# INITIAL COMPETENCY ASSESSMENT FOR PROCEDURAL SEDATION (RN)

This form is to describe what is entailed in completing the initial competency assessment for procedural sedation. It is to be used as a guide for the preceptor and the employee to understand the expected knowledge, skills, and attitude (KSA) that is required to safely monitor a patient receiving procedural sedation.

<table>
<thead>
<tr>
<th>COMPETENCY DOMAIN</th>
<th>METHOD OF VERIFICATION</th>
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<tbody>
<tr>
<td>KNOWLEDGE</td>
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| • Policy for the Use of Sedation and Analgesia During Procedures HS 1327  
  o [Policy for the Use of Sedation and Analgesia During Procedures](#)  
• Sedation Policy Learning Module  
  o [Procedural Sedation Policy Online Learning Module](#)  
• Capnography (EtC02) Education Module for Procedural Sedation and Troubleshooting Strategies  
• EtC02 Skills Competency (Monitor)  
• Knowledge of RN as a qualified healthcare provider practicing within their scope of practice with demonstrated competency for each level of sedation  
  • Verbalizes the appropriate areas that bedside procedural sedation may be performed  
  • Demonstrates how to access clinical privileges  
  • Lippincott review of Capnography |
| SKILLS              | SKILLS                 |
| Pre-Procedure       | Pre-Procedure          |
| • Ability to verbalize definitions of procedural sedation and differentiation between moderate versus deep levels of sedation  
  • Able to verbalize EXCLUSIONS from sedation policy:  
    o Patients receiving “minimal sedation” are excluded.  
    o A single IV or single oral medication, for anti-anxiety prior to a procedure.  
    o Intubated patients receiving mechanical ventilation during and after the procedure.  
    o Patients under constant care of anesthesia practitioners while undergoing invasive or surgical procedures.  
  • Ability to articulate necessary equipment needed to be at bedside  
  • Knowledge of patient’s NPO status (# hours) prior to procedure  
  • Verifies intended level of sedation with physician prior to procedure during Universal Protocol (time out).  
  • Documents “baseline” Aldrete score prior to procedure.  
  • Identifies baseline EtC02 waveform and documents numeric in Care Connect.  
  • Identifies appropriate areas that bedside procedures may be performed using sedation  |
| Procedure for RASS Assessment | Procedure for RASS Assessment |
| +4 COMBATIVE | Overly 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 fully alert, but has sustained awakening (eye-opening/eye contact) to voice |
| -1 DROWSY | Briefly awakens with eye contact (to voice) |
| -2 LIGHT SEDATION | Briefly awakens with eye contact (to voice) |
| -3 MODERATE SEDATION | Movement or eye opening (to voice) |
INITIAL COMPETENCY ASSESSMENT FOR PROCEDURAL SEDATION (RN)

During Procedure
- Ability to verbalize the procedure for performing RASS Scale assessment to properly evaluate level of sedation.
- States the frequency of required vital signs (HR, RR, BP, Sp02, EtCO2, with Level of Sedation using RASS score) and documentation for:
  - Moderate sedation (q15min)
  - Deep sedation (q5min).
- Able to identify the Quality Indicators that must be documented under "Outcomes" row at end of procedure:
  - No adverse response
  - Any adverse reaction or unexpected response to sedation
  - Sedation deeper than intended; or patient fails to respond to physical stimuli
  - Sp02 less than 90% and/or drop of 5% from baseline for > 1 minute.
  - Unplanned intubation/assisted ventilation
  - Use of pharmacologic “reversal agents” (e.g. Narcan or Flumazenil)
  - Decrease in BP or HR requiring intervention (e.g. fluid bolus to increase BP)
  - Failure to respond to physical stimulation
  - Unplanned admission/transfer to higher level of care
  - Cardiac or respiratory arrest

Post-Procedure
- States documentation requirements during post sedation phase of recovery
- States appropriate criteria:
  - For recovery (obtains post procedural Aldrete score, patient CV physiologic variables remain stable for at least 30 minutes after last dose of medication and returned to pre-procedural Aldrete score)
  - For discharge to home (Patient awake, alert, oriented to person, place, time or has returned to pre-sedation level of consciousness)

