

DEPARTMENT OF THE ARMY
Medical Department Activity
Fort Huachuca, AZ 85613

MEDDAC Memo
No. 40-133

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Medical Services
MODERATE SEDATION/ANALGESIA

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1. History. This issue publishes a revision of this publication.

2. Purpose. The purpose of this publication is to provide guidance on the use of moderate sedation/analgesia for outpatients undergoing diagnostic procedures at Raymond W. Bliss Army Health Center (RWBAHC). The Chief, Anesthesia and Perioperative Services (DAPS), is responsible for the annual review of this publication.

3. References.
 - 3.1 The American Society of Anesthesiologists, "Guidelines for Non-operating Room Anesthetizing Locations," (current edition).
 - 3.2 The American Society of Anesthesiologists, "Basic Standards for Preanesthesia Care," (current edition).
 - 3.3 The American Society of Anesthesiologists, "Standards for Basic Anesthetic Monitoring," (current edition).

*This MEDDAC Memo supersedes MEDDAC Memo 40-133, dtd 15 Feb 05

3.4 The American Society of Anesthesiologists, Standards for Post Anesthesia Care,” (current edition).

3.5 The American Society of Anesthesiologists, “Guidelines on Sedation and Analgesia by Non-Anesthesiologists,” (current edition).

3.6 Association of Operating Room Nurses Recommended Practices, “Monitoring the Patient Receiving IV Conscious Sedation,” (current edition)

3.7 Joint Commission on Accreditation of Comprehensive Accreditation Manual for Ambulatory Care; (current edition).

4. SCOPE. This publication applies to RWBAHC staff who are certified or granted clinical privileges to administer pharmacological agents for moderate sedation/analgesia and to qualified support personnel who contribute to the care of the patient.

5. Definitions .

5.1 Physical Status Classification (PS): (see Appendix A).

5.2 Licensed Independent Practitioner (LIP): any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges.

5.3 Sedation: the various degrees of sedation defined in APPENDIX B occur on a continuum. The patient may progress from one degree to another, based on the medications administered, route, and dosages. The determination of patient monitoring and staffing requirements should be based on the patient’s acuity and the potential response of the patient to the procedure.

5.4 Emergency Management: the means for notifying support services such as practitioners skilled in tracheal intubation. Emergency resuscitative equipment must be immediately available on site.

5.9.1 Rescue: Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiological consequences of the deeper-than intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the original level of sedation.

6. General.

6.1 Moderate sedation/analgesia is permitted only in the Specialty Clinic – Endoscopy Room (D-29-1) and the minor procedure room (D-21).

6.2 Sufficient numbers of qualified personnel (not including the licensed independent practitioner) must be present. In addition to the licensed independent practitioner performing the procedure, there must be a "dedicated" certified sedation registered nurse.

6.3 Moderate sedation/analgesia drugs are administered only by a LIP or a registered nurse (RN) certified in moderate sedation/analgesia. The moderate sedation certified nurse must be with the patient at all times and able to recognize and rescue a patient from level 3 (deep sedation/analgesia). Anesthesia services are readily available during all moderate sedation procedures. Moderate sedation procedures are not performed without anesthesia services in-house.

7. Responsibilities:

7.1. Chief, Department of Anesthesia and Operative Services will:

7.1.1 Ensure a uniform level of care for moderate sedation/analgesia patients as well as monitoring this activity through their performance improvement process.

7.1.2 Ensure that LIP's doing procedures requiring moderate sedation have privileges for such procedures. Evidence of necessary training and experience as well as demonstrated competence will be considered prior to recommending such privileges for LIPs during initial privileging and at reappointment.

7.1.3 Ensure sedation nurses responsible for moderate sedation/analgesia are trained in airway management and trained in the safe use of drugs specified by this publication. Trained in airway management shall mean that their training is consistent with the airway management goals and procedures used for Advanced Cardiac Life Support. (ACLS including airway positioning, use of oropharyngeal and nasopharyngeal airways, and application of positive pressure ventilation by self-inflating bag, valve and mask.)

7.1.4 Analyze and report any adverse reactions to include use of reversal agents to the Provision of Care Functional Management Team, Executive Committee of Professional Staff (ECOPS) and the Pharmaceutical and Therapeutics (P&T) committee quarterly.

