WASHINGTON
Medical
Commission

Licensing. Accountability. Leadership.

Rules Workshop

Use of Nitrous Oxide in Office-Based Surgery Settings

January 27, 2025 – 1:30 pm to 3:30 pm

Teams Webinar

Rules Workshop Agenda

WASHINGTON **Medical Commission**
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Virtual via Teams Webinar

Commissioners and staff will attend this workshop virtually.

In-person at Department of Health, TC2 Room 166, 111 Israel Rd. SE, Tumwater, Washington

Monday, January 27, 2025 – 1:30 pm

Use of Nitrous Oxide in Office-Based Surgical Settings

Register for this meeting at: Rules Workshop

Agenda	Page(s)
1. Housekeeping	
2. Attendance verification	
3. Open workshop	
4. Draft language discussion—New section WAC 246-919-603	3-8
5. Written comments discussion a. Washington State Medical Association (WSMA) comment	 9
6. Panel vote	
7. Next steps	
8. Close workshop	
Presentation	10-18

The revision to WAC 246-919-601 Safe and effective analgesia and anesthesia administration in office-based surgical settings on page 22 was approved at the October 7, 2024, workshop. It is included in this packet as informational.

Recordings of Previous Workshops	
July 31, 2024	10/7/2024

[New Section]

WAC 246-919-603 Use of nitrous oxide in office-based settings. (1) The purpose of this rule is to promote and establish consistent standards, continuing competency, and promote patient safety. The commission establishes the following rule for physicians licensed under this chapter who perform surgical procedures and use nitrous oxide in office-based settings.

(2) The use of nitrous oxide is exempt from WAC 246-919-601 requirements if the following conditions are met:

(a) Nitrous oxide is administered at a concentration of 50 percent or less;

(b) Nitrous oxide is used without another inhaled anesthetic, sedative, or opioid drug; and

(c) The following safeguards are in place:

(i) The physician performing the procedure must demonstrate competence by completing a continuing medical education course in nitrous oxide administration;

(ii) At least one healthcare practitioner must be present who is certified in an advanced resuscitative technique such as, but not limited to, the following:

(A) Basic life support (BLS);

(B) Pediatric advanced life support (PALS); or

(C) Advanced pediatric life support (APLS).

(iii) The physician must be capable of resuscitating a patient from deeper sedation levels and ensure the patient's vital signs are monitored;

(iv) The physician performing the procedure must not administer nitrous oxide or monitor the patient;

(v) The licensed provider administering the nitrous oxide must be different from the physician performing the procedure.

Commented [DB1]: Revised after the October 7, 2024 workshop.

(vi) The facility must have a documented plan for transferring patients to a hospital in case of complications, including arrangements for emergency medical services and appropriate escort of the patient to the hospital;

(vii) The physician must maintain legible, complete, comprehensive, and accurate medical records including the following:

(A) Identity of the patient;

(B) History and physical, diagnosis and plan;

(C) Appropriate lab, X-ray, or other diagnostic reports;

(D) Documentation of nitrous oxide administered or dispensed; and

(E) Documentation of vital signs during the nitrous oxide sedation, including respiratory rate, oxygen saturation, heart rate, and blood pressure.

(viii) The following equipment must be available and include:

(A) Suction equipment capable of aspirating gastric contents from the mouth and pharynx;

(B) Portable oxygen delivery system including full face masks and a bag-valve-mask combination with appropriate connectors capable of delivery positive pressure, oxygen enriched ventilation to the patient;

(C) Blood pressure cuff or sphygmomanometer of appropriate size; and

(D) Stethoscope or equivalent monitoring device.

(ix) Nitrous oxide must not be administered to any patient under three years of age. For pediatric patients older than three years, a discussion with the parent or guardian is required to address the specific risks associated with nitrous oxide use in cases where the patient:

(A) Is younger than six years old;

(B) has special needs; or

(C) has airway abnormalities.

This discussion must include reasoning why the pediatric patient can safely receive nitrous oxide in an outpatient environment and any alternatives.

Commented [DB2]: Significant revision to this subsection. Includes excluding the use of N2O on patients younger than 3.

Although no strict minimum age is universally mandated, many healthcare providers avoid using N2O in children under 3 years old due to challenges in cooperation and safety.

(x) Excess nitrous oxide must be removed from the procedure room to protect staff via a scavenging system;

(xi) Equipment used for monitoring patients must be calibrated or performance verified according to manufacturer's instructions; and

(xii) Nitrous oxide must be stored securely and accessible only by authorized individuals.

(3) The physician shall ensure they assess patient responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met, except when their prior baseline is below the noted criteria:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable. Vital signs are not required when a pediatric patient is uncooperative or the emotional condition is such that obtaining vital signs is not possible.

