

## MODERATE SEDATION BY NON-ANESTHESIA PROVIDERS

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive maintains policy that defines the provision of moderate sedation by non-Anesthesia Department of Veterans Affairs (VA) health care providers. **NOTE:** *For the purposes of this directive, non-Anesthesia VA health care providers are VA health care providers other than Anesthesiologists, Certified Registered Nurse Anesthetists (CRNAs) and Anesthesiologist Assistants.*

**2. SUMMARY OF MAJOR CHANGES:** Major changes to this VHA directive include:

- a. Clarifying parameters for the use of medications defined as sedative hypnotics by non-anesthesia providers (see paragraph 6).
- b. Updating the process for obtaining privileges to administer moderate sedation (see Appendix B).
- c. Codifying the quality improvement data requirements and processes for moderate sedation (see paragraph 5).
- d. Changing the requirements for patient evaluation and preparation (see paragraphs 5 and 7 and Appendix C).
- e. Establishing an exception for the administration of ketamine when used for non-sedation purposes (see paragraph 6).
- f. Adding awareness for continuous monitoring of ventilatory function by capnography to supplement pulse oximetry (see paragraph 9).
- g. Adding a requirement for monitoring and documenting level of consciousness (see paragraph 9).
- h. Adding a reference to VHA Directive 1157(1), Out of Operating Room Airway Management, dated June 14, 2018, to ensure VA medical facility moderate sedation providers are aware of the need for the VA medical facility to have an appropriate level of out of operating room airway management (OORAM) support during the hours that moderate sedation is performed and during the subsequent patient recovery period (see paragraph 6).
- i. Establishing uniform post-sedation requirements for patient discharge to temporary or when unaccompanied following moderate sedation (see paragraph 10).

j. Requiring the use of the VA Post-Anesthesia/Sedation Score (VA-PAS) to standardize the evaluation and documentation of patient status following the administration of sedation or anesthesia (see paragraph 3 and Appendix A).

k. Addition of language to ensure that academically affiliated VA medical facilities match or exceed the clinical and educational monitoring standards of the affiliate institution (see paragraph 9.d.).

l. An amendment, dated January 13, 2023, to include competencies in paragraph 5.i.(1)(d) and Appendix B, paragraph 3; include level of consciousness in paragraph 9.e.(3); clarify use of greater and less than in circulatory status in Appendix A; and clarify program office protocol in Appendix E, paragraph a.

**3. RELATED ISSUES:** VHA Directive 1004.08, Disclosure of Adverse Events to Patients, dated October 31, 2018; VHA Directive 1070, Adverse Drug Event Reporting and Monitoring, dated May 15, 2020; VHA Directive 1101.05(2), Emergency Medicine, dated September 2, 2016; VHA Directive 1107, VA Fisher Houses and Other Temporary Lodging, dated March 10, 2017; VHA Directive 1157(1), Out of Operating Room Airway Management, dated June 14, 2018; and VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021.

**4. RESPONSIBLE OFFICE:** The Office of Specialty Care Services (11SPEC) is responsible for the contents of this directive. Questions may be addressed to the Executive Director, National Anesthesia Program at 202-461-7120.

**5. RECISSIONS:** VHA Directive 1073, Moderate Sedation by Non-Anesthesia Providers, dated May 24, 2021, is rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of December 2027. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF  
THE UNDER SECRETARY FOR HEALTH:**

/s/ Erica Scavella, M.D., FACP, FACHE  
Assistant Under Secretary for Health  
for Clinical Services/CMO

**NOTE:** All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

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**CONTENTS**

**MODERATE SEDATION BY NON-ANESTHESIA PROVIDERS**

1. PURPOSE..... 1

2. BACKGROUND..... 1

3. DEFINITIONS ..... 1

4. POLICY ..... 3

5. RESPONSIBILITIES ..... 3

6. MODERATE SEDATION STAFFING..... 7

7. MODERATE SEDATION PRE-PROCEDURE REQUIREMENTS..... 8

8. MODERATE SEDATION RESUSCITATION EQUIPMENT ..... 9

9. MODERATE SEDATION MONITORING AND DOCUMENTATION ..... 9

10. MODERATE SEDATION PATIENT DISCHARGE REQUIREMENTS..... 11

11. TRAINING..... 12

12. RECORDS MANAGEMENT..... 12

13. REFERENCES..... 12

APPENDIX A

DEPARTMENT OF VETERANS AFFAIRS POST-ANESTHESIA/SEDATION SCORE.A-1

APPENDIX B

REQUIREMENTS FOR OBTAINING INITIAL MODERATE SEDATION PRIVILEGES OR SCOPE OF PRACTICE ..... B-1

APPENDIX C

EVALUATION FOR TEMPORARY LODGING WITHOUT AN ACCOMPANYING ADULT ..... C-1

APPENDIX D

MODERATE SEDATION-RELATED EVENT TRACKING FORM ..... D-1

APPENDIX E

PARAMETERS FOR THE SAFE ADMINISTRATION OF KETAMINE FOR NON-  
SEDATION PURPOSES .....E-1

## MODERATE SEDATION BY NON-ANESTHESIA PROVIDERS

### 1. PURPOSE

This Veterans Health Administration (VHA) directive maintains policy that defines the provision of moderate sedation by non-anesthesia Department of Veterans Affairs (VA) health care providers. **AUTHORITY:** 38 U.S.C. § 7301(b).

