Does your Moderate Sedation Program measure up to the standards?

by Tabitha Garbart | https://www.compass-clinical.com/reducing-variability-in-your-moderate-sedation-program-is-key-to-patient-safety

Reducing variability in your Moderate Sedation Program is key to patient safety!

Staff Requirements				
Component	**TJC Accreditation Standard**	**EP**	**Text**	**Strategies for Compliance**
Providers have been granted moderate sedation privileges	MS.03.01.01	2	Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.	Audit medical staff privileges to ensure all providers have current and appropriate privileges and any additional training elements required by Medical Staff Bylaws such as ACLS.
FPPE is performed on specific to the privileges requested	MS.08.01.01	1	A period of focused professional practice evaluation (FPPE) is implemented for all initially requested privileges.	Ensure reviews are being conducted to include moderate sedation for FPPE as defined by the Medical Staff.
OPPE is performed specific to the privileges granted	MS.08.01.03	1	The process for the ongoing professional practice evaluation (OPPE) includes the following: There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice.	Ensure that there is a process in place for ongoing review of all providers that have been granted privileges for moderate sedation in accordance with the Medical Staff Bylaws.
Staff complete initial training and competency for moderate sedation	HR.01.06.01	5	Staff competence is initially assessed and documented as part of orientation.	The healthcare organization determines the initial training requirements for staff. This typically includes a moderate sedation review, kinesthetic training, and ACLS. Ensure that all areas that perform moderate sedation are included in this training.
Staff complete ongoing training and competency for moderate sedation	HR.01.06.01	6	Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.	The healthcare organization determines the ongoing training requirements for staff. This typically includes a moderate sedation review, kinesthetic training, and ACLS. Ensure that all areas that perform moderate sedation are included in this training.

Pre-Procedure Requirements (1)				
Component	**TJC Accreditation Standard**	**EP**	**Text**	**Strategies for Compliance**
Properly executed Informed Consent	RI.01.03.01	1	The hospital follows a written policy on informed consent that describes the following: - The specific care, treatment, and services that require informed consent - Circumstances that would allow for exceptions to obtaining informed consent - The process used to obtain informed consent - How informed consent is documented in the patient record Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent	The organization's policy will describe the process for obtaining informed consent in accordance with law and regulation. Ensure this process is being performed correctly in all areas identified and that consent includes the type of sedation that will be performed. Adding this as a component to the pre-procedure checklist is considered leading practice to ensure compliance.
Documented discussion about risk, benefits, and alternatives	RI.01.03.01	2	The informed consent process includes a discussion about the following: - The patient's proposed care, treatment, and services. - Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation. - Reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.	There must be evidence that a discussion occurred with the patient to discuss risks, benefits, and alternatives to both the procedure and the type of sedation that is being performed. This could be on the informed consent or on a progress note.

Pre-Procedure Requirements (2)				
Component	**TJC Accreditation Standard**	**EP**	**Text**	**Strategies for Compliance**
History and Physical (H&P)	PC.01.02.03	4	The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.	Ensure that a complete H&P is documented no more than 30 days prior to the procedure requiring moderate sedation. Medical Staff Bylaws will define all the components of a H&P. Ensure that both the providers and nurses understand the components that must be documented. Adding this as a component to the pre-procedure checklist is considered leading practice to ensure compliance.
History and Physical Update	PC.01.02.03	5	For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.	If the H&P is not performed on the same day the procedure is taking place, an update must be performed. Remember an update does not take the place of a complete H&P if the H&P was performed more than 30 days ago. If this is the case, a new H&P must be performed. Adding this as a separate component to the pre-procedure checklist is considered leading practice to ensure compliance.
Pre-Sedation Evaluation: ASA classification and airway exam	PC.03.01.03	1	Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a pre-sedation or pre-anesthesia patient assessment	Before initiating sedation, the provider must document a pre-sedation evaluation. Medical Staff Bylaws will define the components of a pre-sedation evaluation. Minimally, the ASA classification must be documented, and an airway exam must be performed. The organization will determine which airway exam will be conducted (i.e., Mallampati).
Pre-Procedure Education	PC.03.01.03	4	Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital provides the patient with preprocedural education, according to his or her plan for care.	Document that pre-procedure education was performed. If a handout was given, ensure that there is a reference as to what information was included in the handout.