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning as appropriate to age and preoperative psychological status;

(d) The patient can sit up unassisted;

(e) The patient can walk with minimal assistance;

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

Commented [DB3]: (3) has been revised since the last workshop on October 7, 2024.

From: Billie Dickinson
To: Boyd, Amelia (WMC)
Cc: jeb; Susanna Barnett
Subject: FW: Rules Workshop: Establishing the Use of Nitrous Oxide in Office-Based Surgical Settings
Date: Tuesday, December 3, 2024 3:15:33 PM
Attachments: image001.png

External Email

Hi Amelia,

Hope you are well and had a nice holiday weekend. Consistent with our previous comments on this rulemaking, the WSMA is supportive of the rules as drafted. The language will ensure patient safety by applying consistent standards for competency and the use of nitrous oxide in office-based settings. We've really appreciated the opportunity to work with WMC commissioners and staff on this rulemaking, as well as revisions to the interpretive statement that previously governed this area of practice.

Please let me know if you have any questions!

Thanks,
Billie

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From: Washington Medical Commission <WAMedicalCommission@public.govdelivery.com>
Sent: Wednesday, October 23, 2024 11:47 AM
To: Billie Dickinson <billie@wsma.org>
Subject: Rules Workshop: Establishing the Use of Nitrous Oxide in Office-Based Surgical Settings

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Use of Nitrous Oxide in Office-Based Surgery Settings

Rules Workshop

January 27, 2025

Agenda

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Attendance Verification

Draft language

Revisions

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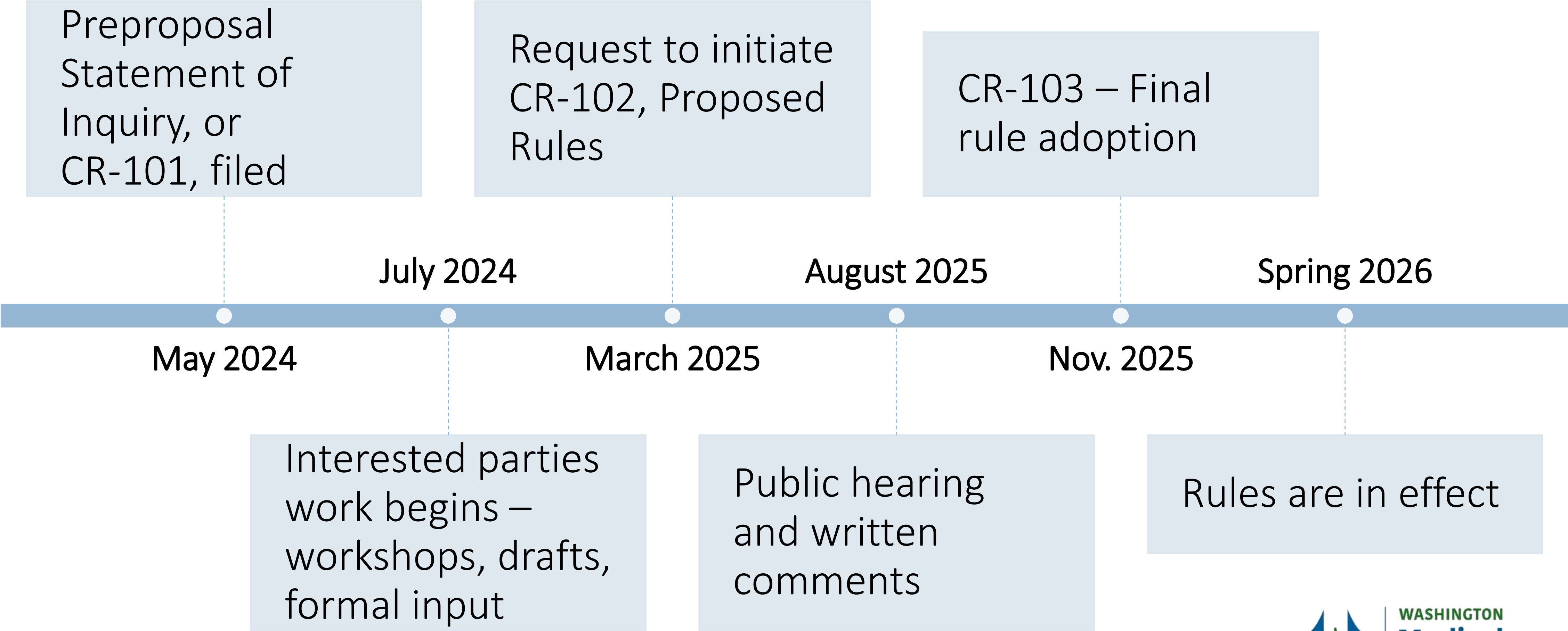
Written Comments

Panel Vote

Proposed Rule Development Timeline



Next Steps

Initiate CR-102

Hearing 8/22/25

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Thank you!

