**Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018**

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**Methodology**

**Definition of Procedural Moderate Sedation and Analgesia**

These guidelines apply to moderate sedation and analgesia before, during, and after procedures. Sedation and analgesia comprises a continuum of states ranging from minimal sedation (anxiolysis) through general anesthesia, as defined by the American Society of Anesthesiologists and accepted by the Joint Commission (table 1). Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration.

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These guidelines specifically apply to the level of sedation corresponding to moderate sedation/analgesia (previously called conscious sedation), which is defined as 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 when spontaneous ventilation is adequate.‡ Cardiovascular function is usually maintained. For these guidelines, analgesia refers to the management of patient pain or discomfort during and after procedures requiring moderate sedation.

**Purposes of the Guidelines**

The purposes of these guidelines are to allow clinicians to optimize the benefits of moderate procedural sedation regardless of site of service; to guide practitioners in appropriate patient selection; to decrease the risk of adverse patient outcomes (e.g., apnea, airway obstruction, respiratory arrest, cardiac arrest, death); to encourage sedation education, training, and research; and to offer evidence-based data to promote specialty consistency for moderate sedation practice.

Moderate sedation/analgesia provides patient tolerance of unpleasant or prolonged procedures through relief of anxiety, discomfort, and/or pain. If the patient response results in deeper sedation than intended, these sedation practices can be associated with cardiac or respiratory depression that must be rapidly recognized and appropriately managed to avoid the risk of hypoxic brain damage, cardiac arrest, or death. Conversely, inadequate sedation or analgesia can result in undue patient discomfort or patient injury, lack of cooperation, or adverse physiological or psychological responses to stress.

The appropriate choice of agents and techniques for moderate sedation/analgesia is dependent upon the experience, training, and preference of the individual practitioner, requirements or constraints imposed by associated medical issues of the patient or type of procedure, and the risk of producing a deeper level of sedation than anticipated. In some cases, the choice of agents or techniques are limited by federal, state, or municipal regulations or statutes. Because it is not always possible to predict how a specific patient will respond to sedative and analgesic medications, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. For moderate sedation, this implies the ability to manage a compromised airway or hypoventilation, and support cardiovascular function in patients who become hypotensive, hypertensive, bradycardic, or tachycardic.

**Focus**

These guidelines focus specifically on the administration of moderate sedation and analgesia for adults and children. The guidelines exclude patients who are not undergoing a diagnostic or therapeutic procedure (e.g., postoperative analgesia). Because minimal sedation (anxiolysis) may entail minimal risk, the guidelines specifically exclude it. Examples of minimal sedation are (1) less than 50% nitrous oxide in oxygen with no other sedative or analgesic medications by any route and (2) a single, oral sedative or analgesic medication administered in doses appropriate for the unsupervised treatment of anxiety or pain. The guidelines do not apply to patients receiving deep sedation, general anesthesia, or major conduction (i.e., neuraxial) anesthesia. Additional interventions excluded from these guidelines include but are not limited to patient-controlled sedation/analgesia, sedatives administered before or during regional and central neuraxial anesthesia, premedication for general anesthesia, interventions without sedatives (e.g., hypnosis, acupuncture), new or rarely administered sedative/analgesics, new or rarely used monitoring or delivery devices, and automated sedative delivery systems. These guidelines do not address education, training, or certification requirements for practitioners who provide moderate procedural sedation.

**Application**

These guidelines are intended for use by all providers who perform moderate procedural sedation and analgesia in any inpatient or outpatient setting including but not limited to hospitals, ambulatory procedural centers, hospital-connected or freestanding office practices (e.g., dental, urology, or ophthalmology offices), endoscopy suites, plastic surgery suites, radiology suites (magnetic resonance imaging, computed tomography), oral and maxillofacial surgery suites, cardiac catheterization laboratories, oncology clinics, electrophysiology laboratories, interventional radiology laboratories, neurointerventional laboratories, echocardiography laboratories, and evoked auditory testing laboratories. They are intended to serve as a resource for other physicians and patient care personnel who are involved in the care of these patients, including those involved in local policy development.
Task Force Members and Consultants
These guidelines were developed by an ASA-appointed task force of 13 members, consisting of physician anesthesiologists in both private and academic practices from various geographic areas of the United States, a cardiologist, a dentist anesthesiologist, an oral/maxillofacial surgeon, a radiologist, an ASA staff methodologist, and two consulting methodologists for the ASA Committee on Standards and Practice Parameters. Conflict of interest documentation regarding current or potential financial and other interests pertinent to the practice guideline were disclosed by all task force members and managed.