### 2. BACKGROUND

a. The goal of moderate sedation is to minimize a patient's pain and anxiety. Moderate sedation is administered routinely at VA medical facilities to increase the comfort of patients undergoing diagnostic and therapeutic procedures. Moderate sedation allows the patient to return to an alert state where safe discharge is possible sooner than would occur with deeper forms of sedation.

b. However, sedation is a continuum, and inadvertent progression from moderate to deep sedation may occur. It is not uncommon for the dose administered to achieve moderate sedation in one patient to obtund another. Because of patient variability, differing sedation requirements for disparate procedures, and changing therapeutic indexes of the multiple medications commonly used for sedation, practitioners trained in and credentialed for moderate sedation must be able to rescue a patient that transitions beyond moderate sedation to deep sedation.

c. For the purposes of this directive, non-anesthesia VA health care providers are VA health care providers other than Anesthesiologists, Certified Registered Nurse Anesthetists (CRNAs) and Anesthesiologist Assistants. Monitored Anesthesia Care (MAC) provided by an Anesthesiologist or CRNA is not moderate sedation. This directive excludes:

(1) Minimal sedation or anxiolysis, during which there is no significant likelihood of loss of the airway. However, if the patient unintentionally crosses into moderate sedation, then moderate sedation criteria defined within this directive will apply.

(2) Life, limb or sight-saving procedures being performed under emergency conditions with appropriate documentation in the electronic health record (EHR).

(3) Procedures carried out in intubated patients in the Intensive Care Unit (ICU) who are already being continuously monitored.

### 3. DEFINITIONS

a. **Sedation-related Event.** Sedation-related Events are unfavorable clinical incidents directly associated with moderate sedation care or services provided within the jurisdiction of a VA medical facility. **NOTE:** *This does not constitute an Adverse Event which is an untoward event as defined by VHA Directive 1004.08, Disclosure of Adverse Events to Patients, dated October 31, 2018, and must be disclosed to the patient or their personal representative as required by that directive. A Sedation Related*

*Event may also be an adverse drug event or adverse drug reaction as defined by VHA Directive 1070, Adverse Drug Event Reporting and Monitoring, dated May 15, 2020, which must be reported as required by that directive.*

b. **Capnography.** Capnography is the noninvasive measurement of the partial pressure of carbon dioxide (EtCO<sub>2</sub>) in a patient's exhaled breath expressed as the CO<sub>2</sub> concentration over time.

c. **Deep Sedation.** 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 a patient's spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

d. **Electronic Health Record.** EHR is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including Computerized Patient Record System (CPRS), Veterans Information Systems and Technology Architecture (VistA) and Cerner platforms. ***NOTE: The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.***

e. **Fast-Track Recovery.** Fast-track recovery is a Phase 1 recovery bypass concept allowing the anesthesia professional or supervising sedation provider and procedure team to determine if a patient has met the criteria to be transitioned to Phase 2 care immediately following the administration of anesthesia/sedation. This direct transfer to Phase 2 recovery may be authorized by an anesthesia professional, supervising sedation provider, or when the Department of Veterans Affairs Post-Anesthesia/Sedation Score (VA-PAS) fast-track criteria are met.

f. **Minimal Sedation.** 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 minimally affected.

g. **Moderate Sedation.** Moderate sedation, formerly called conscious 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 usually adequate. Cardiovascular function is usually maintained.

h. **Phase 1 Recovery.** Phase 1 recovery is a level of care in which close monitoring of a patient is required and the ability to provide airway and ventilatory support is readily available. Phase 1 recovery includes management of hemodynamic stability, pain management, fluid management, and other acute aspects of post-procedural patient

care. Phase 1 recovery can be provided in specifically designated areas (e.g., post-anesthesia recovery unit or intensive care unit). When a patient has demonstrated consistent stability in these elements of care, they may progress to a Phase 2 level of care. Phase 1 recovery incorporates application of a standardized evaluation criteria on admission as well as subsequent vital signs assessment, management of respiratory and hemodynamic changes, monitoring any effects of the procedure (e.g., bleeding and circulation) as well as provision of necessary analgesic and antiemetic therapy.

i. **Phase 2 Recovery.** Phase 2 recovery (e.g., Ambulatory Surgery Unit or ward) occurs after Phase 1 criteria have been met. Care in Phase 2 focuses on continued recovery and the needs of the patient with the goal of preparing the patient to be transferred home or to an extended care facility, or to an appropriate acuity location within the facility. When a patient has demonstrated consistent stability in these elements, they may progress beyond the Phase 2 level of care. VA medical facilities must ensure Registered Nurse (RN) competence in Phase 2 peri-anesthesia nursing consistent with American Society of Perianesthesia Nurses (ASPAN) practice recommendations. **NOTE:** See paragraph 5.i.(3)).