Post your comments to:
Establishing the use of nitrous oxide in office-based surgical settings | Washington Medical Commission

Or send your written comments to:
medical.rules@wmc.wa.gov

WAC 246-919-601 Safe and effective analgesia and anesthesia administration in office-based surgical settings.

(1) Purpose. The purpose of this rule is to promote and establish consistent standards, continuing competency, and to promote patient safety. The commission establishes the following rule for physicians licensed under this chapter who perform surgical procedures and use anesthesia, analgesia or sedation in office-based settings.

(2) Definitions. The following terms used in this subsection apply throughout this section unless the context clearly indicates otherwise:

(a) "Deep sedation" or "analgesia" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(b) "General anesthesia" means a state of unconsciousness intentionally produced by anesthetic agents, with absence of pain sensation over the entire body, in which the patient is without protective reflexes and is unable to maintain an airway, and cardiovascular function may be impaired. Sedation that unintentionally progresses to the point at which the patient is without protective reflexes and is unable to maintain an airway is not considered general anesthesia.

(c) "Local infiltration" means the process of infusing a local anesthetic agent into the skin and other tissues to allow painless wound irrigation, exploration and repair, and other procedures, including procedures such as retrobulbar or periorbital ocular blocks only when performed by a board eligible or board certified ophthalmologist. It does not include procedures in which local anesthesia is injected into areas of the body other than skin or muscle where significant cardiovascular or respiratory complications may result.

(d) "Major conduction anesthesia" means the administration of a drug or combination of drugs to interrupt nerve impulses without loss of consciousness, such as epidural, caudal, or

spinal anesthesia, lumbar or brachial plexus blocks, and intravenous regional anesthesia. Major conduction anesthesia does not include isolated blockade of small peripheral nerves, such as digital nerves.

(e) "Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Minimal sedation is limited to oral, intranasal, or intramuscular medications.

(f) "Moderate sedation" or "analgesia" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(g) "Office-based surgery" means any surgery or invasive medical procedure requiring analgesia or sedation, including, but not limited to, local infiltration for tumescent liposuction, performed in a location other than a hospital or hospital-associated surgical center licensed under chapter 70.41

RCW, or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(3) Exemptions. This rule does not apply to physicians when:

(a) Performing surgery and medical procedures that require only minimal sedation (anxiolysis), or infiltration of local anesthetic around peripheral nerves. Infiltration around peripheral nerves does not include infiltration of local anesthetic agents in an amount that exceeds the manufacturer's published recommendations.

(b) Using nitrous oxide under the requirements in WAC 246-919-603.

(c) Performing surgery in a hospital or hospital-associated surgical center licensed under chapter 70.41 RCW, or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(d~~e~~) Performing surgery utilizing or administering general anesthesia. Facilities in which physicians administer general anesthesia or perform procedures in which general anesthesia is a planned event are regulated by rules related to hospital or hospital-associated surgical center licensed under chapter 70.41

RCW, an ambulatory surgical facility licensed under chapter 70.230 RCW, or a dental office under WAC 246-919-602.

(e~~d~~) Administering deep sedation or general anesthesia to a patient in a dental office under WAC 246-919-602.

(f~~e~~) Performing oral and maxillofacial surgery, and the physician:

(i) Is licensed both as a physician under chapter 18.71 RCW and as a dentist under chapter 18.32 RCW;

(ii) Complies with dental quality assurance commission regulations;

(iii) Holds a valid:

(A) Moderate sedation permit; or

(B) Moderate sedation with parenteral agents permit; or

(C) General anesthesia and deep sedation permit; and

(iv) Practices within the scope of their specialty.

(4) Application of rule.

This rule applies to physicians practicing independently or in a group setting who perform office-based surgery employing one or more of the following levels of sedation or anesthesia:

(a) Moderate sedation or analgesia; or

(b) Deep sedation or analgesia; or

(c) Major conduction anesthesia.

(5) Accreditation or certification.

(a) A physician who performs a procedure under this rule must ensure that the procedure is performed in a facility that is appropriately equipped and maintained to ensure patient safety through accreditation or certification and in good standing from an accrediting entity approved by the commission.

(b) The commission may approve an accrediting entity that demonstrates to the satisfaction of the commission that it has all of the following:

(i) Standards pertaining to patient care, recordkeeping, equipment, personnel, facilities and other related matters that are in accordance with acceptable and prevailing standards of care as determined by the commission;

(ii) Processes that assure a fair and timely review and decision on any applications for accreditation or renewals thereof;

(iii) Processes that assure a fair and timely review and resolution of any complaints received concerning accredited or certified facilities; and

(iv) Resources sufficient to allow the accrediting entity to fulfill its duties in a timely manner.

