 UNIVERSITY of MARYLAND ST. JOSEPH MEDICAL CENTER	APC 20 Procedural Sedation Analgesia by Non-Anesthesia Provider	Policy Executive: VP Medical Affairs/CMO
Patient Care Policy	Assessment & Provision of Care	Policy Owner: Director Nursing
ATTACHMENTS: <ol style="list-style-type: none"> 1. Fasting Guidelines 2. Richmond Agitation Sedation Scale (RASS) 3. ASA Classification 4. Mallampati Classification 5. Adult Procedural Deep Sedation/Analgesia 6. Pediatric Procedural Moderate Sedation/Analgesia 		

VALUE STATEMENT

This policy reflects our value of excellence in that as part of our mission we provide a level of knowledge and skill among all our staff that enables us to provide the highest quality of care. Sedation/analgesia administered to adult and pediatric patients is carried out in such a manner to ensure patient safety and provide for optimal and humane conditions.

PURPOSE

To establish a definite policy for the safe management of a patient receiving sedation/analgesia for diagnostic and therapeutic procedures by non-anesthesiology providers. Knowledge of the pharmacology of various sedative and analgesic drugs allows the clinician to direct qualified licensed professionals to administer specific drugs in an appropriate dose to achieve sedation and analgesia for patients undergoing various diagnostic and therapeutic procedures in the areas outside of the operating room. The policy also includes safe management practices for the adult patient, only in the Emergency Department, requiring “Deep Sedation” for a procedure.

I. RELATED POLICIES / STANDARDS/ REFERENCES

- A. Policy: PR 04 Informed Consent
- B. Policy: PS 02 Universal Protocol
- C. Policy: M 08 Adult Intravenous Medications
- D. Policy: M 08 Pediatric Intravenous Medications
- E. [ASA House of Delegates \(2010\) Advisory on Granting Privileges For Deep Sedation To Non-Anesthesiologist Sedation Practitioners. Committee of Origin: Ad Hoc on Non-Anesthesiologist Privileging.](#)
- F. [ASA House of Delegates \(2016\) Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who are Not Anesthesia Professionals. Committee of Origin: Ad Hoc Committee on Credentialing](#)
- G. [Cote, C. & Wilson, S. \(2016\) Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update. American Academy of Pediatrics.](#)
- H. [Godwin, S. et al \(2014\) Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department. Annals of Emergency Medicine Vol 62 \(2\).](#)

II. SCOPE

- A. This policy applies when patients receive sedation/analgesia for any diagnostic or therapeutic procedures.
- B. Non-anesthesiology providers with appropriate licensure and competency may administer medications for sedation/analgesia under this policy.
- C. Monitoring of procedural sedation/analgesia is performed by a physician or supervised sedation professional, with a completed competency in monitoring patients receiving procedural sedation/analgesia and cannot be the same individual performing the procedure.
- D. Policy Exclusions
 1. Sedation/analgesia given for purposes other than for undergoing diagnostic or therapeutic procedures
 2. Sedation provided by credentialed anesthesia professionals
 3. Patients who are mechanically ventilated and their cardiovascular status is continuously monitored
 4. Emergency situations in which sedation and analgesia is needed for a procedure, when the patient's condition or acuity is such that there is significant risk of death or permanent disability without immediate execution of the procedure
 5. Patients receiving anxiolytics and narcotics, before receiving general or regional anesthesia, for a scheduled or emergency surgical procedure in the OR, Prep and Post-Anesthesia Care Units
 6. Patients receiving medications to control acute post-operative pain or chronic pain
 7. Patients requiring emergency tracheal intubation

III. DEFINITIONS

- A. **Sedation and analgesia** is a continuum and it is not always possible to predict how an individual patient will respond to the medications being administered.
- B. **Rescue** of a patient from a deeper level of sedation than intended is an intervention by a provider proficient in airway management and advanced life support. The qualified provider corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended, or baseline, level of sedation.
- C. **Definitions** for four levels of sedation and analgesia include the following:
 1. **Minimal sedation (anxiolysis)** – A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
 2. **Moderate sedation “conscious sedation”** – A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3. **Deep sedation/analgesia** – A drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
4. **General 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.

