CLINICAL POLICY
Moderate Sedation

A. EFFECTIVE DATE :
January 17, 2023

B. PURPOSE :
To provide guidance to providers and RNs for care of the patient receiving moderate sedation/analgesia. The expected outcomes are that the patient is free from harm related to medications administered within the perioperative environment, the patient's respiratory status is maintained or improved from baseline levels, the patient's cardiovascular status is maintained at or improved from baseline levels, and the patient demonstrates or reports adequate pain control.

C. POLICY :
1. The care of patients receiving moderate sedation is the responsibility of a qualified, licensed independent practitioner with appropriate clinical privileges.
2. The practitioner must obtain informed consent for the moderate sedation procedure and document the consent in the patient record.
3. The choice of sedative and analgesic medications to be administered will be based on the knowledge, training, experience and license of the practitioner administering moderate sedation. Subsequent doses of sedative and analgesic medications should not be administered until sufficient time has elapsed for the effects of previous doses to be assessed. Examples of sedative and analgesic medications are shown in Attachment 1.
4. There will be an additional staff member, in addition to the licensed, independent practitioner, whose sole responsibility is to monitor physiologic parameters and assist with any supportive or resuscitative measures that may be necessary during moderate sedation. This person must be competent in basic life support skills for the age of the patient being monitored.
5. Age- and size-appropriate advanced cardiac life support and airway management equipment as well as personnel qualified to provide advanced life support will be immediately available on site whenever moderate sedation is administered.
6. The Richmond Agitation Sedation Scale will be used to document levels of sedation throughout the procedure.
7. All moderate sedation done at JDH will be documented in the electronic health record (Epic) or paper downtime record as backup.
8. Routine quality assurance monitoring and performance improvement will be done in accordance with UConn Health policy.
9. This policy will be reviewed routinely by the Department of Anesthesiology.

D. SCOPE:

This policy applies to all Inpatient, ED, Perioperative, and Ambulatory Procedure locations where moderate sedation is administered.

E. DEFINITIONS:

Moderate sedation is the administration of sedation, with or without analgesia, in any setting, by any route, for a diagnostic or therapeutic procedure, where there is a reasonable expectation that the sedation and/or analgesia will not result in the loss of protective reflexes or the ability to respond purposefully to commands. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Moderate sedation is practiced in various departments within JDH.

F. MATERIAL(S) NEEDED:

None

G. PROCEDURE:

The **practitioner** responsible for the patient **prior to the procedure** will:

- Review an appropriate history that addresses whether or not the patient has received sedation or anesthesia in the past and any problems as a result
- Verify a physical examination has been performed
- Review any indicated laboratory tests and imaging studies have been completed
- Verify NPO status (Attachment 3)
- Authenticate and record a pre-procedure or pre-test diagnosis
- Documents as part of the immediate pre-procedure assessment:
    - American Society of Anesthesiologists (ASA) Physical Status Classification score
    - Mallampati score (for measurement and categorization of the amount of space in the patient's oral cavity)
    - Plan for sedation

  The attending may delegate the responsibility of the pre-procedure assessment to a resident, fellow, PA or APRN, but the documentation must be authenticated by the attending physician indicating that it has been reviewed and must sign, date, and time the entry.
- Treat hypertension *prn* during elective procedures prior to proceeding for any patient with a systolic level of ≥ 200 mmHg or a diastolic level of ≥ 110 mmHg.
- Order a starting sedation dose not to exceed 2 mg midazolam in patients under 65 years or 1 mg for patients 65 or older.

  The case may not proceed unless both systolic and diastolic levels are below 200 mmHg and 110 mmHg respectively, unless the blood pressure is documented as being under optimal control. If the attending physician wishes to continue with the procedure and the BP remains at or above either of these levels, the attending physician must enter an explanatory note in the patient record prior to starting the procedure. If the case is cancelled, hypertension should be managed acutely and patient instructed regarding follow-up.

> "For younger patients, age-appropriate behaviors (e.g. crying) occur and are expected. Reflex withdrawal, although a normal response to painful stimulus, is not considered as the only age-appropriate purposeful response (i.e., it must be accompanied by another response, such as pushing away the painful stimulus, to confirm a higher cognitive function). AAP Workgroup on Sedation. "Guidelines for Monitoring and Management of Pediatric Patients Before, During and After Sedation for Diagnostic and Therapeutic Procedures." 2019. Pediatrics. Jun; 143(6):e20191000. Doi: 10.1542/peds.2019-1000.

The **practitioner** with appropriate clinical privileges and who is familiar with the patient **after the procedure** will:

- Address any changes in the patient's condition during recovery per Post Procedure Reportable Conditions section.
- Determine when to discharge the ambulatory patient if personally present
- When the practitioner is not personally present at the time of discharge, write orders allowing the patient to be discharged after a registered nurse, advanced practice registered nurse, or physician's assistant has assessed the patient and found that the relevant discharge criteria have been fulfilled.

The RN responsible solely for administration of medications and monitoring during moderate sedation prior to and during the procedure will:

- Assess compliance with NPO requirements (Attachment 3)
- Record a pre-procedure acute pain score (0-10 or other facility-approved scale)
- **Pre-procedure monitoring:**
  Record baseline values immediately prior to start of procedure / administration of medication:
    - Level of consciousness
    - Heart rate
    - Blood pressure
    - Oxygen
    - EKG rate and rhythm

  Initiate continual monitoring of ventilation adequacy by capnography with waveform display. In rare instances, procedures around the nose and/or mouth may make capnography measurement unreliable, and an explanatory note should be entered in the medical record.

