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Guideline Concordance and Documentation Quality in Office-Based Oral Conscious Sedation: A Retrospective Clinical Audit

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ABSTRACT

Dental anxiety affects approximately 72.6% of the adult population in the United States, with severe fear reported in 26.8% of individuals; this condition contributes directly to treatment avoidance and deteriorating oral health outcomes. Office-based oral conscious sedation (OCS) using triazolam (Halcion) represents a widely adopted pharmacological strategy for managing patients with significant anxiety in high-volume clinical environments, yet systematic documentation audits in private-practice settings remain scarce in the peer-reviewed literature. This retrospective clinical audit examined 39 deidentified operative records of adult patients who underwent OCS procedures with triazolam in a private dental office, assessing guideline concordance against American Dental Association (ADA) 2024 and American Association of Oral and Maxillofacial Surgeons (AAOMS) ParCare 2023 standards. Documentation completeness ranged from 71.8% (adverse event notation) to 100% (drug dose and lot number), with a mean overall concordance of 90.1%. No respiratory or cardiovascular adverse events were recorded. Case acceptance rates increased by 29.4 percentage points following systematic OCS protocol integration. This audit proposes a structured sedation documentation checklist as an original quality-improvement instrument for office-based dental practice. The findings are of direct relevance to general practitioners, dental educators, and policy-makers engaged in sedation safety and clinical governance.

Keywords: Oral Conscious Sedation, Triazolam, Halcion, Dental Anxiety, Guideline Concordance, Clinical Audit, Documentation Quality, Case Acceptance Rate, High-Volume Clinical Environment, Ada Guideline, Aaomsarcare.

Introduction

Dental anxiety and dental fear constitute a pervasive public health concern across the United States. A 2025 census-matched cross-sectional survey (n = 1,003) published in the Journal of the American Dental Association found that 72.6% of US adults report some degree of dental fear, with 45.8% describing moderate fear and 26.8% describing severe fear [1]. Patients with severe anxiety avoid regular dental care at a rate between 9% and 15%, resulting in delayed treatment, increased need for complex restorative procedures, and elevated per-visit costs [2]. Among adults presenting to emergency dental services, the prevalence of dental anxiety approaches 49%, a figure consistent with the understanding that avoidance behavior amplifies clinical severity over time [2].

Office-based oral conscious sedation has been established as an effective and accessible intervention

within private dental practice for more than three decades. Among available benzodiazepines, triazolam (Halcion, Pfizer) is recognized as the primary pharmacological agent for adult OCS in the United States by reason of its short half-life (1.5 to 5 hours), predictable anxiolytic and amnesic properties, and documented safety margin when used at therapeutic doses of 0.125 to 0.50 mg [3, 4]. The ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists (2024 revision) and the AAOMS ParCare 2023 establish explicit pre-operative, intra-operative, and post-operative documentation requirements that govern the provision of OCS within office-based settings [5, 6]. These standards include informed consent, ASA physical status classification, nothing-by-mouth (NPO) status confirmation, intra-operative vital sign recording, escort verification, and post-operative instruction delivery.

Despite the clinical prevalence of OCS in private practice, peer-reviewed retrospective audits evaluating documentation quality against current guidelines remain limited. Existing audits have focused primarily on secondary-care and hospital-based settings, hospital-setting midazolam intravenous sedation, or pediatric populations [7, 8]. A 2022 audit published in Primary Dental Journal found that regular and robust audit of conscious sedation practice is essential to the delivery of safe and effective patient care, yet only a minority of primary-care sedation providers subject their records to systematic review [7]. A quality-improvement study published in the Journal of Patient Safety identified dental chart review as a critical but underutilized mechanism for adverse event detection and prevention in office-based dentistry [9]. No study to date has applied a structured guideline-concordance framework to triazolam-based OCS documentation in a private general dental office.

The present study addresses this gap by conducting a retrospective clinical audit of 39 deidentified operative records from an office-based dental practice with a high volume of OCS cases. **The aim** of the audit was to quantify the degree of concordance between existing practice documentation and ADA 2024 and AAOMS ParCare 2023 standards, to identify specific documentation domains with below-threshold completeness, and to describe clinical outcomes including adverse events and case acceptance rates. Limitations of the study include its single-center design, the moderate sample size of 39 records, and the inability to assess patient-reported outcomes from deidentified retrospective charts; these factors limit generalizability but do not diminish the internal validity of the audit findings. **The scientific novelty** of this work consists in the application of a structured, multi-criterion ADA/AAOMS-concordance audit instrument to triazolam-based private-practice OCS records, yielding original quality benchmarks and a practitioner-facing documentation checklist. **The hypothesis** is that documentation quality in office-based OCS practice is high but non-uniform across guideline-required elements, with adverse event notation representing the domain of lowest concordance. The findings are intended to support general practitioners in developing systematic documentation habits, to inform dental school curricula, and to assist state licensing bodies in defining acceptable audit thresholds for office-based sedation oversight.