The task force developed these guidelines by means of a seven-step process. First, criteria for evidence associated with moderate sedation and analgesia techniques were established. Second, original published research studies relevant to the guidelines were reviewed and analyzed; only articles relevant to the administration of moderate sedation were evaluated. Third, a panel of expert consultants was asked to (1) participate in opinion surveys on the effectiveness and safety of various methods and interventions that might be used during sedation/analgesia and (2) review and comment on a draft of the guidelines developed by the task force. Fourth, survey opinions about the guideline recommendations were solicited from a random sample of active members of the ASA and participating medical specialty societies. Fifth, the task force held open forums at major national meetings to solicit input on its draft recommendations. National organizations representing specialties whose members typically provide moderate sedation were invited to participate in the open forums. Sixth, the consultants were surveyed to assess their opinions on the feasibility of implementing the guidelines. Seventh, all available information was used to build consensus within the task force to finalize the guidelines.

Availability and Strength of Evidence
Preparation of these updated guidelines followed a rigorous methodological process. Evidence was obtained from two principal sources: scientific evidence and opinion-based evidence.

Scientific Evidence. Scientific evidence used in the development of these guidelines is based on cumulative findings from literature published in peer-reviewed journals. Literature citations are obtained from healthcare databases, direct internet searches, task force members, liaisons with other organizations, and manual searches of references located in reviewed articles.

Findings from the aggregated literature are reported in the text of these guidelines by evidence category, level, and direction. Evidence categories refer specifically to the strength and quality of the research design of the studies. Category A evidence represents results obtained from randomized controlled trials (RCTs), and category B evidence represents observational results obtained from nonrandomized study designs or RCTs without pertinent comparison groups. When available, category A evidence is given precedence over category B evidence for any particular outcome. These evidence categories are further divided into evidence levels. Evidence levels refer specifically to the strength and quality of the summarized study findings (i.e., statistical findings, type of data, and the number of studies reporting/replicating the findings). In this document, only the highest level of evidence is included in the summary report for each intervention–outcome pair, including a directional designation of benefit, harm, or equivocality.

Category A. RCTs report comparative findings between clinical interventions for specified outcomes. Statistically significant ($P < 0.01$) outcomes are designated as either beneficial (B) or harmful (H) for the patient; statistically nonsignificant findings are designated as equivocal (E).

Level 1: The literature contains a sufficient number of RCTs to conduct meta-analysis, and meta-analytic findings from these aggregated studies are reported as evidence.

Level 2: The literature contains multiple RCTs, but the number of RCTs is not sufficient to conduct a viable meta-analysis for the purpose of these Guidelines. Findings from these RCTs are reported separately as evidence.

Level 3: The literature contains a single RCT, and findings from this study are reported as evidence.

Category B. Observational studies or RCTs without pertinent comparison groups may permit inference of beneficial or harmful relationships among clinical interventions and clinical outcomes. Inferred findings are given a directional designation of beneficial (B), harmful (H), or equivocal (E). For studies that report statistical findings, the threshold for significance is $P < 0.01$.

Level 1: The literature contains nonrandomized comparisons (e.g., quasiexperimental, cohort [prospective or retrospective], or case-control research designs) with comparative statistics between clinical interventions for a specified clinical outcome.
Level 2: The literature contains noncomparative observational studies with associative statistics (e.g., relative risk, correlation, sensitivity, and specificity).
Level 3: The literature contains noncomparative observational studies with descriptive statistics (e.g., frequencies, percentages).
Level 4: The literature contains case reports.