7.2 LIP certified in moderate sedation/analgesia will:

7.2.1 Demonstrate the acquired knowledge of anatomy, physiology, pharmacology, cardiac arrhythmia recognition, and complications related to moderate sedation/analgesia medications;

7.2.2 Assess total patient care requirements during the procedure and recovery. Physiological measurements should include, but are not limited to, respiratory rate, oxygen saturation, blood pressure, cardiac rate and rhythm, and the patient's level of consciousness;

- 7.2.3 Understand the principles of oxygen delivery, respiratory physiology, oxygen transport and oxygen uptake, and can demonstrate the ability to use oxygen delivery devices;
- 7.2.4 Anticipate and recognize potential complications of moderate sedation/analgesia in relation to the type of medication being administered and rescue a patient from deep sedation/analgesia.
- 7.2.5 Implement the requisite knowledge and skills to assess, diagnose and intervene in the event of complications or undesired outcomes, and to institute interventions in compliance with orders (including standing orders) or institutional protocols or guidelines;
- 7.2.6 Demonstrate skill in airway management and resuscitation as evidenced by certification in BLS and pre;
- 7.2.7 Assure that the crash cart is readily available;
- 7.2.8 Provide documentation of 10 cases performed annually to the Chief of the Department of Anesthesia and Operative Services.
- 7.3 A moderate sedation/analgesia certified RN will:
- 7.3.1 Maintain current Basic Life Support (BLS) certification. Advanced Cardiopulmonary Life Support (ACLS) is recommended;
- 7.3.2 Attend re-certification training or provide documentation of 10 moderate sedation cases performed annually to be maintained in their credentials file.
- 7.4 Equipment.
- 7.4.1 A standardized emergency cart must be readily available.
- 7.4.2 Age-specific masks and self-inflating bags with a non-rebreather valve capable of delivering positive pressure ventilation.
- 7.4.3 Functional suction apparatus with appropriate suction catheters must be immediately available.
- 7.4.4 Equipment for noninvasive measurement of blood pressure, oxygen saturation monitoring, and cardiac monitoring must be available and in good working order immediately before, during, and after the procedure. This shall include means for providing supplemental O₂, i.e., nasal prongs, nonrebreather masks. A capnometer is useful in monitoring end-tidal CO₂ and ventilation.

7.4.5 Reversal agents such as Naloxone (Narcan) and Flumazenil (Romazican) must be available.

7.4.6 All equipment shall be inventoried and maintained on a regularly scheduled basis, in accordance with the Emergency Response Protocol, Resuscitative Equipment, and Supplies policy.

7.5 Documentation 7.5.1 Pre-procedure:

7.5.1.1 Clinicians administering moderate sedation/analgesia must perform a history and physical (H&P) examination within 30 days of the procedure that documents relevant aspects of health to include but are not limited to: (1) abnormalities of the major organ systems to include assigning an ASA score (See Appendix A); (2) previous experience with anesthesia to include sedation, regional or general anesthetics; (3) current medications, to include over the counter and herbals and drug allergies; (4) time and nature of last oral intake; (5) examination of heart and lungs; (6) evaluation of the airway (APPENDIX C); (7) laboratory results. In addition to the H&P this information will be documented on a RWBAHC OP 319 (APPENDIX D) checklist in the patient's record.

7.5.1.2 LIP will complete appropriate informed consent for the procedure and moderate sedation to include risks and benefits and alternatives. The patient will be allotted time for questions and answers. The patient will then sign the appropriate consents before the procedure and the administration of moderate sedation/analgesia (APPENDIX E). Patients undergoing moderate sedation for elective procedures should adhere to fasting guidelines: solids/fatty meal-NPO 8 hrs; light meal-6 hrs; clear liquids-2 hrs. Routine medications may be taken with small sips of water at the discretion of the provider (i.e. blood pressure medication).

7.5.1.3 The provider will reassess the patient immediately prior to starting the procedure. This assessment includes confirmation of correct patient, procedure and site verification documented on MEDCOM Form 741-R (APPENDIX F). An active time out will be done in accordance with The Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. This will be observed and documented on RWBAHC Form 533 (APPENDIX G) by a disinterested third party. The clinician is encouraged to consult with the Anesthesia Department whenever problems with sedation are anticipated or if patients have significant underlying medical problems.

7.5.1.4 Laboratory testing should be guided by the patient's underlying medical condition(s) and the likelihood that the results will affect the management of sedation. This should include a pregnancy test if warranted.

7.5.1.5 All patients receiving moderate sedation/analgesia will have venous access. Venous access will be discontinued prior to the patient's discharge.