j. **Reversal Agent.** A reversal agent is any drug used to mitigate the effects of another drug. For this directive, reversal agents refer to flumazenil (a specific benzodiazepine receptor antagonist) and naloxone (a specific mu-opioid receptor antagonist).

k. **VA Post-Anesthesia/Sedation Score.** VA-PAS is the required medical scoring system for the measurement of recovery after sedation or anesthesia. This score establishes a physiologic and mental status baseline following sedation or anesthesia and subsequently determines a patient's readiness for transfer to an area requiring less intensive management after recovery from anesthesia or sedation.

#### 4. POLICY

It is VHA policy that VA health care providers ordering, administering, or supervising moderate sedation in support of patient care or research at VA medical facilities must be qualified and have appropriate credentials, privileges, or scope of practice. Each VA medical facility must implement the requirements of this directive no later than 12 months after publication of this directive.

#### 5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services.** The Assistant Under Secretary for Health for Clinical Services is responsible for ensuring the various Integrated Clinical Communities, where moderate sedation is used, have sufficient resources to implement this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards and applicable regulations.

d. **Chief Officer, VHA Specialty Care Program Office.** The Chief Officer, VHA Specialty Care Program Office (SCPO) is responsible for supporting the National Anesthesia Program (NAP) with monitoring, implementation and compliance with this directive.

e. **Executive Director, National Anesthesia Program.** The Executive Director, NAP, is responsible for:

(1) Ensuring compliance with implementation of this directive through appropriate monitoring activities and providing information to the Assistant Under Secretary for Health for Operations when assistance is needed to address non-compliance.

(2) Approving a uniform training module for moderate sedation. The uniform training module is available at the VA Talent Management System (TMS) website: <https://www.tms.va.gov/SecureAuth35/>. **NOTE:** This is an internal VA website that is not available to the public. See paragraph 11 and Appendix B for additional training information.

(3) Providing guidance to VISNs and VA medical facilities regarding conduct of anesthesia and sedation.

(4) Establishing VA moderate sedation Sedation-related Event quality metrics. **NOTE:** For the required Moderate Sedation Sedation-related Event Tracking Form, see Appendix D.

f. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Communicating the contents of this directive to each of the VA medical facilities across the VISN.

(2) Ensuring that all VA medical facilities within the VISN comply with this directive and that appropriate corrective action is taken if non-compliance is identified.



(3) Providing oversight, review and analysis of aggregated reports for trends and subsequent intervention as indicated. **NOTE:** For the required Moderate Sedation Sedation-related Event Tracking Form, see Appendix D.

**g. Veterans Integrated Services Network Chief Anesthesia Consultant and Veterans Integrated Services Network Chief Certified Registered Nurse Anesthetist Consultant.** The VISN Chief Anesthesia Consultant (VCAC) and VISN Chief Certified Registered Nurse Anesthetist Consultant (VCCC) are responsible for:

(1) Reviewing moderate sedation aggregate quality data from VA medical facilities in their VISN.

(2) Providing guidance as requested to the VISN Director when issues or trends in moderate sedation Sedation-related Events are identified at a VA medical facility.

(3) When appropriate, consulting with the Executive Director, NAP.

**h. VA Medical Facility Director.** Each VA medical facility Director is responsible for:

(1) Ensuring that the VA medical facility staff who perform or oversee moderate sedation comply with this directive and that corrective action is taken if non-compliance is identified.

(2) Ensuring that the contents of this directive are communicated to all VA medical facility staff involved in moderate sedation at the VA medical facility.

(3) Determining the level of sedation privileges by non-anesthesia providers required at the VA medical facility.

(4) Establishing a VA medical facility Sedation Committee to collect and analyze sedation data and monitor overall quality, as well as report moderate sedation data directly to or through a multi-disciplinary committee to an Executive or Clinical Executive Committee.

(5) Ensuring moderate sedation quality improvement data, including program operation and Sedation-related Events, is collected.

(6) Ensuring the involvement of clinical informatics to optimize assessment of moderate sedation quality improvement data and Sedation-related Event data.

(7) Reporting relevant moderate sedation Sedation-related Event quality metrics to the VCAC and the VCCC.

**i. VA Medical Facility Chief of Staff and VA Medical Facility Associate Director for Patient Care Services.**

(1) The VA medical facility Chief of Staff and the VA medical facility Associate Director for Patient Care Services (ADPCS) are responsible for assisting the VA medical facility Director with:

(a) Ensuring that the contents of this directive are communicated to all VA providers involved in moderate sedation at the VA medical facility.

(b) Ensuring that staff who perform moderate sedation comply with this directive.

(c) Ensuring all health care providers performing moderate sedation have current and appropriate privileges, Advanced Cardiac Life Support certification (ACLS) as indicated in VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021; including any additional training elements required by Medical Staff Bylaws.