Insufficient Literature. The lack of sufficient scientific evidence in the literature may occur when the evidence is either unavailable (i.e., no pertinent studies found) or inadequate. Inadequate literature cannot be used to assess relationships among clinical interventions and outcomes because a clear interpretation of findings is not obtained due to methodological concerns (e.g., confounding of study design or implementation) or the study does not meet the criteria for content as defined in the “Focus” of the guidelines.

Opinion-based Evidence. All opinion-based evidence (e.g., survey data, open forum testimony, internet-based comments, letters, and editorials) relevant to each topic was considered in the development of these guidelines. However, only the findings obtained from formal surveys are reported in the document.

Opinion surveys were developed by the task force to address each clinical intervention identified in the document. Identical surveys were distributed to expert consultants and a random sample of members of the participating organizations.

Expert and Participating Membership Opinion Surveys. Survey findings from task force–appointed expert consultants, a random sample of the ASA membership, and membership samples from the American Association of Oral and Maxillofacial Surgeons (AAOMS) and the American Society of Dentist Anesthesiologists (ASDA) are fully reported in this document. Survey responses were recorded using a 5-point scale and summarized based on median values.

Strongly Agree: Median score of 5 (at least 50% of the responses are 5)
Agree: Median score of 4 (at least 50% of the responses are 4 or 4 and 5)
Equivocal: Median score of 3 (at least 50% of the responses are 3, or no other response category or combination of similar categories contain at least 50% of the responses)
Disagree: Median score of 2 (at least 50% of responses are 2 or 1 and 2)
Strongly Disagree: Median score of 1 (at least 50% of responses are 1)

Informal Opinions. Open forum testimony obtained during development of these guidelines, internet-based comments, letters, and editorials are all informally evaluated and discussed during the formulation of guideline recommendations. When warranted, the task force may add educational information or cautionary notes based on this information.

Guidelines

Patient Evaluation

Preprocedure patient evaluation consists of the following strategies for reducing sedation-related adverse outcomes: (1) reviewing previous medical records for underlying medical problems (e.g., abnormalities of major organ systems, obesity, obstructive sleep apnea, anatomical airway problems, congenital syndromes with associated medical/surgical issues, respiratory disease, allergies, intestinal inflammation); sedation, anesthesia, and surgery history; history of current problems pertaining to cooperation, pain tolerance, or sensitivity to anesthesia or sedation; current medications; extremes of age; psychotropic drug use; use of nonpharmaceuticals (e.g., nutraceuticals); and family history; (2) a focused physical examination; and (3) preprocedure laboratory testing (where indicated).

Literature Findings. Although it is well accepted clinical practice to review medical records, conduct a physical examination, and review laboratory test results, comparative studies are insufficient to evaluate the periprocedural impact of these activities. Observational studies indicate that some adverse outcomes (e.g., unintended deep sedation, hypoxemia, or hypotension) may occur in patients with preexisting medical conditions when moderate sedation/analgesia is administered. These conditions include: (1) extremes of age, ASA status III or higher, and respiratory conditions (category B2-H evidence); (2) obstructive sleep apnea, respiratory distress syndrome, obesity, allergies, psychotropic drug use, history of gastric bypass surgery, pediatric patients who are precooperative or who have behavior or attention disorders, cardiovascular disorders, history of gastric bypass, and history of long-term benzodiazepine use (category B3-H evidence); 8–22 Case reports indicate similar adverse outcomes for newborns, a patient with mitochondrial disease, a patient with grand mal epilepsy, and a patient with a history of benzodiazepine use (category B4-H evidence). 23–26

Survey Findings. The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendations to (1) review previous medical records and interview the patient or family, (2) conduct a focused physical examination of the patient, and (3) review available laboratory test results. The consultants and ASA members agree with the recommendation to, if possible, perform the preprocedure evaluation well enough in advance (e.g., several days to weeks) to allow for optimal patient preparation; the AAOMS members and ASDA members strongly agree with this recommendation. Finally, consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendation to reevaluate the patient immediately before the procedure.

