

MODERATE SEDATION BY NON-ANESTHESIA PROVIDERS

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Directive establishes the policy that defines the provision of moderate sedation by providers other than Anesthesiologists and Nurse Anesthetists.
- 2. SUMMARY OF CHANGES:** This Directive clarifies the process for obtaining privileges to administer moderate sedation and the procedures to be followed when moderate sedation is used.
- 3. RELATED ISSUES:** None.
- 4. RESPONSIBLE OFFICE:** The Office of Specialty Care Services (10P4E) is responsible for the contents of this Directive. Questions may be addressed to the National Director of Anesthesia Service at 202-461-7120.
- 5. RESCISSIONS:** VHA Directive 2006-023, dated May 1, 2006, is rescinded.
- 6. RECERTIFICATION:** This VHA Directive is scheduled for recertification on or before the last working day of December 2019.

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MODERATE SEDATION BY NON-ANESTHESIA PROVIDERS

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes the policy that defines the provision of moderate sedation by providers other than Anesthesiologists and Nurse Anesthetists. Those individuals ordering, administering, and supervising moderate sedation in support of patient care must be qualified and have appropriate credentials, plus privileges or scope of practice. Moderate sedation is the current term for what has been previously called conscious sedation or twilight sleep. Deep sedation by Non-Anesthesia Providers will be addressed in a separate VHA Directive. **NOTE:** *This Directive does not apply to minimal sedation or anxiolysis (such as nitrous oxide inhalation without additional medications), during which there is no significant likelihood of loss of the airway; nor procedures carried out in intubated patients in the Intensive Care Unit (ICU) who are already being continuously monitored. Monitored Anesthesia Care (MAC) provided by an Anesthesiologist or Nurse Anesthetist is not moderate sedation.* **AUTHORITY:** 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND: Moderate sedation is done routinely in VHA to increase the comfort of patients undergoing procedures and diagnostic treatments. Moderate sedation can minimize a patient's pain and anxiety. Return of the patient to an alert state where safe discharge can be done is normally faster with moderate sedation than would occur with deeper forms of sedation.

3. POLICY: It is VHA policy that individuals ordering, administering, or supervising moderate sedation in support of patient care must be qualified and have appropriate credentials, privileges or scope of practice.

4. RESPONSIBILITIES:

a. **National Director of Anesthesia.** The National Director of Anesthesia is responsible for maintaining a uniform training module for moderate sedation. The uniform training module is available at the Veteran Affairs (VA) Talent Management System (TMS) Web site (<https://www.tms.va.gov/learning/user/login.jsp>).

b. **Veterans Integrated Service Networks Directors.** Veterans Integrated Service Network (VISN) Directors are responsible for ensuring that all VA medical facilities within their network implement the requirements of this Directive.

c. **Medical Facility Directors.** Medical facilities Directors are responsible for ensuring facility compliance with the following requirements:

(1) Requirements for Obtaining or Renewing Full Privilege or Scope of Practice.

(a) An individual must demonstrate sufficient knowledge to administer, monitor, or supervise moderate sedation by obtaining a passing score on VA's TMS Moderate Sedation test. The passing score (established by TMS) must have been obtained no more than 90 days before the privileging/re-privileging action or scope of practice action. TMS-based Moderate Sedation Training is available with the test for those desiring a refresher course prior to testing.

(b) For transfers in from another VA medical facility, the gaining facility may rely on TMS documentation from the losing facility.

(c) Successful completion and maintenance of Advanced Cardiac Life Support (ACLS) training as described in VHA policy regarding cardiopulmonary resuscitation training or as described in local facility policy.

(d) A period of Focused Professional Practice Evaluation (FPPE) or Ongoing Professional Practice Evaluation (OPPE) specific to moderate sedation care as defined by the facility.

(2) **Hospital Locations.** A list of all hospital locations where moderate sedation is performed must be maintained.

d. **Medical Facility Chief of Staff.** The medical facility Chief of Staff is responsible for ensuring that:

(1) **Moderate Sedation Pre-procedure Evaluation.**

(a) Staff privileged to provide moderate sedation must be involved in planning for and providing moderate sedation care to the patient. *NOTE: For more information on credentialing and privileging see VHA Handbook 1100.19, Credentialing and Privileging.*

(b) The patient chart needs to include an appropriate history and a physical that was done, or updated, within 30 days of the diagnostic or therapeutic procedure for which moderate sedation will be administered.

(c) The patient is informed prior to the therapeutic or diagnostic procedure for which moderate sedation will be administered that arrangements must be made beforehand for transportation home by a responsible individual, such as a family member or friend. Transportation home by Veterans Transportation Service (VTS) is acceptable when national and local VTS policy allows. (See paragraph 4.d.(5)(b)(1)).

(d) Before administering moderate sedation, a licensed independent practitioner (LIP) plans or concurs with the plan for moderate sedation. The LIP must document concurrence with the plan.

(e) A pre-sedation assessment must be performed, which may include the relevant history and physical. The combination of the history and physical, along with the pre-sedation assessment must, at a minimum, include:

1. A review of abnormalities of the major organ systems;

2. An assessment of the airway;

3. A history of any previous adverse experience with sedation or analgesia, as well as regional and general anesthesia;

4. A review of drug allergies and current medications, to include VA and non-VA prescription, over the counter and herbal medication;

5. A review of tobacco, alcohol, or substance use or abuse;

6. Time and nature of last oral intake;

7. A risk assessment, such as the American Society of Anesthesiologists Physical Status; and

(f) A requirement that the patient is re-evaluated for any change(s) since the prior assessment immediately before moderate sedation and that pre-sedation vital signs are documented.

