medications.
□ Remove instruments, bite blocks, gauze, and dental materials from the oral cavity when safe.
□ Call for help and assign specific responsibilities to staff members.
□ Turn the patient's head to the side.
□ Place the patient in a lateral or head-down position when appropriate to facilitate drainage and reduce further aspiration.
□ Suction the mouth and pharynx promptly under direct visualization.
□ Do not perform a blind finger sweep.
□ Assess airway patency, respiratory effort, oxygen saturation, breath sounds, circulation, and level of consciousness.
□ Administer supplemental oxygen.
□ Perform airway positioning and a jaw thrust when needed.
□ Use an appropriate airway adjunct if needed and within the provider's training.
□ Assist ventilation with a bag-mask device if respirations are inadequate.
□ Recognize persistent coughing, wheezing, coarse breath sounds, hypoxemia, respiratory distress, or altered mental status as signs of clinically significant aspiration.
□ Direct a staff member to activate EMS.
□ Tell EMS: "Suspected aspiration of gastric contents during dental treatment or sedation, with persistent respiratory symptoms and hypoxemia."
□ Prepare advanced airway equipment and the AED.
□ Continue suctioning, oxygenation, ventilation support, monitoring, and reassessment.
□ Do not continue the dental procedure after suspected significant aspiration.

□ Recognize that hospital evaluation is required when respiratory symptoms, hypoxemia, altered consciousness, or significant aspiration is suspected.
□ Do not administer routine antibiotics solely because aspiration occurred unless directed by an evaluating medical professional or established treatment protocol.

Key knowledge point

Immediate management focuses on positioning, drainage, suction, airway protection, oxygenation, and ventilation. Persistent cough, wheezing, abnormal breath sounds, hypoxemia, respiratory distress, or altered consciousness following vomiting should be treated as possible clinically significant aspiration and requires EMS evaluation.

Pass standard

Pass if the provider stops treatment, positions the patient to facilitate drainage, suctions promptly, assesses and supports the airway and breathing, recognizes signs of significant aspiration, activates EMS, and continues monitoring.

Needs remediation if the provider leaves the patient supine while vomiting, delays suctioning, performs a blind finger sweep, fails to support oxygenation or ventilation, continues dental treatment, or dismisses persistent hypoxemia.

Scenario 7: Laryngospasm or Acute Upper-Airway Obstruction

Clinical stem

During deep sedation, water and secretions accumulate in the posterior pharynx. The patient suddenly develops inspiratory stridor followed by minimal air movement. There is paradoxical chest and abdominal movement, ventilation is ineffective, and oxygen saturation is rapidly decreasing despite apparent respiratory effort.

The patient has acute upper-airway obstruction consistent with laryngospasm. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop the procedure and discontinue the triggering stimulus.
□ Remove instruments and materials from the oral cavity.
□ Call for help and assign specific responsibilities to staff members.
□ Recognize partial or complete laryngospasm rather than bronchospasm.
□ Position the head appropriately and perform a firm jaw thrust.
□ Suction blood, water, secretions, or debris from the mouth and pharynx under direct visualization.
□ Apply 100% oxygen using a tightly sealed mask.
□ Apply continuous positive airway pressure.

□ Attempt controlled positive-pressure ventilation while maintaining an effective airway position and mask seal.
□ Look for effective chest rise and air movement.
□ Avoid repeated forceful ventilation that causes gastric insufflation without effective chest rise.
□ Monitor oxygen saturation, heart rate, blood pressure, respiratory effort, and cardiac rhythm if available.
□ Direct a team member to activate EMS if the obstruction does not resolve immediately or oxygen saturation is decreasing.
□ Tell EMS: “Persistent laryngospasm or complete upper-airway obstruction during dental sedation with worsening hypoxemia.”
□ Prepare suction, a bag-mask ventilation device, airway adjuncts, advanced airway equipment, emergency medications, and the AED.
□ If trained, authorized, and equipped, deepen anesthesia when appropriate for persistent laryngospasm.
□ If complete laryngospasm persists with worsening hypoxemia, administer an appropriate neuromuscular blocking medication according to the provider’s training and emergency protocol.
□ Establish effective ventilation and secure the airway following neuromuscular blockade.
□ Begin CPR and use the AED if the patient becomes pulseless.
□ Continue close monitoring after resolution because recurrent obstruction, hypoxemia, and negative-pressure pulmonary edema may occur.

Key knowledge point

Laryngospasm is involuntary closure of the vocal cords that may produce partial or complete airway obstruction. Initial management includes stopping the stimulus, suctioning, airway positioning, a firm jaw thrust, 100% oxygen, continuous positive airway pressure, and positive-pressure ventilation. Persistent complete obstruction with falling oxygen saturation requires immediate escalation by a provider trained and equipped to administer a neuromuscular blocker and establish ventilation.

