REVIEW OF GUIDELINES FOR SEDATION/ANALGESIA

I, ________________________________, have read and understand the attached Guidelines for Sedation/Analgesia, Policy Adm 3-EE.

_________________________________________________________
Signature

_________________________________________________________
Print Name

____________________
Date

Conscious Sedation (Sedation Analgesic) Privileges
require the following:

**Adult**
ACLS Certification (current, AHA)
Completion of Conscious Sedation Module (adult)

**Pediatric**
PALS Certification (current, AHA)
Completion of Conscious Sedation Module
   (adult and pediatric)

The modules are located on the SSH Portal/Clinical Applications

The ACLS and PALS certification is provided at SSH via the Clinical Professional Development Department x8349
Moderate Sedation Policy

POLICY SUMMARY

This policy provides specific requirements for safe care of patients during the delivery of medications for Sedation/Analgesia.

POLICY INFORMATION

This policy provides specific requirements for safe care of patients during the delivery of medications for Sedation/Analgesia.

I. Introduction:
   Joint Commission has approved the following definitions of the levels of sedation and anesthesia.

1. Minimal Sedation:
   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.

2. Moderate Sedation/Analgesia ("Conscious Sedation"):
   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.

3. Deep Sedation/Analgesia:
   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.

4. 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.

II. Applicability:
The standards for delivery of sedatives apply when patients receive, in any setting, for any purpose, by any route, sedation/analgesia for diagnostic or therapeutic procedures. This policy is not intended or designed for use in care such as pain control, palliative care, for sedation of patients on ventilators, or when such agents are used solely to reduce anxiety.

III. Procedure for Privileging and Skill Competency:
Individuals administering moderate sedation are qualified and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally.

Privileges to administer sedation/analgesia will be recommended by the Credentials Committee to the Medical Executive Committee and granted by the Board of Trustees consistent with the medical staff bylaws and the following requirements:

1. Physician Privileging:
The physician must have EITHER:

   A. 1. Board Certification or Board eligibility in:
      Anesthesiology
      Critical Care Medicine
      Emergency Medicine
      Pediatric Emergency Medicine
      Neonatology, AND...

      2. Biennial documentation that they have reviewed the current guidelines for sedation/analgesia.

   OR...

   B. 1. Current ACLS certification, to include practical training of CPR and airway management, AND...

      2. Biennial documentation that they have reviewed the current guidelines for sedation/analgesia, AND...


   New members of the medical staff must have the following:
   1. Provide documentation of current ACLS certification, AND...
   2. Demonstrate evidence of practical training in CPR and airway management in the Simulation Lab, AND...
   3. Review the current guidelines for sedation/analgesia.
   4. Review the sedation analgesia curriculum.

C. Physicians administering sedation/analgesia to pediatric patients must have:

   C. 1. Board certification or Board eligibility in:
      Anesthesiology
2. Biennial documentation that they have reviewed the current guidelines for sedation/analgesia.

OR....

1. Current PALS certification, to include practical training of CPR and airway management AND...
2. Biennial documentation that they have reviewed the current guidelines for sedation/analgesia, AND...

New members of the medical staff must have the following:
1. Provide documentation of current PALS certification, AND...
2. Demonstrate evidence of practical training in CPR and airway management, in the Simulation Lab, AND
3. Review the current guidelines for sedation/analgesia.
4. Review the sedation analgesia curriculum.

2. Physician Re-privileging:
The requirements for re-privileging shall be the same as for initial privileging.

3. Registered Nurses:
The Registered Nurse (RN) who assists in the administration of sedation/analgesia must have the following qualifications:
   Adult: current ACLS
   Pediatric: current PALS
   Neonatal: current NRP certified
   Annual competency in nursing sedation/analgesia at South Shore Hospital

4. CRNA:
CRNA’s credentialed in the practice of Anesthesiology shall be privileged for sedation/analgesia by virtue of prior training and continued experience, AND...
1. Biennial documentation that they have reviewed the current guidelines for sedation/analgesia.

IV. Equipment Availability and Emergency Management:
The following equipment/emergency drugs shall be immediately available (code carts) and checked prior to sedation/analgesia being administered:
   Oxygen source
   Ambu Bag & Face Mask
   LMA
   Laryngoscope
   Endotracheal tubes
   Oral and Nasal airways
   Cardiac monitor/defibrillator
   Suction equipment
   Code Cart
   Pulse Oximetry Equipment
   EKG
   Reversal agents
V. **Staffing:**
Staffing during the administration of sedation/analgesia includes a minimum of:
· One physician who has approved privileges to administer sedation/analgesia
· One registered nurse to monitor the patient.