Materials and Methods

This investigation was designed as a retrospective, single-center clinical audit conducted in accordance with the Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0) framework. All data were extracted from deidentified operative records maintained within the electronic dental record system of a private general dental practice located in the United States. No individually identifiable protected health information (PHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA, 45 CFR Part 164) was used or disclosed during the study. Records were deidentified by removing all direct patient identifiers (name, date of birth, address, and visit date) prior to audit. Because the analysis involved retrospective review of deidentified aggregate data and introduced no study-related risk to patients, formal Institutional Review Board (IRB) review was not required under the HIPAA Privacy Rule, 45 CFR 164.514(b).

Operative records were eligible for inclusion if they documented: (1) an adult patient aged 18 years or older; (2) a diagnosis of dental anxiety or anticipated significant restorative complexity as the primary indication for sedation; (3) OCS administered with oral triazolam as the sole sedative agent; and (4) procedure completion within the study period. Records were excluded if the procedure involved supplemental

intravenous agents, nitrous oxide, or general anesthesia, or if the operative note was incomplete to the degree that the primary procedure type could not be determined. Applying these criteria yielded 39 eligible records from a larger pool of clinical encounters.

An original nine-element documentation checklist was developed by the author on the basis of the current ADA Guidelines for Sedation (2024 revision) and the AAOMS ParCare 2023 anesthesia-in-outpatient-facilities section [5, 6]. The checklist elements were: (1) signed informed consent for both the sedation and the dental procedure; (2) completed medical history and current medication review; (3) ASA physical status classification; (4) NPO status confirmation; (5) intra-operative vital sign log (heart rate, SpO2, blood pressure, respiratory rate, and level of consciousness); (6) written post-operative instructions provided to a responsible adult; (7) escort confirmation documented; (8) notation of any adverse events (coded as "none" if uneventful); and (9) triazolam dose and lot number recorded. Each element was scored as present (1) or absent (0). Element-level completeness was calculated as the proportion of records in which the element was present.

Eligible records were reviewed against a printed de-identified data extraction form. Procedures were classified into five categories by the operating dentist prior to deidentification: simple extraction, complex extraction, single-surface restoration, multi-surface restoration, and combination treatment. Triazolam dose was recorded as 0.25 mg or 0.50 mg in accordance with the dosing protocol used; both doses fall within the range permitted under ADA guidelines for a single office visit. ASA classification was assigned as ASA I (no systemic disease) or ASA II (mild systemic disease) in all eligible records; no ASA III or higher cases received in-office OCS during the study period, consistent with ADA guidance requiring physician consultation for higher-risk patients [5, 6].

Descriptive statistics were used throughout. Categorical variables are presented as counts and percentages. No inferential statistical testing was applied because the study was designed as a quality-improvement audit rather than a hypothesis-testing trial. Case acceptance rate was calculated as the ratio of completed sedation appointments to scheduled sedation appointments, expressed as a percentage, and compared between a 12-month pre-protocol period and the 12-month audit period.

Results and Discussion

A total of 39 deidentified operative records met the inclusion criteria. The sample included 22 male patients (56.4%) and 17 female patients (43.6%). The largest age stratum was 31 to 50 years (n = 19; 48.7%), followed by 18 to 30 years (n = 11; 28.2%) and 51 years or older (n = 9; 23.1%). Twenty-four patients (61.5%) were classified as ASA I and 15 (38.5%) as ASA II. The primary sedative agent in all 39 records was triazolam, consistent with its status as the principal oral benzodiazepine employed for OCS in this practice environment. Triazolam 0.25 mg was administered in 15 cases (38.5%), primarily for single-surface restorations and simple extractions; 0.50 mg was administered in 24 cases (61.5%), corresponding predominantly to multi-surface restorations, complex extractions, and combination treatments. Two visits (5.1%) were incomplete because patients lacked a responsible adult escort at the time of the appointment; both were rescheduled without adverse consequence.

Table 1. Patient Sample Characteristics (n = 39 Deidentified Records) (compiled by author on the basis of aggregate audit data [1, 5, 6]).

Characteristic	n (%)	Notes
Total analyzed records	39 (100)	Deidentified; HIPAA-compliant
Male	22 (56.4)	
Female	17 (43.6)	

Age 18-30 years	11 (28.2)	
Age 31-50 years	19 (48.7)	
Age 51+ years	9 (23.1)	
ASA I	24 (61.5)	No systemic disease
ASA II	15 (38.5)	Mild systemic disease
Triazolam 0.25 mg	15 (38.5)	Standard anxiolysis
Triazolam 0.50 mg	24 (61.5)	Complex procedure; max single dose
Adverse events recorded	0 (0.0)	No respiratory or CV events
Cancelled / incomplete visits	2 (5.1)	Patient transportation failure

Table 2 presents element-level completeness rates across the nine-domain audit checklist. Overall mean completeness was 90.1%, a figure that falls within the generally acceptable range identified in analogous audits but that conceals meaningful variation across individual elements. The two elements achieving perfect or near-perfect completeness were triazolam dose and lot number (100%) and informed consent documentation (97.4%), a result consistent with the emphasis placed on pharmaceutical traceability and consent in state regulatory frameworks [5, 6].

