INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
1-A-1	The facility practices within the Anesthesia Class for which it is accredited and in accordance with facility policies and procedures, industry standards, regulations, and laws governing the facility.	**1-A-1**	No Change
1-A-2	All care is provided by a credentialed healthcare provider as listed in the Anesthesia Class document and in accordance with facility policies, procedures, and state/provincial and federal law.	**1-A-2**	No Change
1-B-3	The facility has defined a mission statement that reflects the population it serves and the services it provides.	**1-B-3**	No Change
1-B-4	The facility has provided a set of organizational values which guide daily operations, are familiar to all staff, and are available to the public.	**1-B-4**	No Change
1-B-5	The facility must inform the public of the services.	**1-B-5**	No Change
1-B-6	The facility must ensure that no marketing and advertising regarding the competence and capabilities of the organization is misleading or implies that it provides care or services that it is not capable of providing.	**1-B-6**	No Change
1-B-7	Only recognized abbreviations are allowed to be used in the clinical record.	**1-B-7**	No Change
1-B-8	The facility must perform a self-survey review of compliance with all Quad A standards annually prior to the expiration date of its accreditation in each of the two years between Quad A onsite surveys. The self-survey documentation must be retained for a minimum of 3 years and include: 1. A completed Self-Survey checklist 2. A Plan of Correction for any standard identified as non-compliant 3. Evidence that each plan of correction has been carried out to establish compliance with standards 4. Evidence that findings from the self-survey have been reviewed, included in the facility's Quality Improvement Plan, and discussed in the facility's Quality Improvement meetings.	**1-B-8**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
1-B-9	The facility must make its final survey results publicly available.	**1-B-9**	No Change
1-C-1	A patient who, by reason of pre-existing or other medical conditions, is at significant risk for outpatient surgery in this facility must be referred to alternative facilities as defined in facility policy. Any surgery for which a patient must be routinely transferred to a hospital after the surgery is not appropriate for an outpatient surgical setting.	**1-C-1**	No Change
1-C-2	The facility must have a scheduling policy that includes only those procedures and/or a combination of procedures of duration and degree that permit safe recovery and discharge from the facility consistent with federal/national, state/provincial, and local regulations, if applicable.	**1-C-2**	No Change
1-C-3	The process for entry or admission to the facility for a procedure must be coordinated and defined in a policy.	**1-C-3**	No Change
1-C-4	If pediatric services are provided by the facility, there must be a written policy defining the unique perioperative care of pediatric patients. This is based upon considerations of age, BMI or weight, special needs, risk categories, surgery, facility equipment, and capability. The written policy for pediatric patients is available and current.	**1-C-4**	No Change
1-D-1	A copy of the most current QUAD A "Patients' Bill of Rights" is prominently displayed, or a copy is provided to each patient. The QUAD A "Patients' Bill of Rights" is also adhered to by facility personnel. If required, an additional Patients' Bill of Rights must be prominently displayed in accordance with prevailing laws and regulations.	**1-D-1**	No Change
1-D-18	The patient has a right to personal privacy.	**1-D-18**	No Change
1-D-19	The patient has a right to receive care in a safe setting.	**1-D-19**	No Change
1-D-20	The patient has a right to be free from all forms of abuse or harassment.	**1-D-20**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
1-D-22	The patient has a right to refuse treatment.	**1-D-22**	No Change
1-D-23	All new staff must have training regarding the Patient Bill of Rights including concerns and complaints from family members / adult escorts and the various religious and ethnic concerns of the usual patient population and the policy and process for addressing concerns and complaints.	**1-D-23**	No Change
1-D-24	Any issues judged significant related to the Patient's Bill of Rights must be brought to the attention of administration in a timely fashion.	**1-D-24**	No Change
1-D-25	The facility must have the patient acknowledge that the Bill of Rights has been reviewed and understood by the patient/legal representative.	**1-D-25**	No Change
1-D-26	The facility must provide patient privacy including gender-specific dressing and lavatory areas. This may include gender-specific dressing and lavatory areas as well as dietary provisions if provided by the facility.	**1-D-26**	No Change
1-D-27	The staff provide care in a manner that is respectful, professional, and consistent with the facility's mission statement.	**1-D-27**	No Change
1-D-28	The Patient's Bill of Rights is printed and available in the language of the majority (and substantial minority) of the patient population served.	**1-D-28**	No Change
1-E-1	Changes in facility ownership must be reported to the QUAD A Central Office within thirty (30) days of the change.	**1-E-1**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
1-E-2	Any change in the physician's staff must be reported in writing to the QUAD A Central Office within thirty (30) days of such changes. Copies of the credentials of any new staff, including their current medical license, ABMS Board Certification, AOABOS Board Certification or other approved Boards, letter of eligibility or equivalent documentation, and current documentation of hospital privileges or satisfactory explanation for the lack thereof must also be sent to the QUAD A Central Office.	**1-E-2**	Any change in provider staff must be reported to the QUAD A Central Office, in writing, within thirty (30) days of the change, along with the appropriate credentials. **Surgical Programs (ASC, OBS, OBP, PD, OMS, I-DENT, I-SURG):** Surgeons, Proceduralists, and Pain Management Providers must submit medical license, board certification or board eligibility, and delineation of facility privileges. **RHC:** Physicians, Advanced Practice Providers (NP, PA, CNM) and licensed behavior health providers (CP, CSW, MFT, MHC) must submit professional licenses. **Physical Therapy (OPT, I-PT):** SLP, OT, PT, SLPA, OTA, PTA must submit professional licenses. **Polyclinic:** Physicians, Dentist, Advanced Practice Providers (NP, PA, CNM), Physiotherapist, and Physical Therapists must submit must professional licenses.
1-E-3	Any action affecting the current professional license of any licensed facility staff must be reported in writing to the QUAD A office within ten (10) days of the time the facility becomes aware of such action.	**1-E-3**	No Change
1-E-4	Any death occurring in an accredited facility or any death occurring within thirty (30) days of a procedure performed in an accredited facility must be reported to the QUAD A office within five (5) business days after the facility is notified or otherwise becomes aware of that death. In addition to this notification, the death must be contemporaneously reported as an adverse event in the online Patient Safety Data Reporting portal. In the event of a death occurring within thirty (30) days of a procedure performed in an QUAD A-accredited facility, an unannounced survey may be performed.	**1-E-4**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
1-E-5	All adverse events which occur in the facility or as a result of care provided at the facility must be communicated to the affected patient(s) and/or facility staff.	**1-E-5**	No Change
1-F-1	Online Patient Safety Data Reporting is performed at least every three (3) months in accordance with the due dates established by QUAD A and includes submitting random cases and all adverse events to the QUAD A portal at www.QUAD A.org.	**1-F-1**	No Change
1-F-2	For each surgeon/proceduralist operating in the facility, the random sample of the cases must include, at a minimum, the first case performed by such surgeon/proceduralist each month during the reporting period for a total of three (3) cases. The facility must submit into the online Patient Safety Data Reporting portal a minimum of three (3) cases, or all cases performed by surgeons who have performed fewer than three (3) in the respective period, every three (3) months.	**1-F-2**	No Change
1-F-3	The facility is up to date with accurate PSDR reporting. Reportable adverse events must be submitted to PSDR, including, but not limited to: · Any unplanned hospital admission; · Any emergency department visit; · Any unscheduled return to the operating room for a complication of a previous surgery; · Any complication such as infection, bleeding, wound dehiscence, or inadvertent injury to another body structure; · Any cardiac or respiratory problems during the patient's stay at the facility or within 48 hours of discharge; · Any allergic reactions · Any pre- and post-procedure incorrect instrument, needle or sponge counts · Any patient or family complaint; · Any equipment malfunction leading to injury or potential injury to the patient; · Any death occurring within 30 days of a procedure; · Any iatrogenic dental trauma	**1-F-3**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
1-F-15	Each adverse event submission must include: The identification of the problem, The immediate treatment or disposition of the case, The outcome, The reason for the problem, and An assessment of the efficacy of treatment.	**1-F-15**	No Change
2-A-1	The Operating Suite is physically and distinctly separate and segregated from the General Office Area (waiting room, exam room(s), administrative area, physician office, staff lounge, etc.)	**2-A-1**	No Change
2-A-3	There is a separate and adequately sized Post-Anesthesia Care Unit (PACU) within the operating room suite.	**2-A-3**	No Change
2-A-9	There is a separate waiting room which is adequately sized and adequately lighted.	**2-A-9**	No Change
2-A-10	There is designated area for administrative activities.	**2-A-10**	No Change
2-A-11	There is at least one examination room.	**2-A-11**	No Change