(c) A physician may perform procedures under this rule in a facility that is not accredited or certified, provided that the facility has submitted an application for accreditation by a commission-approved accrediting entity, and that the facility is appropriately equipped and maintained to ensure patient safety such that the facility meets the accreditation standards. If the facility is not accredited or certified within one year of the physician's performance of the first procedure under this rule, the physician must cease performing procedures under this rule until the facility is accredited or certified.

(d) If a facility loses its accreditation or certification and is no longer accredited or certified by at least one commission-approved entity, the physician shall immediately cease performing procedures under this rule in that facility.

(6) Competency. When an anesthesiologist or certified registered nurse anesthetist is not present, the physician performing office-based surgery and using a form of sedation defined in subsection (4) of this section must be competent and qualified both to perform the operative procedure and to oversee the administration of intravenous sedation and analgesia.

(7) Qualifications for administration of sedation and analgesia may include:

(a) Completion of a continuing medical education course in conscious sedation;

(b) Relevant training in a residency training program; or

(c) Having privileges for conscious sedation granted by a hospital medical staff.

(8) At least one licensed health care practitioner currently certified in advanced resuscitative techniques appropriate for the patient age group must be present or immediately available with age-size-appropriate resuscitative equipment throughout the procedure and until the patient has met the criteria for discharge from the facility. Certification in advanced resuscitative techniques includes, but is not limited

to, advanced cardiac life support (ACLS), pediatric advanced life support (PALS), or advanced pediatric life support (APLS).

(9) Sedation assessment and management.

Sedation is a continuum. Depending on the patient's response to drugs, the drugs administered, and the dose and timing of drug administration, it is possible that a deeper level of sedation will be produced than initially intended.

(a) If an anesthesiologist or certified registered nurse anesthetist is not present, a physician intending to produce a given level of sedation should be able to "rescue" a patient who enters a deeper level of sedation than intended.

(b) If a patient enters into a deeper level of sedation than planned, the physician must return the patient to the lighter level of sedation as quickly as possible, while closely monitoring the patient to ensure the airway is patent, the patient is breathing, and that oxygenation, heart rate and blood pressure are within acceptable values. A physician who returns a patient to a lighter level of sedation in accordance with this subsection (c) does not violate subsection (10) of this section.

(10) Separation of surgical and monitoring functions.

(a) The physician performing the surgical procedure must not administer the intravenous sedation, or monitor the patient.

(b) The licensed health care practitioner, designated by the physician to administer intravenous medications and monitor the patient who is under moderate sedation, may assist the operating physician with minor, interruptible tasks of short duration once the patient's level of sedation and vital signs have been stabilized, provided that adequate monitoring of the patient's condition is maintained. The licensed health care practitioner who administers intravenous medications and monitors a patient under deep sedation or analgesia must not perform or assist in the surgical procedure.

(11) Emergency care and transfer protocols. A physician performing office-based surgery must ensure that in the event of a complication or emergency:

(a) All office personnel are familiar with a written and documented plan to timely and safely transfer patients to an appropriate hospital.

(b) The plan must include arrangements for emergency medical services and appropriate escort of the patient to the hospital.

(12) Medical record. The physician performing office-based surgery must maintain a legible, complete, comprehensive, and accurate medical record for each patient.

(a) The medical record must include all of the following:

(i) Identity of the patient;

(ii) History and physical, diagnosis and plan;

(iii) Appropriate lab, X-ray or other diagnostic reports;

(iv) Appropriate preanesthesia evaluation;

(v) Narrative description of procedure;

(vi) Pathology reports, if relevant;

(vii) Documentation of which, if any, tissues and other specimens have been submitted for histopathologic diagnosis;

(viii) Provision for continuity of postoperative care; and

(ix) Documentation of the outcome and the follow-up plan.

(b) When moderate or deep sedation, or major conduction anesthesia is used, the patient medical record must include a separate anesthesia record that documents:

(i) The type of sedation or anesthesia used;

(ii) Name, dose, and time of administration of drugs;

(iii) Documentation at regular intervals of information obtained from the intraoperative and postoperative monitoring;

(iv) Fluids administered during the procedure;

(v) Patient weight;

(vi) Level of consciousness;

(vii) Estimated blood loss;

(viii) Duration of procedure; and

(ix) Any complication or unusual events related to the procedure or sedation/anesthesia.

[Statutory Authority: RCW 18.71.017 and 18.130.050. WSR 20-22-003, § 246-919-601, filed 10/21/20, effective 11/21/20. Statutory Authority: RCW 18.71.017. WSR 17-18-032, § 246-919-601, filed 8/28/17, effective 9/28/17. Statutory Authority: RCW 18.71.017 and 18.130.050(4). WSR 10-16-109, § 246-919-601, filed 8/2/10, effective 9/2/10.]