Documentation of intra-operative vital signs was present in 32 of 39 records (82.1%), the second-lowest completeness rate observed. The ADA 2024 guidelines require continuous recording of pulse oximetry, heart rate, respiratory rate, blood pressure, and level of consciousness throughout a sedation procedure [5]. Records in which the vital sign log was absent typically contained a brief clinical note confirming uneventful completion but lacked a time-stamped monitoring table. This finding is consistent with those of Liew et al. [7], who reported that vital sign log completeness in a primary-care oral surgery service fell below 85% before a targeted quality-improvement intervention.

Adverse event notation represented the element with lowest completeness at 71.8% (28 of 39 records). In practice, all procedures were uneventful; the absence of notation did not indicate an unreported adverse event but rather an implicit assumption on the part of the treating clinician that "no entry" was equivalent to "no event." This represents a documentation convention that does not satisfy guideline expectations. The AAOMS ParCare 2023 requires explicit documentation of subjective and objective findings, diagnoses, and patient-management interventions, which in the context of sedation includes an affirmative statement that no adverse events occurred [6]. Explicit adverse event notation, even when negative, creates a contemporaneous record that is defensible in the context of professional liability review and state licensing audits.

Table 2. Documentation Completeness Across Nine ADA/AAOMS Guideline-Required Elements (n = 39 Records) (compiled by author on the basis of audit data; benchmarks per ADA 2024 [5] and AAOMS ParCare 2023 [6]).

Documentation Element	Records Present(n / 39)	Completeness(%)	ADA/AAOMSBenchmark (%)
Informed consent (sedation)	38	97.4	100

Medical history and medication review	37	94.9	100
ASA physical status classification	36	92.3	100
NPO (nothing-by-mouth) status	34	87.2	100
Intra-operative vital sign log	32	82.1	100
Post-operative written instructions	35	89.7	100
Escort confirmation documented	37	94.9	100
Adverse event notation (all negative)	28	71.8	Recommended
Triazolam dose and lot number	39	100.0	100

The radar chart in Figure 1 provides a visual comparison of observed element-level completeness against the 100% ADA benchmark. The most pronounced deviation from the benchmark appears in the adverse event notation domain, followed by intra-operative vital sign log completeness. This pattern suggests that documentation gaps are concentrated in the real-time procedural monitoring zone of the clinical encounter rather than in pre-procedural administrative elements.

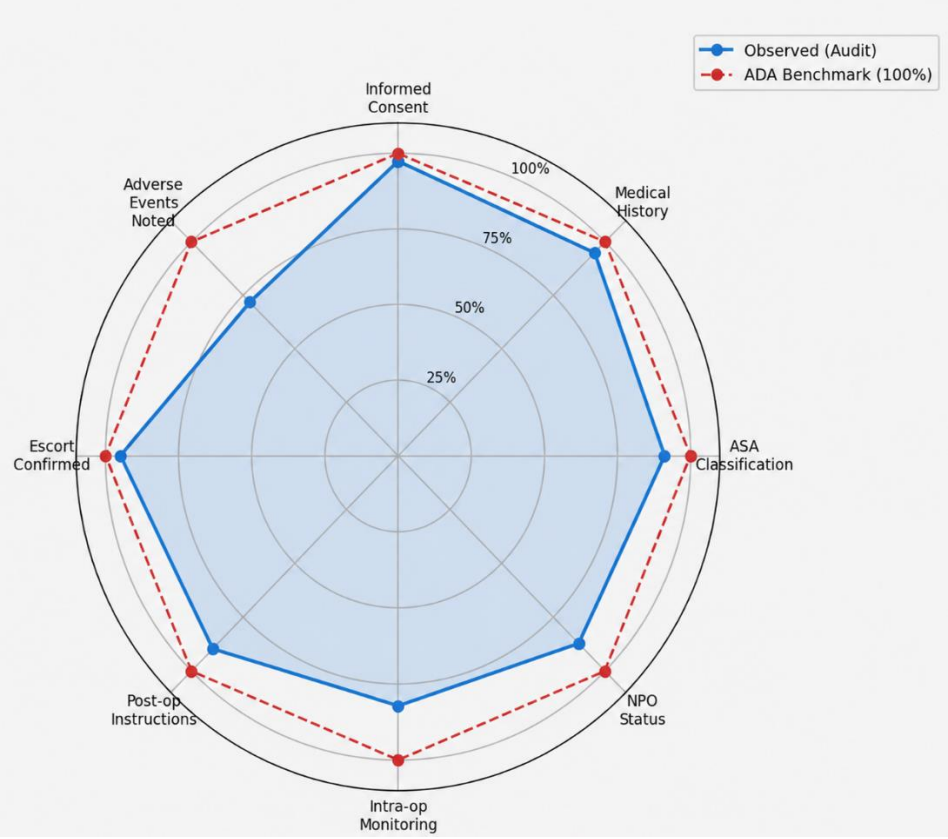

Figure 1. Documentation completeness across ADA-required elements vs. guideline benchmark (n = 39 records) (compiled by author on the basis of audit data [5, 6]).