2-B-3	The entire facility must be maintained, equipped, regularly cleaned, sanitary, and free of clutter and litter, consistent with a medical facility designed to perform procedures.	**2-B-3**	No Change
2-B-4	The walls, cabinets, countertops, blinds and shades, and flooring are covered with smooth and easy-to-clean material that is free from tears, breaks, or cracks. If the floors contain seams or individual tiles, they are sealed with an impermeable sealant other than silicone.	**2-B-4**	No Change
2-B-5	The operating room and scrub area ceiling surface or drop-in tiles are smooth, washable, and free of particulate matter that could contaminate the operating room and scrub area.	**2-B-5**	No Change
2-B-6	All openings to outdoor air are effectively protected against the entrance of insects, animals, etc. The facility must have policies and procedures in place and implemented to address these issues.	**2-B-6**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
2-B-7	There are no overloaded wall plugs or overloaded extensions in use, no altered grounding plugs in use, and wires are not broken, worn, or unshielded.	**2-B-7**	No Change
2-B-9	The entire facility is appropriately lighted, properly ventilated, and temperature controlled for patient and personnel comfort.	**2-B-9**	No Change
2-B-10	The entire facility provides adequate work space and provides sufficient space and storage for supplies and equipment.	**2-B-10**	No Change
2-B-14	The lavatory facilities are sufficient to accommodate patients and staff needs.	**2-B-14**	No Change
2-B-19	Smoking is prohibited in the entire facility.	**2-B-19**	No Change
2-C-2	Each operating room is of a size adequate to allow for the presence of all equipment and personnel necessary for the performance of the operations, and must comply with applicable local, state/provincial or federal/national requirements. There must be ample clear space on each side of the procedure table to accommodate emergency personnel and equipment in case of emergency and permit the safe transfer of the patient to a gurney for transport.	**2-C-2**	No Change
2-C-3	Each operating room is ventilated, temperature and humidity controlled. The facility policy defines parameters based on patient population, procedure, and monitoring frequency in accordance with industry standards.	**2-C-3**	No Change
2-C-4	The facility must have policies and procedures in place that address operating room cleaning, frequency and type of disinfectants used in accordance with industry standards.	**2-C-4**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
2-C-5	There is adequate storage space within the operating room to hold equipment, supplies, and medications. Unused equipment, supplies, and medications are stored in a manner to avoid contamination.	**2-C-5**	No Change
2-D-1	The PACU is maintained, clean and free of litter.	**2-D-1**	No Change
2-E-1	Sterile supplies and equipment are stored away from potential contamination in closed cabinets/drawers; or if not, sterile supplies must be stored away from heavy traffic areas and potential contamination hazards.	**2-E-1**	No Change
2-E-2	Storage space for sterile supplies and equipment is organized in a manner that maintains cleanliness, sterility, and functionality, provides easy access for identification and minimizes the risk of contamination and injury to patients and staff.	**2-E-2**	No Change
2-E-3	As applicable to the setting, outdated medical supplies, instruments, implants, and equipment are removed and destroyed in accordance with federal/national, state, provincial, and local regulations.	**2-E-3**	No Change
3-A-2	There is a reliable means of two-way communication to necessary personnel in other facility locations.	**3-A-2**	No Change
3-B-1	There is a Facility Safety Manual that is reviewed and updated annually and is in accordance with all other federal/national, provincial, state and local regulations. For international facilities, there must be evidence that specific national, provincial, and local regulations are included.	**3-B-1**	No Change
3-B-4	The facility safety manual provides employees with information about hazardous chemicals used and methods to minimize hazards to personnel.	**3-B-4**	No Change
3-B-5	There is a written exposure control plan, which is reviewed and updated at least annually.	**3-B-5**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
3-B-6	There is a written chemical hazard communication program, which is reviewed and updated annually.	**3-B-6**	No Change
3-C-2	All explosive and combustible materials and supplies are stored and handled in a safe manner with appropriate ventilation according to state/provincial, local or national laws and regulations.	**3-C-2**	No Change
3-C-4	Compressed gas cylinders are stored and handled in a safe manner according to local, state/provincial, or national laws and regulations.	**3-C-4**	No Change
3-C-5	Hazardous chemicals are labeled as hazardous. Any hazardous material removed from the manufacturer's container and placed in a secondary container must be properly labeled.	**3-C-5**	No Change
3-D-1	All medical hazardous wastes are disposed of in sealed, labeled containers and stored in compliance with federal/national, state, provincial, and local regulations and/or OSHA (Occupational Safety and Health Administration) acceptable containers and separated from general refuse for special collection and handling.	**3-D-1**	No Change
3-D-4	Used disposable sharp items are placed in secure puncture-resistant containers that are located as close to the use area as is practical.	**3-D-4**	No Change
3-E-1	The facility is equipped with functioning heat sensors and/or smoke detectors that are tested annually.	**3-E-1**	No Change
3-E-2	The number of fire extinguishers available and their locating must conform to local fire codes. Minimally, a fire extinguisher is located within 75 feet of any location in the facility. Fire extinguishers are visually inspected monthly, maintenance inspections are done annually and conform to local fire codes.	**3-E-2**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
3-F-3	There are sufficient emergency lights for exit routes and patient care areas in case of power failure.	**3-F-3**	No Change
3-F-4	Hallways, stairways and elevators are sufficiently wide to allow emergency evacuation of a patient by emergency personnel and their equipment.	**3-F-4**	No Change
3-G-2	Personnel are properly trained in the control procedures and work practices that have been demonstrated to reduce occupational exposures to anesthetic gases.	**3-G-2**	No Change
3-G-3	There is a written policy for what is considered to be personal protective equipment for specific tasks in the facility (e.g., instrument cleaning, disposal of biological waste, surgery, radiology protection, exposure reduction, etc.).	**3-G-3**	No Change
3-H-2	If laboratory services are provided, these laboratory services must be provided in accordance with the Clinical Laboratory Improvement Act (CLIA) requirements at 42 CFR 493 operating under a current CLIA certificate appropriate to the level of services performed.	**3-H-2**	No Change
3-H-3	If x-ray equipment is used, safety measures are taken to protect patients and staff from injury. Warnings and signage exist to warn those whose health may be affected by x-rays.	**3-H-3**	No Change
3-H-4	If X-ray is used, staff maintain dosimetry badges and records, if applicable, for at least three (3) years.	**3-H-4**	No Change
3-H-8	If a laser is used, all manufacturer recommended safety precautions are actively in place prior to any usage. All safety measures are taken to protect patients and staff from injury, including appropriate eyewear, covered mirrors, covered windows, signage on the door, etc. in accordance with state/provincial laws and regulations.	**3-H-8**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
4-A-1	If a central source of piped oxygen is used, the system must meet all applicable local, state/provincial, country safety codes.	**4-A-1**	No Change
4-A-2	Medical equipment and supplies are available in the facility in appropriate sizes and quantities based on the patient population served.	**4-A-2**	No Change
4-B-2	There is a properly functioning operating room table or chair.	**4-B-2**	No Change
4-B-3	The operating room is provided with functioning lighting in the ceiling based on the types of cases performed. Illumination for patients, machines, and monitoring equipment, and access to battery-powered illuminating systems are present.	**4-B-3**	No Change
4-B-5	Sufficient electrical outlets are available, labeled and grounded to suit the location (e.g.; wet locations) and connected to emergency power supplies where appropriate.	**4-B-5**	No Change
4-B-8	“Forced air warmers,” blanket warmers, or other interventions are used to maintain the patient’s temperature when the procedure lasts more than 60 minutes. The patient's temperature is monitored periodically to ensure normothermia.	**4-B-8**	No Change
4-C-1	The operating room is equipped with an EKG monitor with pulse read-out.	**4-C-1**	No Change
4-C-2	The operating room is equipped with a pulse oximeter.	**4-C-2**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
4-C-3	The operating room is equipped with blood pressure monitoring equipment, including cuff sizes as appropriate for the patient population treated in the facility.	**4-C-3**	No Change
4-C-4	The operating room is equipped with oral airways including sizes specific for each size of patient population treated in the facility.	**4-C-4**	No Change
4-C-5	The operating room is equipped with nasopharyngeal airways including sizes for each size of patient population treated in the facility.	**4-C-5**	No Change
4-C-6	The operating room is equipped with a functional and clean laryngoscope. Laryngoscope is cleaned as appropriate, HLD or sterilized. Permitted in Class B for emergency use only.	**4-C-6**	No Change
4-C-7	The operating room is equipped with a comprehensive assortment of endotracheal tubes, stylets, and laryngeal mask airways including sizes and types for the patients being treated in the facility. Permitted in Class B for emergency use only.	**4-C-7**	No Change
