SEDATION AND ANESTHESIA CARE POLICY

PURPOSE: To provide guidelines for personnel who administer sedation or anesthesia to patients undergoing surgical or diagnostic procedures or treatments, regardless of the location where the surgery, procedure or treatment occurs. Patients throughout the Medical Center will receive a comparable level of care, regardless of the level of anesthesia care administered.

I. POLICY:
   a. Sedation and anesthesia care is defined by four levels of sedation and anesthesia; i.e., minimal, moderate sedation/analgesia, deep sedation/analgesia, and anesthesia.
   b. Anesthesia care will be provided by qualified anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) to:
      (1) Administer pharmacologic agents to predictably achieve desired levels of sedation, and
      (2) Monitor patients carefully in order to maintain them at the desired level of sedation.
   c. Individuals administering moderate sedation, deep sedation or anesthesia will be qualified and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally.

II. DEFINITIONS:
   a. LEVEL 1 - Minimal Sedation (anxiolysis) – A drug-induced state during which patients respond normally to verbal command. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
   b. LEVEL 2 - Moderate Sedation/Analgesia (previously termed "conscious sedation") – A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. (Note: reflex withdrawal from a painful stimulus is not considered a purposeful response.) No interventions are required to maintain a patent airway and satisfactory spontaneous ventilation. Cardiovascular function is usually maintained.
   c. LEVEL 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.

d. **LEVEL 4 - Anesthesia** – consists of general anesthesia, 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.

e. **Advanced Cardiac Life Support (ACLS)** – Advanced cardiac life support is defined as the ability to maintain a patent airway in an unconscious patient, the ability to ventilate an unconscious patient, and the ability to diagnose and initiate treatment for life threatening arrhythmias and/or cardiac arrest.

**IV. PROCEDURE:**

a. Level 1, Minimal Sedation, as addressed in this policy will refer to the use of drugs with anxiolytic effects in doses below those reasonably expected to suppress affect ventilatory and cardiovascular functions. Level 1, Minimal Sedation, may be administered by any qualified practitioner with appropriate clinical privileges. No special monitoring or facilities are required other than maintaining verbal or visual contact with the patient until the effects of the medication have reached their peak.

b. Level 2, Moderate Sedation/Analgesia as defined here, specifically excludes administration of sedative-hypnotic or analgesic medication under emergency conditions for the purposes of postoperative analgesia, or when not associated with a specific medical procedure or treatment. Moderate sedation will be administered under the immediate direct supervision of a Licensed Independent Practitioner who is clinically privileged to perform moderate sedation. Moderate sedation will be administered ONLY in areas of the medical center where trained, qualified staff and appropriate equipment are present. The decision to use moderate sedation and the selection of drugs to be used will be made only by appropriately privileged providers (Refer to Attachment A: Medications Approved for Moderate Sedation).

c. Level 3, Deep Sedation/Analgesia, and Level 4, an anesthetic depth of sedation, will be administered by either an anesthesiologist holding appropriate clinical privileges, or a certified registered nurse anesthetist.

d. Individuals administering, monitoring, and/or supervising moderate sedation must have documented competency-based education, training, and experience in:

1. Evaluating patients before performing moderate sedation.
2. Performing the moderate sedation, including rescuing patients who become deeply sedated. This must include the ability to manage a
compromised airway and to provide adequate oxygenation and ventilation.

(3) Understanding the pharmacokinetics of the drugs typically used for moderate sedation as well as the potential effects of the drugs on vital functions.

(4) Performing cardiopulmonary resuscitation (CPR), airway management, and management of cardiac arrhythmias. This requirement may be satisfied by successful completion of Advanced Cardiac Life Support (ACLS) training.
   a) Periodic re-training or renewal of this training must be obtained as recommended by the American Heart Association or other Accredited training entity.
   b) VA providers must complete this training by the time of privileging if they are to administer, monitor, or supervise moderate sedation, or perform procedures that require moderate sedation.

e. The moderate sedation training and competency will be documented and reflected in the individual’s privileges or scope of practice. Further, as part of a clinician’s re-privileging, or an updating of the clinician’s scope of practice, the clinician must show completion of the “Moderate Sedation National Training Program” module in LMS and renewal of ACLS certification.