During Procedure
- Documents accurately, the required vital signs at appropriate intervals with appropriate RASS score (level of sedation) pre-procedure/during and during post-procedure recovery
- Identifies changes in EtCO2 waveform (and numeric values) and demonstrates appropriate troubleshooting and interventions for
  - Erratic or flatness in waveform
  - Changes in numeric value >10 mm hg.
  - Waveform doesn’t return to zero
  - Poor head/neck alignment
  - Draping near airway
  - Shallow breathing (not clearing dead space)
  - Dead space ventilation only (movement of air in/out of airway, not lungs)
  - If value is low, have patient deep breath, value will rise to higher level indicating dead space ventilation
- Demonstrates correct manual ventilation of non-intubated patients (if rescue is required)
- Demonstrates correct assessment and placement of oral airway (if rescue required)
- Absence of loss of plateau of waveform
- Position of head, tongue
- Sudden loss of waveform
- Apnea
- Kinked tubing
- Identifying central versus obstructive apnea
- Central apnea – no chest movement
- Obstructive apnea
- Airflow blocked
- No effective ventilation
- Abdominal movement

<table>
<thead>
<tr>
<th>-4</th>
<th>DEEP SEDATION</th>
<th>No response to voice, but movement or eye opening (to physical stimulation)</th>
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<tbody>
<tr>
<td>-5</td>
<td>UNAROUSABLE</td>
<td>No response to voice or physical stimulation (Physical Stimulation)</td>
</tr>
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<td>• Documents vital signs with “Post Procedure” Aldrete Score Q 30 minutes in Care Connect until patient meets criteria for “Recovery”</td>
<td>• Acknowledges the importance of closely monitoring patient and communicating to physician during the procedure any changes in vital signs or changes in breathing patterns.</td>
</tr>
<tr>
<td>• Accurately assesses patients to be discharged home or returned to home unit using appropriate criteria</td>
<td>• The nurse demonstrates an attitude that incorporates a culture of safety and describes human factors that lead to patient injury during sedation</td>
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<tr>
<td>• Documents the appropriate “Quality Indicator” under the “Outcomes” row at conclusion of procedure</td>
<td>• Engages the Patient/Family in understanding that the patient may have an adverse reaction</td>
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<td>• Advocates for patient insuring physician has obtained appropriate Informed Consents (procedure and for sedation), performed completion of airway assessment, Risk Stratification / ASA Classification pre-sedation, H&amp;P appropriate to procedure.</td>
<td>• The nurse does not participate in unsafe practices during a procedure requiring sedation (i.e. leaving the bedside while procedure occurring)</td>
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</tbody>
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**QSEN Competencies Alignment:** Safety
Patient Care: 
EtC02 During Sedation

- Prior to Sedation, know your patient baseline data: respiratory rate, waveform configuration, and EtC02 value

- When to intervene:
  - 1. Change in value > 10 mmHg (hypoventilations can occur from “drop in respirations” or “shallow breathing”)
  - 2. Significant waveform change (shape or size, erratic, waveform flat line) is earliest indicator of potential problem

- Actions: Assess patient and
  - 1. Insure open airway (re-position head/tongue),
  - 2. stimulate patient,
  - 3. check cannula position,
  - 4. stop drugs,
  - 5. inform MD to pause procedure,
  - 6. reversal agent may be indicated

- What happens when waveform doesn’t return to zero? Check for:
  - 1. Poor head/neck alignment,
  - 2. Draping covering airway,
  - 3. Shallow breathing (not clearing dead space)
  - 4. Dead space ventilation (movement of air in and out of dead space too shallow to enter the lungs)
  - 5. If the value is low have patient deep breath,
  - 6. If after that deep breath value rises this is indicative of over sedation.

- Sudden loss of waveform: Indicates NO Breath Detected!
  - Check for Apnea or Kinked tubing and intervene as appropriate

- Identify Central Versus Obstructive Apnea
  - Central Apnea -- indicates Over-Sedation:
    - no chest movement and loss of waveform -- STOP Sedation!
  - Obstructive Apnea (OSA):
    - 1. Airflow blocked due to OBSTRUCTION
    - 2. No effective ventilation
    - Apnea -- OPEN Airway