(2) Moderate Sedation Staffing.

(a) Sufficient numbers of qualified staff, in addition to the individual performing the procedure, must be present to evaluate the patient, help with the procedure, provide the sedation, monitor, and recover the patient.

(b) The person performing the procedure cannot be the primary individual monitoring the patient.

(c) The person monitoring the patient should not be scheduled to perform other tasks and must be in close physical proximity to the patient to enhance the ability to observe the patient. Once the patient's level of sedation–analgesia and vital signs have stabilized, and safe continuous monitoring for the patient's level of sedation is maintained, it is permissible for the person monitoring the patient to assist with minor, interruptible tasks of short duration that can be accomplished entirely inside the procedure room. *NOTE: Acuity of the patient must be considered when determining if other tasks can be accomplished safely.*

(d) For purposes of moderate sedation, drugs that are anesthetic agents (e.g., propofol, thiopental, methohexital, ketamine, etomidate, etc.) must be administered by an anesthesiologist, nurse anesthetist, or a LIP with the training and ability to rescue a patient from general anesthesia.

(3) Monitoring Equipment.

(a) Appropriate equipment for care and resuscitation must be available in the immediate area where the moderate sedation is administered. This must include appropriate equipment to administer intravenous fluids and drugs, including blood and blood components, as needed.

(b) Appropriate monitoring of the patient includes, but is not limited to: heart rate and oxygenation using pulse oximetry equipment; respiratory frequency and adequacy of pulmonary ventilation; the monitoring of blood pressure at regular intervals; and cardiac monitoring by electrocardiogram (EKG) or use of a continuous cardiac monitoring device. *NOTE: Evaluation of the adequacy of pulmonary ventilation by continual observation of qualitative clinical signs is required.*

(4) Procedural Documentation.

- (a) The use of moderate sedation must be documented in the patient's medical record;
- (b) Appropriate monitoring of vital signs must be done throughout the procedure for which moderate sedation is being administered and documented at 5-minute intervals. Exceptions to this requirement and the reason for such exceptions must be documented.
- (c) Specific drugs, dose and the amount administered, route and time of administration is documented in the medical record or anesthesia record as appropriate.

(5) Post-procedure.

- (a) The patient's status must be assessed immediately after the procedure, including monitoring physiological status, mental status, and pain level. Monitoring during transport to the recovery area may be observational or electronic. It must be at a level consistent with the status of the patient and the potential effect of the procedure or sedation.
- (b) The patient is discharged from the recovery area by a qualified LIP or is discharged according to rigorously applied criteria approved by clinical leaders. The use of approved discharge criteria to determine the patient's readiness for discharge must be documented in the medical record.

1. The outpatient is discharged to an individual who accepts responsibility to get the patient home safely, such as a family member or friend. Unaccompanied patients should not be discharged to public transportation or to DAV or facility van drivers. Transportation home by Veterans Transportation Service (VTS) is acceptable when national and local VTS policy allows. In the absence of an individual who takes responsibility to accompany the patient home, Social Work Service is contacted for assistance or the patient is discharged to observation within the facility. An inpatient will return to the ward.

2. If the procedure is performed at a VA medical facility without inpatient services and the patient requires hospitalization due to unforeseen circumstances that arise during the procedure, the patient should be transferred within 60 minutes to an appropriate site of VA or non-VA care. Arrangements to sites of non-VA care can be secured ahead of time through established contracts to ensure timeliness of transfer. *NOTE: Timeliness of patient transfer in any given situation is dictated by the clinical condition of the patient.*

(6) Outcome Reporting.

- (a) Outcomes must be monitored, including reporting and trending the use of reversal agents.
- (b) The outcomes must be systematically aggregated and analyzed to enhance patient safety and performance.
- (c) Moderate sedation adverse events must be reported, reviewed, trended, and analyzed in a similar fashion as operating room anesthesia adverse events. An absence of moderate sedation adverse events during a reporting period should be noted in the Moderate Sedation Committee

report. *NOTE: This data is to be reported to a multi-disciplinary Moderate Sedation or similar hospital committee that then reports to an Executive or Clinical Executive level board. This data is used to improve performance. Adverse event reporting and follow-up documents are protected as confidential quality assurance records; disclosure of quality assurance records is limited and must comply with VA law, regulations, and policy. Questions regarding disclosure should be directed to the facility Freedom of Information Officer or Quality Manager.*

(d) Health care providers need to document any suspected adverse drug event (ADE) and inform the pharmacist according to local policy.

(e) A Moderate Sedation Toolkit for non-anesthesia providers is available for review at the National Center for Patient Safety's web site (<http://www.patientsafety.va.gov/>) under the publications heading. The toolkit is a resource for personal development and learning.

5. REFERENCES:

a. **American Society of Anesthesiologists.** The Standards for Basic Anesthetic Monitoring, July 2011.

b. **American Society of Anesthesiologists.** Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who Are Not Anesthesia Professionals, (Approved by the ASA House of Delegates on October 25, 2005, and last amended on October 19, 2011).

c. **The Joint Commission.** 2013 Comprehensive Accreditation Manual for Hospitals. November 2012.

6. DEFINITIONS:

a. **Deep Sedation or Analgesia.** Deep sedation is 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.

b. **Minimal Sedation (anxiolysis).** Minimal sedation is 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.

c. **Moderate Sedation or Analgesia (“conscious sedation”).** Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.