STANDARDIZED PROCEDURE

Procedural Sedation/Moderate Sedation

These procedures are intended to describe procedures performed by Nurse Practitioners and/or Certified Nurse Midwives (advanced practice providers) (depending on the clinical privileges granted to the individual practitioner) at UC San Diego Health.

I. Definition

Moderate sedations: A drug-induced depression of consciousness to facilitate a procedure during which patients respond purposefully to verbal commands (reflex withdrawal from a painful stimulus is not considered a purposeful response), 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.

II. Background information

A. Setting: The procedure will occur on adults and children in the hospital setting.

B. Supervision: Direct supervision will not be necessary once competency is determined. The advanced practice provider will notify the physician immediately under the following circumstances:

1. Patient decompensation or intolerance to the procedure
2. Outcome of the procedure other than expected

C. Indications

Patients who require sedation for diagnostic or therapeutic procedures.

D. Contraindication: classification of ASA-3 or ASA-4 require consultation with the Department of Anesthesia. ASA-5 are to be managed by the Anesthesiologist only.

*American Society of Anesthesiology (ASA) Classification of Physical Status*: A standardized description of the patient’s physical status. It is based on the presence of systemic disease and its extent. The classification includes five categories of a patient’s physical status:

1. ASA1: A normal healthy patient.
2. ASA2: A patient with mild systemic disease.
3. ASA3: A patient with a severe systemic disease.
4. ASA4: A patient with severe systemic disease that is a constant threat to life.
5. ASA5: A moribund patient not expected to survive without the procedure.
III. Materials
1. Cardiac monitor
2. Continuous pulse oximeter
3. Respiratory rate monitoring
4. Blood pressure monitor
5. Bag valve mask
6. Oxygen
7. Medication for sedation and reversal agents as indicated
8. Code Cart

IV. Procedural sedation/Moderate sedation

A. Pre-Treatment evaluation
1. Patient identification using two forms of identification (see UCSDHP 300.2). Patient Identification] and consent documented by:
   i. Signed consent form for the procedure.
   ii. Informed consent for the procedure documented by a physician (Refer to UCSDHP 339.1, for more detailed information about informed consent).

2. A History and Physical Assessment is required for any procedure requiring monitored sedation, anesthesia or post-procedure observation of the patient elsewhere in the hospital (Refer to Medical Staff Rules and Regulations for details on H&P requirements).

3. If the History and Physical Assessment was performed less than thirty (30) days prior to the procedure, an Interval Assessment must be completed in the medical record addressing whether or not there are any changes in the patient’s history or physical exam findings, and if so, what changes are noted. If the History and Physical Assessment is more than thirty (30) days old, a complete new History and Physical Assessment must be performed and documented in the chart. The History and Physical Assessment must include:
   i. Vital signs, including pain assessment
   ii. Allergies
   iii. Pertinent system review
   iv. Pertinent medical history specific to patient’s medical condition(s), including any family history of sedation/anesthesia complications
   v. Focused physical assessment including airway assessment
   vi. Medication Reconciliation (see UCSDHP 327.2)
vii. A same day, pre-procedure assessment of the patient’s medical status, including an assessment of the airway must be documented by the physician or advanced practice provider.

4. Immediately preceding sedation procedures, vital signs are taken and documented by the procedural sedation competent Registered Nurse with any abnormalities of the patient’s observed condition documented and discussed with the physician.

i. Time Out Verification - Prior to sedation, a pre-procedure brief to confirm the patient’s identify, the procedure and the site, including marking, may be conducted using active communication techniques. Prior to the actual procedure the final complete time out must be performed with the responsible/attending physician. The Time Out will be conducted in the location where the procedure will be performed and will involve the entire team (see UCSDHP 561.2).

ii. This time out will be documented in the Procedure Record.

B. Procedure

Intra-Procedure:

A physician’s or APP’s order for all medications and doses given during the procedure is documented and signed by the physician or APP prescribing these medications in the electronic medical record. This will serve as the physician or APP order for medication and treatment received. A separate physician or APP order sheet is not necessary.

Verbal Orders: The orders will be immediately and completely read or repeated back to the authorizing provider verbally prior to administration and documented as such in the medical record.

1. Medication drug name, dose, route, administering personnel, and time given will be documented in the EMR.

2. Patient monitoring during the procedure will be documented in the EMR.

C. Post-Procedure Documentation

1. Post procedure physician or APP order

2. Post procedure instructions

3. Procedure note

V. Competency Assessment
A. Initial Competence

1. Advanced Practice Professional (APP). Nurse Practitioners, Physician Assistants, and Certified Nurse Midwifes who are credentialed may perform moderate sedation without direct supervision of a physician. Requirements for credentialing include:

   i. Must have clinical privileges at UCSD
   ii. Must be granted the privilege to perform moderate sedation by the credentialing process
   iii. Completion of the procedural sedation ecourse (i.e., adult or neonatal course) and successful completion of the adult procedure sedation exam ecourse.
   iv. In adult care areas completion of an American Heart Association (AHA) accredited Advanced Cardiac Life Support Course (ACLS) or completion of the UC San Diego Health Advanced Resuscitation Training (ART) course which provides ACLS equivalent education; if ACLS, ART training must be completed within six (6) months. ACLS/ART training provides airway management training and competency evaluation.
   v. In pediatric areas: completion of an AHA accredited Pediatric Advanced Life Support course (PALS). In neonatal care areas completion of AHA and American Academy of Pediatrics (AAP) joint accredited Neonatal Resuscitation Provider (NRP) Program.

   v. Complete five (5) proctored moderate sedation procedures by an attending physician privileged in moderate sedation

B. Continued proficiency

Recredentialing: Successful completion of the procedure sedation exam ecourse every two years and maintenance of ART or ACLS certification

VII. RESPONSIBILITY
Senior Director of Advanced Practice office number (858) 249-2677

VIII. HISTORY OF POLICY

Reference Policy: Sedation for Procedures
Policy Number: UCSDHP 370.1