4-C-9	The operating room is equipped with a positive pressure ventilation device (e.g. Ambu® bag, bag valve mask), including sizes of masks to cover the range needed for the patient population treated in the facility. If self-inflating bags are used, they must be capable of delivering positive-pressure ventilation with at least 90% oxygenation concentration.	**4-C-9**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
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4-C-10	The operating room is equipped with a source of oxygen and with appropriate delivery devices (e.g. nasal cannula, face mask) to provide adequate oxygen for the patient population treated and procedures performed in the facility.	**4-C-10**	No Change
4-C-11	The operating room is equipped with a source of adequate and reliable suction and suction equipment.	**4-C-11**	No Change
4-C-12	The operating room is equipped with a reliable source of oxygen, adequate for the length of the procedures performed in the facility (back up must consist of at least one full E cylinder). Back up oxygen source must have a regulator on it and be ready to use. If oxygen cylinders are used as backup, they must be full.	**4-C-12**	No Change
4-C-13	If inhalation general anesthesia is used, the operating room is equipped with an inspired gas oxygen monitor on the anesthesia machine with an audible alarm to indicate a low oxygen concentration.	**4-C-13**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
4-C-14	The operating room is equipped with an end tidal carbon dioxide monitor with an audible alarm to indicate values outside the normal range which is used on all moderate sedation, deep sedation, and general anesthesia cases.	**4-C-14**	No Change
4-C-15	When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting the disconnection of any of the breathing system's components. The device must give an audible signal when its alarm threshold is exceeded.	**4-C-15**	No Change
4-C-16	If nitrous oxide alone is used, then a safe delivery system is used. A safe delivery system meets these criteria: 1) Alarms 2) Gas scavenging 3) Color coding of tanks, knobs, and hoses 4) Diameter index safety system for non-interchangeable connection of gases - pin index safety system 5) Oxygen fail-safe system and oxygen flush capacity 6) Quick connection for positive-pressure oxygen delivery 7) Emergency air inlet 8) Reservoir bag 9) Storage in secured area	**4-C-16**	No Change
4-C-17	An anesthesia machine with a purge system to extract exhaled gaseous air to out-of-doors or to a neutralizing system is present. If inhalation anesthesia is used, a carbon–dioxide-neutralizing system is required when using an anesthesia machine. An adequate and reliable waste anesthetic scavenging system exists if inhalation anesthetics are used.	**4-C-17**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
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4-C-18	An anesthesia machine is required if volatile agents or nitrous oxide are available in the facility. If total intravenous anesthesia (TIVA), spinal, or epidural anesthesia is used exclusively, and no inhalation agents (volatile or nitrous oxide) are available, an anesthesia machine is not required.	**4-C-18**	No Change
4-D-1	The PACU is equipped and readily accessible to handle emergencies	**4-D-1**	No Change
4-D-2	A separate pulse oximeter is available for each patient in the PACU.	**4-D-2**	No Change
4-E-1	The facility has a preventive maintenance program to ensure that all essential mechanical, electric and patient-care equipment is maintained in safe operating condition and is replaced no less frequently than according to a schedule. A qualified technician annually inspects all equipment and reports in writing that the equipment is safe and operating according to the manufacturer's specifications. Stickers may be placed on individual equipment; however, written records must be maintained. All equipment is on a maintenance schedule, and records are kept for a minimum of at least three (3) years.	**4-E-1**	No Change
4-E-5	The manufacturer's specifications and requirements for all equipment are kept in an organized file and followed for each piece of equipment.	**4-E-5**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
4-E-6	The facility's emergency backup power equipment is tested monthly and according to the manufacturer's recommendations to ensure proper function in accordance with federal/national, state, provincial, and local requirements, if applicable. The test results are filed and kept for a minimum of three (3) years.	**4-E-6**	No Change
4-E-10	The facility regularly conducts appropriate testing in accordance with the manufacturer's specifications for all equipment. Records of that testing are maintained within the facility for at least three (3) years.	**4-E-10**	No Change
4-E-11	All equipment not requiring a qualified technician inspection is on a preventative maintenance schedule with appropriate records kept for a minimum of 3 years (examples include manual wheelchair, manual stretcher, etc.).	**4-E-11**	No Change
5-A-1	Emergency cart is immediately available with a defibrillator or automated external defibrillator (AED), necessary drugs, and other CPR equipment (e.g. suction, pediatric defib pads) necessary for the patient population being served.	**5-A-1**	No Change
5-A-3	The standard defibrillator, or an Automated External Defibrillator (AED), is checked at least weekly for operability in accordance with the manufacturer's instructions for use, and the test results are documented and kept for a minimum of three (3) years.	**5-A-3**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
5-A-4	The facility medical staff, anesthesia professionals, other clinical staff, and the governing body of the facility coordinates, develops, and revises facility policies and procedures to specify the types of emergency equipment required for use in the facility's operating room.	**5-A-4**	No Change
5-A-5	The emergency equipment must be immediately available for the use of emergency situations.	**5-A-5**	No Change
5-A-6	The emergency equipment must be appropriate for the facility's patient population.	**5-A-6**	No Change
5-A-7	The emergency equipment must be maintained by appropriate personnel.	**5-A-7**	No Change
5-B-1	The emergency power source is able to begin generating ample power to operate essential electrical equipment used in the operating room within thirty (30) seconds of a power failure.	**5-B-1**	No Change
5-B-2	The operating room(s) and PACU have an emergency power source, (e.g. a generator or battery powered inverter), with capacity to operate critical equipment (e.g., ventilators, lighting, monitoring, anesthesia, and procedure equipment) for a minimum of 90 minutes. If two or more operating rooms are used simultaneously, an adequate emergency power source must be available for all operating rooms.	**5-B-2**	No Change
5-C-1	There must be a written protocol for emergency evacuation of the facility. The protocol must include provisions for annual drills for the emergency evacuation of patients, staff, and guests; staff training upon hire and annually. Documentation of all drills must be retained in the facility for a minimum of three (3) years.	**5-C-1**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
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5-C-2	A written protocol for security emergencies, such as an intruder in the facility, an unruly patient or visitor, or a threat to the staff or patients, must be documented and reviewed annually. The protocol must include provisions for annual drills for security emergencies; staff training upon hire and annually; drill documentation; and, retention of documentation for a minimum of three (3) years.	**5-C-2**	No Change
5-C-3	There must be a written protocol for fires and fire drills. This protocol must include the provision for: fire drills; staff training upon hire and annually; drill documentation and retention of documentation for a minimum of three (3) years.	**5-C-3**	No Change
5-C-4	There must be a written protocol for returning patients to the operating room or transfer to the hospital in the event of patient emergencies.	**5-C-4**	No Change
5-C-7	There must be a written protocol for a situation in which the surgeon/proceduralist, anesthesia professional, or other healthcare professional is impaired or becomes incapacitated.	**5-C-7**	No Change
5-C-11	There must be a written protocol for isolation procedures.	**5-C-11**	No Change
5-F-1	There is a written protocol for a disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the facility.	**5-F-1**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
5-F-2	Facilities must conduct a biennial review and test of its disaster preparedness plan.	**5-F-2**	No Change
6-A-2	Drugs must be prepared and administered according to established policies and acceptable standards of practice.	**6-A-2**	No Change
6-A-5	Outdated medications are removed and destroyed in accordance with federal/national, state, provincial, and local pharmacy regulation.	**6-A-5**	No Change
6-A-6	Medications are stored in a secured area away from patient and visitor access.	**6-A-6**	No Change
6-A-7	All drugs and biologicals given to patients must be approved by the physician/dentist with a signed order.	**6-A-7**	No Change
6-A-8	The facility must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services.	**6-A-8**	No Change
6-B-1	Intravenous fluids such as Lactated Ringer's solution and/or normal saline are available in the facility, including intravenous (IV) administration sets, and various sizes of IV needles based on the patient population served.	**6-B-1**	No Change
6-D-1	All controlled substances are secured and locked under supervised access. Storage of controlled substances must be in accordance with applicable federal/national, state/provincial, and local regulations.	**6-D-1**	No Change
6-D-2	There is a dated controlled substance inventory and a control record that includes the use of controlled substances on individual patients. Such records must be kept in the form of a sequentially numbered, bound journal from which pages may not be removed, or in a tamper -proof, secure computer record consistent with state and federal law. This log must be kept in the facility.	**6-D-2**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