Pass standard

Pass if the provider recognizes laryngospasm, stops stimulation, suctions, performs a jaw thrust, applies 100% oxygen and positive airway pressure, calls for help, prepares advanced airway rescue, and escalates appropriately when the obstruction persists.

Needs remediation if the provider mistakes complete laryngospasm for mild bronchospasm, fails to remove the stimulus or suction, does not apply positive airway pressure, delays rescue while oxygen saturation decreases, or administers a neuromuscular blocker without the ability to ventilate and manage the airway.

Scenario 8: Angina Pectoris

Clinical stem

A 62-year-old patient with a known history of stable angina develops substernal chest pressure during a stressful dental procedure. The discomfort is similar to previous episodes, does not radiate, and began

approximately two minutes ago. The patient is conscious, the blood pressure is 148/86 mmHg, and the patient has prescribed nitroglycerin.

The patient reports chest pressure similar to previous episodes of stable angina. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop dental treatment immediately.
□ Remove instruments and materials from the oral cavity.
□ Call for help and assign staff members appropriate emergency responsibilities.
□ Position the conscious patient comfortably, generally semi-reclined.
□ Reassure the patient and reduce anxiety and physical exertion.
□ Assess airway, breathing, circulation, mental status, pain characteristics, and associated symptoms.
□ Record the time the symptoms began.
□ Monitor blood pressure, heart rate, respiratory rate, oxygen saturation, and cardiac rhythm if available.
□ Obtain the emergency kit and AED.
□ Assist the patient with prescribed nitroglycerin or administer office nitroglycerin according to the provider's training and emergency protocol.
□ Assess blood pressure before administering nitroglycerin.
□ Confirm that the patient has not recently taken a phosphodiesterase-5 inhibitor and has no other known contraindication to nitroglycerin.
□ Reassess blood pressure and symptoms after each nitroglycerin dose.
□ Provide oxygen if the patient is hypoxemic, dyspneic, or clinically unstable.
□ Reassess the chest discomfort promptly after rest and nitroglycerin.
□ Activate EMS if the pain is new, different, more severe, occurs at rest, is not promptly relieved, recurs, or is accompanied by dyspnea, diaphoresis, nausea, weakness, hypotension, or altered mental status.
□ Treat unresolved, changing, or atypical chest discomfort as possible acute coronary syndrome.
□ Do not allow the patient to drive home with unresolved or concerning chest discomfort.
□ Continue monitoring until symptoms resolve appropriately or EMS assumes care.

Key knowledge point

Stable angina is generally predictable and may improve with rest or prescribed nitroglycerin. New, changing, persistent, severe, or rest-related chest discomfort should be treated as possible acute coronary syndrome. Angina commonly presents as pressure, squeezing, fullness, or discomfort caused by insufficient oxygen delivery to the heart muscle.

Pass standard

Pass if the provider stops treatment, evaluates and monitors the patient, assists with prescribed nitroglycerin when appropriate, reassesses the response, and recognizes when symptoms require EMS activation and management as possible acute coronary syndrome.

Needs remediation if the provider continues treatment, administers nitroglycerin without assessing blood pressure or contraindications, dismisses persistent pain because the patient has a history of angina, or permits a symptomatic patient to leave without appropriate evaluation.

Scenario 9: Suspected Myocardial Infarction or Acute Coronary Syndrome

Clinical stem

A 58-year-old patient with hypertension and diabetes develops heavy substernal chest pressure during dental treatment. The pain radiates to the left arm and jaw and is accompanied by shortness of breath, nausea, and diaphoresis. The discomfort has continued for more than five minutes and is different from anything the patient has previously experienced.

The patient has persistent chest pressure with radiation, dyspnea, nausea, and diaphoresis. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop dental treatment immediately and clear the oral cavity.
□ Recognize suspected acute coronary syndrome or myocardial infarction.
□ Call for help and assign specific responsibilities to staff members.
□ Direct a staff member to call 911 immediately.
□ Tell EMS: “Suspected acute coronary syndrome with persistent radiating chest pressure, shortness of breath, nausea, and diaphoresis.”
□ Record the time the symptoms began.
□ Position the conscious patient comfortably, generally semi-reclined, and minimize exertion.
□ Assess airway, breathing, circulation, mental status, and vital signs.
□ Monitor oxygen saturation and cardiac rhythm if available.
□ Provide oxygen if the patient is hypoxemic, dyspneic, in shock, or otherwise clinically unstable.
□ Administer 162 to 325 mg of chewable aspirin if the patient is alert, can chew and swallow, has no known aspirin allergy, has no active major bleeding, and has not been advised by a health care professional to avoid aspirin.
□ Assist with prescribed nitroglycerin or administer office nitroglycerin according to the provider’s training and protocol when blood pressure and contraindication screening permit.
□ Do not delay EMS activation while waiting to determine whether nitroglycerin relieves the pain.
□ Obtain and apply the AED as soon as practical.
□ Prepare for dysrhythmia or sudden cardiac arrest.
□ Begin high-quality CPR and use the AED immediately if the patient becomes unresponsive, is not breathing normally, and has no definite pulse.
□ Continue monitoring, reassurance, and reassessment until EMS assumes care.
□ Do not allow the patient to walk or drive to the hospital.

