Sedation-Analgesia Quality Improvement
Sedation Analgesia Credentialing

For New Credentialing
- Completion of the Sedation Analgesia Course and satisfactory completion of the post-course test.
- ACLS or PALS certification

For Renewal
- Performance of at least ten (10) adult or pediatric sedation procedures within the last year. If not, new credentialing is necessary.
- Completion of the CME update on sedation analgesia and post-course test within 6 months prior the date of reappointment.
Sedation analgesia course or CME update includes:

- Viewing the online course
- Receiving a passing score on the online test
The qualified sedation-analgesia personnel must fill out the sedation analgesia Outcomes Evaluation Tool for every SA case.

Specific indicators must be monitored.
Continuous Quality Improvement

- This is based on a review of the data obtained from the sedation-analgesia Outcomes Evaluation Tool.
- When pre-determined adverse criteria are met, a review and corrective action must be undertaken.
The Chairperson of the appropriate department is responsible for adherence of his or her staff to these guidelines.

The Chairperson or his/her designee must conduct at a minimum yearly quality assurance reviews of personnel and procedures.
A yearly report of the Outcomes Data will be presented in writing to the Chair of the Department of Anesthesiology.
Sentinel Events That Require Review

- Any patient requiring intubation
- SpO₂ below 90% for over 5 minutes
- Any life-threatening variation of VS
- Intractable nausea or vomiting
- Any use of reversal agents
- Respiratory or cardiac arrest
- Seizure
- Anaphylaxis
- Unplanned admission to monitored units or hospital setting
- Any case where review is thought beneficial
Pre-Procedure Competency I

- Recognizes components of a history and physical
- Appropriate airway exam and assessment
- Identifies patient ASA status
- Addresses appropriate NPO status
- Recognizes potential cases requiring consultation
- Reviews and identifies plan with appropriate documentation
- Reviews consent and documents risk/benefit discussion
Procedure Competency II

- Knowledge of the pharmacology of drugs being used, including drug dose ranges and routes
- Understanding of the potential complications and possible interventions
- Identifies indications/dosages of reversal agents
- Ability to assess that all required equipment is present
Monitoring Competency 1

- Demonstrates knowledge of appropriate monitors and required frequency of measurement
- Interprets monitoring data and intervenes appropriately
- Ability to adjust monitor alarms
- Demonstrates correct responses to alarms
- Correct evaluation of respiratory rate and effort
- Demonstrates airway rescue skills
Monitoring Competency II

- Ability to describe/score/document sedation levels
- Demonstrates knowledge in patient positioning and use of side rails
- Demonstrates knowledge of restraint policy
- Ability to recognize need to rescue and the proper procedure to follow
- Ability to document preprocedure, postprocedure, and discharge PAR scores
- Appropriate use of:
  - Assessment Form
  - Sedation Monitoring Form
  - Outpatient Discharge Form
Post-Procedure Competency

- Able to identify discharge criteria
- Knows steps to follow when D/C criteria not met
- Documents correctly discharge information
- Verify patient/companion’s comprehension of D/C orders
- Knowledge of use of Outcome Evaluation Tool
The Outcomes Evaluation Tool

- A Concurrent Outcomes Monitoring Form must be filled out by the qualified monitoring health care professional.
- The data from these forms will be the source for patient care improvement and serve for review on re-credentialing for SA.
- At least 10 procedures must be done per year for renewal of SA privileges.
SEDATION-ANALGESIA
CONCURRENT OUTCOMES MONITORING FORM

Instructions: 1. Complete this form following each episode of sedation/ analgesia.
   2. Fax completed form to Clinical Quality Management, (305) 585-2551 within 24 hours of completion.

Patient Name ____________________________ Medical Record # ___________

Unit _____ Administered by _____________ Monitored by ___________ Attending ____

Procedure _______________________________

Date of sedation/ analgesia episode __________
<table>
<thead>
<tr>
<th>Monitoring/Outcomes Criteria</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1. Completed pre-sedation/analgesia checklist</td>
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<td>2. Documented allergies</td>
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<td>3. NPO status as per policy</td>
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<td>4. Weight documented</td>
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<td>5. Pregnancy (if fertile female)</td>
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<td>Verbal or Lab confirmation?</td>
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<td>6. Documentation of Vital signs and level of Consciousness during the procedure</td>
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<td>7. Documentation of pre-and post-procedure Vital signs and PAR score</td>
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<td>8. Documentation of side rails</td>
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<td>9. Positive pressure ventilation required (ambu bag assistance or intubation)</td>
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<td>10. Reversal Agents administered</td>
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<td>11. Vital sign variation &gt;30% baseline</td>
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<td>12. Cardiac arrhythmias of new onset</td>
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<td>13. Intractable nausea or vomiting</td>
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<td>14. Seizure or neuro deficit</td>
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<td>15. Post-procedure admission to increased level of care (floor, ICU, PARU, É )</td>
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Outcomes Evaluation Tool III

Outcomes:
1. Did the patient experience any adverse outcomes as a result of this procedure?
   Yes _________ No _________ If yes, what was the complication? _______________________
   ___________________________________________________________________________

2. Did the adverse outcome occur as a result of the sedation/analgesia, or from a complication
   of the procedure? __________________________________________________________________
   ____________________________________________________________________________

3. If the patient had an adverse outcome, what actions were taken? _______________________
   ____________________________________________________________________________

For Clinical Quality Management Use Only:
Referred to: IPM Committee [ ] OMP Committee [ ] Risk Management Department [ ]

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