New VA providers that administer, monitor, or supervise moderate sedation or perform procedures that require moderate sedation must have had, or must complete, this training within 90 days of employment with VA. This will be validated by their respective Service. Current VA providers that administer, monitor, or supervise moderate sedation, or perform procedures that require moderate sedation, must complete this training by the time of reappraisal for privileging.

f. Assessment and Monitoring of Patient
   (1) Pre-procedure
   a) Staff privileged to provide moderate sedation will be involved in planning for and providing moderate sedation care to the patient. The patient chart needs to include an appropriate history and a physical done, or updated, within 30 days of the procedure. All assessments of patients undergoing moderate sedation must be signed by a licensed independent practitioner (LIP) prior to sedation. 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, with a focused physical examination including vital signs, auscultation of the heart and lungs, and assessment of the airway.
      2. A review of any previous adverse experience with sedation/analgesia as well as regional and general anesthesia.
4. A review of tobacco, alcohol or substance use or abuse, or use of over-the-counter herbal medications.
5. Time and nature of last oral intake (nil per os—"NPO" status)
6. An assessment of risk such as the American Society of Anesthesiologists (ASA) Physical Status.
7. Airway evaluation (Mallampati 1-4)
8. American Society of Anesthesiologists (ASA) risk stratification (1-5)

b) The patient's sedation or anesthesia care plan will be communicated among involved providers.

c) Immediately before the induction of sedation or anesthesia, re-evaluate the patient, review the medical record and determine whether the patient is still an appropriate candidate to undergo the planned sedation or anesthesia. This re-evaluation must be documented in the patient's record. The re-evaluation must include documentation of pre-procedure vital signs.

d) For any location in which moderate sedation is administered, the following equipment must be available in the immediate area and functioning:
   1. Blood pressure monitoring device
   2. Pulse oximeter
   3. End tidal carbon dioxide capnography (ETCO2) monitoring capability
   4. Source of supplemental oxygen and apparatus for delivery
   5. Suction apparatus with appropriate suction catheters
   6. Defibrillator and code cart immediately available to procedure room
   7. Equipment to administer IV fluids and drugs, including blood and blood components, as needed

e) Informed Consent will be obtained, after discussing with the patient the risks, benefits, potential complications, any alternative options associated with the planned procedure, and the need to administer blood or blood components.

f) No ambulatory procedure involving sedation will begin without the admitting staff member verifying that a designated, responsible adult is physically present in the procedure department. This adult must confirm that they will accompany the patient after discharge and ensure that the patient will not be the driver. (Attachment B: Transportation Restrictions for Patients Scheduled to Receive Moderate Sedation).
For those patients who present without a designated, responsible adult the options include: rescheduling the procedure or offering the procedure without sedation if appropriate. Use of the lodging program is not an acceptable alternative. If delaying a procedure could result in a negative outcome for a patient, arrangements for hospital admission should be made.

g) Sedation or anesthesia will be administered under the immediate direct supervision of a physician or dentist.

h) Baseline information which at a minimum includes level of consciousness (using an approved scale), oxygen saturation, respiratory rate, heart rate, blood pressure, and weight in kg versus pounds, will be obtained and recorded prior to administration of medication for sedation or anesthesia.

i) All women who are scheduled to receive moderate sedation are required to have a pregnancy test (urine specimen or blood serum test for pregnancy, if unable to obtain a urine sample) performed on the date of service prior to the procedure. This includes women who have not had menses due to birth control or other hormonal treatment.

The only exceptions to this rule are:
- Hysterectomy
- Post-menopausal with no history of menses for one year
- Bilateral tubal ligation

Elective procedures will be canceled if the pregnancy test is positive. If delaying the procedure could result in patient harm, the provider will discuss risk vs. benefit with the patient at time of consent and document risks vs. benefits in the consent form. If feasible, the patient's gynecologist should be consulted prior to patient consent.

