SCOPE:
All Medical Staff

PURPOSE:
In compliance with the standards of The Joint Commission, the following guidelines establish minimum standards for moderate sedation.

DEFINITIONS:

1. Non-Anesthesiologist Sedation Practitioner: Physicians, dentists, or podiatrists who are qualified by education, training and licensure to administer moderate sedation.

2. Supervised Sedation Professional: A licensed registered nurse, advanced practice nurse or physician assistant who is trained to administer medications and monitor patients during moderate sedation under the direct supervision of a non-anesthesiologist sedation practitioner or an anesthesiologist.

3. Minimal sedation (anxiolysis): 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.

4. Moderate sedation/analgesia (conscious sedation)[1]: A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

5. Deep sedation/analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully (reflex withdrawal is not considered to be a purposeful response) 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.

6. Anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
POLICY:

A. Introduction

Moderate sedation represents a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

B. Intent

Because sedation-to-anesthesia is a continuum, it is not always possible to predict how an individual patient receiving medication with the intent to achieve moderate sedation will respond. These guidelines are intended to ensure the safe administration and management of these agents.

c. Expectations

1. The expected norm of moderate sedation with some situations reaching deep sedation. Anesthesia is not an intended level and generally requires active airway management.
2. Moderate sedation will be provided by qualified individuals who are trained in professional standards and techniques.
3. These guidelines apply to all locations and all patients of Providence Everett Medical Center where moderate sedation is administered.
4. The Non-Anesthesiologist Sedation Practitioner must be prepared to rescue patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation.
5. PRMCE patients going off site to receive moderate sedation are subject to the same moderate sedation standards. A PRMCE RN with moderate sedation competencies will accompany the patient off site.

PROCEDURE:

A. Personnel

1. Requirements

   a. The Non-Anesthesiologist Sedation Practitioner must be credentialed by PRMCE to prescribe and administer moderate sedation.
   b. The Supervised Sedation Professional must meet PRMCE moderate sedation competencies in order to administer moderate sedation medications and monitor patients undergoing moderate sedation. (See PRMCE Policy #11769 - Procedural Sedation)
   c. In addition to the physician performing the procedure and the Supervised Sedation Professional assigned to monitor the
patient during the moderate sedation, the following must be considered when preparing for the procedure:

i. If the physician requires procedural assistance, a technician, PCP, or other qualified individual should be present.

ii. If in the judgment of the physician or nurse assigned to monitor the patient, in collaboration with his/her charge nurse or manager, it is deemed necessary for patient safety to have a third person trained in airway management present or on alert during the procedure, RT or the Administrative Supervisor should be contacted for assistance.

d. Physicians are asked to coordinate scheduling of procedures requiring moderate sedation with the nurse manager or charge nurse in order to optimize staff availability and promote patient safety.

2. Physician Responsibilities

a. Determine whether the patient is a candidate for moderate sedation.

b. Perform a pre-procedure assessment to include past medical history, physical examination, airway assessment, and anesthesia history.

c. A documented history and physical examination must be on the chart. If the H&P is dictated and not transcribed, a handwritten note by the physician with procedure, medications, allergies and note "H&P dictated" is acceptable.

d. Inform the patient/guardian about the risks and alternative to sedation and obtain and document informed consent.

e. Be present during administration of moderate sedation.

f. Assist in completion of the moderate sedation documentation.

g. Be immediately available in the post procedure period for patients who become unstable during moderate sedation until such time as the patient exhibits stable vital signs and is assessed as being stable.

h. Be available by pager or phone for consultation during recovery period.

B. Equipment

1. Required at bedside

a. Oxygen source

b. Equipment for oxygen administration (nasal cannula, masks)

c. Self-inflating resuscitation bag with appropriately sized mask

d. Functioning suction source

e. Emergency call system

f. Electrical outlet connected to emergency power supply

g. Continuous Pulse oximetry with appropriately set audible alarms

h. Automatic blood pressure device with appropriately set audible alarms
i. Consider RT or anesthesia consult to monitor airway in patients of ASA Class III or IV
j. ECG monitor for all patients with appropriately set audible alarms.
k. Pharmacologic Reversal agents

