1.0 DEFINITIONS

1.1 Procedural Sedation:
Procedural sedation and analgesia refers to the technique of administering sedatives or dissociative agents with or without analgesics to induce an altered state of unconsciousness that allows the patient to tolerate painful or unpleasant procedures while preserving cardiorespiratory function. Procedural sedation is viewed as a continuum ranging from light (minimal) to deep sedation based on the titration of selective sedatives and analgesics.

1.2 Minimal Sedation:
Minimal Sedation (anxiolysis) is a drug-induced state in which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Medication used for this purpose and for sedation of mechanically ventilated patients or for urgent/emergent endotracheal intubation is covered by separate protocols.

1.3 Moderate Sedation/Analgesia:
Moderate Sedation/Analgesia (conscious 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.

1.4 Deep Sedation/Analgesia:
Deep Sedation/Analgesia, is a drug-induced depression of consciousness during
which patients can’t 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 to maintain a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Deep sedation and anesthesia is restricted to use by an anesthesia provider, unless the patient is already intubated and has stable airway protection. (i.e., use of Propofol for an intubated patient)

1.4.1 In Margaretville Hospital, induction is used by the ED mid-level providers for emergency airway management only (See Rapid Sequence Intubation- Margaretville policy)

1.4 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 if 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.

2.0 POLICY

2.1 The Chairman of Anesthesia assists in establishing guidelines to ensure that procedural sedation is administered in a safe and appropriate manner consistent with the patient’s needs.

2.2 This policy applies to all departments administering procedural sedation.

2.3 Procedural sedation will only be administered in appropriate settings where facilities, competent personnel, and all necessary equipment is available for any foreseeable emergency situation.

2.3.1 The administration of Propofol and monitoring of patients receiving Propofol is restricted to the following departments and associated staff: Department of Anesthesia (Physicians, CRNAs); Emergency Department (Physicians, Mid-Level Providers, RNs); Intensive Care (Physicians, Mid-Level Providers, RNs); and in clinical settings where the patient is intubated and receiving a continuous infusion of Propofol (i.e., ICU, ED, PACU, or during the transport of a patient to another setting)

2.4 Only staff that have successfully completed the Procedural Sedation Competency and meet ongoing competency requirements will administer procedural sedation.

2.4.1 Physician requirements (non-anesthesiologists)
Non-anesthesiologists physicians who administer procedural sedation/analgesia must be ACLS certified and meet the credentialing requirements of the medical staff required for procedural sedation administration.
2.4.1.1 Mid-level ED providers at Margaretville Hospital who administer procedural sedation including induction for emergency airway management only, must be ACLS and ATLS certified and meet the credentialing requirements for procedural sedation administration and RSI including completion of annual competencies.

2.4.2 Nursing requirements:
2.4.2.1 Maintain BLS and ACLS certification. PALS is required for those administering pediatric procedural sedation.
2.4.2.2 Knowledge of cardiac rhythm identification
2.4.2.3 Completion of annual Procedural Sedation Competency via Performance Manage/Net Learning.

2.5 The physician/LMP administering procedural sedation is responsible for obtaining consent.

2.6 The Anesthesia Department will be consulted for those patients who are at risk for losing protective reflexes during procedural sedation.

2.7 An additional staff member [other than the physician/LIP performing the procedure and the nurse monitoring the patient] will remain in the procedure area during the administration of procedural sedation and will remain available until the patient reaches a RASS of -1 to 0, and or an Aldrete Score of 6 or higher. (Aldrete is used in some settings, i.e., Cath Lab, IR, PACU)

2.8 Reversal agents (Romazicon and Narcan) will be readily available for use as needed.

2.9 For unexpected outcomes or adverse events, an Event Notification Form will be completed immediately via RDE (Remote Data Entry) in MIDAS.

3.0 RELATED POLICIES:

3.1 Rapid Sequence Intubation- Margaretville only policy

4.0 PROCEDURE:

4.1 Propofol Specifics

Due to the potential for rapid, profound changes in sedative/anesthetic depth and the lack of antagonist medications, agents such as Propofol require special attention. Even if moderate sedation is intended, patients receiving Propofol should receive care consistent with that required for deep sedation.

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1 Statement on Safe Use of Propofol; Committee of Origin: Ambulatory Surgical Care (Approved by the ASA House of Delegates on October 27, 2004, and amended on October 21, 2009)
4.1.1 Continuous infusion of Propofol for the intubated patient requires continuous hemodynamic monitoring by competent staff trained in sedation.

4.1.2 During the administration of Propofol, patients should be monitored without interruption to assess level of consciousness, and to identify early signs of hypotension, bradycardia, apnea, airway obstruction and/or oxygen desaturation.

4.1.3 Monitoring for the presence of exhaled carbon dioxide should be utilized (unless invalidated by the nature of the patient, procedure or equipment) because movement of the chest will not dependably identify airway obstruction or apnea.

4.2 **Procedural Sedation Requirements:**

4.2.1 **Equipment and supplies:**

All equipment will be available and in demonstrated working capacity. The Bio-medical equipment used shall be inventoried and maintained on a regularly scheduled basis by the hospital’s Biomedical Engineering Department.

4.2.1.1 A self-inflating positive-pressure oxygen delivery system must be immediately available. Various size and age appropriate bag and mask sizes must be available in those areas which care for pediatric patients.

4.2.1.2 Oxygen source, nasal cannula and a non-rebreathing mask

4.2.1.3 Suction source (portable or wall)

4.2.1.4 An emergency cart which should include the necessary age appropriate equipment and drugs to treat any emergency ranging from apnea to cardiac arrest.