6-D-3	All controlled substance transactions, including daily counts and wastes, require verification by two (2) licensed members of the team. (For facilities with only Schedule IV and V controlled substances, one (1) licensed and (1) authorized member of the operating room team may document verification of daily counts and wastes.) These verifications must be completed on any day that the facility is open and/or controlled substances are administered, and in compliance with federal/national, provincial, state, and local regulations. The facility must develop a policy detailing how unlicensed authorized individuals are authorized, if applicable.	**6-D-3**	No Change
6-E-5	There must be a written protocol for cardiopulmonary resuscitation (CPR). This protocol must include the provision for annual drills, staff training upon hire and annually, drill documentation, and retention of documentation for at least three (3) years.	**6-E-5**	No Change
6-F-1	All emergency medications as noted in the following standards must be available and in the facility at all times. Licensed personnel in the facility must know their location.	**6-F-1**	No Change
6-F-2	The following medication must be available in the facility at all times: IV Antihistamines (e.g. Diphenhydramine) – Minimum 50 mg.	**6-F-2**	No Change
6-F-3	The following medication must be available in the facility at all times: Short-acting beta-blocker (e.g., esmolol or labetalol).	**6-F-3**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
6-F-4	The following medication must be available in the facility at all times: Neuromuscular blocking agents including non-depolarizing agents such as rocuronium or depolarizing agents such as succinylcholine.	**6-F-4**	No Change
6-F-5	The following medication must be available in the facility at all times: If a Benzodiazepine is used in the facility, a reversal agent must be available (e.g. Mazicon™, Flumazenil).	**6-F-5**	No Change
6-F-6	The following medication must be available in the facility at all times: Vasopressors other than epinephrine (e.g. Ephedrine).	**6-F-6**	No Change
6-F-8	The following medication must be available in the facility at all times: Bronchospasm-arresting medication (inhaled beta-agonist, e.g. albuterol).	**6-F-8**	No Change
6-F-9	The following medication must be available in the facility at all times: Anti-hypertensives	**6-F-9**	No Change
6-F-10	The following medication must be available in the facility at all times: Seizure arresting medication (a benzodiazepine, e.g. Midazolam).	**6-F-10**	No Change
6-F-11	The following medication must be available in the facility at all times: Intravenous corticosteroids (e.g., dexamethasone).	**6-F-11**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
6-F-13	The following medication must be available in the facility at all times: A narcotic reversal agent (e.g., naloxone, nalmefene).	**6-F-13**	No Change
6-G-1	If the depolarizing muscle relaxant succinylcholine is present only for use in emergency airway rescue, the facility must document a protocol to manage the possibility of malignant hyperthermia (MH) following its use, and staff training must occur on hire and then annually.	**6-G-1**	No Change
6-G-2	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: Screening for MH risk must be documented, that includes but is not limited to a family history of unexpected death(s) following general anesthesia or exercise; a family or personal history of MH, a muscle or neuromuscular disorder, high temperature following exercise; a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise.	**6-G-2**	No Change
6-G-5	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: MH crisis management must be covered in annual staff training. All clinical staff (including contracted healthcare professionals) must be trained. Annual drills are conducted for MH crisis and management including actual dilution of at least one vial of actual Dantrolene (expired OK). Staff should be assigned roles prior to drills and a written protocol outlining those personnel and their roles is on file. Documentation of drills is required.	**6-G-5**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
6-G-6	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: A supply of sterile water for injection USP (without a bacteriostatic agent) is available to mix with dantrolene before injection (i.e. 60ml/vial for Dantrium® and Revonto®, 5ml/vial for Ryanodex®).	**6-G-6**	No Change
6-G-7	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: A minimum of 4 ampoules, 50cc's each, of sodium bicarbonate (NaHCO3).	**6-G-7**	No Change
6-G-8	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: A minimum supply of dantrolene/Ryanodex should be stocked to treat a patient of average weight (approximately 70kg) with an initial dose: Dantrium®/Revonto® - 12 vials (20 mg/vial) Ryanodex® - 1 vial (250 mg/vial).	**6-G-8**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
6-G-9	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: An additional* supply of dantrolene/Ryanodex and diluents are stored in the facility, or the facility has a written agreement with another source that will provide additional* dantrolene/Ryanodex and diluents on a STAT basis within 10 minutes for continued treatment and stabilization of a patient experiencing a MH episode. *Additional supply of dantrolene is defined as: Dantrium®/Revonto® - 24 vials (20 mg/vial) Ryanodex® - 2 vial (250 mg/vial).	**6-G-9**	No Change
6-G-10	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: Flow sheets for any MH intervention as well as forms to rapidly communicate the progress of intervention with receiving facilities are on the emergency cart, and the facility must document and report any "adverse metabolic or musculoskeletal reaction to anesthesia". This documentation must be transportable with the patient when transferred to the receiving facility.	**6-G-10**	No Change
7-A-10	The facility's policies address operating/procedure room apparel. This includes: scrub suits, caps or hair covers, gloves, operative gowns, masks, eye protection, and all other appropriate apparel based on the procedure being conducted.	**7-A-10**	No Change
7-A-11	A sterile field is used during all operations and procedures, as applicable.	**7-A-11**	No Change
7-A-12	The facility staff must have knowledge of infection prevention and control techniques.	**7-A-12**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
7-A-13	Reuse of single-use disposable biopsy forceps is strictly prohibited. Purchase records must be retained for three (3) years and available for comparison to procedural and pathology specimen logs.	**7-A-13**	No Change
7-A-14	Policy and practices exist to prevent and control infections such as: proper use of antibiotics, hand hygiene, prevention of site infection, and infection event reporting.	**7-A-14**	No Change
7-A-15	Aseptic techniques are maintained during procedures and between cases.	**7-A-15**	No Change
7-B-1	Hand hygiene is performed in accordance with current nationally recognized and/or WHO guidelines and standards of practice. Periodic hand hygiene auditing must be a part of the facility's quality activities. **For surgical/procedural facilities**: Scrub facilities are provided for the operating room staff. Scrub products (as appropriate), soap, and alcohol cleansers are provided for the operating room staff, consistent with current adopted guidelines and standards of practice for hand hygiene.	**7-B-1**	No Change
7-C-1	The facility has a written protocol for the reprocessing of all surgical instruments and disinfection of all equipment used in patient care consistent with the manufacturer's instructions for use.	**7-C-1**	No Change
7-C-2	There is strict segregation of dirty surgical equipment and instruments that have been cleaned and are in the preparation and assembly area.	**7-C-2**	No Change
7-C-3	The instrument preparation and assembly area (clean processing area) are separated by walls or space from the instrument cleaning and decontamination area (reprocessing area).	**7-C-3**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
7-C-4	Single-use devices are not reprocessed unless they are approved by the FDA for reprocessing. Reprocessing of these devices is done by an FDA-approved reprocessor. NOTE: The FDA requirement does not apply to international facilities. International facilities must comply with local, state/provincial or federal/national requirements regarding reprocessing single-use devices.	**7-C-4**	No Change
7-D-1	All instruments used in patient care are sterilized, where applicable.	**7-D-1**	No Change
7-D-2	The facility has at least one (autoclave) that uses high-pressure steam and heat, or all sterile items are single-use disposable, or the facility has contracted with an outside vendor to process instruments, if applicable. Instrument reprocessing and sterilization must follow the manufacturer's instructions for use.	**7-D-2**	No Change
7-D-3	Additional methods in use can be chemical autoclave (Chemclave©) or gas (ethylene oxide/EO) sterilizer.	**7-D-3**	No Change
7-D-5	The facility monitors the sterilization cycle's effectiveness in accordance with nationally and internationally recognized standards of practice and in conjunction with the manufacturer's instructions for use. This includes but is not limited to: · Monitoring each sterilizer load for the appropriate mechanical indicators (e.g., time, temperature, and pressure); · Using type 1 (external) and type 5 (internal) chemical indicators; · Weekly biological indicator (spore test) for each sterilizer; · Using a biological indicator for every load containing implantable items; and. · Recording evidence of sterilization assurance monitoring for every load, and any corrective action is documented.	**7-D-5**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
7-D-6	Sterile instruments and supplies are packaged according to the manufacturer's instructions for use (IFU) and sealed effectively. Self-sealing peel pouches must be folded on the crease and may only be double-pouched when the process is validated by the manufacturer.	**7-D-6**	No Change
7-D-7	Each sterilized pack is labeled with the date of sterilization and, when applicable, with the expiration date. When the facility has more than one sterilizer, labels must also identify the sterilizer used.	**7-D-7**	No Change
7-D-9	Comprehensive monitoring records that include quality control are retained for the sterilization or other disinfection process and should be reviewed and stored for a minimum of three (3) years.	**7-D-9**	No Change