(d) Ensuring Focused Professional Practice Evaluation (FPPE), Ongoing Professional Practice Evaluation (OPPE) and competencies are performed specific to the level of sedation in which the providers are privileged to engage. Examples of specific FPPE/OPPE elements may include the need to admit a patient to the Emergency Room post-sedation, and the need for an unplanned admission to the VA medical facility or to a higher level of care (e.g., ICU) post-sedation.

(e) Ensuring that quality improvement data including program operation and Sedation-related Events are collected.

(2) The VA medical facility Chief of Staff is responsible for assisting the VA medical facility Director with:

(a) Appointing a chair to the VA medical facility Sedation Committee (or equivalent) to oversee collection and analysis of sedation data and monitor overall quality (e.g., Chief/Lead Anesthesia Service).

(b) Ensuring the chair of the Sedation Committee (or equivalent) reports moderate sedation data directly or through a multi-disciplinary committee to an Executive or Clinical Executive Committee.

(3) The VA medical facility ADPCS is responsible for assisting the VA medical facility Director with:

(a) Ensuring non-Licensed Independent Practitioner (LIP) staff participating in moderate sedation complete initial and ongoing training for moderate sedation and capnography and demonstrate competency. Capnography training must have an action plan and timeline for resolution of less than 12 months from the time of publication of this directive.

(b) Ensuring implementation of VA-PAS in all Phase 1 and 2 recovery areas and that staff complete initial and ongoing training and competency requirements, including education regarding the concept of fast-track recovery with VA-PAS.

(c) Ensuring RN competence in Phase 1 and Phase 2 peri-anesthesia nursing practices that are consistent with ASPAN practice recommendations.

(d) Ensuring compliance, documentation and outcome monitoring if a VA medical facility approves the use of criteria for discharge from sedation/anesthesia by non-LIP staff. VA-PAS is the required VA discharge criteria tool.

j. **VA Medical Facility Sedation Committee Chair.** The VA medical facility Sedation Committee Chair is responsible for:

(1) Ensuring the Sedation Committee reports Sedation-related Events (including Adverse Drug Events [ADEs]) at least quarterly to an executive level committee either directly or through a multidisciplinary committee, including the reporting of events considered sentinel events according to VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, dated March 4, 2011. Absence of Sedation-related Events during a reporting period must be noted in the report. Events must be separated by the level of planned sedation (e.g., moderate or deep sedation).

(2) Maintaining a list of all specific areas where moderate sedation is performed and ensuring the following outcomes are monitored, systematically aggregated and analyzed to assure and enhance patient safety (*see Appendix D for an example*).

(3) Specifically addressing the total number of moderate sedation cases and the subset of those associated with adverse outcomes, including ADEs.

(4) Assessing quality improvement data and trending Sedation-related Events, including outcome parameters in Appendix D and reporting at least quarterly to the VCAC or VCCC.

***NOTE:*** *This data is used to improve patient safety Sedation-related Events reporting and follow-up documents are protected as confidential quality assurance records; disclosure of quality assurance records is limited and must comply with statutes and VA regulations and policies. Questions regarding disclosure should be directed to the VA medical facility Privacy Officer or Quality Manager, in accordance with VHA Directive 1320, Quality Management and Patient Safety Activities, dated July 10, 2020.*

## **6. MODERATE SEDATION STAFFING**

a. An appropriate level of Out of Operating Room Airway Management (OORAM) support must be available during the hours that moderate sedation is performed and during the subsequent patient recovery period as required in VHA Directive 1157(1), Out of Operating Room Airway Management, dated September 19, 2018.

b. The health care provider performing the procedure must not be the primary individual monitoring the patient. The individual responsible for monitoring the patient must be trained in the recognition of apnea and airway obstruction and be authorized to seek additional help when appropriate.

c. Appropriately trained health care staff (e.g., RNs) monitoring the patient must not be scheduled to perform additional tasks and must be in close physical proximity to the patient to enhance their ability to observe the patient. Once the patient's level of sedation and vital signs have stabilized and safe, continuous monitoring of 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.

d. Non-anesthesia VA health care providers, as defined in paragraph 2.c., may not administer medications that are categorized as sedative hypnotics (e.g., propofol, methohexital, ketamine, etomidate) except in the following circumstances:

(1) Propofol, ketamine, methohexital, or etomidate administered for the purpose of immediately securing the airway by endotracheal intubation.

(2) Ketamine administered as an IV infusion by non-anesthesia, non-deep sedation providers for purposes other than the provision of moderate sedation (see Appendix E).

e. Individuals intending to provide a deeper plane of sedation or utilize medications defined as sedative hypnotics for the purpose of this directive need to meet the requirements set forth in VHA Notice 2022-18, Deep Sedation, dated December 20, 2022.