	Minimal Sedation	Moderate Sedation/Analgesia	Deep Sedation/Analgesia	General Anesthesia
Responsiveness	Normal response to verbal stimulation	Purposeful response to verbal tactile stimulation	Purposeful response following repeated or painful stimulation	Unarousable even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular Function	Unaffected	Usually maintained	Usually maintained	May be impaired

IV. SEDATION/ANALGESIA AREAS

- A. Any patient care area where procedures are performed on patients that require sedation/analgesia ordered and administered by a non-anesthesiologist.
- B. These locations must have the requisite monitoring capability, resuscitation equipment, and competent supportive staff, as specified by this policy.

V. PERSONNEL

- A. **Sedation Provider** - A licensed physician (allopathic or osteopathic), dentist, podiatrist, or allied health provider (physician assistant or nurse practitioner), who has not completed postgraduate training in anesthesiology, but is specifically trained and credentialed to, administer or supervise the administration of procedural sedation and analgesia.
- B. **Supervised Sedation Professional**
 1. A registered nurse (RN), nurse practitioner (NP), or physician assistant (PA) with completed competency to administer prescribed medications and monitor patients, during moderate sedation, under the direct supervision of a non-anesthesiologist sedation provider or an anesthesiologist.

2. The non-anesthesiologist sedation provider supervises the administration of moderate sedation. Non-anesthesiologist sedation provider may directly supervise patient monitoring and the administration of sedative and analgesic medications by a supervised sedation professional.
3. Alternatively, they may personally perform these functions; with the provision that the individual monitoring the patient should be distinct from the individual performing the diagnostic or therapeutic procedure.
4. NP & PA may perform focused pre-procedure history/physical and obtain consent.

VI. PHARMACOLOGICAL AGENTS

A. Sedation/analgesia includes use of the following agents administered according to standard practice.

1. Benzodiazepines – Diazepam, Midazolam, Lorazepam
2. Opiates – Fentanyl, Morphine, Hydromorphone
3. Barbiturates–Pentobarbital, Methohexital
4. Ketamine
5. Use of the following agents for Deep Sedation per ATTACHMENT 5- Etomidate, Propofol

B. Reversal Agents

1. Naloxone (Narcan) – for reversal of opioid effect.
2. Flumazenil (Romazicon) – for reversal of benzodiazepines effects

VII. PRE-PROCEDURE

A. Supervised Sedation Professional Responsibility

1. Record time and nature of last oral intake. See ATTACHMENT 1 for Fasting Guidelines
2. Review the patient’s chart for the presence of Informed Consent for S&A, and the Focused H&P with patient ASA and Mallampati Classification
3. Baseline vital signs: temperature, blood pressure, heart rate and cardiac rhythm, respiratory rate, O₂ saturation, pain score, and sedation, are obtained and recorded.
4. Capillary refill replaces blood pressure in pediatric patients (age <12 year old).
5. Assess and record baseline level of sedation. See ATTACHMENT 2.
6. Ensure height and weight are recorded
7. Ensure current medication reconciliation list
8. Verify allergies and/or previous adverse drug reactions
9. Assess for any history of tobacco, alcohol or recreational drug use
10. Obtain pregnancy test on women of child-bearing age who are unable to ensure that they are not pregnant (based on history)
11. Ensure availability of a responsible person to escort patient home
12. Ensure equipment is present, working properly with audible alarms. Resuscitation medications and emergency equipment are appropriate for patient size and age, to include at a minimum:
 - a. Airways
 - b. Capnography