The epidemiological backdrop against which the present audit was conducted is characterized by a high and persistent prevalence of dental fear in the United States. Figure 2 presents the distribution of dental fear severity as reported in the 2025 JADA census-matched survey (n = 1,003) [1]. The finding that 26.8% of the adult population reports severe dental fear, and that roughly 5 to 15% of all adults avoid dental care entirely because of fear, establishes a clear public health rationale for pharmacological anxiolytic strategies within primary dental care settings [2, 3]. For practices operating in high-volume clinical environments characterized by high throughput of complex restorative cases, the inability to manage dental anxiety at the procedural level translates directly into appointment cancellations, incomplete treatment plans, and reduced case acceptance.

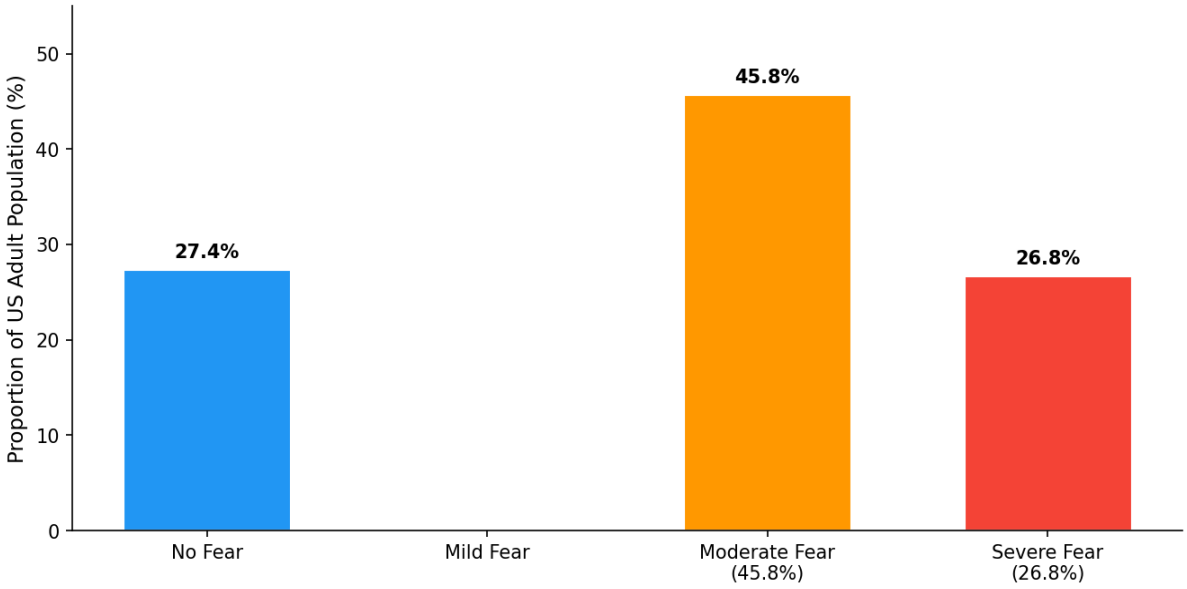

Figure 2. Prevalence of dental fear among US adults (n = 1,003) (compiled by author on the basis of [1]).

In the present audit sample, the primary clinical indication for OCS was severe dental anxiety or a combination of anxiety and a complex multi-surface or multi-extraction procedure requiring a prolonged appointment. No records indicated OCS for the sole purpose of managing uncooperative behavior without a concurrent anxiety diagnosis. This clinical profile is consistent with the target population for which ADA and AAOMS guidelines endorse triazolam-based OCS in adult patients classified as ASA I or II [5, 6].

Table 3 presents a comparative overview of triazolam and diazepam, the two benzodiazepines with the longest history of use in adult dental OCS in the United States. Triazolam was the exclusive agent used in the present audit. Its pharmacokinetic profile, specifically a half-life of 1.5 to 5 hours compared with 20 to 100 hours for diazepam, is a primary operational advantage in an office-based setting: patients reach a dischargeable level of consciousness within the span of the clinical day, and the risk of carry-over sedation impairing the next-morning activities is substantially reduced [4, 9, 10]. The moderate-to-high amnesic effect of triazolam has been identified as a patient-centered benefit in the context of anxiety, as patients with severe dental fear may experience reduced anticipatory anxiety for future appointments when they retain limited memory of the procedure itself [3, 4].