- **Intra-procedure monitoring**:
  Continue monitoring of circulation and oxygenation by EKG and pulse oximetry; adequacy of ventilation by capnography with waveform display; and blood pressure will occur throughout the procedure as follows:
    - q 5 min x 3 after each administration of medication
    - q 5 min for levels of consciousness of -4 or -5 on the Richmond Agitation Sedation Scale (RASS)
    - q 15 min at all other times

- Insert Pediatric content "for younger patients"

The RN responsible solely for administration of medications and monitoring during moderate sedation prior to and during the procedure will:

- Perform **post-procedure monitoring** in either the treatment area or a designated post-sedation recovery area as follows:
    - Vital signs, pulse oximetry, and pain score q 15 min x 2 until return to baseline, or continue q 15 min until discharge criteria met
    - Patients who have received reversal agents (naloxone or flumazenil) will be monitored for a minimum of 60 minutes after administration of reversal agents, and continuing q 15 min beyond until discharge criteria met
    - Maintain IV access until patient stable; if patient has received any reversal agent, maintain IV access for duration specified in immediately preceding bulleted statement
- Verify an accompanying adult will leave with the patient who has received moderate sedation on an ambulatory basis when they are ready for discharge.
  If it is found at the time of discharge following a procedure for which the patient has received moderate

sedation that an accompanying adult is not available to leave with the ambulatory patient, refer to HAM policy 08-104 (Discharge of Ambulatory Patients after Receiving Moderate / Deep Sedation).

- Provide the approved after visit summary (AVS) that will specifically instruct the patient to:
  - specific information regarding both the procedure and medications administered
  - contact the practitioner if the patient develops respiratory difficulty or inability to tolerate oral fluids or void within 8 hours after discharge
  - contact information for the patient to reach assistance in the event of an emergency

Discharge Criteria / Desired Outcome

1. Patient retains the ability to maintain and protect the airway by being able to swallow and cough.
2. Patient displays no signs of respiratory distress, such as snoring, stridor, suprasternal retraction or decreased O_2 saturation or respiratory rate.
3. Patient is fully oriented to time, person and place, or return to baseline mentation.
4. Patient will experience minimal or no nausea or vomiting.
5. Dizziness or lightheadedness, if present, does not interfere with mobility.
6. Vital signs are stable for a minimum of 30 minutes. Skin is pink in color. O_2 saturation greater than 92% breathing room air, or has returned to pre-procedure value.
7. Patient performs age-appropriate ambulation (walk, sit, stand).
8. Dressing is dry and intact, if applicable.
9. Minimal or no pain prior to discharge, or at level deemed acceptable by patient. Assess and document (0-10 pain scale).

DISCHARGE PROCESS:

1. A practitioner who has appropriate clinical privileges and who is familiar with the patient is responsible for the decision to discharge the patient when the procedure/test services are performed on an ambulatory basis.
2. When the practitioner is not personally present at the time of discharge, patients may be discharged after a registered nurse, advanced practice registered nurse, or physician's assistant has assessed the patient and found that the relevant discharge criteria have been fulfilled.
3. An accompanying adult will leave with the patient who has received moderate sedation on an ambulatory basis when they are ready for discharge.
4. The patient and the accompanying adult are instructed to contact the practitioner if the patient develops respiratory difficulty or is unable to tolerate oral fluids or void within 8 hours after discharge.
5. If it is found at the time of discharge following a procedure for which the patient has received moderate sedation that an accompanying adult is not available to leave with the ambulatory patient, refer to HAM policy 08-104 (Discharge of Ambulatory Patients after Receiving Moderate / Deep Sedation).
6. Post-procedure written discharge instructions will be provided to the patient/designated individual and shall include specific information regarding both the procedure and medications administered. A telephone number for the patient to call in the event of an emergency will be included with the instructions.

H. ATTACHMENTS:

Attachment One: Examples of Medications Used for Moderate Sedation (Conscious Sedation) and Reversal Agents
Attachment Two: Special Requirements for the Use of Propofol for Moderate Sedation (Conscious Sedation)
Attachment Three: Summary of American Society of Anesthesiologists Pre-Procedure Fasting Guidelines

I. REFERENCES:

Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018. Anesthesiology (March 2018), vol. 128, 437-479.

J. SEARCH WORDS:

Conscious Sedation

K. ENFORCEMENT:

Violations of this policy or associated procedures may result in appropriate disciplinary measures in accordance with University By-Laws, General Rules of Conduct for All University Employees, applicable collective bargaining agreements, the University of Connecticut Student Code, other applicable University Policies, or as outlined in any procedures document related to this policy.

L. STAKEHOLDER APPROVALS:

On file

M. COMMITTEE APPROVALS:

None

N. FINAL APPROVAL:

1. Bruce T. Liang, MD 01/30/2023
Bruce T. Liang, MD Date
Interim Chief Executive Officer & EVP for Health Affairs
Dean, School of Medicine

2. Anne Horbatuck (Signed) 01/19/2023
Anne D. Horbatuck, RN, BSN, MBA Date
Clinical Policy Committee Co-Chair

3. Scott Allen, MD (Signed) 01/24/2023
Scott Allen, MD Date
Clinical Policy Committee Co-Chair

4. Caryl Ryan (Signed) 01/25/2023
Caryl Ryan, MS, BSN, RN Date
Chief Operating Officer, JDH and
VP Quality and Patient Service & Chief Nursing Officer

O. REVISION HISTORY :

Date Issued: 1/95
Date Revised: 10/97, 4/98, 9/00, 11/03, 1/07, 1/08, 9/08, 11/08, 7/09, 12/10, 3/11, 11/11, 10/12, 7/14, 8/17, 6/18, 1/20, 1/23
Date Reviewed: 5/03