## **7. MODERATE SEDATION PRE-PROCEDURE REQUIREMENTS**

a. Staff privileged to provide moderate sedation must be involved in the planning and provision of sedation care to the patient.

b. In addition to the routine procedural prerequisites recorded in the EHR the following must also be included:

(1) Preoperative testing guided by patient status and comorbidities must be ordered pre-procedure and be reviewed by the sedation provider or proceduralist prior to the procedure. If indicated, appropriate specialty consultation will be obtained prior to the procedure.

(2) Documentation of LIP supervision and concurrence with or preparation of the plan for moderate sedation.

(3) A pre-sedation assessment must contain the relevant history and physical and include:

(a) An assessment and documentation of the status of the airway. Patients with potentially compromised airways due to anatomic or other reasons (e.g., limited mouth opening due to disease or surgery) should have an evaluation by an anesthesiology provider as part of the pre-procedure evaluation.

(b) A history of any previous adverse experience with sedation, analgesics, regional or general anesthesia.

(c) A review of tobacco, alcohol, substance use or misuse.

(d) The time and nature of last oral intake. The fasting requirements set forth by the American Society of Anesthesiology Practice Guidelines should be considered for non-emergent cases. These guidelines are available at <https://pubs.asahq.org/anesthesiology/article/126/3/376/19733/Practice-Guidelines-for-Preoperative-Fasting-and>. **NOTE:** *This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

(e) An assignment of a risk assessment score according to the American Society of Anesthesiologists' Physical Status (ASA score).

(f) A re-evaluation of the patient immediately prior to the initiation of sedation for any change(s) since the prior assessment, including pre-sedation vital signs.

(4) An Anesthesiology consultation should be considered for patients with significant, severe comorbidities with a view to identifying the high-risk patient for possible anesthesia participation in sedation care.

## **8. MODERATE SEDATION RESUSCITATION EQUIPMENT**

Appropriate equipment and medications (including reversal agents) for the delivery of care and resuscitation must be available in the immediate area where moderate sedation is performed. This must include equipment for airway management (e.g., oral and nasal airways, bag-valve mask, emergency airway equipment such as laryngeal mask airways), emergency cardiovascular medications and equipment for intravenous access and fluid resuscitation.

## **9. MODERATE SEDATION MONITORING AND DOCUMENTATION**

a. Physiologic monitoring must include intermittent blood pressure, continuous electrocardiography and continuous pulse oximetry. Alarms must be set appropriately and enabled for the entire episode of sedation (see also paragraph 9.e.).

b. The adequacy of ventilatory function must be monitored and documented. Capnography should be considered during the conduct of moderate sedation, especially for high-risk patients, at the discretion of the proceduralist.

c. Acuity of the patient must be considered when determining if other tasks can be accomplished safely. Continuous EtCO<sub>2</sub> monitoring and documentation is required if the sedation nurse will be performing additional, repeated tasks.

d. For VA medical facilities with trainees involved in the provision of moderate sedation, the requirements for monitoring, including capnography, must match or exceed the academic affiliate's training requirements.

e. Peri-procedural documentation of moderate sedation in the patient's EHR must include specific medication dosing, route and time of administration. Further, physiological parameters must be monitored and documented as follows:

(1) Physiologic parameters monitored continuously:

(a) Heart rate.

(b) Pulse Oximetry.

(c) EtCO<sub>2</sub> if utilized.

(2) Physiologic parameters documented at least every 5 minutes:

(a) Blood pressure.

(b) Heart rate.

(c) Level of consciousness (e.g., Alert, Verbal, Pain, Unresponsive (AVPU) scale), see also paragraph 9.e.(3)(d).

(3) Physiologic parameters documented at least every 15 minutes:

(a) Pulse Oximetry.

(b) Heart rhythm.

(c) Capnography (if utilized).

(d) Level of consciousness (e.g., AVPU scale) if continuous capnography is utilized and documented as set forth in paragraph 9.e.(1)(c).

f. Moderate sedation documentation must include all required physiologic parameters and pharmacologic data as described in paragraph 9.a.-e. This is best accomplished by using the EHR integrated anesthesia module. **NOTE:** VA medical facilities must provide documentation through the EHR system in use at their facility. If an EHR module cannot be used, VA medical facilities must provide complete data sets as noted above and in Appendix A to ensure comprehensive, quality data is acquired by VISN and VHA leaders. Use of a CPRS template with data tracking capabilities created by the national template workgroup will be accepted in lieu of EHR anesthesia module until a universal module is available. Alternatively, if neither the anesthesia module nor

the CPRS module is utilized, facilities will be responsible for providing complete data sets as noted above to ensure comprehensive quality data is acquired (i.e., physiologic data and medications). VA medical facilities will also be responsible for providing data analyses as noted in Appendix D. When a Sedation-related Event occurs, requisite data must be recorded as outlined in Appendix D and reported to the VA medical facility Sedation Committee.

g. If a first attempt at a procedure is unsuccessful and the sedation provider judges the procedure likely to be successful at the same level of sedation using a different technique or approach, re-sedation may be attempted once. If the target level of sedation is achieved during the second attempt but the procedure is still unsuccessful and further attempts are needed that will require a deeper level of sedation, anesthesia consultation should be initiated.

h. Post-procedural documentation of an assessment immediately after the procedure and prior to transport to the recovery area must include vital signs, mental status and pain level.

i. Monitoring during transport to the recovery area may be observational or electronic depending on the condition of the patient and the potential effects of the procedure or sedation.