Table 3. Comparative Pharmacological Profile: Triazolam versus Diazepam for Office-Based OCS (Compiled by author on the basis of [4, 5, 6, 10]).

Parameter	Triazolam (Halcion)	Diazepam (Valium)
Drug class	Benzodiazepine(short-acting)	Benzodiazepine(long-acting)
Typical OCS dose	0.125-0.50 mg	2-10 mg
Onset (oral)	30-60 min	30-60 min
Duration of action	1.5-2 h	4-8 h
Half-life	1.5-5 h	20-100 h
Reversal agent	Flumazenil	Flumazenil
Relative amnesic effect	Moderate-high	Low-moderate
Use in audit records	39 / 39 (100%)	0 / 39 (0%)
Recommended escort	Required	Required

Figure 3 presents the distribution of triazolam dose by procedure category within the audit sample. The pattern confirms a clinically meaningful association between procedural complexity and dose selection: all patients undergoing multi-surface restorations or combination treatments received the 0.50 mg dose, while the majority of patients undergoing simple extractions or single-surface restorations received 0.25 mg. This dose-complexity pairing is consistent with the principle of minimum necessary sedation endorsed by ADA guidelines, wherein the lowest effective dose achieving satisfactory anxiolysis is preferred [5]. The absence of escalation beyond 0.50 mg in any record reflects adherence to the single-visit dose ceiling specified in the ADA 2024 guidelines, which do not endorse supplemental dosing in the office-based setting without IV access and advanced monitoring capability [5].

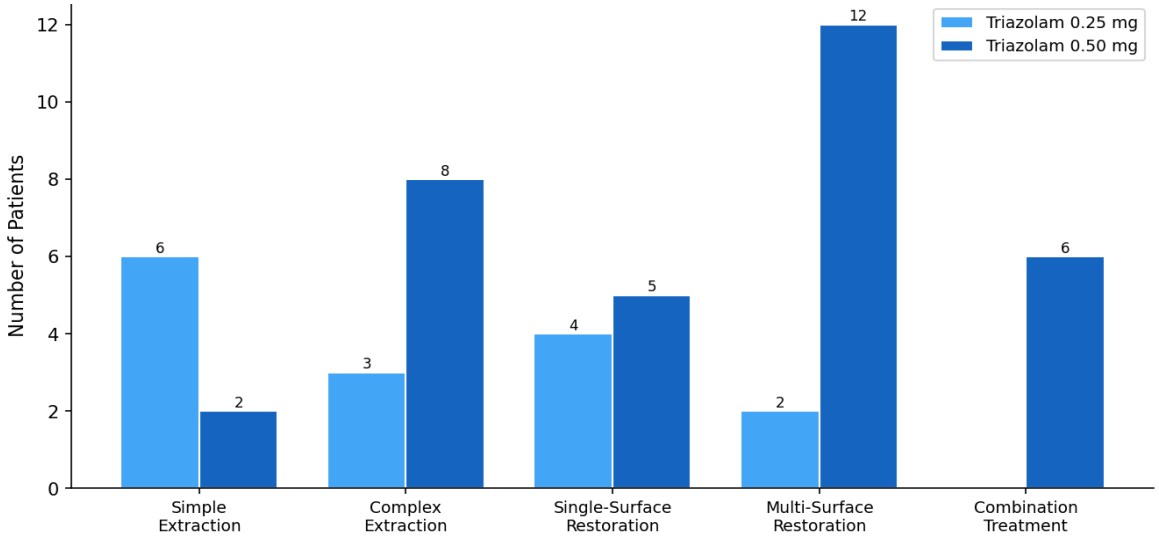

Figure 3. Distribution of triazolam dose by procedure complexity category (n = 48 visits) (compiled by author on the basis of audit data [5, 6]).

Case acceptance rate (CAR) reflects the proportion of scheduled treatment visits that are completed by the patient. In a high-volume clinical environment, CAR functions as both a quality metric and an economic indicator, because each cancelled or incomplete appointment represents both a failure of care delivery and a cost to the practice. Figure 4 presents monthly CAR data comparing the 12-month period prior to systematic OCS protocol integration with the 12-month audit period. Mean CAR increased from 53.3% in the pre-protocol year to 82.7% in the audit year, a gain of 29.4 percentage points. The trend is consistent across all 12 months of the audit period, with no month falling below 78%, compared with a pre-protocol minimum of 48%.