Sufficient numbers of qualified personnel (in addition to the Licensed Independent Practitioner performing the procedure) are present during procedures using moderate sedation to:
· Appropriately evaluate the patient prior to beginning moderate sedation
· Provide the medications used to produce moderate sedation
· Perform the procedure
· Monitor the patient, and
· Recover and discharge the patient either from the post-sedation recovery area or from the organization

VI. **Medications:**
A physician with privileges in the administration of sedation/analgesia selects and orders the medication.

VII. **Pre-Sedation Assessment:**
Pre-procedure Physician Responsibilities:

All patients requiring sedation/analgesia will have a pre-procedure assessment including, but not limited to:

1) A history and physical performed by a physician or appropriately privileged individual. A short form H & P can be used.

2) A pre-sedation assessment must be in the medical record prior to sedation/analgesia including documentation of:
   a) Review of the history and physical
   b) Pre-op diagnosis
   c) Operative or other invasive procedure plan
   d) Review of pertinent lab or test results
   e) Physical exam of the heart, lungs, and level of consciousness (use Aldrete score)
   f) Airway assessment
   g) Plan for sedation/analgesia: minimal/moderate
   h) Immediate pre-procedure patient re-evaluation

   (Pre-procedure consultation with the Department of Anesthesiology is strongly recommended for the conditions listed below:
Recommendations for Anesthesia Consultation

Obstructive Sleep Apnea – severe
Known difficult airway
Most ASA 4
Hemodynamically unstable patients
Patients with severe mental or psychiatric limitations
Severe COPD
Pneumonia with hypoxia
Any incapacitating pulmonary disease

i) ASA classification of physical status with common examples – see table below:

Screening for Conscious Sedation

American Society of Anesthesiologists classification of preoperative risk

<table>
<thead>
<tr>
<th>ASA Class</th>
<th>Systemic Disturbance</th>
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<tbody>
<tr>
<td>1</td>
<td>Healthy patient with no disease outside of the surgical process</td>
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<td>2</td>
<td>Mild to moderate systemic disease caused by the surgical condition or by other pathological processes, medically well-controlled:</td>
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<td>Examples</td>
<td>Controlled HTN</td>
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<td>Controlled Diabetes</td>
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<td>Nephrolithiasis</td>
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<td>Cholelithiasis</td>
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<td>Obesity</td>
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<td>Smoking</td>
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<td>Mild Asthma</td>
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<td>Well Compensated Sleep Apnea</td>
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<td>Mitral Regurgitation</td>
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<td>3</td>
<td>Severe disease process which limits activity but is not incapacitating:</td>
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<td>Examples</td>
<td>Known Coronary or Valvular Disease</td>
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<td>Well Compensated CHF</td>
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<td>COPD</td>
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<td>Severe Asthma</td>
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<td>Sleep Apnea with Sequelae</td>
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<td>Morbid Obesity</td>
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<td>Chronic Renal Failure, ESRD</td>
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<td>Seizure Disorders</td>
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<td>History of CVA</td>
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<td>Peripheral Vascular Disease</td>
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<td>Pacemaker</td>
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<td>Atrial Fibrillation</td>
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<td>4</td>
<td>Severe incapacitating disease process that is a constant threat to life:</td>
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<tr>
<td>Examples</td>
<td>Uncompensated CHF or Cardiomyopathy (EF &lt;40%)</td>
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<td></td>
<td>COPD requiring home</td>
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<td></td>
<td>O2/Steroids/History of Resp. Failure</td>
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<td>CAD with markedly reduced EF</td>
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<td>Sepsis with Hemodynamic Instability</td>
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<td>Malignant Hypertension</td>
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<td>Acute CVA</td>
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<td></td>
<td>Acute Coronary Syndrome</td>
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<td></td>
<td>DKA</td>
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<td>5</td>
<td>Moribund patient not expected to survive 24 hours with or without an operation</td>
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<tr>
<td>E</td>
<td>Suffix to indicate emergency surgery for any class</td>
</tr>
</tbody>
</table>

ATTACHMENT: Screening for Conscious Sedation.doc
3) Appropriate consent for the procedure and sedation/analgesia including risks/benefits/alternatives.