4.2.1.5 Readily available Narcan and Romazicon/Flumazenil

4.2.1.6 A pulse oximeter

4.2.1.7 A blood pressure monitor with continuous capability

4.2.1.8 Cardiac monitor

4.2.1.9 During moderate or deep sedation, monitoring for the presence of exhaled carbon dioxide should be utilized (unless invalidated by the nature of the patient, procedure or equipment) because movement of the chest will not dependably identify airway obstruction or apnea.²

4.2.2 **Pre-Procedure requirements:**

4.2.2.1 The physician administering procedural sedation will perform a pre- procedure health evaluation and physical assessment and will complete documentation on the *Short History and Physical Form* or department and/or physician specific forms.

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² Standards for Basic Anesthetic Monitoring – Committee of Origin: Standards and Practice Parameters. (Approved by the ASA House of Delegates on October 21, 1986, and last amended on October 20, 2010 with an effective date of July 1, 2011.)
4.2.2.1 This requirement is not applicable in the event of intubation for emergency airway management in Margaretville Hospital.

4.2.2 The procedural RN will perform a pre-procedure assessment and will document, or confirm existing documentation of the following:

4.2.2.1 Baseline Vital Signs (blood pressure, pulse, respiratory rate, temperature)

4.2.2.2 Weight in kilograms

4.2.2.3 Baseline level of consciousness

4.2.2.4 Baseline oxygen saturation

4.2.2.5 Drug allergies

4.2.2.6 Medication history

4.2.2.7 Relevant medical/surgical history

4.2.2.8 NPO status

4.2.2.9 Baseline ability of the patient to communicate

4.2.2.10 Baseline EKG strip

4.2.2.11 Pain Assessment

4.2.2.12 Determination of pregnancy status is required in all females of menstrual age, except those with hysterectomy and menopause. LMP and applicable gynecologic history is required.

4.2.2.12.1 Based on the information obtained in the above step a pregnancy test will be performed at the physician’s discretion.

4.2.2.13 Verify informed consent has been obtained and is completed.

4.2.2.14 Establish IV access or establish patency of an existing IV in all patients undergoing procedural sedation (even in oral sedation cases).

4.2.2.15 Initiate discharge teaching prior to sedation.

4.2.3 **Intra Procedure Requirements**

4.2.3.1 “Time-Out” verification shall be performed prior to the start of medication.

4.2.3.2 Continuous oxygen via nasal cannula

4.2.3.3 Blood pressure, pulse and respirations every 5 minutes or more frequent if needed.

4.2.3.4 Continuous monitoring of cardiac rate and rhythm, pulse oximetry and ETCO2 (when used)

4.2.3.5 Assess patient’s ability to manage secretions, suction as necessary

4.2.3.6 Observe for patient’s response to medication and for physiological and psychological changes. Report to MD any changes in level of consciousness, restlessness, cyanosis, pallor, flushing, allergic reaction, N/V.

4.2.3.7 Document administration time of all medications and agents administered.
4.2.3.8 Continually assess the patient’s response to medications and procedure.

4.2.4 Immediate Post Procedure Requirements (after the last dose of medication was given)

4.2.4.1 The RN will remain with the patient until Discharge or Transfer criteria is met.
4.2.4.2 Assess patient’s pain level, level of sedation and tolerance of procedure.
4.2.4.3 Obtain VS every 5 minutes x 3 following the last dose of medication then every 15 minutes x 2 or more frequently if needed.
4.2.4.4 If a reversal agent is required the patient must be monitored for no less than 60 minutes.
4.2.4.5 Prior to discontinuation of the monitoring, the patient’s vital signs must return to within 20% of baseline for 2 consecutive readings. The patient must achieve a RASS score of -1 to 0 or an Aldrete score of 8 (used in some settings) or return to baseline assessment.
4.2.4.6 Patients must meet Discharge/Transfer criteria stated below, prior to leaving the post-procedure area.

4.3 Inpatient Transfer and Discharge to Home Criteria

4.3.1 Patients who meet the following criteria may be transported by non-licensed personnel to the receiving department after report has been given to the accepting nurse.
4.3.1.1 Vital signs are stable, within 20% of baseline for 2 consecutive readings.
4.3.1.2 Level of consciousness returned to pre-procedure level.
4.3.1.3 RASS score=0 or Aldrete score=8 or at pre-procedure baseline.
4.3.1.4 Patient and/or responsible party can verbalize an understanding of post-procedure instructions.
4.3.1.5 Pain comfort goal is met with or without medications.
4.3.1.6 If applicable, bleeding is controlled.

4.4 Other Discharge Criteria to be met by Out-Patient

4.4.1 Discharge should be no sooner than 30 minutes after administration of and/or no sooner than one hour after administration of reversal medication.
4.4.2 Patient will tolerate fluids with minimal nausea and without vomiting.
4.4.3 Patient will be able to ambulate to the level he/she did pre-procedure and the IV will be removed following ambulation.
4.4.4 Discharge instructions for procedural sedation and post procedure instructions will be reviewed. Understanding will be demonstrated by the patient and/or responsible party and their signature will be obtained.
4.4.5 Transportation home will be verified.
4.4.6 Patient should have family, significant other, or friends available to observe and/or assist at home for the first 24 hours.

5.0 DOCUMENTATION:

5.1 Documentation will be completed in the EMR or on the paper record as applicable to each clinical setting.

Note: Some departments (i.e., Interventional Radiology) will utilize their individual flow sheets. It has been established that these flow sheets meet minimum documentation requirements as outlined by this policy.

5.2 Post-procedure report will be given to a licensed professional on all patients returning to or relocating to another nursing setting.

5.3 Discharge Instructions will be reviewed with the out-patient and/or their representative and all signatures obtained.