Key knowledge point

Acute coronary syndrome requires immediate EMS activation. While awaiting EMS, an alert adult with nontraumatic acute chest pain may be encouraged to chew and swallow 162 to 325 mg of aspirin unless the person has a known aspirin allergy or has been advised by a health care professional not to take aspirin.

Pass standard

Pass if the provider recognizes possible acute coronary syndrome, activates EMS immediately, administers aspirin when appropriate, evaluates oxygen and nitroglycerin use correctly, obtains the AED, and prepares for cardiac arrest.

Needs remediation if the provider delays EMS while waiting for symptoms to resolve, continues dental treatment, allows the patient to drive, fails to obtain the AED, or administers aspirin or nitroglycerin despite a clear contraindication.

Scenario 10: Hypotension or Shock

Clinical stem

During sedation, the patient becomes pale and less responsive. The blood pressure decreases from 132/78 mmHg to 72/38 mmHg. The heart rate is 54 beats per minute, oxygen saturation is 94%, and respirations are shallow. No rash or wheezing is present.

The patient has severe hypotension, decreased responsiveness, bradycardia, and shallow respirations. What do you do next?

Pass requires the provider to demonstrate or verbalize:

□ Stop the procedure immediately.
□ Discontinue administration of sedative or anesthetic medications.
□ Remove instruments and materials from the oral cavity.
□ Call for help and assign specific emergency responsibilities to staff members.
□ Position the patient supine and elevate the legs when not contraindicated.
□ Assess airway, breathing, circulation, mental status, pulse quality, skin signs, and possible causes.
□ Open and maintain the airway.
□ Administer oxygen.
□ Assist ventilation with a bag-mask device if respirations are shallow or inadequate.
□ Monitor blood pressure frequently.
□ Monitor oxygen saturation, respiratory rate, heart rate, and cardiac rhythm if available.
□ Assess for hemorrhage, excessive medication effect, vasovagal reaction, anaphylaxis, myocardial ischemia, dysrhythmia, hypoglycemia, or another possible cause.
□ Establish or confirm IV access when available and within the provider’s training.
□ Administer an appropriate isotonic crystalloid fluid bolus when hypovolemia, vasodilation, or medication-related hypotension is suspected and fluids are not contraindicated.
□ Direct a team member to activate EMS because the patient has severe hypotension, altered responsiveness, and respiratory depression.
□ Tell EMS: “Severe hypotension with decreased responsiveness, bradycardia, and shallow respirations during dental treatment or sedation.”
□ Use cause-specific emergency treatment when the likely cause is identified.

□ Administer epinephrine promptly if anaphylaxis becomes apparent.
□ Manage clinically significant bradycardia according to the provider's training and emergency protocol.
□ Consider reversal of sedative medications when appropriate, available, and within the provider's training, while continuing airway and ventilation support.
□ Obtain the AED and prepare for cardiovascular collapse.
□ Begin CPR and use the AED if the patient becomes pulseless.
□ Reassess the patient after every intervention and communicate whether the patient is improving or deteriorating.
□ Continue monitoring and supportive care until EMS assumes care.

Key knowledge point

Hypotension is a clinical finding rather than a specific diagnosis. Management begins with stopping contributing medications, positioning the patient, supporting airway and ventilation, evaluating circulation, monitoring closely, and identifying the cause. Persistent severe hypotension, altered mental status, respiratory depression, chest pain, dysrhythmia, or signs of shock require EMS activation.

Pass standard

Pass if the provider recognizes clinically significant hypotension, stops contributing medications, positions the patient appropriately, supports oxygenation and ventilation, evaluates likely causes, provides IV fluids when appropriate, activates EMS, and prepares for cardiovascular collapse.

Needs remediation if the provider continues administering sedatives, leaves the patient upright despite severe hypotension, fails to support ventilation, treats only the blood-pressure number without evaluating the underlying cause, or delays EMS despite altered responsiveness.