I. Definition:
Moderate sedation is defined as 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 patient airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Advanced Health Practitioners (AHPs) are not allowed to administer deep sedation or anesthesia (with the exception of Certified Nurse Anesthetists (CRNAs).

It is recognized that most sedatives can cause different levels of sedation, according to the dose administered. Therefore, instead of listing which drug agents may be used for moderate sedation, this standardized procedure will focus on the desired outcome of moderate sedation.

AHPs who are approved for administering sedation should be able to rescue patients who enter a deeper than intended level of sedation. This implies the ability to manage a compromised airway, hypoventilation, apnea, and cardiovascular instability.

Note
In order for AHP to be approved for this procedure, the following requirements must be met:

1. AHP must be ACLS, PALS, or NRP certified, depending on patient population
2. AHP must have a DEA license with appropriate schedules for medications being used
3. Sedation lecture must be viewed and post-test completed with a score of at least 80%
4. AHP must be proficient in airway management (Bag-mask ventilation at a minimum)
5. Appropriate code cart with emergency respiratory equipment must be in room

II. Background Information

A. Setting: The setting (inpatient vs outpatient) and population (adults vs pediatrics) for the Advanced Health Practitioner (AHP) is determined by the approval of the privileges requested on the AHP Privilege Request Form. If a pediatric procedure is being done, make sure Child Life Services is involved and use age appropriate language and age appropriate developmental needs with care of children (as appropriate to the situation).

B. Supervision:
The necessity of the procedure will be determined by the AHP in verbal collaboration with the attending physician or his/her designee. Direct supervision will not be necessary once competency is determined, as provided for in this procedure. At that time, general or indirect supervision is acceptable.
STANDARDIZED PROCEDURE
MODERATE SEDATION (Adult, Peds, Neonatal)

Designee is defined as another attending physician who works directly with the supervising physician and is authorized to supervise the AHP.

The AHP will notify the physician immediately upon being involved in any emergency or resuscitative events or under the following circumstances:

1. Patient decompensation or intolerance to the procedure
2. Outcome of the procedure other than expected
3. Patient achieving a deeper level of sedation than intended (Dr. Zwass)

C. Indications:
   1. Patients requiring procedural sedation for certain procedures.
   2. Patients requiring sedation during the period they are intubated. These patients are often at a deeper level of sedation than moderate - this is an extension of the continuum of care they are receiving. For these patients, monitoring will take place to ensure the resumption/recovery to the previous state will occur. (Dr. Zwass)

D. Precautions:
   1. Proper respiratory and cardiovascular monitoring as well as provisions for managing airway and cardiovascular emergencies must be in place.
   2. Assess patient for allergies or adverse reactions to sedative agent.

III. Materials
   1. Appropriate monitoring equipment: pulse oximeter, ECG, blood pressure (arterial catheter or non-invasive blood pressure cuff set to inflate every 1-5 minutes).
   2. Emergency supplies and equipment
      a. Suction equipment
      b. Bag and mask ventilation equipment
      c. Supplemental oxygen
      d. Intubation equipment immediately available
      e. Intravenous access (if indicated)
      f. Appropriate rescue meds such as reversal and vasoactive agents
   3. Sedation agents

IV. Procedure

A. Pre-treatment evaluation:
   1. For procedural sedation, the following must be completed:
      a. Informed consent must be obtained. This must be completed prior to the delivery of sedation.
      b. Pre-procedure assessment, which must include:
      c. A documented directed history and physical examination within 30 days of procedure and an updated interval history and physical exam within 24
STANDARDIZED PROCEDURE
MODERATE SEDATION (Adult, Peds, Neonatal)

hours of sedation stating that there are no changes from the prior examination or describing the change.

d. An assignment of ASA physical status
e. Assignment of the pre-procedure Modified Aldrete Score
f. Evidence of verification of compliance with NPO status (unless procedure is an emergency, i.e. intubation for respiratory failure)

B. Set up:
Insure emergency equipment is attached and in working order – bag and mask equipment, suction, and oxygen

C. Patient preparation
1. If sedation is being done on an emergent basis and patient was not NPO, then empty stomach with OG/NG tube if appropriate for the patient population
2. Perform time-out, using two patient identifiers

D. Perform the procedure
1. Verify pre-procedure assessment and monitoring guidelines
2. Order and administer sedation agent(s)
3. Continuously assess patient response (LOC, sedation level, blood pressure, heart rate, pulse oximetry, ability to protect airway)

E. Post-procedure
Monitor LOC, respiratory, and cardiovascular parameters, until return to baseline.

F. Follow-up treatment
Pertinent lab monitoring and imaging if needed. Reversal agents if indicated (Incident report needed if reversal agent used).

G. Termination of Procedure
1. Moderate sedation is no longer needed.
2. Moderate sedation will be terminated and the sedation plan reassessed with the attending physician if:
   a. Patient demonstrates significant, unanticipated respiratory or cardiac compromise
   b. The level of anticipated sedation is not adequate for the procedure to be safely performed

V. Documentation
A. Documentation is in the electronic medical record
   1. Documentation of the pretreatment evaluation
STANDARDIZED PROCEDURE
MODERATE SEDATION (Adult, Peds, Neonatal)

2. Record the time out, indications, procedure, the outcome, patient tolerance, medications given, and the plan in the note.

3. Documentation will include the “Sedation Record” form

B. All abnormal or unexpected findings are reviewed with the supervising physician.

VI. Competency Assessment

A. Initial Competence

1. The AHP will be instructed on the efficacy and the indications of this therapy and demonstrate understanding of such.

2. The AHP will demonstrate knowledge of the following:
   a. Medical indication and contraindications of Moderate Sedation
   b. Risks and benefits of the procedure
   c. Related anatomy and physiology
   d. Consent process (if applicable)
   e. Steps in performing the procedure
   f. Documentation of the procedure
   g. Ability to interpret results and implications in management.

3. AHP will observe the supervising physician perform each procedure three times and will write sedation orders and administer sedation for three months under the direct supervision of an attending physician, with physician co-signature on all sedation orders.

4. Supervising physician will document AHP’s competency prior to performing procedure without supervision.

5. The AHP will ensure the completion of competency sign off documents and provide a copy for filing in their personnel file and a copy to the medical staff office for their credentialing file.

B. Continued proficiency

1. The AHP will demonstrate competence by successful completion of the initial competency.

2. Each candidate will be initially proctored and signed off by an attending physician. AHP must write a minimum of ten moderate sedation orders per year. In cases where this minimum is not met, the attending must again sign off the procedure for the AHP. The AHP will be signed off after demonstrating 100% accuracy in completing the procedure.
3. Demonstration of continued proficiency shall be monitored through the annual evaluation.

4. A clinical practice outcomes log is to be submitted with each renewal of credentials. It will include the number of procedures performed per year and any adverse outcomes. If an adverse outcome occurred, a copy of the procedure note will be submitted.

VII. RESPONSIBILITY
Questions about this procedure should be directed to the Chief Nursing and Patient Care Services Officer at 353-4380.

VIII. HISTORY OF PROCEDURE
Written June 2008
Revised September 2012 by the Subcommittee of the Committee for Interdisciplinary Practice
Reviewed by the Committee on Interdisciplinary Practice
Prior revision October 2008
Approved by the Executive Medical Board and the Governance Advisory Council.

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