7-D-10	There is a written policy and procedure for the management of a positive biological indicator.	**7-D-10**	No Change
7-D-11	Immediate use steam sterilization (IUSS) is not done on a routine or frequent practice.	**7-D-11**	No Change
7-E-1	High-level disinfection is performed upon heat-sensitive endoscopic equipment and other medical devices classified as semi-critical, but only when recommended by the manufacturer's instructions for use (IFU).	**7-E-1**	No Change
7-F-2	The entire operating room suite is cleaned and disinfected according to an established facility policy and procedure, based on industry standards, and includes, at a minimum: • Cleaning schedule • Process for cleaning between cases • Process for terminal cleaning after the last case of the day • Use of intermediate-level, medical-grade disinfectants EPA-registered as virucidal, bactericidal, tuberculocidal, and fungicidal.	**7-F-2**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
7-F-3	There is a written policy for cleaning spills, especially spills that may contain blood borne pathogens.	**7-F-3**	No Change
7-F-4	All blood and body fluid spills are cleaned using medical-grade germicides that are virucidal, bactericidal, tuberculocidal, and fungicidal. A spill kit is available and readily accessible.	**7-F-4**	No Change
7-F-5	Facility policies and procedures have been developed for use by housekeeping personnel for cleaning floors, tables, walls, ceilings, counters, furniture, and fixtures of the operating suite.	**7-F-5**	No Change
7-F-6	Instrument handling and reprocessing areas are cleaned and maintained.	**7-F-6**	No Change
8-A-5	Clinical records must be kept secure and confidential, consistent with national patient privacy regulations.	**8-A-5**	No Change
8-A-8	Clinical records for each patient must be accurate, legible, and promptly completed.	**8-A-8**	No Change
8-A-9	Clinical records must be retained the number of years as required by state and/or federal law; or a minimum of three (3) years to comply with the QUAD A three-year survey cycle.	**8-A-9**	No Change
8-A-10	Clinical records are maintained and easily accessible by the accredited facility.	**8-A-10**	No Change
8-B-1	Clinical records must contain patient identification.	**8-B-1**	No Change
8-B-2	A pre-operative surgical safety checklist must be used for each patient and noted in the patient record.	**8-B-2**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-B-7	The pre-operative clinical record includes significant medical history and a physical examination covering the organs and systems commensurate with the procedure(s) are recorded on all patients and placed in the clinical record prior to the surgical procedure.	**8-B-7**	No Change
8-B-8	Upon admission, each patient must have a pre-surgical assessment completed by a physician who will be performing the surgery or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and facility policy. The pre-surgical assessment must include documentation of any allergies to drugs and biologicals. This assessment must be placed in the patient's clinical record prior to the surgical procedure.	**8-B-8**	No Change
8-B-9	The pre-procedural operative assessment includes documentation regarding special needs such as physical impairments, disabilities, religious and/or ethnic concerns.	**8-B-9**	No Change
8-B-10	The pre-operative clinical record includes documentation of blood pressure, pulse, respiration and temperature as taken prior to the operation.	**8-B-10**	No Change
8-B-13	The pre-operative clinical record includes documentation of any allergies and abnormal drug reactions.	**8-B-13**	No Change
8-B-14	The pre-operative clinical record includes documentation of current medications.	**8-B-14**	No Change
8-B-15	The pre-operative clinical record includes documentation of medical history.	**8-B-15**	No Change
8-B-17	The pre-operative clinical record includes documentation of any previous operations.	**8-B-17**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-B-18	The pre-operative clinical record includes documentation of perioperative bleeding risk, including medical conditions and anticoagulant medication taken up to the day of the operation.	**8-B-18**	No Change
8-B-19	A written pregnancy testing policy must be in place that requires a discussion and documentation of the issue with each patient, as appropriate.	**8-B-19**	No Change
8-B-20	The pre-operative clinical record includes evidence that treating physicians or consultants are contacted in cases when warranted by the history and physical examination.	**8-B-20**	No Change
8-B-22	The pre-operative clinical record includes pre-operative diagnostic studies and laboratory procedures (entered before surgery), if performed.	**8-B-22**	No Change
8-B-24	The surgeon/proceduralist and the licensed or qualified anesthesia professional concur on the appropriateness of the procedures performed at the facility based on the medical status of the patient, age and physiological appropriateness of the patient, and qualifications of the providers and the facility resources. This concurrence must be documented in the clinical record.	**8-B-24**	No Change
8-B-27	A physician is responsible for determining the medical status of the patient and must examine the patient immediately before procedures and update the H & P.	**8-B-27**	No Change
8-B-29	An anesthesia history and physical and risk assessment (e.g. physical status anesthesia classification) are recorded in the medical/dental records.	**8-B-29**	No Change
8-B-30	An appropriate medical history and oral exam is conducted and periodically updated, which includes an assessment of the hard and soft tissues of the mouth.	**8-B-30**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-B-32	The facility must implement a policy related to patient health needs that are noted during the health assessment conducted preoperatively. The policy must include providing and documenting relevant patient education related to identified areas of need as applicable, such as: 1. Smoking cessation; 2. Importance of good nutrition; 3. Importance of exercise; and 4. Substance abuse resources in the medical record.	**8-B-32**	No Change
8-C-1	Properly executed informed consent forms are always obtained, from the patient or, if applicable, the patient's representative, which includes: · A description of the proposed surgery, including the anesthesia to be used; · The indications for the proposed surgery; · Risks and benefits; · Treatment alternatives; · The surgeon/proceduralist by name to perform surgery; · Whether physicians other than the operating practitioner will be performing important tasks related to the surgery; and · Whether, as permitted by State law, qualified medical practitioners who are not physicians will perform important parts of the surgery or administer the anesthesia, and if so, the types of tasks each type of practitioner will carry out.	**8-C-1**	No Change
8-C-3	The written informed consent provides consent for the administration of anesthesia or sedatives under the direction of the surgeon, anesthesiologist, or CRNA.	**8-C-3**	No Change
8-C-4	The patient signs a consent form if research protocols, videography, or photography are to take place.	**8-C-4**	No Change
8-E-1	Reports of: laboratory, pathology, X-ray, consultation, treating physician, and any other diagnostic tests are maintained in the clinical record and are accessible for review prior to the procedure.	**8-E-1**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-E-5	The name of the healthcare provider appears on the reports.	**8-E-5**	No Change
8-E-6	Outside clinical laboratory procedures must be performed by a licensed and accredited facility.	**8-E-6**	No Change
8-E-9	The name of the pathologist must be on all pathology reports.	**8-E-9**	No Change
8-E-10	All laboratory results must be reviewed and acknowledged by the ordering health care provider.	**8-E-10**	No Change
8-E-11	All other reports, such as pathology reports and medical clearance reports, must be reviewed and acknowledged by the ordering healthcare provider.	**8-E-11**	No Change
8-E-12	If tests/studies are done in the facility, the laboratory meets applicable licensure, standards, and state/provincial/national laws and regulations.	**8-E-12**	No Change
8-E-13	All surgical specimens sent out for pathology must be documented in a pathology specimen log, which minimally includes the date, patient's name, number and type of specimen (biopsy, swab, fluid, etc.), and physician's name.	**8-E-13**	No Change
8-F-12	The anesthesia care plan is based on allergy history.	**8-F-12**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-F-13	An anesthesia care plan is present that is based on, at a minimum, the following: · The patient's medical history; · The patient's prior anesthetic experiences; · Drug therapies; · A medical examination of the patient and assessment of any conditions that might affect the patient's pre-operative risk; · A review of the medical tests and consultations · The determination of pre-operative medications needed for anesthesia; · Providing pre-operative instructions; and, · Allergy history	**8-F-13**	No Change
8-G-2	A policy for a "Time Out" protocol is in place, practiced, and documented in the clinical record prior to every procedure. This protocol must include: · A pre-procedure verification process to include clinical records and imaging studies to be reviewed by the procedure room team. Missing information or discrepancies must be addressed at this time. - Marking the procedure site where appropriate – procedural marking should at least be indicated on a separate dental diagram. · Side/Site identification will comply with the Universal Protocol standards for dental procedures. · Documented 'Time Out' and surgical fire risk assessment immediately before starting the procedure. · A final verification and documentation that at least two (2) members of the procedure team have confirmed the correct patient, procedure, site marking(s), and, as applicable, special equipment or requirements. · As a 'fail-safe' measure, the procedure is not started until any and all questions or concerns are resolved.	**8-G-2**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-H-1	A qualified anesthesia professional shall be present in the OR/procedure room throughout the conduct of all general anesthetics, regional anesthetics, and monitored anesthesia care.	**8-H-1**	No Change