- c. Oxygen
 - d. Ambu bag and mask
 - e. Intubation equipment
 - f. Positive pressure breathing device
 - g. Suction device and supplies
 - h. Pulse oximetry
 - i. ECG monitor
 - j. Defibrillator
 - k. Pharmacological antagonists: Narcan and Romazicon
 - l. Pediatric / Neonate Code Sheet, if applicable
- B. Provider Responsibility
1. To predict and prevent possible complications during sedation and analgesia, a Focused History and Physical examination involving airway and cardiorespiratory systems is completed.
 2. The Provider performing the procedure determines whether the patient is appropriate for procedural sedation given by a non-anesthesiologist. This determination is to be based on the intended procedure, the level of sedation/analgesia thought to be required to complete the procedure, the patient's medical status, as defined by their ASA Classification in the Focused History and Physical, and their airway evaluation and Mallampati Classification.
 3. An anesthesiology consult is recommended if airway problems or hemodynamic instability is present or anticipated. Anesthesia Consultation examples:
 - a. Patients with severe systemic disease (e.g., severe obstructive pulmonary disease, coronary artery disease, congestive heart failure, pulmonary hypertension, critical heart valve disease, and ASA Class IV and V) in which the sedation/analgesia and/or the complexity of the procedure would reduce the patient reserve, resulting in a threat to life. See ATTACHMENT 3.
 - b. Patients with significant oxygenation, or anatomic airway/ventilation abnormalities as noted by history or physical exam
 - c. Patients where the expected procedure requires that sedation be taken to levels greater than that covered in this policy
 - d. Mallampati measurement Class III and IV. See ATTACHMENT 4.
 4. A Focused History and Physical exam or review of the most recent H&P of the patient includes:
 - a. Prior anesthetic/sedation experience (e.g., difficult intubation, adverse reaction, pain threshold, sensitivity to medications for sedation and anesthesia, etc.)
 - b. H&P within the last 30 days prior to this sedation
 - c. History of airway problems such as snoring, sleep apnea, airway obstruction, history of recent cold/cough, limited neck motion, history of difficult intubations, abnormal reaction to anesthesia, dysmorphic facial features, advanced rheumatoid arthritis
 - d. Diseases/disorders of major systems (heart, lungs, liver, kidney & neurologic) and other abnormalities
 - e. Indicate ASA Class. See ATTACHMENT 3.

- f. Perform an Airway Evaluation, including the Mallampati classification. This is a visual assessment of the airway and a very simple method to predict airway obstruction and potential difficult intubation, if needed, during sedation and analgesia administration. This involves physical examination of oropharynx to detect abnormal anatomy. The Mallampati classification relates tongue size to pharyngeal size and should be documented on the Focused H&P or appropriate electronic documentation field
 - g. The Focused History, and Physical examination, may be performed by a NP or PA, approved by the physician administering sedation/ analgesia. Validation of Focused History and Physical examination, performed by the NP or PA, is ultimately the responsibility of the physician providing sedation/analgesia.
 - h. The focused history and physical examination may be documented either separately or as a part of the electronic documentation.
 - i. In emergency situations, as much of an assessment and physical exam as possible is completed without delaying the emergently needed procedure.
5. Obtain and Document Informed Consent
- a. The patient or legal guardian is informed about the risks, benefits, and alternatives to sedation as a component of the planned procedure.
 - b. For emergency situations: Follow Policy PR4, Informed Consent.

VII. INTRA PROCEDURE

- A. Supervised Sedation Professional Responsibility
- 1. RN managing the care of the patient receiving sedation/analgesia has no other responsibility that would leave the patient unattended or compromise continuous monitoring.
 - 2. Pre-sedation vital signs and level of sedation for the patient is documented before proceeding with the administration of sedation/analgesia.
 - 3. Respiratory rate, oxygen saturation, capnography
 - a. continuously assess
 - b. document every 5 minutes
 - 4. Blood pressure, heart rate and cardiac rhythm
 - a. assess & document BP every 5 minutes
 - b. continuously monitor cardiac rhythm
 - 5. Sedation assessment
 - a. utilize Richmond Agitation-Sedation Scale (RASS)
 - b. continuously assess
 - c. document every 5 minutes
 - d. level of consciousness is not assessed during procedures where the patient is required to be in a sleep state (e.g., EEG)
 - 6. Audible alarms on physiologic monitoring equipment are set and used during sedation/analgesia, to alert providers to abnormal values
 - 7. Documentation of vital signs and level of sedation, for patients receiving oral sedation/analgesia, is every 15 minutes. The patient with an altered level of consciousness from oral sedation requires more frequent and intensive assessment.