7.5.2 Intra-procedure:

7.5.2.1 Monitoring. A dedicated moderate sedation certified nurse will monitor the patient continually throughout the procedure. Monitoring will include but is not limited to: (1) level of consciousness; (2) observation of ventilatory function; (3) with appropriate alarms, continuous pulse oximetry and electrocardiogram, respirations, pulse and blood pressure (4) pain level. Documentation will be on the standardized sedation form (APPENDIX H) every five minutes by the moderate sedation certified nurse.

7.5.2.2 Medication – A LIP selects and orders the medication and must be present within the department during the initial and continued administration of the medication. These medications will be documented on along with other orders by the LIP. Authorized sedatives, opioids, and antagonists used are listed on Appendix I. (Authorized Medication for Moderate Sedation/Analgesia and Suggested Safe medication Dosage Range). The dosage guidelines are suggested maximum doses. The qualified registered nurse should only administer the sedative agents under medical supervision. The RN will verbally read back the medication order to the LIP. The RN will document "VORB" (verbal order read back) on the standardized sedation form in the medications block of RWBAHC OP 318.

7.5.3 Post-procedure:

7.5.1 After the procedure, the patient must be monitored by a nurse or LIP in a suitable location (Post Anesthesia Care Unit).

7.5.2 Recovery Care. The Aldrete Scoring System will be used for the recovery of patients following sedation (APPENDIX K). Patients shall be observed until they are no longer at increased risk for cardio-respiratory depression. Patients will be alert and responsive, or mental status returned to baseline. Vital signs will be taken and documented upon arrival to recovery and every fifteen minutes thereafter until the patient meets discharge criteria.

7.5.3 Significant variations in physiologic parameters will be reported to the LIP immediately, including a variation of plus or minus 20 % in BP; arrhythmias; oxygen saturation 5% below baseline; dyspnea, apnea, or hypoventilation; diaphoresis; inability to arouse the patient; the need to maintain the patient's airway mechanically; and other untoward or unexpected patient responses.

7.5.2 Intra-procedure: 7.6 Discharge

7.6.1 A physician or LIP using Post Anesthesia Recovery Scoring (PARS) criteria will discharge the patient from the PACU when a PARS score of 10 is achieved. For those patients where a PARS score is not applicable, a return to the pre-sedated level of responsiveness is required for discharge. The following criteria should also be considered: absence of vomiting, no complications from the procedure, able to cough, patient and accompanying adult have received all necessary instructions, follow-up appointment arranged, if needed, and written instructions given. Written instructions may include diet, medications, activities and signs and symptoms of complications, plus appropriate actions to take should complications occur.

7.6.2 If antagonists/reversal agents were required, a minimum of two hours should have elapsed after the last administration of reversal agents. This is to ensure patients do not become re-sedated after reversal effects have abated. DA 4106 should be completed on all reversals given and reviewed by an anesthesia provider.

7.7 Performance Improvement Activities.

7.7.1 Continuous Performance Improvement activities will be conducted on an ongoing basis. Performance Tools will be used and re-designed as needs for improvement change. Tracking and monitoring adverse events provides opportunity to learn and improve.

7.7.2 Anesthesia Services will be responsible for tracking, trending, and identifying potential performance improvement initiatives and report to the Provision of Care Functional Management Team and Executive Committee of Professional Staff (ECOPS) and the Pharmaceutical and Therapeutics Committee on a quarterly basis. This DOES NOT replace the DA Form 4106 for reportable occurrences.

7.7.3 Certification and annual re-certification (or 10 documented moderate sedation cases) is mandatory for sedation nurses involved in moderate sedation. Initial certification requires attendance at classes that emphasize a review of dysrhythmias, airway management and drugs used for moderate sedation (Documentation of 10 cases (documented on Moderate Sedation Record, Appendix K) or attendance at a moderate sedation/analgesia re-certification class annually should be annotated in the certified moderate sedation nurse's Competency Assessment Folder (CAF). Anesthesia Services is responsible for tracking current certification as well as coordinating classes to ensure RNs are able to obtain necessary training.

7.7.4 The officer in charge of each sedation site is responsible for verifying the competence of all involved staff prior to the administration of moderate sedation/analgesia medication.

7.8 Each department/service providing moderate sedation/analgesia shall post this publication in each area where it is practiced.

The proponent of this publication is the Department of Anesthesia and Perioperative Services. Send comments and suggested improvements to Commander, USAMEDDAC, ATTN: MCXJ-DS, Fort Huachuca, Arizona 85613-7040

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APPENDIX A
Risk Assessment

American Society of Anesthesiologists (ASA) Physical Status (PS) Classification

CLASS I

There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathologic process for which operation is to be performed is localized and is not a systemic disturbance.