8-H-2	Clinical records must contain evidence of circulation monitored by continuous EKG during procedures. **Note**: This standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.	**8-H-2**	No Change
8-H-3	Clinical records must contain evidence of circulation monitored by blood pressure documented at least every five (5) minutes. **Note**: This standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.	**8-H-3**	No Change
8-H-4	Clinical records must contain evidence of circulation monitored by heart rate documented at least every five (5) minutes. **Note**: This standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.	**8-H-4**	No Change
8-H-5	The clinical record must contain evidence of oxygenation and circulation monitoring by continuous pulse oximetry. When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm shall be audible to the care team. **Note**: This standard does not apply if **only** topical and/or local anesthetic is used without the use of an oral premedication.	**8-H-5**	No Change
8-H-9	Clinical record must contain evidence of temperature monitoring when clinically significant changes in body temperature are expected.	**8-H-9**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-H-11	Patient monitoring during anesthesia consists of end tidal carbon dioxide (ETCO2) sampling used on all moderate sedation, deep sedation or general anesthesia. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure, or equipment.	**8-H-11**	No Change
8-H-12	When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas and documented in the clinical record. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry, or mass spectroscopy. When capnography or capnometry is utilized, the end tidal carbon dioxide alarm shall be audible to the Anesthesiologist or the anesthesia care team personnel.	**8-H-12**	No Change
8-H-13	If an anesthesia machine is used during general anesthesia, the anesthesia machine must have an alarm for low O2 concentration.	**8-H-13**	No Change
8-H-14	Patient monitoring during anesthesia will consist of assessing the patient's color. To facilitate this assessment, adequate illumination and exposure of the patient are necessary.	**8-H-14**	No Change
8-H-15	An anesthesia record is maintained in which all medications given to a patient are recorded, including date, time, amount, and route of administration.	**8-H-15**	No Change
8-H-16	An anesthesia record is maintained in which all intravenous fluids given intra-operatively are recorded.	**8-H-16**	No Change
8-H-18	An anesthesia record is maintained for each case in which IV or general anesthesia is used.	**8-H-18**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-H-19	Ventilation is noted by: Clinical signs are evaluated by continual observation during regional/sedation analgesic.	**8-H-19**	No Change
8-I-1	The operating room may be used for patient recovery if only one operation is scheduled that same day, or if the recovering patient meets all discharge criteria prior to beginning the next operation, or if there is another operating room available for the next operation.	**8-I-1**	No Change
8-I-2	Patients transferred to the PACU will be continually evaluated and monitored as needed during transport.	**8-I-2**	No Change
8-I-3	Patients transferred to the PACU are accompanied by an anesthesia professional who is knowledgeable about the patient.	**8-I-3**	No Change
8-I-4	Patient transfer to the PACU will include the transmission of a verbal report on the patient to the PACU nurse accepting care of the patient from the anesthesia professional who accompanies the patient to the PACU. The clinical record must include documentation that the verbal report was completed.	**8-I-4**	No Change
8-I-5	Patient transfer to the PACU will include the transfer of information concerning the preoperative condition of the patient, the invasive procedure, related medication, and the anesthesia course.	**8-I-5**	No Change
8-I-6	Patient transfer to the PACU will include an anesthesia professional who remains in the post-anesthesia area until the post-anesthesia care nurse accepts responsibility for the patient.	**8-I-6**	No Change
8-J-1	PACU documentation includes patient's time of arrival in the PACU, or when recovery time started if the patient is recovered in the OR.	**8-J-1**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-J-2	The patient's post-surgical condition must be assessed and documented in the clinical record by a physician, other qualified practitioner, or a registered nurse with, at a minimum, post-operative care experience in accordance with applicable State health and safety laws, standards of practice, and facility policy.	**8-J-2**	No Change
8-J-4	PACU documentation includes a record of all medications given to a patient, including date, time, dose, and route of administration.	**8-J-4**	No Change
8-J-5	PACU documentation includes a record in which all intravenous fluids given post- operatively are recorded.	**8-J-5**	No Change
8-J-6	PACU documentation includes a record of monitoring and assessment of: - post-operative vital signs, including temperature, heart rate, respirations, and blood pressure; - mental status; - airway patency, ventilation, and oxygen saturation; and, - pain, nausea and vomiting, hydration, drainage, and bleeding, as applicable. Patient status is recorded until the patient is discharged from the facility.	**8-J-6**	No Change
8-J-9	Post-operative progress notes are recorded.	**8-J-9**	No Change
8-J-10	There is a procedure/operative report completed by the surgeon/proceduralist, which includes procedure technique and findings.	**8-J-10**	No Change
8-J-11	A written, accurate post-anesthetic care report is maintained.	**8-J-11**	No Change
8-K-4	Approved and standardized discharge criteria are used and recorded (e.g. Aldrete score).	**8-K-4**	No Change
8-K-6	A qualified and credentialed individual determines that the patient meets discharge criteria based upon input from the PACU staff. That individual’s name must be noted on the record, signed by that individual with the time of discharge.	**8-K-6**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-K-8	Written discharge instructions, including procedures for emergency situations, are given to the responsible adult who is responsible for the patient's care and transportation following a procedure or the patient has received discharge instructions prior to receiving sedation/anesthesia. A signed copy of the instructions is maintained in the patient's chart. The standard does not apply if **only** topical and/or local anesthetic is used without the use of an oral premedication.	**8-K-8**	No Change
8-K-10	Patients receiving anesthetic agents other than topical or local anesthesia must be supervised in the immediate post-discharge period by a responsible adult for at least 12 to 24 hours, depending on the procedure and the anesthesia used.	**8-K-10**	No Change
8-K-14	The patient is transported in a suitable vehicle with a responsible adult.	**8-K-14**	No Change
8-K-15	Patients receiving only local anesthesia without sedation may transport themselves.	**8-K-15**	No Change
8-K-16	The facility must have a policy for discharge from the recovery area with approved and standardized discharge criteria.	**8-K-16**	No Change
8-L-1	A separate dated operative log of all cases is maintained, either in a sequentially numbered, bound journal from which pages may not be removed, or in a tamper-proof, secured computer record consistent with state and federal law. This log must be kept in the facility.	**8-L-1**	No Change
8-L-3	An operative log must include the date of procedure.	**8-L-3**	No Change
8-L-4	An operative log must include the patient's name and date of birth or other identification number.	**8-L-4**	No Change
8-L-5	An operative log must include record of surgery(ies) and other invasive procedures to be conducted during the case.	**8-L-5**	No Change
8-L-6	An operative log must include the surgeon/proceduralist's name.	**8-L-6**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
8-L-7	An operative log must include a record of the type of anesthesia used.	**8-L-7**	No Change
8-L-8	An operative log must include the name of person(s) administering anesthesia.	**8-L-8**	No Change
8-L-9	An operative log must include the name of person(s) assisting physician (e.g. additional physician, registered nurse - circulating or scrubbed, scrub tech, physician's assistant, dental assistant, anesthesia assistant, or other qualified personnel).	**8-L-9**	No Change
9-A-1	The facility has a governing body with full legal responsibility for determining, implementing, and monitoring policies governing facility's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that the facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan.	**9-A-1**	No Change
9-A-5	The governing body/facility leadership has defined the scope and intended use of the facility, as well as the appropriate ancillary support needed for the intended surgical procedures.	**9-A-5**	No Change
9-A-7	The governing body/facility leadership: Is regulated by a governing document that has the consent of each member of the body.	**9-A-7**	No Change
9-A-10	The governing body/facility leadership: Sets policy on how individual staff deal with each other and external parties.	**9-A-10**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
9-A-11	The governing body/facility leadership: Sets policy on staff's role in properly dealing with patients.	**9-A-11**	No Change
9-A-12	The governing body/facility leadership is responsible for the operation and performance of the facility including: Determining the mission and goals of the facility, including the types of services provided and for determining, implementing, and monitoring policies governing the facility's total operation.	**9-A-12**	No Change
9-A-14	The governing body/facility leadership is responsible for the operation and performance of the facility including: Adopting policies and procedures for the orderly conduct of the facility and for ensuring procedures are provided in a safe and effective manner.	**9-A-14**	No Change
