

## 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. Changing the process for obtaining privileges to administer moderate sedation.
- b. Changing the requirements for patient evaluation and preparation.
- c. Adding a requirement for continuous capnography monitoring.

d. 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 7).

e. Adding an evaluation process for temporary lodging for patients without an accompanying adult (see Appendix C).

**3. RELATED ISSUES:** VHA Directive 1004.08, Disclosure of Adverse Events to Patients, dated October 31, 2018; VHA Directive 1101.05(2), Emergency Medicine, dated September 2, 2016; 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 National Director of Anesthesia Service at [vhanas@med.va.gov](mailto:vhanas@med.va.gov).

**5. RECISSIONS:** VHA Directive 1073, Moderate Sedation by Non-Anesthesia Providers, dated December 30, 2014, is rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of May 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

May 24, 2021

VHA DIRECTIVE 1073

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

/s/ Kameron Matthews, MD, JD, FAAFP  
Assistant Under Secretary for Health  
for Clinical Services

***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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## 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. **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. This directive does not apply to minimal sedation or anxiolysis nor to procedures carried out in intubated patients in the Intensive Care Unit (ICU) who are already being continuously monitored. Monitored Anesthesia Care (MAC) provided by an anesthesiologist or CRNA is not moderate sedation.* **AUTHORITY:** 38 U.S.C. § 7301(b).

### 2. BACKGROUND

Moderate sedation is done routinely at VA medical facilities to increase the comfort of patients undergoing diagnostic and therapeutic procedures. Moderate sedation can minimize a patient's pain and anxiety. With moderate sedation the patient returns to an alert state where safe discharge is normally faster than would occur with deeper forms of sedation. Sedation is a continuum and inadvertent progression from moderate to deep sedation, although rare, may occur.

### 3. DEFINITIONS

a. **Adverse Drug Event.** Adverse events are untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers.

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

c. **Deep Sedation (Analgesia).** 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 spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

d. **Electronic Health Record.** 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 allowing the anesthesia professional 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 or when the Department of Veterans Affairs Post Anesthesia Score (VA-PAS) fast track criterion is met.

f. **Minimal Sedation (Anxiolysis).** 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 or Analgesia.** Moderate sedation is the depression of consciousness as achieved by the careful titration of medications to the point where the patient still responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. In such a state, no interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Reflex withdrawal from a painful stimulus is not considered a purposeful response.

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 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, circulation,) as well as provision of necessary analgesia and antiemetic therapy.

i. **Phase 2 Recovery.** Phase 2 recovery (e.g., Ambulatory Surgery Unit or floor) 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.

j. **Reversal Agent.** A reversal agent is any drug used to reverse the effects of another drug, including anesthetics, neuromuscular blockers, narcotics, anticoagulants, or other potentially toxic agents. 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 medical scoring system for the measurement of recovery after sedation or anesthesia. This score is used to establish a physiologic and mental status baseline upon arrival in the recovery area, as

well as to subsequently determine a patient's readiness for transfer to an area of the hospital requiring less intensive care after recovery from anesthesia or sedation.

#### 4. POLICY

It is VHA policy that any VA health care providers ordering, administering, or supervising the performance of 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 to perform moderate sedation. Each VA medical facility must implement the requirements of this directive no later than 6 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 Clinical Services is responsible for ensuring the various Integrated Clinical Communities 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. **Director, VHA Office of Specialty Care Services.** The Director, VHA Office of Specialty Care Services is responsible for supporting NAS with monitoring implementation and compliance with this directive.

e. **Director, National Anesthesia Service.** The Director, National Anesthesia Service (NAS), is responsible for:

(1) Maintaining a uniform training module for moderate sedation. The uniform training module is available at 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. Please see paragraph 11 for additional training information.

(2) Providing guidance to VISNs and VA medical facilities regarding moderate sedation.

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 a tracking form example, 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 and VISN Chief Certified Registered Nurse Anesthetist Consultant are responsible for:

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

(2) Responding as delegated by the VISN Director when issues or trends in moderate sedation adverse events are identified at a VA medical facility.

(3) When appropriate, consulting with the Director, National Anesthesia Service.

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

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

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

(3) Ensuring that quality improvement data, including program operation and adverse events, is collected.

(4) Ensuring the involvement of clinical informatics to optimize assessment of quality improvement data and adverse event trending.

(5) Reporting trends in adverse events to the VISN Chief Anesthesiology Consultant and the VISN Chief Certified Registered Nurse Anesthetist Consultant.

