MINIMUM AND MODERATE CONSCIOUS SEDATION

Purpose:

To outline the management before, during, and immediately following a procedure utilizing conscious sedation.

Definitions:

Sedation- For the purpose of this policy and procedure, sedation refers to administration of a medication to provide anxiety reduction, amnesia, or analgesia during a procedure. This policy and procedure does not refer to: (1) muscle relaxants given to paralyze a patient in the intensive care units, (2) medications administered to alleviate pain following a procedure or resulting from a disease process, and/or (3) sedation given to make a patient rest comfortably.

Minimal Sedation – (Anxiolysis) 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. In this stage, the following should be present:

1. Normal respirations;
2. Normal eye movements; and
3. Intact protective reflexes. Amnesia may or may not be present. The patient is technically awake, but under the influence of the drug administered; and
4. The determination of patient monitoring and staffing requirements by the responsible physician should be based on the patient's acuity and the potential risk of complication. Staffing during minimal sedation should include one registered nurse or qualified practitioner to observe the patient's response to medication(s).

Conscious Sedation - (moderate sedation/analgesia) a drug induced depression of consciousness which:

1. Protective reflexes are maintained,
2. Patient's ability to maintain a patent airway independently and continuously,
3. Permits purposeful response by the patient to verbal commands, either alone or accompanied by light tactile stimulation (reflex withdrawal from a painful stimulus is not considered a purposeful response), and
4. Cardiovascular function is usually maintained.

Deep Sedation – see Policy 5.9.2
**Location:**

Conscious sedation is administered in various departments within the organization, for example, endoscopy, cardiac cath, special procedures, surgery clinic, inpatient units, etc.

**Policy:**

1. **The physician shall order the pharmacological agent to be administered for sedation.** An anesthesiologist is available 24 hours a day for consultation as needed.

2. **Staffing**
   a. Sufficient numbers of qualified personnel (in addition to the Physician performing the procedure) are present during procedures using moderate (conscious) sedation to:
   b. Appropriately evaluate the patient prior to beginning moderate (conscious) sedation,
   c. Provide the moderate sedation,
   d. Perform the procedure,
   e. Monitor the patient, and
   f. Recover and discharge the patient from either the post-sedation recovery area or from LSUHSC-S.

3. **Equipment and Monitoring:**
   a. Appropriate equipment for care and resuscitation is available for monitoring vital signs including heart and respiratory rates and oxygenation using pulse oximetry equipment.
   b. Heart rate and oxygenation are continuously monitored by pulse oximetry.
   c. Respiratory frequency and adequacy of pulmonary ventilation are continually monitored.
   d. Blood pressure is measured at regular intervals.
   e. EKG is monitored in patients with significant cardiovascular disease or when dysrhythmias are anticipated or detected.

4. **Competency Requirements:**
   a. Qualified individuals are trained in professional standards and techniques:
      1) To administer pharmacologic agents to predictably achieve desired levels of sedation, and
      2) To administer pharmacologic agents to reverse the level of sedation, and
      3) To monitor patients carefully in order to maintain them at the desired level of sedation.
   b. RN's administering conscious sedation agents shall not exceed the maximum dose listed in Hospital Formulary or Nursing Policy I:50-IV Therapy – Conscious Sedation.
1) For dosage of sedation agents and antagonists staff may refer to:
2) Hospital Formulary
3) Nursing Policy I:50 -IV Therapy – Conscious Sedation
4) Drug Inserts

c. Individuals administering conscious sedation are qualified and have the appropriate credentials to manage patients at whatever level of sedation is achieved, either intentionally or unintentionally.
d. Included in the qualifications of individuals providing conscious sedation are competency-based education, training and experience in:
   1) Evaluating patients prior to performing conscious sedation.
   2) Practitioners intending to induce conscious sedation are competent to manage a compromised airway and to provide adequate oxygenation and ventilation. Completion of an ACLS/PALS course is recommended.
   3) Performing the conscious sedation to include methods and techniques required to rescue those patients who unavoidably unintentionally slip into a deeper-than-desired level of sedation or analgesia (i.e., Practitioners who have appropriate credentials and are permitted to administer conscious sedation are qualified to rescue patients from deep sedation).

5. The RN managing the care of the patient receiving conscious sedation shall not leave the patient unattended or otherwise compromise continuous monitoring.