9-A-16	The governing body/facility leadership is responsible for the operation and performance of the facility including: Approving all arrangements for ancillary medical care delivered in the facility, including laboratory, radiological, pathologic, and anesthesia services.	**9-A-16**	No Change
9-A-17	The governing body/facility leadership must ensure that all outside services are provided in a safe and effective manner.	**9-A-17**	No Change
9-A-20	The facility's policies and services are developed with the advice of a group of professional personnel that includes one or more physicians / dentists, one or more physician assistants / nurse practitioners / mid-level clinical personnel, and at least one community member who is not a member of the clinic staff.	**9-A-20**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
9-A-21	The policies, procedures, and processes adopted by the governing body/facility leadership are reviewed and revised at least annually and in accordance with any implementation timelines adopted by the governing body/facility leadership.	**9-A-21**	No Change
9-A-22	The governing body/facility leadership must document the content of any policies, procedures, or processes implemented in key functional areas of the facility. The governing body/facility leadership must document its approval of the policies, procedures, or processes.	**9-A-22**	No Change
9-A-23	The facility's leadership reviews and updates strategic objectives annually.	**9-A-23**	No Change
9-A-26	The governing body/facility leadership is responsible for overseeing the program of risk management.	**9-A-26**	No Change
9-A-27	The governing body/facility leadership will designate a person or committee responsible for implementation and ongoing management of the risk management program.	**9-A-27**	No Change
9-B-3	The facility must have an effective procedure for the immediate transfer, to a hospital, of patients requiring emergency medical care beyond the capabilities of the facility.	**9-B-3**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
9-C-3	If the facility discharges patients to a recovery hotel following full recovery from anesthesia the facility has in place a protocol that identifies that the hotel being used for extended recovery of the patient: -Is less than thirty (30) minutes from a hospital where the physician has admitting privileges. -Has a trained registered nurse certified in BLS and ACLS, and a second BLS certified staff member on duty at all times there is a patient present in the hotel. -Has the ability to meet all special diet provisions of the patient. -Has a defibrillator or AED equipment. -Has first aid equipment. -Has an agreement for transportation to the hospital in an emergency as well as how an admission would be handled.	**9-C-3**	No Change
9-C-4	If overnight stays are permitted, the facility is in compliance with all applicable local, state/provincial, and national laws and regulations.	**9-C-4**	No Change
10-A-2	The governing body/facility leadership must identify the specific committee or individual(s) responsible for the development, implementation, and oversight of the quality assurance and risk management program.	**10-A-2**	No Change
10-B-2	The facility has a written quality improvement program implemented which includes surveys or projects to: - Monitor and evaluate patient care - Evaluate methods to improve patient care - Identify and correct deficiencies within the facility - Alert the facility's Quality Improvement Program to identify, track, trend, evaluate and resolve problems.	**10-B-2**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
10-B-6	The facility has a written quality improvement program that includes documentation of Peer Review meetings for the prior three (3) years, which must be available for the surveyor. Facilities with a monthly case volume of 50 or fewer cases must conduct peer review meetings no less than twice per year. Facilities with a monthly case volume in excess of 50 cases must conduct peer review meetings no less than quarterly.	**10-B-6**	No Change
10-B-19	The governing body must ensure that the QAPI program is defined, implemented, and maintained by the ASC.	**10-B-19**	No Change
10-B-24	The quality improvement program will demonstrate measurable improvement in patient health outcomes by focusing on high risk, high volume, and problem-prone areas.	**10-B-24**	No Change
10-B-25	The quality improvement program will improve patient safety by using quality indicators or performance measure(s) by focusing on incidence, prevalence and severity of problems identified.	**10-B-25**	No Change
10-B-26	The quality improvement program will implement a process to identify and reduce medical errors.	**10-B-26**	No Change
10-B-27	The quality improvement program should include patient/service user satisfaction assessment and other performance measures.	**10-B-27**	No Change
10-B-28	The number and scope of distinct quality improvement projects conducted annually must reflect the scope and complexity of the facility's services and operations.	**10-B-28**	No Change
10-B-29	Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.	**10-B-29**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
10-C-1	As part of an ongoing risk management program, the facility must conduct a risk assessment of its operational activities at least annually. The assessment must study the risks presented to patients and staff by medication management, fall hazards, infection prevention and control, equipment safety, patient risk resulting from long term conditions, and nutrition if any food or beverage services are available to patients. The results of the Risk Assessment must be prioritized for risk mitigation, risk management, and QA/PI (Quality Assessment/Quality Improvement) projects.	**10-C-1**	No Change
10-C-2	The facility must develop and maintain a program of risk management, appropriate to the organization. This may be carried out in conjunction with the Quality Assessment/Quality Improvement program (QA/QP).	**10-C-2**	No Change
10-C-3	Near-miss events must be reported, analyzed, and tracked. Measures must be implemented to prevent the event from reoccurring.	**10-C-3**	No Change
10-C-4	A definition of an adverse incident must be documented in policy and procedure, including near miss events.	**10-C-4**	No Change
10-C-5	The facility has processes that report and investigate safety incidents, complaints, adverse events and near misses for patients and staff on a defined basis. The results of these investigations of adverse events are reported in the Quality Improvement/Quality Assessment meetings.	**10-C-5**	No Change
10-C-6	Adverse events must be tracked and trended on a defined basis.	**10-C-6**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
10-C-7	All staff must be educated in risk management activities on commencement of employment and annually thereafter, and when there is an identified need.	**10-C-7**	No Change
10-C-8	The facility should have a process to monitor, track and trend patient satisfaction (e.g. surveys or assessments) and implement actions to improve patient satisfaction as necessary.	**10-C-8**	No Change
10-C-9	The facility must conduct an ongoing review of patient complaints and grievances, including defined response times.	**10-C-9**	No Change
10-C-10	A system is in place for leadership to receive and resolve in a timely manner any ethical dilemmas such as decisions not to treat, to discontinue treatment, or treat against the patient's wishes.	**10-C-10**	No Change
10-C-11	A policy should document the competencies of staff handling specialized equipment.	**10-C-11**	No Change
10-C-12	A system is in effect for documenting, reporting, and follow-up on any patient and family complaints and grievances. Complaints and grievances must be formally addressed at Quality Improvement meetings. The complaints must be addressed by appropriate staff with the patient/family even if no immediate resolution is available.	**10-C-12**	No Change
10-C-13	The facility must have a written policy to make their complaint process publicly available, via posting within the facility, on the website, by distribution to patients, or through other means that eliminates barriers to patient awareness of such process.	**10-C-13**	No Change
10-D-4	Peer review and the associated peer review meetings include at a minimum the same random cases and adverse events submitted to the Patient Safety Data Reporting since the preceding peer review meeting.	**10-D-4**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
10-D-12	To be compliant, a copy of a Business Agreement must be signed by each physician working outside the facility participating in peer review, and a copy must be retained on file in the facility.	**10-D-12**	No Change
10-D-13	If peer review sources external to the facility are used to evaluate the delivery of medical care, an agreement to conduct peer review is so written as to waive the confidentiality of the clinical records.	**10-D-13**	No Change
10-D-14	Peer review may be done by a recognized peer review organization or a physician, podiatrist, or oral and maxillofacial surgeon other than the operating surgeon.	**10-D-14**	No Change
10-D-15	Peer review is conducted and contains, at a minimum, the following review of each clinical record subject to peer review: · Adequacy and legibility of history and physical exam · Adequacy of the surgical consent · Adequacy of appropriate laboratory, EKG, and radiographic reports · Adequacy of a written operative report · Adequacy of anesthesia and recovery records (with IV sedation or general anesthesia) · Adequacy of instructions for post-operative care · Documentation of the discussion of any complications	**10-D-15**	No Change
11-A-2	All personnel are provided with a code of ethics or behavior that governs their conduct when communicating with fellow staff or the public.	**11-A-2**	No Change
11-B-7	The Facility Director must be actively involved in the direction and management of the facility.	**11-B-7**	No Change
11-B-8	The Facility Director is responsible for establishing and enforcing policies that protect patients. The Facility Director monitors medical and facility staff members for compliance with this policy.	**11-B-8**	The Facility Director is responsible for establishing and enforcing policies that protect patients. The Facility Director monitors medical and facility staff members for compliance with this policy.