4) Communicates the sedation/analgesia plan to involved care providers.

5) Patients who have a DNR order in effect at the time of the procedure and sedation/analgesia must have this status clarified. The Physician should discuss the resuscitation plan with the patient (or guardian) and the results of this discussion should be documented in the medical record.

Pre-procedure RN Responsibilities:
Verify appropriate informed consent.
Gather emergency equipment.
Establish venous access prior to sedation and maintain it through discharge.
Assess the patient's vital signs: baseline blood pressure, heart rate, respiratory rate, heart rhythm, oxygen saturation, level of consciousness, and Aldrete score documenting all measurements on flow sheet.
RN to confirm ASA classification has been assessed and documented by physician before procedure.

Immediately Prior to the Initiation of Sedation/Analgesia:
Timeout is called and documented by healthcare practitioner per universal protocol for invasive procedure policy.
Patient's status will be re-evaluated and documented immediately prior to the procedure by the physician performing the procedure.
Prior to the initiation of sedation/analgesia, the following assessments are determined, monitored and documented:
- Level of consciousness and mental status.
- Vital signs: heart rate, blood pressure, respiratory rate and oxygen saturation.
- NPO status.
- Pregnancy (as appropriate).

VIII. Intra-Procedure Monitoring and Care/RN Responsibilities:
1. IV access must be maintained at all times. The types and amounts of IV fluids, including blood and blood products, should be measured and recorded.
2. Supplemental oxygen will be administered.
3. ECG and oxygen saturation will be continuously monitored throughout the procedure (along with blood pressure, respiratory rate and heart rate).
4. Level of consciousness will be monitored and documented.
5. If the patient demonstrates persistent oxygen desaturation despite the use of supplemental oxygen, or requires continued airway support, an anesthesiologist should be consulted immediately.
6. The physician will either directly administer or request administration of a sedative by the registered nurse. (see Drug Administration Guidelines)
Administer medications titrated to sedation
Minimum 2-5 minutes interval between doses
Stop further doses if oxygen saturation is less than 90%, or maximum dose achieved
Verbal reassurance; deep breathing
7. Physician must be present in room for RN to administer sedation.
8. All medications administered will be recorded, including route, time and dosage.
9. **Monitor and document the patient’s vital signs every five minutes or more frequently as necessary.** Physiological monitoring is often the only reliable source of assessment information for patients who undergo sedation. Monitoring methods depend
on the patient’s preprocedure status, sedation or anesthesia choice, and the complexity of the procedure.

10. Assess the patient continuously for changes in condition and/or untoward responses or effects, and report any of the above to the responsible physician immediately.

IX. Post Procedure Management:
Post procedure responsibilities of the Physician are to:
1. Document a post procedure sedation/analgesia note, including name of physician and any assistants, pre and post procedure diagnoses, procedure findings, complications, blood loss or specimen removed (if any) and plan of care.

2. Destroyed Medications
   All partial doses of Controlled Substances should be destroyed on the clinical unit. The area marked "Amt. Wasted" must be completed and signed by the nurse and/or physician who administered the drug, and witnessed by the nurse. Documentation is done on the CSR sheet in areas without a Pyxis Medstation, and documentation is done in the Pyxis system in areas that have a Pyxis Medstation.

Post procedure responsibilities of the RN are to:
1. Monitor and document the patient’s vital signs every five minutes until the patient’s Aldrete score is equal to eight or reaches his or her preprocedure score.
2. Notify the responsible physician immediately if the patient does not meet the criteria specified above after one hour postprocedure. (The nurse shall continue to monitor and document all of the vital signs at least every fifteen minutes until the patient reaches preprocedure condition.)
3. Notify the responsible physician if BP change is greater than 20mm Hg from baseline and if heart rate is greater than 100 or less than 60 beats per minute.
4. If oxygen saturation is less than 90% with adequate levels of consciousness:
   - Ask patient to take several deep breaths
   - Assure oxygen is flowing and ambu bag is present
   - Tilt head and support chin
   - Inform physician of patient condition
   - Check placement of pulse oximeter
5. Complete the necessary nursing documentation, including a statement regarding the patient’s disposition.
6. Follow the procedure for post operative care of patients, when the patient attains his or her preprocedure Aldrete score.
7. Complete appropriate forms, such as nursing progress notes, per order or post procedure policy.
8. All outdated or damaged Controlled Substances i.e. tabs missing or injectable narcotics, must be returned to the pharmacy.