## 10. MODERATE SEDATION PATIENT DISCHARGE REQUIREMENTS

a. The decision for fast-track recovery and discharge from Phase 1 or Phase 2 must be documented in the EHR by:

(1) A qualified LIP using independent clinical judgment; or

(2) A qualified non-LIP, such as nursing staff, using VA-PAS (see Appendix A).

**NOTE:** Use of VA-PAS for discharge from sedation/anesthesia by non-LIP staff must be approved by the VA medical facility leadership.

b. 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 VA medical facility without inpatient services must:

(1) Deliver necessary immediate treatment(s) to stabilize the patient's condition.

(2) Facilitate transfer as soon as possible to a site that can support the Veteran's needs. Arrangements for transfer to sites of community care must 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.*

c. When moderate sedation is performed with the medications addressed in Appendix C and once discharge criteria are met, a patient may be discharged from Phase 2 recovery to home if they are accompanied. If unaccompanied, a patient may

only be discharged with proper transportation arranged according to VHA Directive 1695(1), Veterans Transportation Services, dated September 18, 2019. If leaving unaccompanied, the only acceptable modes of transportation to the patient's home are described in the Post Sedation Anesthesia Care and Discharge Toolkit (see paragraph 13.o. for website link). Alternatively, if a patient meets the eligibility requirements for the consideration of temporary lodging according to VHA Directive 1107, VA Fisher Houses and Other Temporary Lodging, dated March 10, 2017, the patient may be discharged to a temporary lodging as specified in Appendix C.

## 11. TRAINING

a. Required Moderate Sedation training is addressed in Appendix B, Requirements for Obtaining Initial Moderate Sedation Privileges or Scope of Practice.

b. The following additional training is recommended: A Moderate Sedation Toolkit for non-anesthesia providers is available for review at the National Center for Patient Safety's website: <https://www.patientsafety.va.gov/professionals/onthejob/sedation.asp>. The toolkit is a resource for personal development and learning.

## 12. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

## 13. REFERENCES

a. VHA Directive 1004.08, Disclosure of Adverse Events to Patients, dated October 31, 2018.

b. VHA Directive 1070, Adverse Drug Event Reporting and Monitoring, dated May 15, 2020.

c. VHA Directive 1107, VA Fisher Houses and Other Temporary Lodging, dated March 10, 2017.

d. VHA Directive 1139, Palliative Care Consult Teams and Veterans Integrated Service Network Leads, dated September 9, 2022.

e. VHA Directive 1157(1), Out of Operating Room Airway Management, dated June 14, 2018.

f. VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021.

g. VHA Directive 1320, Quality Management and Patient Safety Activities, dated July 10, 2020.



h. VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.

i. VHA Directive 1695(1), Veterans Transportation Services, dated September 18, 2019.

j. VHA Notice 2022-18, Deep Sedation, dated December 20, 2022.

k. VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, dated March 4, 2011.

l. American Society of Anesthesiologists. Practice Guidelines for Moderate Procedural Sedation and Analgesia, <https://www.asahq.org/standards-and-guidelines>.

m. American Society of Anesthesiologists. ASA Physical Status Classification System. American Society of Anesthesiologists/ASA House of Delegates/Executive Committee, dated October 23, 2019. <https://www.asahq.org/-/media/sites/asahq/files/public/resources/standards-guidelines/asa-physical-status-classification-system>.

n. American Society of Anesthesiologists. Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures: An Updated Report by the American Society of Anesthesiologists Task Force on Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration, <https://pubs.asahq.org/anesthesiology/article/126/3/376/19733/Practice-Guidelines-for-Preoperative-Fasting-and>. **NOTE:** *This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

o. VA National Center for Patient Safety (NCPS). A Moderate Sedation Toolkit for Non-Anesthesiologists, <https://www.patientsafety.va.gov/professionals/ontheconsob/sedation.asp>.

p. Post Sedation Anesthesia Care and Discharge Toolkit: <https://dvagov.sharepoint.com/:f:/r/sites/social-work-matters/VA%20SW%20Leadership%20Quick%20Links/Post%20Sedation%20Anesthesia%20Care%20and%20Discharge%20Toolkit?csf=1&web=1&e=yriYcL>. **NOTE:** *This is an internal VA website that is not available to the public.*