(2) Intra-procedure

a) The person performing the interventional procedure cannot be the individual who is providing moderate sedation and monitoring the patient. A sufficient number of qualified staff (in addition to the individuals performing the procedure and sedation) must be present to assist with intra-procedural tasks.

b) During moderate sedation, drugs that are anesthetic agents such as: propofol (Diprivan), thiopental (Pentothal), methohexital (Brevital), ketamine (Ketalar), etomidate (Amidate) must be administered by an anesthesiologist or nurse anesthetist.

c) The patient's physiological status will be monitored during intra- and post-sedation periods. Requirements include: continuous monitoring of respiratory rate, ETCO2, adequacy of pulmonary ventilation, pulse oximetry; measurement of heart rate and blood
pressure at regular intervals. EKG will be utilized to monitor cardiac function.

d) All monitoring will be documented on a written record prior to administration of medication, and at least every five minutes thereafter throughout the procedure (Exceptions to this requirement and the reason for such exceptions must be documented). In the recovery phase, monitoring will continue at least every 15 minutes, for a minimum of 30 minutes, after the last drug administration for sedation or anesthesia. Monitoring will continue for a minimum of 90 minutes if the patient has required naloxone or flumazenil (sedation reversal agents).

e) The patient's response to care provided throughout the procedure will be documented in the patient's medical record. Intra-procedure documentation will include:
   1. Time of dosage, route, drugs and agents utilized
   2. Evidence of continuous monitoring
   3. Record of any unusual occurrence(s) during sedation/anesthesia
   4. Documentation of sedation status using the Richmond Agitation-Sedation Scale (RASS). The RASS is the preferred instrument and all staff is strongly encouraged to use this instrument. (Attachment C: Richmond Agitation-Sedation Scale)

f) The patient's status must be assessed immediately after the procedure is completed. The assessment, which must be documented, is to include monitoring physiological status, mental status and pain level using the Visual Analog Scale (VAS) grades 1-10.

g) Immediate post-procedure monitoring, including during transport to the recovery area, is at a level consistent with the status of the patient and the potential effect of the procedure or sedation.

(3) Post-procedure

a) The patient's post-procedure status will be assessed on admission to and before discharge from the post-sedation or post-anesthesia recovery area. Post-procedure documentation will include:
   1. Status of patient on admission to post-sedation or post-anesthesia recovery area
   2. Vital signs and level of consciousness
   3. Unusual events or post-procedure complications during post-sedation/anesthesia management of care

b) Patients who have received sedation as outpatients are to be discharged in the company of a designated adult who accepts responsibility for the patient. Patients are not allowed to drive, nor may they be discharged unaccompanied via public or VA transportation.
Ambulance service without a designated adult is allowable only for those patients returning to an extended care nursing facility. Patients should be instructed that they are not to operate motor vehicles, heavy machinery, or sign legal documents (etc.) for 24 hours after receiving moderate or deep sedation/analgesia.

g. Monitoring and Evaluation of Care
(1) Outcomes of patients undergoing moderate or deep sedation will be collected, aggregated and analyzed to enhance patient safety and performance. Monitoring and evaluation activities will include the following information and be monitored by Anesthesia staff or Designee and reported through Critical Care Committee:
   a) Evaluation of documentation compliance
   b) Review of all cases requiring unplanned ventilatory assistance post-procedure
   c) Review of all unanticipated hospital admissions or admission to ICU from a ward after a procedure
   d) Review of all cardiac or respiratory arrests as related to moderate or deep sedation and anesthesia
   e) Review of all cases of moderate or deep sedation requiring reversal of narcotic or sedative medication with naloxone or flumazenil. Use of a reversal agent is not considered de facto evidence of an adverse outcome.

(2) Moderate sedation adverse events must be reported, reviewed, trended and analyzed in conjunction with OR anesthesia adverse events and the data used to improve performance.