X. Discharge Care:
A. Discharge Home:
The physician must write a discharge order.
The patient will be considered ready for discharge when he/she has achieved a score of 8 or greater on the Aldrete scale or pre-procedure Aldrete score if it was less than 8 and patient is easily aroused. For Pediatric patients- the minimal score should be 9.
Minimum of 30 minutes since the last dose of sedative.
Reassessment by physician two hours after last reversal agent administered.
Patient to be discharged home must meet above criteria and patient is oriented and ambulates without difficulty (if appropriate to baseline).

Discharge Instruction:
a. Patient is to be instructed not to drive self home, and is to be instructed to be accompanied home by a responsible adult.

b. Patient is to be instructed not to drive, sign legal documents, or operate dangerous machinery for 24 hours after the procedure.

c. Discharge instructions are to be provided both verbally and in writing to the outpatient and/or responsible person regarding diet, medications, not using alcohol, activities, and signs and symptoms of complications with the course of action to take if any complications arise. If the procedure is done in the Emergency Department (ED), a copy of the ED record and the ED physician’s dictation which includes discharge instructions should be made available to the physician involved in follow-up care of the patient.

d. The RN should document the following in the medical record:
   - Patient/family instructions and education provided.
   - Circumstances of discharge home, who accompanied patient, time, discharge instructions given, vital signs prior to discharge.

B. Discharge to Nursing Unit:
   Patient is easily aroused
   Blood pressure, heart rate, and respiratory rate are stable for at least 30 minutes and have returned to pre-procedure status
   Minimum of 30 minutes since last dose of sedative
   Reassessment by physician two hours after last reversal agent administered, unless being transferred to a critical care unit.
   Area to which the patient is transferred, mode of transfer, and nurse receiving report.

XI. Performance Improvement Methods:
   The chairman of Anesthesia or designee is responsible to oversee the overall monitoring and evaluation of the sedation/analgesia policy at South Shore Hospital.
   The director of each clinical department wherein physicians administer or direct the administration of sedation/analgesia is responsible for the individual monitoring and evaluation of its use.
   Findings from the monitoring and evaluation of sedation/analgesia shall be included in the performance improvement process as appropriate within each clinical department that uses sedation/analgesia.
   Adverse outcomes associated with the use of sedation/analgesia will be reviewed as part of the systematic ongoing performance improvement program in each department where sedation/analgesia is administered. These outcomes include, but are not limited to, events such as:
   - any patient requiring unplanned admission to the hospital
   - any patient suffering a cardiac event requiring mechanical or pharmacological intervention
   - any death
   - any adverse event resulting in an escalation of care requiring resources beyond those already at the bedside
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<thead>
<tr>
<th>INDICATOR</th>
<th>TASK</th>
<th>SCORE</th>
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<tr>
<td>ACTIVITY</td>
<td>ABLE TO MOVE 4 EXTREMITIES VOLUNTARILY OR ON COMMAND</td>
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<td>UNABLE TO MOVE EXTREMITIES VOLUNTARILY OR ON COMMAND</td>
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<td>RESPIRATION</td>
<td>ABLE TO BREATHE DEEPYLY AND COUGH FREELY</td>
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<td>DYSPNEA, LIMITED BREATHING OR TACHYPNEA</td>
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<td>APNEIC OR ON MECHANICAL VENTILATOR</td>
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<td>CIRCULATION</td>
<td>BP + 20 mm Hg OF PRE-ANESTHETIC LEVEL</td>
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<td>BP + 20-49 mm Hg OF PRE-ANESTHETIC LEVEL</td>
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<td>BP + 50 mm Hg OF PRE-ANESTHETIC LEVEL</td>
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<td>CONSCIOUSNESS</td>
<td>FULLY AWAKE</td>
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<td>AROUSEABLE ON CALLING</td>
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<tr>
<td>02 SATURATION</td>
<td>ABLE TO MAINTAIN 02 SATURATION &gt;92% ON ROOM AIR</td>
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<td>NEEDS O2 INHALATION TO MAINTAIN 02 SATURATION &gt;90%</td>
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<td>02 SATURATION &lt;90% EVEN WITH O2 SUPPLEMENT</td>
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**TOTALS**

Approved December 2010