CLASS II

Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

CLASS III

Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define with finality the degree of disability.

CLASS IV

Indicative of the patient with severe systemic disorder that is already life threatening and not always correctable by the operative procedure.

CLASS V

The moribund patient who has little chance of survival but has submitted to operation in desperation.

APPENDIX B
Levels of Sedation

DEFINITIONS OF FOUR LEVELS OF SEDATION AND ANALGESIA

1 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.

2 Moderate sedation/analgesia ("conscious sedation")

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 patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3 Deep sedation/analgesia

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.

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 is 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.

APPENDIX C
Airway Risk Assessment

1. Positive pressure ventilation, with or without endotracheal intubation, may be necessary if respiratory compromise develops during sedation. This may be more difficult in patients with atypical airway anatomy. Also, some airway abnormalities may increase the likelihood of airway obstruction during spontaneous ventilation. Factors that may be associated with difficulty in airway management are:

- a. History
- b. Previous problems with sedation, analgesia, and/or anesthesia
- c. Stridor, snoring, or sleep apnea
- d. Dysmorphic facial feature like Pierre-Robin syndrome, trisomy 21 e. Advanced rheumatoid arthritis

2. Physical Examination

- a. Habitus – Significant obesity (especially involving the neck and facial structures)
 - b. Head and neck – Short neck, limited neck extension, decreased hyoid-mental distance, neck mass, cervical spine disease or trauma, tracheal deviation
 - c. Mouth – Small opening, edentulous, protruding incisors, loose or capped teeth, high arched palate, macroglossia, tonsillar hypertrophy, nonvisible uvula
 - d. Jaw – Micrognathia retrognathia, trismus, significant malocclusion
3. Modified Mallampati:
Pharyngeal Classification

<u>Class</u>	<u>Components Visualized Oropharyngeal</u>
I	Soft palate, uvula, tonsillar pillars.
II	Base of the tongue obscures the tonsillar pillars, but the posterior pharyngeal wall is visible below the soft palate.
III	Soft palate (potential difficult airway)
IV	Essentially nothing visualized, not even soft palate (difficult airway).

APPENDIX D
 RWBAHC OP 319, Moderate Sedation Documentation Form

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA			
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.			
REPORT TITLE MODERATE SEDATION DOCUMENTATION FORM		OTSG APPROVED (Date) IYYYY/MM/DD	
Procedure & Provider Data			
Procedure:		Date:	
Location:		Diagnosis:	
Physician/CRNA:			
Patient Data & Baseline Vitals			
Time:	Age:	mos/years	Weight: kg/lbs
Pulse:	BP:	SpO2: %	LOC*:
Pain Scale (0-10):		Site:	
* Level of Consciousness (LOC) Score 0 Alert and Aware 1 Resting Quietly, eyes Open 2 Eyes Closed, Responds to Voice 3 Eyes Closed, Responds to Touch 4 Unresponsive			
PRE-PROCEDURE CHECKLIST (Please circle yes or no and list pertinent findings)			
1. History and Physical Exam Complete? (to include Airway Assessment)	YES / NO	Mallampati I II III IV	
2. Allergies or Adverse Anesthesia Reactions?	YES / NO		
3. Current Medications Reviewed?	YES / NO		
4. Pre-procedure Studies Done? (Labs, EKG, CXR, etc)	YES / NO		
5. Pregnancy Status Assessed? (HCG done)	YES / NO		
6. NPO Status? (Time of last food or drink)	YES / NO		
7. Informed Consent.	YES / NO		
PRE-ANESTHESIA (Sedation) ASSESSMENT: (Physician circle one)			
PS 1 - Healthy Patient			
PS 2 - Mild Systemic Disease (Controlled HTN, Asthma/COPD, Diabetes, Smoker)			
PS 3 - Moderate Systemic Disease (Uncontrolled HTN or Diabetes, Prior MI, Stable Angina)			
PS 4 - Severe Systemic Disease that is a Constant Threat to Life (unstable Angina, Incapacitating Illness)			
Patient Determined to be an Appropriate Candidate for Planned Sedation? YES NO Physician will circle yes or no then print and sign name.			
Print Physician/CRNA Name:		Physician/CRNA Signature:	Date/Time
Monitoring and Discharge Records: See reverse of this form.			
PREPARED BY (Signature & Title)		DEPARTMENT/SERVICE/CLINIC	DATE (Continue on reverse)
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle, grade, date; hospital or medical facility)		<input type="checkbox"/> HISTORY:PHYSICAL <input type="checkbox"/> FLOW CHART <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (Specify): <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT	