(3) Suspected adverse drug events will be documented. Pharmacy will be notified as per local policy.

V. RESPONSIBILITIES:
   a. Chief, Anesthesia Section – Responsibilities include oversight of the Sedation and Anesthesia Care policy and assures Anesthesiology staff are available for consultation regarding moderate sedation.
   b. Chiefs of Services using Moderate Sedation - responsible for assuring that service-specific procedures are developed for all areas within their service in which moderate sedation is carried out. Provide regular review and appropriate quality improvement activities with respect to moderate sedation monitoring and practices. Determine necessary credentials for privileging of moderate sedation providers within the service. Encourage the use of standardized language and criteria for documentation of sedation levels throughout the institution.
   c. Individual Practitioners Providing Sedation – responsible for overall supervision of the administration and rendering of sedation in compliance with the policy and procedures for sedation and anesthesia care. Specifically, responsible for preoperative evaluation of the patient, including the determination that the patient is an appropriate candidate to undergo the planned procedure. Responsible for discharging patients from the post-sedation or post-anesthesia
recovery area. Responsible for the accuracy and completion of documentation pre-, intra-, and post-sedation management.

d. Chief of Staff – responsible for the quality of sedation and anesthesia care provided to patients throughout the Medical Center.

e. Medical Center Director – responsible for approving privileges of individuals providing sedation and anesthesia care.
VI. REFERENCES:


b. Registered Nurses Engaged in the Administration of Sedation and Analgesia: Formerly Considerations for Policy Development Number 4.2 (retrieved October 31, 2013 from - http://www.aana.com/resources2/professionalpractice/Documents/PPM%20Consid%204.2%)


VII. RESCISSION: Medical Center Memorandum 11-18, dated December 2010

VIII. EXPIRATION DATE: December 2016

IX. FOLLOW-UP RESPONSIBILITY: Chief, Anesthesia Section

Linda D. Smith, FACHE
Medical Center Director

Attachments:
Attachment A: Medications Approved for Moderate Sedation
Attachment B: Transportation Restrictions for Patients Scheduled to Receive Moderate Sedation
Attachment C: Richmond Agitation-Sedation Scale