B. Physician Responsibility

1. Select and order administration of sedation /analgesic medications.
2. Combinations of sedative and analgesic agents should be administered with caution for the procedure being performed, and based upon condition of the patient. Combinations of sedative and analgesic agents can potentiate respiratory depression. This emphasizes the need to appropriately reduce the dose of each component, as well as the need to continually monitor respiratory function.
3. Intravenous sedation/analgesia is given in small incremental doses that are titrated to the desired level of sedation.
4. Sufficient time elapses between the doses of each drug to allow the effect of each dose to be assessed before subsequent drug administration.
5. When drugs are administered by non-intravenous route (oral, rectal, intranasal and intramuscular), allowance should be made for the time required for the absorption before supplemental medication is considered.
6. Before administering any pharmacologic reversal in patients who become hypoxic or apneic:
 - a. Encourage or stimulate the patient to breathe deeply
 - b. Provide positive pressure ventilation if spontaneous respirations are inadequate
 - c. Provide supplemental oxygen

VIII. POST PROCEDURE

- A. Because the discomfort/pain of the procedure and any affect it had on the patient's vital signs is gone, the patient is monitored immediately after the procedure and administration of sedation/analgesia, until they return to their pre-procedure level of sedation, and maintain SBP > 90 and HR < 100 for adults, or values, at the discretion of the provider. Monitoring is recorded every 15 minutes and consists of heart rate and cardiac rhythm for adults, blood pressure, respiratory rate, oxygen saturation, capnography (end title carbon dioxide, etCO₂), and level of sedation.
- B. The recovery area is equipped with appropriate monitoring and resuscitation equipment
- C. The recovery area is staffed by individuals with a completed competency in monitoring, and recognition of complications, of procedural sedation/analgesia.
- D. An individual able to establish a patent airway and deliver positive pressure ventilation should be immediately available.
- E. The physician performing the procedure or his physician designee should be available for consultation until the patient is fully recovered from sedation/analgesia.
- F. Upon completion of the recovery of the patient the nurse documents the "Outcomes" of the sedation in the appropriate electronic documentation flowsheet for that unit/recovery area.

IX. DISCHARGE CRITERIA

- A. For discharge from the procedural/ recovery area, the patient must:
 1. Be alert and oriented or at their baseline level of sedation
 2. Have vital signs and pulse oximetry within acceptable limits and stable
 3. Return to baseline ambulation status
 4. Inpatients: return to baseline status prior to transfer back to their nursing unit

5. Outpatients: be discharged in the company of a responsible adult or have made other suitable arrangements for transportation home. Patients should not drive until after a night's sleep. Appropriate discharge instructions, and a phone number to call in case of questions or emergency, are provided.
- B. Any patient who has received a reversal agent should be observed in the recovery area for at least 90 minutes after the agent has been administered.

X. SUPERVISED SEDATION PROFESSIONAL COMPETENCY

- A. Professionals with licensure and completed competency may administer the sedating medications, and/or monitor patients who receive sedation/ analgesia.
- B. Supervised Sedation Professional is defined as a RN, NP or PA.
- C. The ability to administer and/or monitor patients undergoing sedation/analgesia is be granted with evidence of the following every two years:
 1. Review of this policy
 2. Achieve a minimum 90% score on the written competency exam
 - a. Developed by the Department of Anesthesiology for the NP or PA
 - b. Developed by the Department of Nursing, for nurses.
 3. Current BLS certification to demonstrate competency in airway management
 4. Current ACLS certification or Code Blue Level II Review Course