Intra-Procedure Requirements				
Component	**TJC Accreditation Standard**	**EP**	**Text**	**Strategies for Compliance**
Reassessment immediately prior to the administration of sedation	PC.03.01.03	8	The hospital reevaluates the patient immediately before administering moderate or deep sedation or anesthesia.	Ensure that moderate sedation documentation includes that a reassessment was completed immediately before the sedation is administered when the patient is on the procedural table. This could be documented in the pre-sedation assessment or on the intra-procedure documentation. Ensure each area where moderate sedation is performed has a consistent place to document this component.
Time-Out	UP.01.03.01	5	Document the completion of the time-out. Note: The hospital determines the amount and type of documentation.	Ensure each area has a consistent place to document that a time-out was conducted meeting the requirements of the organization's policy.
Monitoring Vital Signs (VS), Level of Consciousness (LOC), Wave Form Capnography-End Tidal CO2 monitoring (ETCO2 only if required by hospital policy)	PC.03.01.05	1	During operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the patient's oxygenation, ventilation, and circulation are monitored continuously.	The organization's policy determines the frequency of documenting VS, LOC, and if ETCO2 is required. There are different scales to document LOC (i.e., Ramsey). Refer to the organization's policy to determine which scale should be used. Leading practice is to document these items every five minutes during the procedure.
Documenting sedation medication and events	RC.02.01.03	1	The hospital documents in the patient's medical record any operative or other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia.	Document complications or the use of reversal agents in the patient's medical record.

Post-Procedure Requirements (1)				
Component	**TJC Accreditation Standard**	**EP**	**Text**	**Strategies for Compliance**
Nursing assessment after sedation	PC.03.01.07	1	The hospital assesses the patient's physiological status immediately after the operative or other high-risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia.	The organization's policy defines the frequency of documentation and the required elements of the nursing assessment. Some hospitals decide to document an Aldrete score before the procedure, immediately after the procedure, and at intervals post-procedure to determine if the patient meets discharge criteria.
Monitoring of pain and level of consciousness after sedation	PC.03.01.07	2	The hospital monitors the patient's physiological status, mental status, and pain level at a frequency and intensity consistent with the potential effect of the operative or other high-risk procedure and/or the sedation or anesthesia administered.	The organization's policy defines the frequency of documentation. There are different scales to document LOC (i.e., Ramsey), refer to the organization's policy to determine which scale should be used. Leading practice is to document these items in correlation with the time intervals for post-procedure vital signs.
Immediate post-procedure note or brief op note	RC.02.01.03	7	When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.	If the electronic medical record does not allow the full procedure report to be entered immediately after the procedure, an immediate post-procedure note must be written before the patient transfers to the next level of care and before the proceduralist leaves the immediate area. Remember that a dictated note may not be available immediately after the procedure because of the transcription process. Best practice is to create a template guided by Medical Staff Bylaws to ensure that all components are being documented. This note must include, at minimum, the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.
Post-procedure or operative report	RC.02.01.03	5	An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.	Even if an immediate post-procedure note is written, a full report must be written or dictated before the patient is transferred to the next level of care. Medical Staff Bylaws will guide providers on the required components of this post-procedure report. Ensure that the type of sedation used in included in this report.

Post-Procedure Requirements (2)				
Component	**TJC Accreditation Standard**	**EP**	**Text**	**Strategies for Compliance**
Procedure reports requirements	RC.02.01.03	6	The operative or other high-risk procedure report includes the following information: - The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s) - The name of the procedure performed - A description of the procedure - Findings of the procedure - Any estimated blood loss - Any specimen(s) removed - The postoperative diagnosis	Best practice is to create a template guided by Medical Staff Bylaws to ensure that all components are being documented. This note must include, at minimum, the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, any estimated blood loss, specimens removed, and postoperative diagnosis.
Discharge Order	PC.03.01.07	4	A qualified licensed independent practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified licensed independent practitioner, patients are discharged according to criteria approved by clinical leaders.	Ensure that an order for discharge is on the chart or that an approved protocol is used to determine readiness for discharge. This protocol must be approved by the medical staff, should define criteria for discharge and is specified in the policy/procedure.
Discharge Education: Procedure and Sedation education	PC.04.01.05	7	The hospital educates the patient, and also the patient's family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.	Ensure that patient discharge instructions are included in the patient's medical record and contain education regarding the procedure and the sedation medication. Examples of sedation education for adults include not driving, operating heavy machinery, or making life decisions for 24 hours. If sedation is used on a pediatric patient, instructions include remaining under adult supervision until the patient is fully recovered from the effects of the sedation.

Program Requirements				
Component	**TJC Accreditation Standard**	**EP**	**Text**	**Strategies for Compliance**
Performance Improvement Data	PI.01.01.01	5	The hospital collects data on the following: Adverse events related to using moderate or deep sedation or anesthesia.	Each area that performs moderate sedation should report data to the quality department on adverse events. These events should be tracked, trended, and analyzed to ensure there is not a pattern. These events should be reported up through committee to the governing body as defined by the organization.
Staff accountability for program requirements	LD.04.01.05	4	Staff are held accountable for their responsibilities.	Staff will be held accountable to both the information in the Medical Staff Bylaws and the organization's policy. Remember to reduce variability between documentation as accrediting bodies will be reviewing records from each area that moderate sedation is performed.

If you have concerns that your program does not measure up to the standards, contact Compass today to discuss how we can help build or strengthen your Moderate Sedation Program.

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