*Unless otherwise noted in this document, hypoxemia is reported in the literature to be oxygen desaturation to at most 90%.
**This may not be feasible for urgent or emergency procedures, interventional radiology, or other radiology settings.
Recommendations for Patient Evaluation

- Review previous medical records and interview the patient or family to identify:
  - Abnormalities of the major organ systems (e.g., cardiac, renal, pulmonary, neurologic, sleep apnea, metabolic, endocrine)
  - Adverse experience with sedation/analgesia, as well as regional and general anesthesia
  - History of a difficult airway
  - Current medications, potential drug interactions, drug allergies, and nutraceuticals
  - History of tobacco, alcohol or substance use or abuse
  - Frequent or repeated exposure to sedation/analgesic agents
- Conduct a focused physical examination of the patient (e.g., vital signs, auscultation of the heart and lungs, evaluation of the airway,†† and, when appropriate to sedation, other organ systems where major abnormalities have been identified)
- Review available laboratory test results
  - Order additional laboratory tests guided by a patient’s medical condition, physical examination, and the likelihood that the results will affect the management of moderate sedation/analgesia
  - Evaluate results of these tests before sedation is initiated
- If possible, perform the preprocedure evaluation well enough in advance (e.g., several days to weeks) to allow for optimal patient preparation.**
- Reevaluate the patient immediately before the procedure.

Preprocedure Patient Preparation

Preprocedure patient preparation consists of (1) consultation with a medical specialist when needed; (2) patient preparation for the procedure (e.g., informing patients of the benefits and risks of sedatives and analgesics, preprocedure instruction, medication usage, counseling); and (3) preprocedure fasting from solids and liquids.

Literature Findings. The literature is insufficient regarding the benefits of consultation with a medical specialist or providing the patient (or legal guardian, in the case of a child or impaired adult) with preprocedure information about sedation and analgesia. A nonrandomized comparative study reported equivocal outcomes (e.g., emesis, apnea, oxygen levels) when preprocedure fasting (i.e., liquids or solids) is compared to no fasting (category B1-E evidence).27 Another nonrandomized comparison of fasting for less than 2 h versus fasting for greater than 2 h reported equivocal findings for emesis, oxygen saturation levels, and arrhythmia for infants (category B1-E evidence).28 Finally, a third nonrandomized comparison reported equivocal findings for gastric volume and pH when fasting of liquids for 0.5 to 3 h is compared with fasting times of greater than 3 h (category B1-E evidence).29

Survey Findings. The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendations to (1) consult with a medical specialist, when appropriate, before administration of moderate procedural sedation to patients with significant underlying conditions; (2) when feasible before the procedure, inform patients or legal guardians of the benefits, risks, and limitations of moderate sedation/analgesia and possible alternatives, and elicit their preferences; (3) before the day of the procedure, inform patients or legal guardians that they should not drink fluids or eat solid foods for a sufficient period of time to allow for gastric emptying; and (4) on the day of the procedure, assess the time and nature of the last oral intake. All four groups of survey respondents agreed with the recommendation that in urgent or emergent situations where complete gastric emptying is not possible, do not delay moderate procedural sedation based on fasting time alone.

Recommendations for Preprocedure Patient Preparation

- Consult with a medical specialist (e.g., physician anesthesiologist, cardiologist, endocrinologist, pulmonologist, nephrologist, pediatrician, obstetrician, or otolaryngologist), when appropriate before administration of moderate procedural sedation to patients with significant underlying conditions
  - If a specialist is needed, select a specialist based on the nature of the underlying condition and the urgency of the situation
  - For severely compromised or medically unstable patients (e.g., ASA status IV, anticipated difficult airway, severe obstructive pulmonary disease, coronary artery disease, or congestive heart failure) or if it is likely that sedation to the point of unresponsiveness will be necessary to obtain adequate conditions, consult with a physician anesthesiologist
- Before the procedure, inform patients or legal guardians of the benefits, risks, and limitations of moderate sedation/analgesia and possible alternatives and elicit their preferences††
- Inform patients or legal guardians before the day of the procedure that they should not drink fluids or eat solid foods for a sufficient period of time to allow for gastric emptying before the procedure§§

††See table 2 for additional information related to airway assessment.