XI. PROVIDER CREDENTIALING

- A. The guidelines for procedural sedation education, competency, and credentialing are determined by the Chief of the Department of Anesthesia.
- B. The department granting primary privileges for any procedure requiring sedation/analgesia also specifically grants the privilege of “procedural sedation/analgesia (moderate)” based on the providers training and experience. Assessment of competency through education, training and experience is the responsibility of the individual department chief.
- C. To be credentialed the provider will;
 1. View “Adult Procedural Sedation: A Training Program for Providers”
 2. Secure a minimum of 90% score on the procedural sedation post-test.
 3. Formally acknowledge this policy.
 4. Non-critical care providers must also provide evidence of current Advanced Cardiac Life Support (ACLS) certification. Those providing pediatric sedation must provide evidence of Pediatric Advanced Life Support (PALS) certification.
- D. For providers with privileges for moderate sedation at other accredited organizations, they provide evidence of current ACLS, formally acknowledge this policy and provide evidence of equivalent moderate sedation competency from the other organization.

XII. OVERSIGHT

- A. Oversight of procedural sedation / analgesia by non-anesthesiology providers is the responsibility of the Chief of Anesthesiology and / or his designees.
- B. The Quality Management Department performs random review of a determined number of sedation/analgesia cases per month to include 100% of the cases where an “Unplanned Event” was identified.

- C. The results of the random case reviews are reviewed with the Chief of Anesthesiology quarterly for process compliance, and to identify potential areas for process improvement.
- D. All sedation/analgesia cases where an Unplanned Event has been identified are referred to the Chief of Anesthesia for further review.
- E. Unplanned Events include:
 1. Use of reversal agent(s)
 2. Allergic response
 3. Cardiac arrest
 4. Cardiac distress
 5. Change in required level of care
 6. Intubation or positive pressure ventilation
 7. Respiratory arrest
 8. Respiratory distress
 9. Symptomatic change in vital signs
 10. Vomiting (non GI procedure)
 11. Other quality or safety concern

ATTACHMENT 1

**Summary of American Society of Anesthesiologists
Pre-Procedure Fasting Guidelines***

Ingested Material	Minimum Fasting Period**
Clear liquids***	2 hours
Human milk	4 hours
Infant formula	6 hours
Non-human milk [#]	6 hours
Light meal ^{##}	6 hours

* These recommendations apply to healthy patients who are undergoing elective procedures. They are not intended for women in labor. Following the Pre-Procedure Fasting Guidelines does not guarantee a complete gastric emptying has occurred. In emergency situations, when the Guidelines cannot be adhered to, the physician providing sedation/analgesia may proceed with the procedure while using precautions to minimize the risk of pulmonary aspiration.

**The fasting periods apply to all ages.

***Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee.

[#]Since non-human milk is similar to solids in gastric emptying time, the amount ingested must be considered when determining an appropriate fasting period.

^{##}A light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may prolong gastric emptying time. Both the amount and type of foods ingested must be considered when determining an appropriate fasting period.

ATTACHMENT 2**Level of Sedation**

Level of sedation is assessed according to the Richmond Agitation and Sedation Scale (RASS).

	Score	Term	Description
Alert, restless, or agitated	+4	Combative	Overtly combative, violent, immediate danger to staff
	+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive
	+2	Agitated	Frequent, non-purposeful movement, fights ventilator
	+1	Restless	Anxious but movements not aggressive vigorous
	0	Alert and calm	
Not Alert	-1	Drowsy	Not fully alert, but has sustained awakening (eye opening/eye contact) to voice (≥ 10 seconds)
	-2	Light sedation	Briefly awakens with eye contact to voice (< 10 seconds)
	-3	Moderate sedation	Movement or eye opening to voice, but no eye contact
	-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation
	-5	Unarousable	No response to voice or physical stimulation

