REPORTING A TIER 2 EVENT

TIER TWO EVENTS:

Other incidents must be reported to the RCDSO in writing within 10 days of knowledge of the event.

- Unscheduled treatment of a patient in a hospital within 10 days of a procedure performed with sedation or general anesthesia.
- Any use of a benzodiazepine or opioid antagonist.
- Any serious cardiac or respiratory adverse event requiring administration of a medication for its management.

1. COMPLETION OF REPORT

NAME OF PERSON COMPLETING THIS REPORT:

TITLE:

TELEPHONE: DATE REPORT COMPLETED:

2. GENERAL INFORMATION

SEDATION FACILITY PERMIT HOLDER:

FACILITY ADDRESS:

DENTAL TREATMENT PERFORMED BY:

DATE OF THE INCIDENT: DAY: MONTH: YEAR:

SEDATION PERFORMED BY:

LEVEL OF SEDATION INTENDED AND MODALITY:

3. PATIENT INFORMATION

PATIENT IDENTIFICATION NUMBER (IF APPLICABLE):

PATIENT NAME:

HT: WT: GENDER: ☐ MALE ☐ FEMALE AGE:

DATE OF BIRTH:

ASA CLASSIFICATION:

TREATMENT PROPOSED:

TREATMENT PERFORMED:

	Column 1	Column 2	Suspected Etiology
Airways & Breathing	☐ Naloxone ☐ Flumazenil ☐ Oral airway	☐ Tracheal intubation ☐ Neuromuscular blockade ☐ Pulmonary aspiration ☐ Bag mask valve ventilation	☐ Apnea ☐ Respiratory depression ☐ Upper airway obstruction ☐ Laryngospasm ☐ Oxygen desaturation ☐ Abnormal capnography
Circulation	☐ Bolus IV fluids ☐ Vasoactive drug administration		☐ Hypotension ☐ Hypertension ☐ Bradycardia ☐ Trachycardia ☐ Cardiac arrest
Neuro	☐ Anticonvulsant administration		☐ Nausea ☐ Vomiting ☐ Seizure or seizure-like movements ☐ Myoclonus/muscle rigidity
Allergy	☐ Administration of antihistamine ☐ Administration of inhaled ß-agonist ☐ Administration of epinephrine (adrenaline) for anaphylaxis		☐ Allergic reaction ☐ Anaphylaxis
Other			☐ Patient active resistance or need for restraint ☐ Sedation complication ☐ Paradoxical response ☐ Unpleasant recovery reaction/agitation ☐ Unpleasant recall

4. OFFICE RESPONSE TO THE EVENT

For each question: Please answer using the space provided **OR** if more space is required, attach a WORD file, appropriately named.

1. IF THIS INCIDENT HAD PROGRESSED WITHOUT CORRECTIVE ACTION, WHAT MIGHT THE OUTCOME HAVE BEEN FOR THE PATIENT? *(check one)*

☐ **Please see my attached WORD file, named "1. Progress answer".**

☐ **Answer:**

2. WHAT PREVENTED THIS INCIDENT FROM BECOMING MORE SERIOUS? *(check one)*

☐ **Please see my attached WORD file, named "2. Prevent answer".**

☐ **Answer:**

3. WHAT STEPS HAVE BEEN TAKEN TO PREVENT FUTURE OCCURENCES SUCH AS CHANGE TO POLICY OR PROCEDURES? GIVE DETAILS. *(check one)*

☐ **Please see my attached WORD file, named "3. Steps answer".**

☐ **Answer:**

5. SUBMISSION OF TIER REPORT FORM

Tier report forms must be submitted through the College's secure email system.

To access the secure email system and submit the form, contact eventreports@rcdso.org to request a secure email link.

Once you receive the secure email link, log in to your secure email to respond to the email with the following documentation:

1. completed Tier Report form (including any additional WORD files)
2. a copy of the related sedation or anesthesia record (if applicable)
3. the patient's medical history review documentation

You may also include related clinical notes.

DENTIST WHO PROVIDED TREATMENT OR SEDATION PROVIDER - I HAVE REVIEWED THE CONTENTS OF THIS REPORT:

SIGNATURE: _____

DATE: _____

PRINTED NAME: _____

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