2. Immediately available on unit
   a. Code cart
   b. Emergency airway in code cart equipment (masks, airways, endotracheal tubes, and laryngoscopes with blades)

   c. Documentation and Monitoring
      1. The objective of monitoring the patient during moderate sedation is to ensure the adequacy of ventilation, oxygenation and circulatory function. The following guidelines for monitoring are considered a minimum standard, which is required for any patient receiving moderate sedation.
      2. The following standard documentation must be included in the patient's record. Individual departments may elect to exceed these guidelines if appropriate for their patient population.
         a. Pre-Procedure
            i. A valid informed consent
            ii. Personnel involved
            iii. History and physical/airway examination
            iv. Discussion of risks
            v. IV access
            vi. Vital signs
            vii. NPO status
            viii. Patient/guardian teaching
            ix. Name of responsible party to escort patient home
         b. Intra-Procedure - Pre-procedure "Time Out"
            i. Vital signs and Oxygen saturation will be monitored continuously and recorded at least every 5 minutes as indicated with contemporaneous documentation of intervention(s). A practitioner with moderate sedation privileges must be present at all times during the procedure for which moderate sedation is being provided.
            ii. Record depth of sedation, including responsiveness to verbal and physical stimuli using Aldrete Scoring System. The depth of assessed sedation must be recorded at 5 minute intervals throughout the period of sedation and analgesia.
            iii. Time and dosage of medications administered and patient response.
            iv. A description of the procedure performed and patient response.
            v. In the event that an adverse reaction to anesthetic occurs, the medical record must include time and description of

c. Post-Procedure Monitoring and Recovery Criteria
   i. Following completion of the procedure, the patient must be assessed and monitored by an RN.
   ii. Vital signs will be monitored at least every 15 minutes for no less than 30 minutes from administration of last doses of sedation medication.
   iii. Patients will be recovered using the Aldrete Scoring System.
   iv. The physician will be notified if the patient does not meet discharge criteria.
   v. Administration of reversal agents requires monitoring at least two hours to detect potential re-sedation.
   vi. If administration of reversal agents occurs, the timing of the last dose of the reversal agent is to be included in the Hand-off communication report and must be reported per policy.

d. Discharge
   i. Patients must exhibit stable vital signs at or within 20% of admission vital signs, absence of respiratory distress, and have an aldrete score of at least 8 unless base line was lower.
   ii. Patient or family can verbalize post-sedation discharge instructions or verbal report has been given to nursing unit receiving patient.
   iii. Provide patient or family written discharge instructions, which include the names and phone numbers of hospital or medical staff to contact in the event of an emergency.
   iv. For inpatients, document area to which patient transferred, mode of transfer, and name of the person receiving report. For outpatients document discharge time and who accompanied patient.
   v. Patients undergoing moderate sedation are not allowed to drive themselves home and must be discharged to the care of a competent adult.

D. NPO Status: Each unit administering moderate sedation may define its own policy on NPO status, as dictated by the planned procedure. The following guidelines may serve as this policy for elective procedures.
   1. Patient less than 2 years old: Breast milk up to 4 hours before procedure. May take clear liquids up to 2 hours before procedure; may take solids up to 6 hours before procedure. Then NPO.
   2. Patient greater than 2 years old: May take clear liquids up to 2 hours before procedure; may take solids up to 6 hours before procedure. Then NPO.

E. Reporting of Adverse Events:
1. All cases in which the following events occur and are directly related to deep sedation are reported to Risk Management/Patient Safety. An unusual occurrence report will be completed by the supervised sedation professional and reviewed by the appropriate QA body.
   a. All cases in which unplanned naloxone or flumazenil are administered.
   b. All cases in which unplanned mechanical ventilation is required as a result of the procedure.
   c. All unanticipated hospital admissions or increased level of care.
   d. All cases in which SpO₂ is < 88% for 5 minutes or any single reading of 80% unless this reflects patient's baseline or is deemed artifactual.
   e. Any significant new atrial or ventricular dysrhythmias, or hemodynamic instability.

2. These identified adverse outcomes of patients undergoing moderate sedation are collected in the aggregate in order to identify opportunities to improve care.

REFERENCES:

1. A discussion of processes to be considered for use by an organization performing sedation/analgesia is found in "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologist," and can be located at the ASA website at http://www.asahq.org/publicationsandservices/sedation1017.pdf.


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