ATTACHMENT 3

ASA CLASSIFICATION

**CLASSIFICATION OF THE
AMERICAN SOCIETY OF ANESTHESIOLOGISTS**

Status	Definition
I	A normal healthy patient
II	A patient with mild systemic disease (e.g., smoking, well controlled hypertension, obesity or DM, asthma)
III	A patient with severe systemic disease that limits activity, but is not incapacitating (e.g., CAD, history of MI, poorly controlled airway disease)
IV	A patient with incapacitating systemic disease that is a constant threat to life (e.g., acute MI)
V	A moribund patient not expected to survive 24 hours with or without operation
VI	Organ donation
E	Emergency is added to the previously defined ASA physical status

ATTACHMENT 4

MALLAMPATI CLASSIFICATION

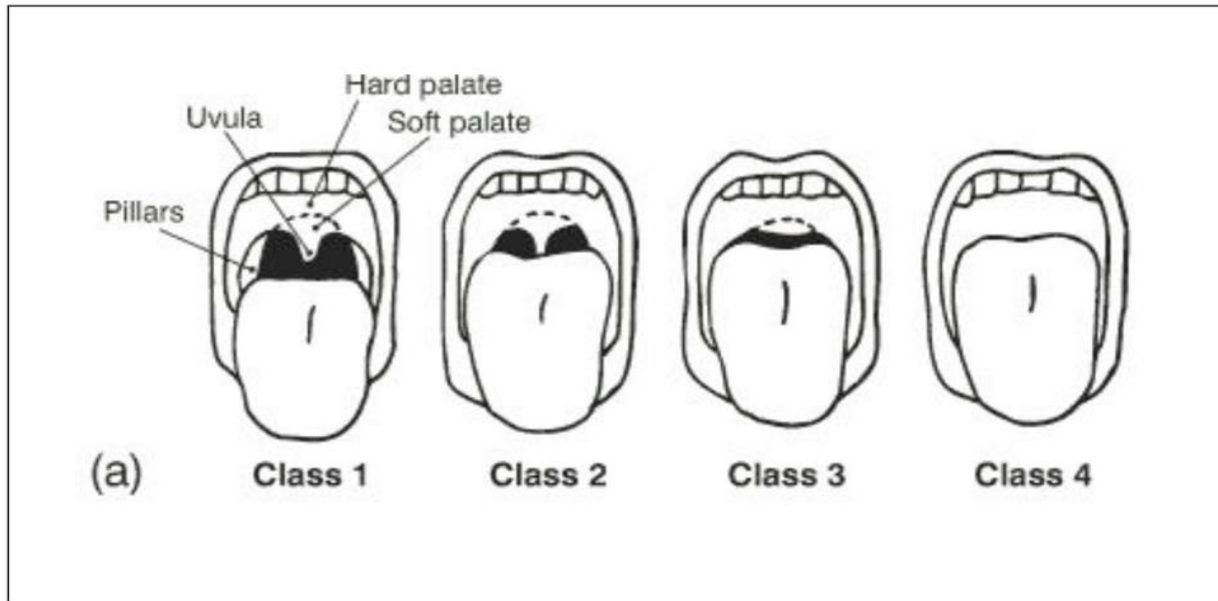


Figure 1. The Mallampati score:

Class 1. Complete visualization of the soft palate

Class 2. Complete visualization of the uvula

Class 3. Visualization of only the base of the uvula

Class 4. Soft palate is not visible at all

The assessment is performed with the patient sitting up straight, mouth open and tongue maximally protruded, without speaking or saying “ahh.”