Distribution: A & B
## Attachment A: Medications Approved for Moderate Sedation

<table>
<thead>
<tr>
<th>DRUG</th>
<th>PHARMACOKINETICS</th>
<th>DOSAGE/ADMINISTRATION</th>
<th>SPECIAL CONSIDERATIONS</th>
<th>PRECAUTIONS/CONTRAINDICATIONS/SIDE EFFECTS</th>
</tr>
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<tbody>
<tr>
<td>Narcotic Analgesics:</td>
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<tr>
<td>- Fentanyl</td>
<td>Onset: within 30 seconds Peak: 5-15 minutes Duration: 30-60 minutes Metabolized: liver Elimination: pulmonary, hepatic</td>
<td>25-100 mcg (0.7-2 mcg/kg) IV injecting slowly and titrate to patient response. Maximum Dose: 250 mcg in one hour</td>
<td>Reduce dose when given with other sedatives. High doses may produce increased muscle tone and rigidity.</td>
<td>Precautions: Elderly, high risk or hypovolemic patients. Patients with COPD or bradyarrhythmias. Contraindications: Hypersensitivity Side Effects: Hypotension, bradycardia, apnea, respiratory depression, nausea, miosis, muscle rigidity.</td>
</tr>
<tr>
<td>- Meperidine (Demerol)</td>
<td>Onset: &lt;1 minute Peak: 5-20 minutes Duration: 2-4 hours Metabolized: liver Elimination: hepatic</td>
<td>25-100 mg (0.5-2 mg/kg) IV slowly injecting. Maximum Dose: 1 g/day (20 mg/kg/day).</td>
<td>Meperidine and normeperidine levels can accumulate at high doses. Can cause delirium or seizures in repeated high doses in patients with renal/hepatic impairment.</td>
<td>Precautions: Elderly, high risk or hypovolemic patients, acute abdominal conditions, severe hepatic or renal impairment. Addison's disease, head injury, asthma. Contraindications: Hypersensitivity. Causes severe and often fatal reactions in patients who are receiving MAO inhibitors. Side Effects: Hypotension, cardiac arrest, respiratory depression, respiratory arrest, euphoria, seizures, chest wall rigidity.</td>
</tr>
<tr>
<td>- Morphine</td>
<td>Onset: &lt;1 minute Peak: 5-20 minutes Duration: 2-7 hours Metabolized: liver Elimination: hepatic</td>
<td>2.5-15 mg (0.1-0.2 mg/kg) IV administered very slowly. Maximum Dose: Parenteral doses of morphine in excess of 30 mg are likely to produce serious toxic effects in the normal adult.</td>
<td>Incidences of reactivation of herpes simplex have occurred after this drug has been administered. May be caused directly by mechanical irritation of the sensory nerves when the patients scratch or by opioid activity in the medulla.</td>
<td>Precautions: Elderly, high-risk patients. Addison's disease, acute abdominal conditions, ulcerative colitis, hepatic or renal impairment. Contraindications: Hypersensitivity. Side Effects: Hypotension, hypertension, chest wall rigidity, bradycardia, bronchospasm, dysphoria, urinary retention, constipation, nausea, miosis, pruritus.</td>
</tr>
<tr>
<td>Opioid Antagonist</td>
<td>Onset: 1-2 minutes Peak: 5-15 minutes Duration: 1-4 hours Metabolized: liver Elimination: hepatic</td>
<td>0.1-2 mg IV titrating slowly to patient response. May repeat at 2-3 minute intervals. Maximum Dose: 10 mg</td>
<td>Excessive dosage of naloxone may result in reversal of analgesia and cause other significant side effects. Could cause acute abstinence syndrome in persons physically dependent on opioids. Reversal effect may wear off before narcotic effect.</td>
<td>Precautions: Patients with preexisting cardiac disease or who have received potentially cardiotoxic drugs and those physically dependent on opioids. Contraindications: Hypersensitivity. Side Effects: Tachycardia, hypertension, hypotension, arrhythmias, pulmonary edema, tremulousness, reversal of analgesia, seizures, nausea, vomiting, sweating.</td>
</tr>
<tr>
<td>DRUG</td>
<td>PHARMACOKINETICS</td>
<td>DOSAGE/ ADMINISTRATION</td>
<td>SPECIAL CONSIDERATIONS</td>
<td>PRECAUTIONS/ CONTRAINDICATIONS/ SIDE EFFECTS</td>
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</tbody>
</table>
| **Benzodiazepines:**  
- Diazepam  
(Valium)  
Reversal agent-Flumazenil (refer to end of page) | Onset: <2 minutes  
Peak: 3-4 minutes  
Duration: 15-60 minutes  
Metabolized: liver with active metabolites  
Elimination: hepatic | 2-10 mg (0.1-0.2 mg/kg) IV to be injected slowly, taking at least 1 minute for each 5 mg  
Maximum Dose: 20 mg in one hour. | Inject slowly through large veins to reduce thrombophlebitis. Do not mix or dilute with other solutions or drugs. | Precautions: Elderly/high risk or hypovolemic patients.  
Contraindications: Hypersensitivity, acute narrow angle or open angle glaucoma, psychosis.  
Side Effects: Bradycardia, hypotension, respiratory depression, drowsiness, ataxia, paradoxical excitement. |
| **-Lorazepam**  
(Athyran)  
Reversal agent-Flumazenil (refer to end of page) | Onset: 1-5 minutes  
Peak: 15-20 minutes  
Duration: 6-10 hours  
Metabolized: liver  
Elimination: mainly renal, hepatic | 1-4mg (0.02-0.08mg/kg) IV to be injected slowly, at a rate not to exceed 2mg/min with repeated aspiration. Dilute with an equal volume of NS for injection.  
Maximum Dose: 4mg | Inject slowly. Intra-arterial injection may produce arterio-spasms resulting in gangrene. Treat with phentolamine (5-10mg in 10 ml NS). Stop injection immediately if painful. | Precaution: Elderly or debilitated patients. High risk or acutely ill patients.  
Contraindications: Patients with known hypersensitivity to benzodiazepines or any ingredients in the parenteral formulation. acute-angle closure glaucoma.  
Side Effects: Hypotension, hypertension, bradycardia, tachycardia, respiratory depression, visual disturbances, dizziness, agitation, hysteria, nausea. |
| **-Midazolam**  
(Versed)  
Reversal agent-Flumazenil (refer to end of page) | Onset: 30-60 seconds  
Peak: 3-5 minutes  
Duration: 15-18 minutes  
Metabolized: liver  
Elimination: renal | 0.5-5mg (0.025-0.11mg/kg) IV-titrated slowly to the desired effect (e.g., onset of slurred speech).  
Maximum Dose: 15mg | Monitor respiratory and cardiac function continuously. Do not administer as a bolus. | Precautions: Reduce dose with elderly, high-risk, hypovolemic patients and with concomitant use of other sedatives or narcotics.  
Contraindications: Hypersensitivity, patients with acute narrow-angle or open-angle glaucoma.  
Side Effects: Tachycardia, hypotension, vasovagal episodes, hypoventilation, bronchospasm, euphoria, agitation. |
| **Benzodiazepine Receptor Antagonist**  
-Flumazenil  
(Romazicon) | Onset: 1-2 minutes  
Peak: 2-10 minutes  
Duration: 45-90 minutes  
Metabolized: liver  
Elimination: hepatic | 0.2mg IV over 15 sec. If desired level of consciousness is not obtained, 0.2 mg may be repeated at 1 min. intervals.  
Maximum Dose: 1mg. In the event of reseadation: repeat doses at 20 min intervals up to 3mg/hr. | The reversal of benzodiazepine effects may be associated with the onset of seizures in certain high-risk populations. Inject into large vein to minimize pain. | Precautions: Patients who have responded to this drug should be monitored carefully up to 120 minutes for reseadation.  
Contraindications: Not to be used in the cases of serious tricyclic antidepressant poisoning.  
Side Effects: Arrhythmias, hypertension, angina, seizures, agitation, nausea. |
attachment b: transportation restrictions for patients scheduled to receive moderate sedation