## DEPARTMENT OF VETERANS AFFAIRS POST-ANESTHESIA/SEDATION SCORE

## Phase 1 Discharge Criteria

<b>OXYGENATION</b>	<b>Points</b>
SpO <sub>2</sub> ≥ 94% (or baseline) on room air	2
SpO <sub>2</sub> ≥ 94% (or baseline minus 2%) with oxygen	1
SpO <sub>2</sub> < 94% (or baseline minus 2%) with oxygen	0
<b>PAC(U) RESPIRATORY STATUS</b>	
Normal breathing, deep cough on command	2
Inadequate coughing or coughing without command	1
Tachypneic, Dyspneic, requires assisted ventilation or airway device	0
<b>CIRCULATORY STATUS</b>	
BP/HR less than 20% or 20 mmHg of baseline	2
BP/HR 20-40% or 20-40 mmHg, no orthostasis	1
BP/HR greater than 40% or 40 mmHg, or orthostasis	0
<b>LEVEL OF CONSCIOUSNESS</b>	
Fully awake or easily awakened	2
Arousable, but delayed	1
Not responding or responding only with tactile stimulation	0
<b>PAIN</b>	
Minimal or none – Pain score 0-4 or at tolerable level or at baseline	2
Moderate, requiring oral medication – Pain score 5-7 or 3 above baseline	1
Severe, requiring intravenous opioid treatment – Pain score 8-10	0
<b>NAUSEA/VOMITING</b>	
Minimal or none	2
Moderate (requiring medication)	1
Severe	0
<b>LEVEL OF ACTIVITY</b>	
Able to move all extremities voluntarily or on command, or moves all extremities with the exception of extremity treated with peripheral nerve block, or patient baseline (e.g., SCI)	2
Moves at least two extremities (or baseline moving less than all extremities)	1
Unable to voluntarily move extremities on command	0

**Score of 13 is fit for discharge from Phase 1**

**NOTE:** For discharge by criteria to Phase 2 the patient must have a minimum score of 13. A patient with a score < 13 can be discharged from Phase 1 after a documented review from a qualified Licensed Independent Practitioner (LIP). If the patient is unable to meet scoring threshold, Hospital admission vs. Monitored bed is recommended. For fast tracking to Phase 2 recovery by criteria, the patient should have had no IV controlled substances within 30 minutes.

Phase 2 Discharge Criteria	Points
<b>PAIN</b>	
Minimal or none – Pain score 0-4 or at tolerable level or at baseline	2
Moderate, requiring oral medication – Pain score 5-7 or 3 above baseline	1
Severe, requiring intravenous opioid treatment – Pain score 8-10	0
<b>NAUSEA/VOMITING</b>	
Minimal or none	2
Moderate (requiring medication)	1
Severe	0
<b>CIRCULATORY STATUS</b>	
BP/HR less than 20% or 20 mmHg of baseline	2
BP/HR 20-40% or 20-40 mmHg, no orthostasis	1
BP/HR greater than 40% or 40 mmHg, or orthostasis	0
<b>ACTIVITY and MENTAL STATUS</b>	
Oriented x 3 AND has steady gait (at baseline for non-ambulating patients)	2
Oriented x 3, OR has steady gait, (returning to baseline for non-ambulating patients)	1
Neither Oriented x3 or steady gait	0
<b>SURGICAL SITE/DRESSING</b>	
Dry and Clean or Not Applicable (e.g. Endoscopy)	2
Wet but stationary and marked/minimal bleeding	1
Growing area of wetness/active bleeding	0

**Score of 9 is fit for discharge.** A patient with a score < 9 can be discharged from Phase 2 after a documented review from a qualified LIP.

**NOTE:** A score of “0” in any category or any deterioration in patient condition excludes eligibility for discharge unless approved by a qualified surgeon/proceduralist.

**REQUIREMENTS FOR OBTAINING INITIAL MODERATE SEDATION PRIVILEGES  
OR SCOPE OF PRACTICE**

1. An individual must demonstrate sufficient knowledge to administer, monitor or supervise moderate sedation by:

a. Obtaining a passing score on the Department of Veterans Affairs (VA) Talent Management System (TMS) Moderate Sedation test. The passing score (established by TMS) must have been obtained no more than 120 days before the privileging or scope of practice action. This may be accomplished through successful completion of:

(1) National Moderate Sedation Test Out Exam (VA TMS Item #31266); or

(2) National Moderate Sedation Didactic Training with the test (VA TMS Item #32979) for those desiring or requiring (unsuccessful test out) a refresher.

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

2. Advanced Cardiac Life Support (ACLS) certification or equivalent according to Veterans Health Administration (VHA) Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021.

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

**4. REQUIREMENTS FOR REAPPRAISAL/REASSESSMENT OF MODERATE  
SEDATION PRIVILEGES OR SCOPE OF PRACTICE**

a. Continued moderate sedation competency must be demonstrated at the time of reappraisal of privileges or scope of practice. Continued competency must include the demonstration of moderate sedation skill over the prior evaluation period as well as current cognitive understanding. Successful continued competency over time may be documented in the Ongoing Professional Practice Evaluation (OPPE) or periodic competency assessment with subsequent re-privileging or updating of a scope of practice or functional statement in accordance with local policy. If the OPPE or competency assessment review does not demonstrate ongoing successful moderate sedation practice, then the individual must be considered a new applicant for moderate sedation privileges or scope of practice and go through the process defined above for initial privileges or scope of practice.

b. Current ACLS certification or equivalent as stated in VHA Directive 1177.

