Health
Western Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

WSHR-2234

DENTAL CONSCIOUS SEDATION CLINICAL PROCEDURE SAFETY CHECKLIST

Sign-In 1- Before starting sedation

DENTAL SEDATIONIST and **RN** confirm:

Proceduralist and DA's present** to complete procedure .... ☐ Yes ☐ **NO**

Correct patient .... ☐ Yes ☐ **NO**

Correct procedure

1. *Anaesthetic Assessment (WSHR-2184)* completed and reviewed .... ☐ Yes ☐ **NO**
2. Medical History and allergies/adverse reactions reviewed........ ☐ Yes ☐ **NO**
3. Premedication .... ☐ **YES** ____________ ☐ No
4. Fluid Management Plan ☐ NIL ☐ SALINE ☐ HARTMANNS ☐ 5% GLUCOSE ☐ OTHER ____________
5. PONV Management Plan .... ☐ **YES** ____________ ☐ No
6. Falls Risk .... ☐ **YES Management Plan:** ____________ ☐ No

Correct Site

1. IVC Access Plan .... ☐ Yes ☐ **NO** ☐ N/A
2. EMLA........ ☐ Yes Time applied ____________ ☐ No

Consent

1. Written consent is present and valid .... ☐ Yes ☐ **NO**
2. Patient identity correct on consent .... ☐ Yes .... ☐ **NO**
3. Usual medication consumed/withheld as directed........ ☐ Yes ☐ **NO** ☐ N/A

Significant airway risk identified .... ☐ **YES Management Plan:** ____________ ☐ No

Sedation equipment checked and functional .... ☐ Yes ☐ **NO**

Loose crowns/dentures/teeth present .... ☐ **YES** ☐ No

Fasted appropriately.......☐ Yes ☐ **NO** Time last food: ____________ Time last drink: ____________

Escort present................☐ Yes ☐ **NO** Name: ____________ Contact number: ____________

Appropriate discharge transport organised........ ☐ Yes Details: ____________ ☐ **NO**

SEDATIONIST NAME ____________ **Signature** ____________ **Date** ____/____/____

Sign-In 2- Before starting sedation

PROCEDURALIST** confirms:

Correct patient .... ☐ Yes ☐ **NO**

Correct Procedure

1. Dental/Surgical Assessment completed and reviewed .... ☐ Yes ☐ **NO**
2. Medical History and allergies/adverse reactions reviewed .... ☐ Yes ☐ **NO**

Correct site .... ☐ Yes ☐ **NO**

Consent

1. Written consent present and valid .... ☐ Yes ☐ **NO**
2. Patient identity correct on consent .... ☐ Yes ☐ **NO**

Imaging present .... ☐ Yes ☐ **NO** **Reason no imaging available** ____________

Dental equipment present and functional .... ☐ Yes ☐ **NO**

Consumables present and sterile .... ☐ Yes ☐ **NO** ☐ N/A

Risk of major bleeding ...... ☐ **YES** ☐ No **Management Plan** ____________

PROCEDURALIST** NAME ____________ **Signature** ____________ **Date** ____/____/____

BINDING MARGIN - NO WRITING

Created 200617 Review 200617

DENTAL CONSCIOUS SEDATION CLINICAL PROCEDURE SAFETY CHECKLIST

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DENTAL CONSCIOUS SEDATION CLINICAL PROCEDURE SAFETY CHECKLIST

Sign-In 3- Immediately before starting procedure

PROCEDURALIST** confirms:

ALL TEAM MEMBERS introduce themselves by name and role .... ☐ Yes ☐ **NO**

PROCEDURALIST-LED TEAM verbally confirms

1. Correct patient identity .... ☐ Yes ☐ **NO**
2. Planned procedure matches consent .... ☐ Yes ☐ **NO**
3. Planned site matches consent .... ☐ Yes ☐ **NO**
4. Patient position correct .... ☐ Yes ☐ **NO**
5. Imaging present & reviewed .... ☐ Yes ☐ **NO**
6. Antibiotics administered .... ☐ Yes ☐ **NO** ☐ N/A
7. VTE prophylaxis applied .... ☐ Yes ☐ **NO** ☐ N/A

☐ **PROCEDURALIST**** briefs team-procedural anticipated critical events
☐ **SEDATIONIST** briefs team-anaesthetic anticipated critical events
☐ **RN** briefs team- specific nursing concerns
☐ **DENTAL ASSISTANTS** brief team- specific assisting concerns

DA's confirm dental equipment present and functional .... ☐ Yes ☐ **NO**
PROCEDURALIST and SEDATIONIST** confirm sterility of equipment and consumables .... ☐ Yes ☐ **NO** ☐ N/A

PROCEDURALIST** NAME ______________ **Signature** ______________ **Date** ____/____/____

Sign-Out- Before patient and team leave procedural area

TEAM DEBRIEF

1. Patient recovery plan including falls management plan .... ☐ **YES** ☐ No
2. **Proceduralist**** - any specific concerns .... ☐ **YES** ☐ No
3. **Sedationist** - any specific concerns .... ☐ **YES** ☐ No
4. **RN** - any specific concerns .... ☐ **YES** ☐ No
5. **Dental assistants** - any specific concerns .... ☐ **YES** ☐ No

DENTAL ASSISTANTS confirm

1. Instrument count/tray list correct .... ☐ Yes ☐ **NO** ☐ N/A
2. Specimens/images labelled correctly .... ☐ Yes ☐ **NO** ☐ N/A
3. Faulty equipment documented, tagged and relevant staff advised .... ☐ Yes ☐ **NO** ☐ N/A

PROCEDURALIST**

1. Procedural documentation .... ☐ Completed
2. Postop instructions .... ☐ Given to patient and carer
3. Postop prescription issued .... ☐ Yes ☐ **NO** ☐ N/A
4. Follow-up appointment issued .... ☐ Yes ☐ **NO** ☐ N/A
5. Blood loss documented .... ☐ Yes ☐ **NO** ☐ N/A
6. Ongoing blood loss addressed...☐ Yes Management Plan ______________ ☐ **NO** ☐ N/A

SEDATIONIST

1. Handover (ISBAR) to recovery staff .... ☐ Yes ☐ **NO** ☐ N/A
2. Sedation documentation .... ☐ Completed
3. Post-treatment VTE plan .... ☐ Yes ☐ **NO** ☐ N/A

DENTAL ASSISTANT NAME ______________ **Signature** ______________ **Date** ____/____/____

Clinical note: recovery phase scores and discharge checks are documented on WSLHD Anaesthetic Assessment Form WSHR-2184.

**** When dental conscious sedation is being administered for the purpose of obtaining diagnostic imaging, the Proceduralist is the RADIOGRAPHER.**

BINDING MARGIN - NO WRITING

NO WRITING