**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 are responsible for assisting the VA medical facility Director with:

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

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

(c) Ensuring all non-anesthesia health care providers performing moderate sedation have current and appropriate privileges, Advanced Cardiac Life Support certification (ACLS) or equivalent according to VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021, and any additional training elements required by Medical Staff Bylaws.

(d) Ensuring staff engaging in moderate sedation complete initial and ongoing training for moderate sedation and demonstrate competency.

(e) Ensuring Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) is performed specific to moderate sedation for providers engaging in moderate sedation.

(f) Ensuring that quality improvement data including program operation and adverse 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 Moderate Sedation Committee (or equivalent) to collect and analyze moderate sedation data and monitor overall quality.

(b) Ensuring the chair of the Moderate 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 Associate Director for Patient Care Services is responsible for assisting the VA medical facility Director with:

(a) Ensuring non-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 6 months from the time of publication of the directive.

(b) Ensuring the implementation of VA-PAS in all Phase 1 and 2 recovery areas and that staff complete initial and ongoing training and competency requirements.

(c) Ensuring compliance, documentation and outcome monitoring if a VA medical facility allows use of VA-PAS for discharge from sedation/anesthesia by non-LIP staff.

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

(1) Ensuring the Moderate Sedation Committee submits a moderate sedation report (at least quarterly) directly or through a multidisciplinary committee (e.g., an Executive or Clinical Executive level board) to facility leadership. An absence of moderate sedation adverse events during a reporting period must be noted in the Moderate Sedation Committee report.

(2) Maintaining a list of all specific areas where moderate sedation is performed and ensuring pertinent outcomes as listed below are monitored, systematically aggregated and analyzed to assure and enhance patient safety.

(3) Ensuring that adverse drug events (ADE) and other adverse outcomes associated with moderate sedation are reported to the Moderate Sedation Committee as appropriate.

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

(5) Assessing quality improvement data and adverse event trending including the following outcome parameters (see Appendix D):

(a) Cases cancelled due to patient discomfort or anxiety;

(b) Cases with unplanned escalation in the continuum of sedation (e.g., from moderate to deep sedation);

(c) Patients receiving reversal agents: flumazenil or naloxone;

(d) Patients requiring placement of nasal trumpet or oral airway (not including bite block for oral procedures);

(e) Patients requiring placement of supraglottic airway (e.g., LMA) or endotracheal tube;

(f) Patients requiring assisted ventilation with bag-valve-mask;

(g) Patients that experience a decrease in oxygen saturation <85% for more than 3 minutes;

(h) Patients with respiratory rates less than 8 or EtCO<sub>2</sub> higher than 60 mm Hg for more than 3 minutes;

- (i) Patients that experience an unplanned admission within 24 hours of the procedure;
- (j) Patients that incur an unplanned patient transfer to an Emergency Department in the peri-procedural period;
- (k) Cases with a code call or activation of an emergency response during the procedure and recovery period.

**NOTE:** *This data is used to improve patient safety. Adverse event 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 policy regulations and policies. Questions regarding disclosure should be directed to the VA medical facility Privacy Officer or Quality Manager.*

## 6. MODERATE SEDATION STAFFING

- a. An appropriate level of Out of Operating Room Airway Management (OOORAM) support must be available on site 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.
- c. Appropriately trained health care staff (e.g., Registered Nurses) monitoring the patient must not routinely perform additional tasks during the conduct of moderate sedation and must remain in close physical proximity to the patient to enhance their ability to observe the patient.
- d. For purposes of moderate sedation, medications that are categorized as sedative hypnotics (e.g., propofol, methohexital, ketamine, etomidate) must be administered by an anesthesiologist, CRNA, or a Licensed Independent Practitioner (LIP) with the training and ability to rescue a patient from general anesthesia who is also privileged as an OOORAM level 3 provider (see VHA Directive 1157(1)). Due to their narrow therapeutic index, the use of etomidate, propofol, methohexital and ketamine requires a level of care comparable to that encountered in a general anesthetic. These medications are not appropriate for use in moderate sedation due to their propensity to evolve to deep sedation and general anesthesia with little advance warning. Should deep sedation be entertained, a separate deep sedation consent and a process that clearly identifies the deep sedation privileged provider responsible for the administration, monitoring and documentation of deep sedation, distinct from the proceduralist, is required. **NOTE:** *Ketamine in a total dose of less than or equal to 0.5 mg/kg is excepted and may be prescribed by non-anesthesia providers.*

## 7. MODERATE SEDATION PRE-PROCEDURE REQUIREMENTS

a. Staff privileged to provide moderate sedation must be involved in the planning and provision of moderate 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 the patient status and comorbidities must be ordered pre-procedure and be reviewed by the provider of the moderate sedation or proceduralist prior to the procedure. If indicated based on the testing results, appropriate specialty consultation will be obtained prior to the procedure.