## EVALUATION FOR TEMPORARY LODGING WITHOUT AN ACCOMPANYING ADULT

1. Evaluation of the patient's possible need for non-clinical temporary lodging and their capability for self-care in an unsupervised setting prior to procedural scheduling is recommended.

### 2. ELIGIBILITY

a. Patient must have been able to provide self-care prior to the procedure and is expected to be able to provide self-care following the procedure.

b. Patient may not be receiving post-operative opiate analgesics.

c. Patient may not have a diagnosis of sleep apnea.

d. Patient must have a sleep apnea screening assessment conducted by the procedural provider and documented to assess for the probability of undiagnosed sleep apnea. A score indicative of undiagnosed moderate sleep apnea may negate eligibility for Temporary Lodging.

e. The decision will be dependent on the sedative(s) or anesthetic(s) provided. Most Veterans will be Temporary Lodging eligible approximately 5 hours after the last administration of intravenous or inhalant sedating agent. For the purposes of moderate sedation, controlled substance medications such as fentanyl and midazolam, with particularly short half-lives are preferred, and referenced below:

(1) The elimination half-life of fentanyl ( $t_{1/2\beta}$ ) is 219 minutes or 3.65 hours.

(2) The median elimination half-life of midazolam is 1.8 hours (range 2.1 to 6.2 hours).

### 3. DETERMINATION

At the time of consideration for transition to temporary lodging a Department of Veterans Affairs (VA) provider will determine and document the patient's current medical stability in the patient's electronic health record (EHR), including acknowledgement that the patient is capable of self-care in an unsupervised setting.

**MODERATE SEDATION-RELATED EVENT TRACKING FORM**

PLEASE COMPLETE THIS FORM FOR EACH SEDATION-RELATED EVENT AND ATTACH THE MODERATE SEDATION PRE-PROCEDURE ASSESSMENT AND FLOW SHEET.

<b>Sedation-Related Event Tracking</b>	<b>Yes</b>	<b>No</b>
Were reversal agents administered (e.g., naloxone, flumazenil)?		
Was placement of an oral airway or a nasal trumpet necessary? <i>(This does not include placement of a bite block for oral procedures)</i>		
Was a supraglottic airway placed? (e.g., laryngeal mask airway (LMA))		
Was it necessary to assist the patient's ventilation (e.g., bag-valve-mask)?		
Did the patient's oxygen saturation decrease to <85% for more than 3 minutes?		
Was a code blue activated related to the procedure/sedation?		
Additional element if reporting any of the above: was capnography utilized and documented for the procedure?		

**PARAMETERS FOR THE SAFE ADMINISTRATION OF KETAMINE FOR NON-  
SEDATION PURPOSES**

Ketamine that is not administered for the purpose of sedation may be prescribed by non-anesthesia providers within established safety parameters as specified below.

**NOTE:** *Ketamine should not be administered as an IV bolus by non-anesthesia, non-deep sedation providers.*

a. Infusion up to 1mg/kg ideal body weight (IBW) administered over 30 minutes to 2 hours in a single day as set forth in a national specialty program office-approved protocol (e.g., mental health, chronic pain, emergency medicine, pharmacy).

b. Continuous infusions of less than or equal to 0.5mg/kg/hour IBW may be admitted to wards. Minimum monitoring and documentation requirements:

(1) Initiation of Infusion. Non-invasive blood pressure, respiratory rate, sedation scale, and oximetry every hour for the first 4 hours. A Licensed Independent Practitioner (LIP) or level 3 Out of Operating Room Airway Management (OOORAM) provider is to remain at bedside for first 15 minutes of the infusion.

(2) Continuation of Infusion. Non-invasive blood pressure, respiratory rate and sedation scale every 4 hours for the duration of ketamine therapy.

(3) A Code team is immediately available.

c. Continuous infusions of greater than 0.5mg/kg/hour IBW must be admitted to the Intensive Care Unit (ICU) or similar monitored unit in addition to the above monitoring and documentation requirements.

d. Palliative care dosing as per their specialty guidelines and Veterans Health Administration (VHA) directives (e.g., palliative care consult complexity level 3 or higher inpatient in accordance with VHA Directive 1139, Palliative Care Consult Teams and Veterans Integrated Service Network Leads, dated September 9, 2022).

e. Continuous infusions of greater than 5 days require an Anesthesia consultation.

**NOTE:** *In all other circumstances, due to their narrow therapeutic index and lack of reversal agents, sedative hypnotics must be administered by an Anesthesiologist, Certified Registered Nurse Anesthetist (CRNA) or an LIP with the training and ability to manage an airway and rescue a patient from general anesthesia. Administration of these medications in any dose is not considered moderate sedation and is considered to be within the scope of deep sedation. If the individual is a non-anesthesia LIP, they must be privileged as both an OOORAM level 3 provider and as a deep sedation provider. Deep sedation is outside the scope of this directive.*