APPENDIX E
Consent Form

DISCHARGE RECORD

Page 2 of 2

TIME IN:		SURGICAL PROCEDURE:				Hx:	
Anesthesia:						EBL:	
Pre-op BP 20% 						INTRACP MEDS:	
TIME						CARDIAC MONITOR YES NO	
CRITERIA	ARR	15	30	45	60	RHYTHM	
ACTIVITY						OXYGEN YES NO	
RESP.						AMT. VIA.	
CIRC.						B/P MONITOR YES NO	
L.O.C.						PULSE OX YES NO	
COLOR						BRAKE ON YES NO	
TOTAL						Additional Notes:	
SaO2							
O2							
TEMP							
PULSE							
RESP							
BP							
PAIN							
Time of Discharge:		AM/PM					
Discharge Pain Score (0-10):							
Discharge PARS Score:		/10					
Released via: <input type="checkbox"/> assisted walking <input type="checkbox"/> wheelchair <input type="checkbox"/> bed/gurney							
Released by:							
Released to:							
Discharge Instructions given to patient/responsible adult: <input type="checkbox"/> yes <input type="checkbox"/> no							
Initials:							
IV Fluids and Rate:				IV DC'd@			
Site:		Appearance:				Initials:	

APPENDIX F Procedure and Site Verification

MEDICAL RECORD - PROCEDURE AND SITE VERIFICATION RECORD

For use of this form, see MEDCOM Cir 40-17

Name of Procedure/Surgery:

PROCESS	STAFF'S SIGNATURE*	INITIALS*	DATE AND TIME
1st verification (ward/ambulatory procedure unit/clinic). Prior to pre-op medication administration. I verified all of the following: <ol style="list-style-type: none"> a. Intended procedure (with side/level/site) is written clearly on consent and consent is signed by provider. b. Patient identified using two patient identifiers. c. Patient/parent/guardian and witness have signed the consent. d. Patient/parent/guardian verbalizes understanding of the intended procedure and points to the site. 	Licensed Staff Member**		
2nd verification - Operating provider (ward/ambulatory procedure unit/clinic/holding area). Prior to pre-op medication administration. I verified all of the following: <ol style="list-style-type: none"> a. Correct patient. b. Procedure (with side/level/site) and operating provider listed on consent are correct. c. With patient's involvement, I have written my initials on the surgical site. Note: Patient refusal of marking will be annotated by the operating provider in the patient's medical record.	Operating Provider		
2nd verification - Anesthesia provider and OR nurse/licensed staff member (holding area). Prior to pre-op medication administration. I verified all of the following: <ol style="list-style-type: none"> a. Patient, procedure (side/level/site), and operating provider listed on consent are correct. b. Consent matches H&P or progress note. c. The operating provider's initials have been written on the operative site. 	Anesthesia Provider		
	OR Nurse/Licensed Staff Member**		
3rd verification/TIME OUT - OR nurse/licensed staff member (OR or procedural area). Prior to incision I verified all of the following: <ol style="list-style-type: none"> a. Patient's ID (name and SSN) has been reviewed and is consistent with the consent. b. The operating provider verbally confirmed (TIME OUT) with the team the following: <ol style="list-style-type: none"> 1. Patient's name, procedure, side/level/site, position, implant(s) and special equipment (as applicable). 2. The patient information is consistent with the consent and H&P or progress note. 3. Scans/x-rays available per operating provider's request. 	OR Nurse/Licensed Staff Member**		

*Write the signature and initials once; thereafter, only initials are required.

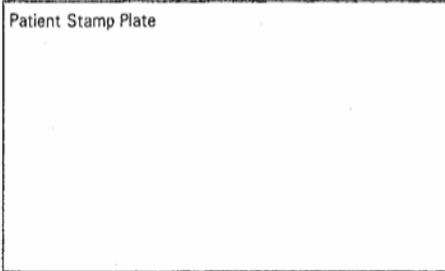
**In outpatient clinics not requiring a licensed staff member's participation in the procedure, the verification will be completed by the non-licensed staff in attendance at the procedure.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; FMP/SSN; date; hospital or medical facility)

Notes:

APPENDIX G
Surgery Confirmation RWBAHC Form 533
SURGERY CONFIRMATION

Patient Stamp Plate



Prior to incision I verify that work was stopped and the operating provider (surgeon) verbally confirmed with the entire operating team:

- Patient Name
- Procedure being performed
- Side Level/Site is marked with the initials of the surgeon
- Position of patient is appropriate

NA Implant is appropriate for the patient

NA Special equipment

By checking the above items I am confirming that the surgeon verbally confirmed with the operating staff all of the above items.