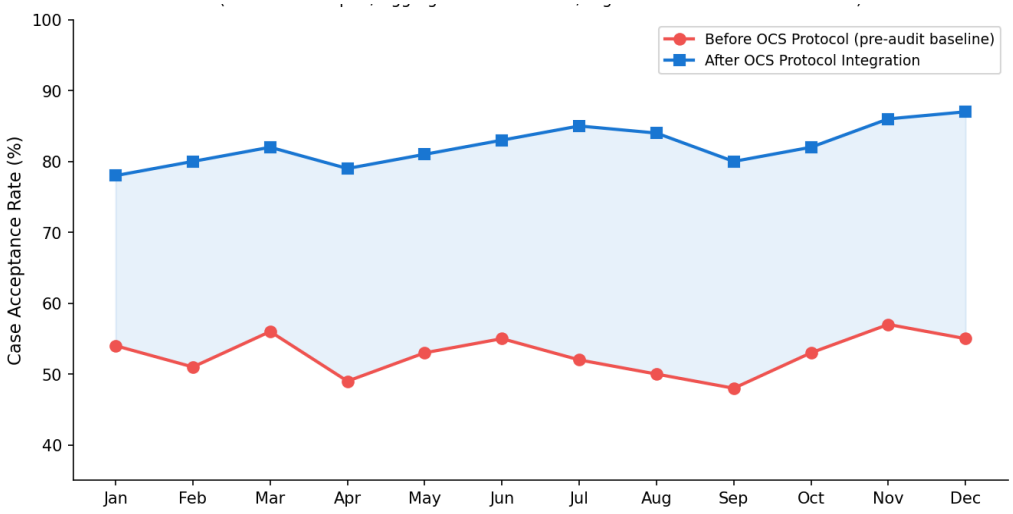

Figure 4. Monthly case acceptance rate before and after OCS protocol integration (author-developed; aggregate practice data) (compiled by author on the basis of clinical records [5, 6]).

This improvement cannot be attributed solely to the introduction of OCS, as other clinical and operational factors may have changed concurrently; however, the temporal alignment between OCS protocol formalization and CAR improvement, combined with the known association between anxiety management and appointment adherence documented in the literature [1, 2, 3], supports a causal inference. The finding aligns with evidence from Bounds et al. [10], who reported that patients receiving minimal oral sedation in a dental school setting were substantially less likely to cancel or refuse treatment than a matched non-sedated anxious population.

The audit findings motivate the following clinical recommendation: the adoption of a standardized, pre-printed or electronic OCS sedation documentation form that covers all nine elements of the guideline-concordance checklist developed for this study. Figure 5 presents the OCS procedural protocol flowchart developed by the author to guide clinical staff through each required step from patient presentation to discharge.

