MODERATE SEDATION

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P *indicates a recommendation or evidence relevant to pediatric care.*

MEDICAL ABBREVIATIONS & ACRONYMS

ACLS – Advanced cardiac life support
ANA – American Nurses Association
ARD – Acute respiratory distress
ASA – American Society of Anesthesiologists
AUCDesat – Area under the curve of oxygen desaturation
BIS – Bispectral index
BMI – Body mass index
CAD – Coronary artery disease
CAPS – Computer-assisted personalized sedation
CMS – Centers for Medicare & Medicaid Services
CO_2 – Carbon dioxide
COPD – Chronic obstructive pulmonary disease
CPAP – Continuous positive airway pressure
CVA – Cerebrovascular accident
DIC – Disseminated intravascular coagulation
DM – Diabetes mellitus
ECG – Electrocardiogram
EGD – Esophagogastroduodenoscopy
ERCP – Endoscopic retrograde cholangiopancreatography
ESRD – End-stage renal disease
HTN – Hypertension
MI – Miocardial infarction
PACU – Postanesthesia care unit
PADSS – Post-Anesthetic Discharge Scoring System
PALS – Pediatric advanced life support
PCA – Postconceptual age
RCT – Randomized controlled trial
RN – Registered nurse
SAMBA – Society for Ambulatory Anesthesia
SaO_2 – Oxygen saturation of arterial blood
SpO_2 – Oxygen saturation as detected by pulse oximeter
TIA – Transient ischemic attack

GUIDELINE FOR CARE OF THE PATIENT RECEIVING MODERATE SEDATION/ANALGESIA

The Guideline for Care of the Patient Receiving Moderate Sedation/Analgesia was approved by the AORN Guidelines Advisory Board and become effective December 15, 2015. It was presented as a proposed guideline for comments by members and others. The recommendations in the guideline are intended to be achievable and represent what is believed to be an optimal level of practice. Policies and procedures will reflect variations in practice settings and/or clinical situations that determine the degree to which the guideline can be implemented. AORN recognizes the many diverse settings in which perioperative nurses practice; therefore, this guideline is adaptable to all areas where operative or other invasive procedures may be performed.

Purpose

This document provides guidance for care of the patient receiving moderate sedation/analgesia provided by a registered nurse (RN) in the perioperative practice setting. Guidance is provided for determining the scope of nursing practice related to administration of moderate sedation/analgesia, patient selection criteria, presedation patient assessment (eg, airway, difficult mask ventilation, obstructive sleep apnea), intraoperative sedation assessment, staffing, monitoring, medication administration, and postoperative discharge criteria.

The goal of moderate sedation/analgesia is drug-induced, mild depression of consciousness achieved with the use of sedatives or a combination of sedatives and analgesic medications, most often administered intravenously, and titrated to achieve a desired effect. The primary goal of moderate sedation/analgesia is to reduce the patient's anxiety and discomfort. Moderate sedation also can facilitate cooperation between the patient and care providers. Moderate sedation produces a condition in which the patient exhibits a mildly depressed level of consciousness and an altered perception of pain but retains the ability to respond appropriately to verbal or tactile stimulation. The patient maintains protective reflexes and may experience some degree of amnesia.[1]

The desired effect is a level of sedation with or without analgesia that enables the patient to tolerate diagnostic, therapeutic, and invasive procedures through relief from anxiety and pain. The four distinct characteristics of moderate sedation/analgesia are the following:

- The patient is able to respond purposefully to verbal commands or light tactile stimulation.
- The patient maintains his or her protective reflexes and is able to communicate verbally.
- The patient maintains adequate, spontaneous ventilation.
- There are minimal variations in the patient's vital signs.[1]

Depth of sedation occurs across a continuum from minimal sedation to moderate sedation/analgesia, **deep sedation/analgesia**, and finally general anesthesia. Patients' responses to the medications for moderate sedation/analgesia are unpredictable. The patient may slip into a deeper level of sedation than intended; therefore, practitioners who administer moderate sedation/analgesia should be able to rescue a patient who enters deep sedation/analgesia.[1]

This following topics are outside the scope of this document: local anesthesia, local monitored anesthesia care, general anesthesia, regional anesthesia (eg, spinal, epidural), total intravenous anesthesia, minimal sedation, deep sedation, endotracheal intubation, laryngoscopy, awake intubation, dental office procedures, fospropofol, etomidate, propofol administration in the emergency room and intensive care unit, sedation for intubated and mechanically ventilated patients, palliative care, premedication for general anesthesia, pain management following discharge from the postanesthesia care unit (PACU), and proceduralist techniques. It is not the intent of this guideline to address situations that require the services of an anesthesia professional or to substitute the services of a perioperative RN in those situations that require the services of an anesthesia professional.

Moderate sedation/analgesia may be referred to as moderate sedation, conscious sedation, nurse-administered procedural sedation, nurse-administered propofol sedation, or procedural sedation and analgesia. The term moderate sedation/analgesia is used throughout this document in the recommendations and activities. Other terms may be seen in the rationales if the cited literature refers to moderate sedation/analgesia by another term.

Evidence Review

A medical librarian conducted systematic searches of the databases MEDLINE®, CINAHL®, and the Cochrane Database of Systematic Reviews in April 2013 and November 2014, and limited results to meta-analyses, systematic reviews, randomized and non-randomized trials and studies, reviews, and guidelines. The librarian also conducted a non-systematic search of the Scopus® database. The searches were limited to literature published in English between 2006 and November 2014. At the time of the initial searches, the librarian established weekly alerts on the search topics and until April 2015, presented relevant alert results to the lead author.