Printed Name:

Signature:

Date:

APPENDIX H
RWBAHC FORM 318, Moderate Sedation Monitoring

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA		Page 1 of 2
REPORT TITLE MODERATE SEDATION MONITORING		OTSG APPROVED (Date) (YYYY/MM/DD)
PHYS STATUS	*LOC Scale	Remarks and Observations <input type="checkbox"/> Patient ID, Chart review & permit checked @ _____ <input type="checkbox"/> Patient reassessed immediately prior to sedation. BP _____ HR _____ RR _____ SpO2 _____
1 2 3 4 5 E	1. Aware	
BODY WEIGHT	2. Moderate	
KG	3. Deep	
LB		
Medications		
SpO2		
*LOC Score		
Pain Level		
O2 LPM		
HEART RATE AND NIBP		RECOVERY AT:
KEY:		
SBP - V		
DBP - A		
HR - O		
200		
180		
160		
140		
120		
100		
80		
60		
40		
20		
Patient Position		
IV Summary	Medication Summary (drug-dose_	PAIN:
Gauge	Fentanyl _____mcg	PARS:
Site	Versed _____mg	CONDITION:
Solution		TEMP: RESP: SpO2:
ml Infused		BP: HR:
Physician Name:		
Technician Name:		
Monitor Signature:		
PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)		<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT

DISCHARGE RECORD

TIME IN:		SURGICAL PROCEDURE:				Hx:			
Anesthesia:						EBL:			
Pre-op BP 20% 						INTRACP MEDS:			
TIME						CARDIAC MONITOR	YES NO		
CRITERIA	ARR	15	30	45	60	RHYTHM			
ACTIVITY						OXYGEN	YES NO		
RESP.						AMT.	VIA:		
CIRC.						B/P MONITOR	YES NO		
L.O.C.						PULSE OX	YES NO		
COLOR						BRAKE ON	YES NO		
TOTAL						Additional Notes:			
SaO2									
O2									
TEMP									
PULSE									
RESP									
BP									
PAIN									
Time of Discharge:								AM/PM	
Discharge Pain Score (0-10):									
Discharge PARS Score:						/10			
Released via:						<input type="checkbox"/> assisted walking <input type="checkbox"/> wheelchair <input type="checkbox"/> bed/gurney			
Released by:									
Released to:									
Discharge Instructions given to patient/responsible adult:						<input type="checkbox"/> yes <input type="checkbox"/> no			
Initials:									
IV Fluids and Rate:				IV DC'd@					
Site:		Appearance:			Initials:				

APPENDIX I

Authorized Medication for Moderate Sedation/Analgesia and Suggested Safe Medication Dosage Range

GENERAL CAUTIONS: 1. Individualize dose. 2. Do not give by rapid or single bolus IV administration. 3. Expect individual response to vary with age, physical status, and concomitant medications. 4. Use small increments to achieve the appropriate level of sedation. 5. Wait 2 or more minutes after each increment to evaluate sedative effect fully.

Medication	Dosage	Comments
<u>SEDATIVES:</u>		
Midazolam (Versed)	PO - 0.5-0.7 mg/kg IM - 0.1-0.3 mg/kg IV - 0.05 mg/kg	
Diazepam (Valium)	PO - 0.15-0.3 mg/kg	
<u>OPIOIDS:</u>		
Fentanyl	IV - 0.001-0.003 mg/kg (1-3 mcg/kg)	
Morphine		Oral preparation is sustained release
Demerol	PO - 0.5-1.0 mg/kg IM - 0.1 mg/kg IV - 0.1 mg/kg	
	IM - 1mg/kg IV - 1mg/kg	
<u>ANTAGONISTS:</u>		
Flumazenil (Romazicon)		Partial antagonism
(For Benzodiazepines)	IV - 0.01-0.02mg IV - 0.4-1.0 mg	Complete antagonism Benzodiazepine withdrawal-induced seizures; residual sedation and hypoventilation
Naloxone (Narcan) (For Opioids)	IV - 0.01-0.10 mg/kg	Titrate to desired effect (brief duration of action) Pediatric dose not yet