6. Prior to pharmacologic agent administration:
   a. Explain/reinforce, with the patient:
      - Sedation purpose
   b. Confirm IV access and immediate availability of antagonists, emergency medication/equipment, crash cart, equipment for monitoring vital signs (heart & respiratory rate) and oxygenation using pulse oximeter, blood pressure machine, suction, oxygen, and airway/intubation equipment. IV access is required for all patients receiving conscious sedation regardless of sedation route.
   c. The physician preprocedure assessment shall be documented in the medical record. It shall include a history of family/personal problems with anesthesia/sedation, auscultation of the heart and lungs, airway evaluation, pertinent physical exam, review of abnormal laboratory results, and evaluation of blood/blood component requirements (if applicable). Additionally, the physician shall obtain informed consent; form a preprocedure diagnosis and plan, and a sedation plan. The physician shall review the history and physical, patient's allergies, current medications, and NPO status prior to the procedure.
   d. If history/physical has been completed within the last 30 days and a copy is available on the chart, staff shall document significant changes in patient status.
   e. The RN shall assess NPO status (exception: emergency procedures),
current medications, allergies/adverse reactions, tobacco/alcohol/drug use, pregnancy, and level of activity, psychological status, level of consciousness, skin, pain level, and the musculoskeletal system prior to the procedure. The RN shall document a plan of care prior to the procedure. The RN shall document preprocedure, intraprocedure, and postprocedure assessments/interventions in the medical record.

f. The post-procedure plan shall be completed by either the MD or RN.

g. The RN shall notify the Physician and document:

1) Prior to beginning conscious sedation; NPO not maintained for 6 hours for solids/2 hours for clear liquids prior to beginning conscious sedation, history or symptoms of acute or chronic respiratory illness, unexplained fever, or other signs of an acute illness.

2) Post sedation assessed changes suggesting possible complications (see 7c).

7. Patient Care

a. Document medication dosage/times and patient response, type and amount of fluids, blood/blood products administered, pertinent interventions results, and any other events of importance.

b. Monitors heart rate and oxygenation continually by pulse oximetry. Monitors respiratory rate and adequacy of ventilations, level of consciousness (modified Ramsey Score, etc), response to verbal commands, pain intensity, and blood pressure (except when blood pressure monitoring will interfere with ability to maintain sedation). Documents as noted below:

1) Obtain and document baseline findings prior to the procedure.

2) Monitor all parameters continuously during the procedure, documenting at least every 15 minutes and more often as indicated. Attach monitor strip to patient record if able to obtain a monitor strip.

3) Monitor and document a minimum of every 15 minutes x 2 following the procedure. If a reversal agent has been used, monitor and document at least q 15 minutes x 4 following the procedure. Ensure the patient meets the following discharge criteria:

a) Stable vital signs and oxygen saturation,

b) Returns to pre-sedation level of consciousness and/or until patient is completely arousable and responsive and/or responding appropriately for age, and

c) Able to ambulate with minimal assistance if tolerated by physical status and surgical procedure. The pediatric patient’s activity/mobility level is appropriate for their age.

d) The Modified Post Anesthesia Discharge Scoring System shall be used for those patients discharged home. Patients must have a score of greater than or equal to 9 for discharge
home or be reassessed and discharged by a physician. Refer to Attachment A.
e) If discharge criteria are not met, the physician shall be notified. The Physician must reassess the patient and determine appropriate action.

c. Continuously monitor the patient during the procedure and until protocol is discontinued for the following complications. Staff shall initiate emergency protocols, notify the physician, document complications and complete a variance report for the following:
   1) Signs and symptoms suggesting respiratory distress or airway impairment
   2) Signs and symptoms suggesting pharmacologic overdose, and
   3) Signs and symptoms suggesting unexpected drug effect.

8. Discharge instructions will be given and documented. Outpatients will be discharged to a responsible adult who will accompany them from the hospital. If there is no responsible adult available, the patient may be admitted to the 23-hour observation unit, etc.

9. Outpatients will be escorted by hospital personnel to appropriate exit or waiting room.

10. Outcomes of patients undergoing conscious sedation are collected and analyzed in the aggregate to identify opportunities to improve patient care.

Administrator

_1/21/04__________
Date

Approved by Clinical Board: 11/21/00, 1/20/04
Written: 7/96
Revised: 8/96, 5/98, 10/00, 12/03
Attachment A

Table 4. Modified Post-Anesthesia Discharge Scoring System (Modified PADSS)

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>2 = within 20% of preoperative value</th>
<th>1 = 20% to 40% of preoperative value</th>
<th>0 = 40% of preoperative value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulation</td>
<td>2 = steady gait/no dizziness</td>
<td>1 = with assistance</td>
<td>0 = none/dizziness</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>2 = minimal</td>
<td>1 = moderate</td>
<td>0 = severe</td>
</tr>
<tr>
<td>Pain</td>
<td>2 = minimal</td>
<td>1 = moderate</td>
<td>0 = severe</td>
</tr>
<tr>
<td>Surgical bleeding</td>
<td>2 = minimal</td>
<td>1 = moderate</td>
<td>0 = severe</td>
</tr>
</tbody>
</table>

**Note:** Maximum total score is 10; patients scoring 9 or 10 are considered fit for discharge home.