(2) LIP documentation of concurrence with or preparation of the plan for moderate sedation.

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

(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 or analgesia, or regional or general anesthesia.

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

(d) An assessment and documentation of the time and nature of last oral intake with adherence to the American Society of Anesthesiologists' Physical Status (ASA) pre-procedure fasting guidelines (excluding the administration of medications required for the procedure).

(e) An assignment and documentation of a risk assessment score according to the ASA.

(f) A re-evaluation of the patient immediately prior to the initiation of moderate sedation for any change(s) since the prior assessment, which will be documented as the first entry on the procedural record and will include pre-sedation vital signs.

(4) An Anesthesiology consultation should be obtained for high-risk patients with comorbidities such as severe obstructive sleep apnea, severe chronic obstructive airway disease, Body Mass Index (BMI) greater than 40, severe organ dysfunction or failure, chronic opioid therapy, those identified at risk for potential adverse drug interactions, and any other significant risks identified by the evaluating provider.

## 8. MODERATE SEDATION RESUSCITATION EQUIPMENT

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

## 9. MODERATE SEDATION MONITORING AND DOCUMENTATION

a. Documentation of moderate sedation in the patient's EHR must include:

(1) Periprocedural documentation:

(a) Specific medication dosing, route and time of administration.

(b) Physiologic parameters monitored continuously:

1. Physiologic parameters recorded at least every 5 minutes:

2. Heart rate.

3. Blood pressure.

(c) Physiologic parameters recorded at least every 15 minutes:

1. Pulse Oximetry.

2. EtCO<sub>2</sub> by continuous waveform capnography.

3. Respiratory rate.

(2) Post-procedural documentation of an assessment immediately after the procedure and prior to transport to the recovery area that includes vital signs, mental status, and pain level.

(3) 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.

b. Any exception to the above documentation requirements and the reason for such exception(s) must be documented in the individual EHR.

## 10. MODERATE SEDATION PATIENT DISCHARGE REQUIREMENTS

a. The discharge decision must be documented in the EHR by the moderate sedation provider.

b. Discharge from recovery (e.g., Phase 1 or Phase 2) requires documentation of the patient's recovery by:

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

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

**NOTE:** Use of VA-PAS for discharge from sedation/anesthesia by non-LIP staff must be approved by the VA medical facility Executive Council of Medical Staff, Associate Director for Patient Care Services or equivalent.

c. 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 services immediately to stabilize the patient's condition.

(2) Facilitate transfer as soon as possible to a facility 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.*

d. When moderate sedation is performed with the medications addressed in Appendix C and once discharge criteria are met, patient may be discharged from Phase 2 recovery to home if they are accompanied. If unaccompanied, the patient may be discharged to a temporary lodging as specified in Appendix C. A patient may not be discharged without proper transportation arranged (see VHA Directive 1695, 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 at <https://dvagov.sharepoint.com/sites/VHACMSWS/SocialWork/Post%20Sedation%20Anesthesia%20Care%20%20Discharge/Forms/AllItems.aspx?viewpath=%2Fsites%2FVHACMSWS%2FSocialWork%2FPost%20Sedation%20Anesthesia%20Care%20%20Discharge%2FForms%2FAllItems.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

## 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 1157(1), Out of Operating Room Airway Management, dated June 14, 2018.
- b. VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021.
- c. VHA Directive 1695, Veterans Transportation Services, dated September 18, 2019.
- d. American Society of Anesthesiologists. Practice Guidelines for Moderate Procedural Sedation and Analgesia, <https://www.asahq.org/standards-and-guidelines>.
- e. 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>.
- f. American Society of Anesthesiologists. Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who Are Not Anesthesia Professionals, <https://www.asahq.org/standards-and-guidelines>.
- g. The Joint Commission. 2019 Comprehensive Accreditation Manual for Hospitals. January 2019.
- h. VA National Center for Patient Safety (NCPS). A Moderate Sedation Toolkit for Non-Anesthesiologists, <https://www.patientsafety.va.gov/professionals/ontheconsob/sedation.asp>.
- i. Post Sedation Anesthesia Care and Discharge Toolkit: <https://dvagov.sharepoint.com/sites/VHACMSWS/SocialWork/Post%20Sedation%20Anesthesia%20Care%20%20Discharge/Forms/AllItems.aspx?viewpath=%2Fsites%2FVHACMSWS%2FSocialWork%2FPost%20Sedation%20Anesthesia%20Care%20%20Discharge%2FForms%2FAllItems.aspx>. **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>
SpO2 $\geq$ 94% (or baseline) on room air	2
SpO2 $\geq$ 94% (or baseline minus 2%) with oxygen	1
SpO2 < 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 +/- 20% or 20 mmHg of baseline	2
+/- 20-40% or 20-40 mmHg, no orthostasis	1
+/- 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 to Phase 2 the patient must have a minimum score of 13. Patient with a score < 13 can be discharged from Phase 1 after a review from a qualified provider. If the patient is unable to meet scoring threshold, Hospital admission vs. Monitored bed is recommended. For fast tracking to Phase 2 recovery, the patient should have had no IV controlled substances within 30 minutes.