ATTACHMENT 5

ADULT PROCEDURAL DEEP SEDATION/ANALGESIA

- A. Medications given for the purposes of achieving deep sedation to facilitate performing a procedure in adult patients (age > 12 years old) is limited to the Emergency Department and to Emergency Physicians who are currently credentialed to administer deep sedation/analgesia.
- B. Such providers are qualified to “rescue” patients from an unintended state of general anesthesia and are competent to diagnose and manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.
- C. All of the minimum requirements in this policy pertaining to documentation, assessments, equipment, and monitoring are required for the pre, intra, and post-procedure phases of care for the patient receiving Deep Sedation/Analgesia.
- D. The sedation provider for adult deep procedural sedation/analgesia must:
 - 1. Be a Board certified emergency medicine physician credentialed in “moderate, and deep” sedation/analgesia
 - 2. Administer all medications intended to induce a state of deep sedation
 - 3. Be solely dedicated to the task of sedation and monitoring
 - 4. Not be the person performing the procedure
- E. The procedure provider can be anyone credentialed to do the procedure
- F. A nurse may be present to document but may not administer medications for deep sedation.
- G. Medications restricted for the purposes of achieving deep sedation due to their narrow therapeutic window include:
 - 1. Propofol
 - 2. Etomidate
- H. The sedation provider remains at the patient’s bedside and continue to monitor the patient until, achievement of stable vital signs, the patient is capable of maintaining their own airway, and until the patient is responding to verbal commands, at which time they may handoff the care to a nurse appropriately qualified to recover a patient from moderate sedation.
- I. Competency :
 - 1. Complete the adult moderate and deep procedural sedation module and score a minimum of 90% on the post test
 - 2. Show evidence of competence in their specialty, airway management, and cardiovascular support as determined by the ED department chief
 - 3. Formally acknowledge this policy
 - 4. Privileges for deep sedation at other facilities is not accepted as a substitute for any of the above requirements for those seeking adult deep sedation privileges.

ATTACHMENT 6**PEDIATRIC PROCEDURAL
MODERATE SEDATION/ANALGESIA**

1. All patients aged *12 years or younger* are considered “pediatric” for procedural sedation.
2. It is recognized that the sedation of children is different from the sedation of adults and requires a different knowledge base and skill set than that which is required for adults. Therefore, pediatric moderate sedation may only be performed by Emergency Department (ED) physicians, ED CRNPs, ED Physician Assistants and Pediatric Hospitalists who are currently credentialed to administer pediatric procedural sedation/analgesia. Such providers are qualified to rescue pediatric patients from an unintended state of deep sedation and are qualified to diagnose and manage complications unique to pediatric patients, particularly airway complications.
3. Deep sedation in the pediatric patient is limited to the anesthesiology provider. If it is anticipated that a level of deep sedation is required to safely and successfully perform a procedure in a pediatric patient, an Anesthesiology consult is obtained.
4. All requirements contained in this procedural sedation/analgesia policy pertaining to documentation, assessments, equipment, and monitoring are required for pediatric procedural sedation/analgesia for the pre, intra, and post-procedure phases of care.
5. The supervised pediatric sedation professional must be a RN, NP, or PA who has a completed competency to administer medications and monitor pediatric patients during moderate sedation under the direct supervision of a non-anesthesiologist pediatric sedation provider. This individual is trained in Pediatric Advanced Life Support (PALS).
6. Competency
 - A. Non-anesthesiology provider for pediatric procedural sedation/analgesia:
 - 1) Complete the pediatric procedural sedation/analgesia module and score at least 90% on the post test
 - 2) Demonstrate competence in advanced pediatric life support skills; recognized as a core competency of ED physicians, at the discretion of the department chief.
 - 3) Demonstrate competence in advanced pediatric life support skills, demonstrated by PALS certification for ED CRNPs, ED Physician Assistants and Pediatric Hospitalists, at the discretion of the department chief.
 - 4) Formally acknowledge this policy
 - 5) Privileges for pediatric procedural sedation/analgesia at other facilities is not accepted for any of the above requirements for those seeking this privilege here.
 - B. Supervised pediatric sedation professional:
 - 1) PALS certified or pass the Emergency Nurse Pediatric Course
 - 2) Complete the pediatric procedural sedation/analgesia module developed by the Department of Anesthesiology for providers, or the Department of Nursing for nurses.
 - 3) Achieve a minimum of 90% score on the written competency exam