<table>
<thead>
<tr>
<th>transportation type</th>
<th>with dra*</th>
<th>without dra*</th>
<th>destination</th>
<th>acceptable</th>
<th>not acceptable</th>
<th>comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>car / taxi / bus</td>
<td>x</td>
<td></td>
<td>any destination</td>
<td>x</td>
<td></td>
<td>patient not allowed to drive</td>
</tr>
<tr>
<td>car / taxi / bus</td>
<td></td>
<td>x</td>
<td>any destination</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>dav van / va shuttle</td>
<td>x</td>
<td></td>
<td>any destination</td>
<td>x</td>
<td></td>
<td></td>
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<tr>
<td>dav van / va shuttle</td>
<td></td>
<td>x</td>
<td>any destination</td>
<td></td>
<td>x</td>
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</tr>
<tr>
<td>ambulance</td>
<td>x</td>
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<td>any destination</td>
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<td>ambulance</td>
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<td>x</td>
<td>nursing home (ecf)</td>
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<tr>
<td>ambulance</td>
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<td>any destination (except ecf)</td>
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<tr>
<td>engineering van</td>
<td></td>
<td></td>
<td>any destination</td>
<td>x</td>
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</tr>
</tbody>
</table>

("dra = designated, responsible adult) ambulance or va transport drivers are not a substitute for dra

plan of care for the domiciliary patient post-moderate sedation

- the domiciliary resident scheduled for an outpatient procedure will take the va shuttle to cvamc on the morning of the procedure.
- at the completion of the procedure, the procedure/recovery nurse will call the domiciliary nurse practitioner to give a “hand-off” report (phone number contacts: x6782 or cell 266-0116). if unable to contact np, call the domiciliary chief at x6202.
- the domiciliary nurse will notify the domiciliary assistant (da) that the resident needs to be picked up.
- the da will drive a government vehicle to cvamc, walk to the procedure department to pick up resident, escort resident back to the vehicle and drive resident back to the domiciliary.
- the da will sign-in the domiciliary resident and walk resident to his/her room.
### Attachment C: RICHMOND AGITATION-SEDATION SCALE