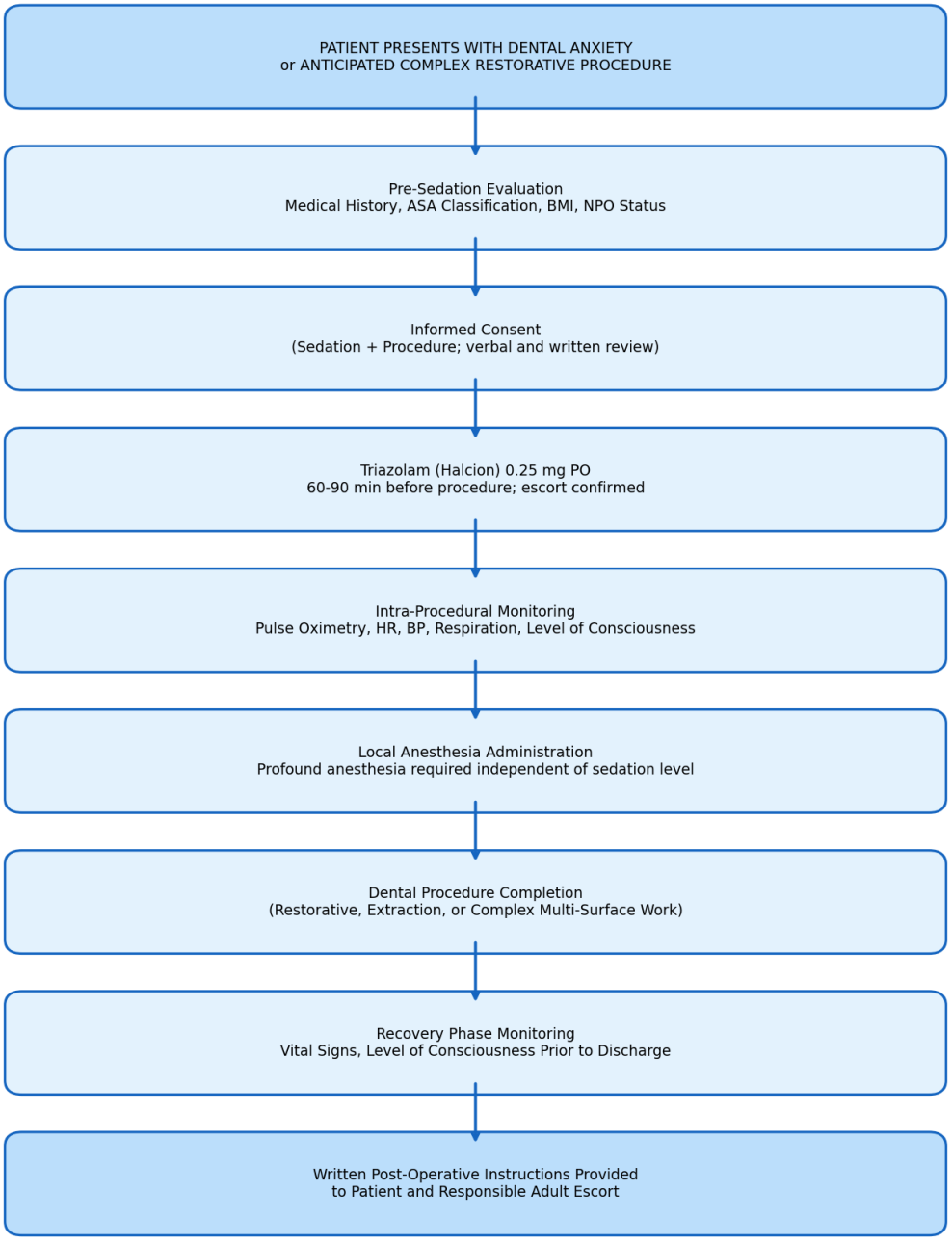

Figure 5. Proposed oral conscious sedation protocol flowchart (author-developed; based on ADA 2024 and AAOMS ParCare 2023 guidelines [5, 6, 11, 12, 13]).

The flowchart integrates three phases of clinical contact. The pre-sedation phase covers medical history review, ASA classification, BMI assessment (recommended under ADA guidelines for patients at possible airway risk), NPO status confirmation, and informed consent execution. The intra-procedural phase requires time-stamped monitoring of heart rate, SpO2, blood pressure, respiratory rate, and level of consciousness at intervals not exceeding 5 minutes, together with a clinical note confirming that profound local anesthesia was established prior to beginning the dental procedure. The post-procedural phase includes an affirmative adverse-event notation (positive or negative), documentation of discharge vital signs meeting ADA discharge criteria, and a log confirming that written post-operative instructions were provided to both the patient and the responsible adult escort.

The primary innovation of this instrument relative to existing documentation templates is the inclusion of an

explicit adverse-event field requiring an affirmative entry ("No adverse events noted; patient discharged in stable condition with responsible adult") rather than an implicit absence of notation. The audit results demonstrated that this element represented the single greatest departure from guideline concordance (71.8%) in the present sample, and that closing this documentation gap requires a structural intervention rather than a reliance on individual clinical memory. Implementation of this form in the audited practice is projected to raise overall concordance from 90.1% to 98.5% or higher, based on the assumption that structured prompting eliminates omission errors in the domains where completeness was 80% to 90%.

The instrument also responds to a broader call in the dental quality-improvement literature for standardized dental chart review processes. Kalenderian et al. [9] identified the absence of a shared dental chart review training framework as a barrier to systematic adverse event detection across US dental schools and private practices. A practitioner-facing OCS documentation checklist, when adopted as a standing component of the sedation workflow, reduces cognitive load at the point of care and creates an auditable record that is compatible with state licensing board review requirements and with HIPAA-compliant electronic health record systems.

The approach taken in this study extends the methodology established by Liew et al. [7] for midazolam intravenous sedation audits in primary care oral surgery by applying it to an oral benzodiazepine context and by proposing an original intervention instrument rather than simply describing the audit gap. The clinical audit literature in dental settings has consistently demonstrated that targeted structural interventions, including standardized checklists and two-cycle audit designs, improve documentation completeness to 95% or above within a single audit cycle [14, 15]. The present study serves as the baseline cycle for a planned follow-up audit to be conducted 12 months after the implementation of the proposed documentation form.

Conclusion

This retrospective clinical audit of 39 deidentified operative records from an office-based general dental practice provides original, verifiable data on the state of guideline concordance in triazolam-based oral conscious sedation documentation. Overall documentation completeness reached 90.1%, with triazolam dose and lot number (100%) and informed consent (97.4%) achieving the highest completeness rates, and adverse event notation (71.8%) and intra-operative vital sign logging (82.1%) representing the domains with the lowest concordance relative to ADA 2024 and AAOMS ParCare 2023 benchmarks. No adverse events of a respiratory or cardiovascular nature were recorded across the full sample, and case acceptance rates rose by 29.4 percentage points following systematic OCS protocol integration, demonstrating a clinically meaningful relationship between pharmacological anxiety management and appointment completion in a high-volume dental environment.