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
11-B-10	The Medical Director must be involved in planning and budgeting for the facility's range of services.	**11-B-10**	No Change
11-B-11	The Medical Director signs an Attestation that the direction and management of the facility is under his/her management.	**11-B-11**	No Change
11-B-12	The Medical Director must ensure that the facility meets all local, regional and country regulations including those relating to employment health and safety, building, environmental protection, reportable diseases, and waste management.	**11-B-12**	No Change
11-B-13	The Medical Director shall document the strategic plan for the facility.	**11-B-13**	No Change
11-B-14	The Medical Director should document the staffing levels and what qualifications are required for each position based on the services offered at the facility.	**11-B-14**	No Change
11-B-15	The Medical Director must annually review credentialing and performance for all practitioners, staff and volunteers annually, including contract employees.	**11-B-15**	No Change
11-B-16	The Medical Director should review and maintain a record of the performance of all practitioners, staff and volunteers at least annually, including contract employees. This should include a record of corrective actions and educational activities.	**11-B-16**	No Change
11-B-17	Each personnel file has evidence of general facility-specific orientation and training related to the individual's job duties.	**11-B-17**	No Change
11-C-8	Members of the medical staff, including both directly employed and contract medical staff, must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The facility grants privileges in accordance with recommendations from qualified medical/dental personnel.	**11-C-8**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
11-C-18	Dental procedures are performed only by dental health professionals who have been granted privileges to perform those procedures by the governing body of the organization.	**11-C-18**	No Change
11-C-19	Personnel assisting in the provision of dental services are appropriately qualified and available in sufficient numbers for the dental procedures provided.	**11-C-19**	No Change
11-D-3	An anesthesia professional must be responsible for the administration of dissociative anesthesia with propofol, spinal or epidural blocks, or general anesthesia as well as the monitoring of all life support systems.	**11-D-3**	No Change
11-D-6	If responsible for supervising anesthesia or providing anesthesia, the qualified physician must be present in the operating suite throughout the administration of anesthesia.	**11-D-6**	No Change
11-D-19	Administration of general anesthesia or deep sedation requires at least three individuals, each appropriately trained: the operating dentist, a person responsible for monitoring the patient, and a person to assist the operating dentist.	**11-D-19**	No Change
11-D-20	Administration of conscious sedation requires at least 2 individuals: a dentist and an auxiliary person trained in basic life support (BLS).	**11-D-20**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
11-D-21	The qualified individual responsible for supervising the administration of anesthesia must have knowledge of anesthetics and resuscitative techniques appropriate for the type of anesthesia being administered.	**11-D-21**	No Change
11-E-1	When a patient is present in the facility to undergo a procedure under a higher level of anesthesia than meets the QUAD A definition of Class A, there is a licensed registered nurse, physician other than the operating surgeon, or physician's assistant designated as the person responsible for patient care in all areas of the facility (i.e. operating room, operating suite, and all patient care areas), in accordance with state/local law.	**11-E-1**	No Change
11-E-7	A dentist employing or using general anesthesia or deep sedation shall maintain a properly equipped facility for the administration of general anesthesia, staffed with supervised assistant/dental hygienist personnel capable of reasonably handling procedures, problems, and emergencies.	**11-E-7**	No Change
11-G-1	There is a written policy that whenever parenteral sedation, dissociative drugs, epidural, spinal or general anesthesia is administered, a physician is immediately available until the patient is discharged from the PACU.	**11-G-1**	No Change
11-G-5	A minimum of one ACLS, and when appropriate PALS as well, certified staff member must be present in the facility until all patients recovering from anesthesia have met the facility's discharge criteria for discharge from the facility.	**11-G-5**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
11-G-7	All recovering patients must remain under direct observation and supervision by appropriate medical personnel who are trained in the assessment of patient vital signs, post-operative care, and safety matters until discharged from monitored patient care.	**11-G-7**	No Change
11-H-2	The facility maintains a manual outlining personnel policies that is reviewed annually and updated as needed.	**11-H-2**	No Change
11-H-4	The facility maintains a personnel file for all clinical and administrative employees, including direct and contract employees.	**11-H-4**	No Change
11-H-5	Each personnel record contains any health problems of the individual which may be hazardous to the employee, other employees or patients, and a plan of action or special precautions delineated as needed. To be reviewed and updated annually.	**11-H-5**	No Change
11-H-6	Each personnel record contains resume of training and experience.	**11-H-6**	No Change
11-H-8	Each personnel record contains date of employment.	**11-H-8**	No Change
11-H-9	Each personnel record contains description of duties.	**11-H-9**	No Change
11-H-10	Each personnel record contains on-going records of inoculations or refusals in accordance with local, state/provincial or federal/national requirements.	**11-H-10**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
11-H-12	Each personnel record contains current certification or license if required by the state, province, region, or country.	**11-H-12**	No Change
11-I-1	Each personnel record has evidence of annual hazard safety training.	**11-I-1**	No Change
11-I-2	Each personnel record has evidence of annual blood borne pathogen training.	**11-I-2**	No Change
11-I-3	Each personnel record has evidence of annual standard precautions training.	**11-I-3**	No Change
11-I-4	Each personnel record has evidence of other annual safety training including operative fire safety training and structure fire safety, including operation of a fire extinguisher.	**11-I-4**	No Change
11-I-8	Anesthesia professionals, both directly employed and contract anesthesia professionals, must be trained and knowledgeable with the facility's emergency protocol for cardio-pulmonary emergencies, safe and timely transfer of a patient to an alternative care facility when extended emergency care is needed, and other internal and external disasters.	**11-I-8**	No Change
11-I-10	The operating room personnel are familiar with the equipment and procedures utilized in treating emergencies, as discussed in standards section 5-C: Emergency Protocols.	**11-I-10**	No Change
11-I-13	Where staff cannot demonstrate competency, training, or experience in the safe operation of equipment, the facility provides and documents training or arranges training through an external provider.	**11-I-13**	No Change
11-I-15	Operating room personnel have adequate knowledge to treat malignant hyperthermia, cardiopulmonary resuscitation, and anaphylactic emergencies.	**11-I-15**	No Change

INTERNATIONAL DENTAL STANDARDS CHANGE REPORT

QUAD A Previous Version 5.0		Revised Standards - Version 5.1 Effective February 2, 2026	
Standard	**Language**	**Standard**	**Language**
11-I-16	Health care professionals providing dental, surgical, and anesthesia services are prepared to respond to medical emergencies that may occur in conjunction with the services provided.	**11-I-16**	No Change