**RICHMOND AGITATION-SEDATION SCALE**

<table>
<thead>
<tr>
<th>Score</th>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>Combative</td>
<td>Overtly combative or violent; immediately danger to staff</td>
</tr>
<tr>
<td>+3</td>
<td>Very agitation</td>
<td>Pulls on or removes tube(s) or catheter(s) or has aggressive behavior toward staff</td>
</tr>
<tr>
<td>+2</td>
<td>Agitated</td>
<td>Frequent nonpurposeful movement or patient-ventilator dyssynchrony</td>
</tr>
<tr>
<td>+1</td>
<td>Restless</td>
<td>Anxious or apprehensive but movements not aggressive or vigorous</td>
</tr>
<tr>
<td>0</td>
<td>Alert and calm</td>
<td>Not fully alert, but has sustained (more than 10 seconds) awakening, with eye contact, to voice</td>
</tr>
<tr>
<td>-1</td>
<td>Drowsy</td>
<td>Briefly (less than 10 seconds) awakens with eye contact to voice</td>
</tr>
<tr>
<td>-2</td>
<td>Light sedation</td>
<td>Any movement (but no eye contact) to voice</td>
</tr>
<tr>
<td>-3</td>
<td>Moderate sedation</td>
<td>No response to voice, but any movement to physical stimulation</td>
</tr>
<tr>
<td>-4</td>
<td>Deep sedation</td>
<td>No response to voice or physical stimulation</td>
</tr>
<tr>
<td>-5</td>
<td>Unarousable</td>
<td>No response to voice or physical stimulation</td>
</tr>
</tbody>
</table>

**Procedure**

1. Observe patient. Is patient alert and calm? (score 0)  
   Does patient have behavior that is consistent with restlessness or agitation (score +1 to +4 using the criteria listed above, under DESCRIPTION)?

2. If patient is not alert, in a loud speaking voice state patient’s name and direct patient to open eyes and look at speaker. Repeat once if necessary. Can prompt patient to continue looking at speaker.  
   Patient has eye opening and eye contact, which is sustained for more than 10 seconds (score -1).  
   Patient has eye opening and eye contact, but this is not sustained for 10 seconds (score -2).  
   Patient has any movement in response to voice, excluding eye contact (score -3).

3. If patient does not respond to voice, physically stimulate patient by shaking shoulder and then rubbing sternum if there is no response to shaking shoulder.

4. Patient has any type of movement to physical stimulation (score -4).

5. Patient has no response to voice or physical stimulation (score -5).
1. This Memorandum No. 11-18, dated December 2013 is corrected (or amended) as follows:

IV Procedure e:
delete highlighted text. The moderate sedation training and competency will be documented and reflected in the individual’s privileges or scope of practice. At a minimum these requirements can be satisfied by the annual completion of the “Moderate Sedation National Training Program” module in LMS and biennial renewal of ACLS certification.

and replace with below

e. The moderate sedation training and competency will be documented and reflected in the individual’s privileges or scope of practice. Further, as part of a clinician’s re-privileging, or an updating of the clinician’s scope of practice, the clinician must show completion of the “Moderate Sedation National Training Program” module in LMS and renewal of ACLS certification.

New VA providers that administer, monitor, or supervise moderate sedation or perform procedures that require moderate sedation must have had, or must complete, this training within 90 days of employment with VA. This will be validated by their respective Service. Current VA providers that administer, monitor, or supervise moderate sedation, or perform procedures that require moderate sedation, must complete this training by the time of reappraisal for privileging.

b. File this Erratum Sheet at the back of the Memorandum.