**Phase 2 Discharge Criteria**

**Points**

**PAIN**

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

**NAUSEA/VOMITING**

Minimal or none	2
Moderate (requiring medication)	1
Severe	0

**CIRCULATORY STATUS**

BP/HR +/- 20% or 20 mmHg of baseline	2
+/- 20-40% or 20-40 mmHg, no orthostasis	1
+/- 40% or 40 mmHg, or orthostasis	0

**ACTIVITY and MENTAL STATUS**

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

**SURGICAL SITE/DRESSING**

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**

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

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

4. The Associate Director for Patient Care Services has responsibility for the non-LIP education and training on the discharge process, using the VA Post Anesthesia Score (VA-PAS) and capnography (e.g., VA TMS Item #100021, Capnometry and Capnography).

**5. 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 time period as well as current cognitive understanding. Successful continued competency over time may be documented in the Ongoing Professional Practice Evaluation (OPPE) specific to moderate sedation 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.

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APPENDIX B**

b. Current ACLS certification or equivalent.

## EVALUATION FOR TEMPORARY LODGING WITHOUT AN ACCOMPANYING ADULT

1. Evaluation of the patient's possible need for 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 and documented by the procedural provider 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 for eligibility will be dependent on the sedatives provided. Anxiolytics and analgesics are by nature reversible and their effects are of limited duration. Most Veterans will be Temporary Lodging eligible approximately 5 hours after the last administration of a sedating agent. For the purposes of moderate sedation, controlled substance medications eligible for consideration of the use of temporary lodging are fentanyl and midazolam.

(1) The terminal half-life of fentanyl is  $t_{1/2\alpha}$  10 to 30 minutes and the  $t_{1/2\beta}$  is 2 to 4.5 hours.

(2) The terminal half-life of midazolam is 1.5-2.5 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 patient's electronic health record (EHR), including an assessment that the patient is capable of self-care in an unsupervised setting.

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APPENDIX D

**MODERATE SEDATION ADVERSE EVENT TRACKING FORM**

**PATIENT NAME:**

**SOCIAL SECURITY NUMBER:**

**PROCEDURE LOCATION:**

**DATE:**

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**ATTENDING PHYSICIAN**

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**MONITORING ASSISTANT**

**TITLE**

<b>Moderate Sedation Adverse Event Tracking</b>	<b>Yes</b>	<b>No</b>
Were reversal agents administered (naloxone, flumazenil) peri-procedurally?		
Was the procedure cancelled due to patient discomfort or anxiety?		
Was the planned level of sedation escalated (e.g. moderate to deep sedation)?		
Was placement of an oral airway or a nasal trumpet necessary peri-procedurally? (This does not include placement of a bite block for oral procedures)		
Was placement of a supraglottic airway (e.g. LMA) necessary peri-procedurally?		
Was it necessary to assist the patient's ventilation (e.g. bag-valve-mask) peri-procedurally?		
Did the patient's oxygen saturation decrease to <85% for more than 3 minutes peri-procedurally?		
Did the patient ( <i>outpatient</i> ) require an unplanned admission within 24 hours of procedure?		
Did the patient require an unplanned admission to the emergency department related to the procedure/sedation?		
Did the patient ( <i>inpatient</i> ) require an unplanned transfer to a higher level of care related to the procedure/sedation?		
Was a code blue activated in the peri-procedure period related to the procedure/sedation?		
Was capnography employed for the procedure, and if not, was there documentation regarding the exception?		

PLEASE COMPLETE THIS FORM FOR EACH PATIENT WHO HAD AN ADVERSE EVENT AND ATTACH A THE MODERATE SEDATION PRE-PROCEDURE ASSESSMENT AND FLOW SHEET.