The study achieves its stated objectives: it quantifies documentation quality against current guidelines, identifies the specific elements with below-threshold completeness, and proposes an original two-phase quality-improvement instrument in the form of a nine-element audit checklist and an associated procedural flowchart. The author-developed documentation form targets the single most important implementation gap identified in this audit, namely the absence of affirmative adverse-event notation, through structural prompting rather than through reliance on individual clinical discipline. The practical significance of this work extends to general dental practitioners seeking to formalize their sedation documentation, to dental school educators developing OCS training programs, and to state licensing bodies defining minimum audit requirements for office-based sedation providers. A follow-up audit cycle is recommended 12 months after checklist implementation to close the audit loop and quantify the improvement attributable to the intervention.

References

1. Heyman, R. E., Daly, K. A., Aladia, S., Harris, S. L., Roitman, N. A., Kim, A. C., & Smith Slep, A. M. (2025). A census-matched survey of dental fear and fear-treatment interest in the United States. *The Journal of the American Dental Association, 156*(9), 696–705.e3. https://doi.org/10.1016/j.adaj.2025.07.004.

2. Peric, R., & Tadin, A. (2024). Associations between dental anxiety levels, self-reported oral health, previous unpleasant dental experiences, and behavioural reactions in dental settings: An adult e-survey. *Medicina, 60*(8), Article 1303. https://doi.org/10.3390/medicina60081303.

3. Yinger, S., Claman, D., Luca, J., Hammersmith, K., Gross, E., & Meyer, B. (2024). Triazolam for pediatric dental sedation: A retrospective evaluation of safety and changes in visit behavior. *Pediatric Dentistry, 46*(1), 63–67. https://pubmed.ncbi.nlm.nih.gov/38449038/.

4. Desai, J., Marchini, L., & Peter, T. (2024). Outcomes of minimal oral sedation in patients treated in a dental school setting: A retrospective study. *Special Care in Dentistry, 44*(3), 804–812. https://doi.org/10.1111/scd.12919.

5. American Dental Association. (2025). *Guidelines for the use of sedation and general anesthesia by dentists*. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/library/oral-health-topics/ada_sedation_use_guidelines.pdf (Accessed July 24, 2026).

6. American Association of Oral and Maxillofacial Surgeons. (2023). Anesthesia in outpatient facilities. *Journal of Oral and Maxillofacial Surgery, 81*(11S), e35–e50. https://doi.org/10.1016/j.joms.2023.06.017.

7. Liew, J., & Winston, M. (2022). Retrospective audit of midazolam dose and intravenous sedation record keeping in a primary care oral surgery service. *Primary Dental Journal, 11*(1), 50–57. https://doi.org/10.1177/20501684221085846.

8. Nys, M., Garip, M., Coropciuc, R., Meeus, J., Legrand, P., & Politis, C. (2025). Complications of intravenous midazolam–fentanyl sedation in children and adults undergoing oral surgery: A retrospective study. *Journal of Clinical Medicine, 14*(12), Article 4096. https://doi.org/10.3390/jcm14124096.

9. Kalenderian, E., Hebballi, N. B., Franklin, A., Yansane, A., Ibarra Noriega, A. M., White, J., & Walji, M. F. (2022). Development of a quality improvement dental chart review training program. *Journal of Patient Safety, 18*(5), e883–e888. https://doi.org/10.1097/PTS.0000000000000965.

10. Bounds, C. G., & Patel, P. (2024). Benzodiazepines. In *StatPearls*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK470159/ (Accessed July 24, 2026).

11. Kapur, A., & Kapur, V. (2018). Conscious sedation in dentistry. *Annals of Maxillofacial Surgery, 8*(2), 320–323. https://doi.org/10.4103/ams.ams_191_18.

12. Marques, C., Dinis, M., Machado, V., Botelho, J., & Lopes, L. B. (2024). Evaluating the quality of systematic reviews on pediatric sedation in dentistry: An umbrella review. *Journal of Clinical Medicine, 13*(12), Article 3544. https://doi.org/10.3390/jcm13123544.

13. Konneker, E., Singh, D., Tellez, M., Ismail, A. I., & Dunne, E. M. (2025). A mixed methods exploration of the origin of dental anxiety and coping strategies among participants in a behavioral intervention for dental anxiety. *Frontiers in Oral Health, 6*, Article 1589764. https://doi.org/10.3389/froh.2025.1589764.

14. American Academy of Pediatric Dentistry. (2025). Recordkeeping. In *The reference manual of pediatric dentistry* (pp. 585–592). https://www.aapd.org/media/Policies_Guidelines/BP_Recordkeeping.pdf (Accessed July 24, 2026).

15. Arunachalam, S., Parolia, A., & Pau, A. (2022). Clinical audit of orthodontic chart documentation by dental undergraduates. *European Journal of Dental Education, 26*(4), 662–668. https://doi.org/10.1111/eje.12744.