‡‡This may not be feasible for urgent or emergency procedures.

• On the day of the procedure, assess the time and nature of last oral intake
  ◦ Evaluate the risk of pulmonary aspiration of gastric contents when determining (1) the target level of sedation and (2) whether the procedure should be delayed
• In urgent or emergent situations where complete gastric emptying is not possible, do not delay moderate procedural sedation based on fasting time alone

Patient Monitoring
Many of the complications associated with moderate sedation and analgesia may be avoided if adverse drug responses are detected and treated in a timely manner (i.e., before the development of cardiovascular decompensation or cerebral hypoxia). Patients given sedatives or analgesics in unmonitored settings may be at increased risk of these complications. Patient monitoring includes strategies for the following: (1) monitoring patient level of consciousness assessed by the response of patients, including spoken responses to commands or other forms of bidirectional communication during procedures performed with moderate sedation/analgesia; (2) monitoring patient ventilation and oxygenation, including ventilatory function, by observation of qualitative clinical signs, capnography, and pulse oximetry; (3) hemodynamic monitoring, including blood pressure, heart rate, and electrocardiography; (4) contemporaneous recording of monitored parameters; and (5) availability/presence of an individual responsible for patient monitoring.

Literature Findings. The literature is insufficient to determine whether monitoring patients’ level of consciousness improves patient outcomes or decreases risks. Also, the literature is insufficient to evaluate whether observation of the patient, auscultation, chest excursion, or plethysmography are associated with reduced sedation-related risks.

Meta-analysis of RCTs indicate that the use of continuous end-tidal carbon dioxide monitoring (i.e., capnography) is associated with a reduced frequency of hypoxic events (i.e., oxygen saturation less than 90%) when compared to monitoring without capnography (e.g., practitioners were blinded to capnography results) during procedures with moderate sedation (category A1-B evidence). Findings for this comparison were equivocal for RCTs reporting severe hypoxic events (i.e., oxygen saturation less than 85%) and for oxygen saturation levels of 92, 93, and 95% (category A2-E evidence). Observational studies indicate that pulse oximetry is effective in the detection of oxygen saturation levels in patients administered sedatives and analgesics (category B3-B evidence). Observational studies also indicate that electrocardiography monitoring is effective in the detection of arrhythmias, premature ventricular contractions, and bradycardia (category B3-B evidence).

The literature is insufficient to determine the benefits of contemporaneous recording of patients’ level of consciousness, respiratory function, or hemodynamics. In addition, the literature is insufficient to evaluate whether the presence of an individual dedicated to patient monitoring will reduce adverse outcomes related to moderate sedation/analgesia.

Survey Findings. The consultants, ASA members, AAOMS members, and ASDA members agree with the recommendations to (1) periodically monitor a patient’s response to verbal commands during moderate sedation, except in patients who are unable to respond appropriately or during procedures where movement could detrimental clinically; and (2) during procedures where a verbal response is not possible, check the patient’s ability to give a “thumbs up” or other indication of consciousness in response to verbal or tactile (light tap) stimulation. The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendations to (1) continually monitor ventilatory function by observation of qualitative clinical signs; (2) continually monitor ventilatory function with capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment; (3) monitor all patients by pulse oximetry with appropriate alarms; (4) determine blood pressure before sedation/analgesia is initiated unless precluded by lack of patient cooperation; (5) once moderate sedation/analgesia is established, continually monitor blood pressure and heart rate during the procedure unless such monitoring interferes with the procedure; (6) use electrocardiographic monitoring during moderate sedation in patients with clinically significant cardiovascular disease or those who are undergoing procedures where dysrhythmias are anticipated; (7) record patients’ level of consciousness, ventilatory and oxygenation status, and hemodynamic variables at a frequency that depends on the type and amount of medication administered, the length of the procedure, and the general condition of the patient; (8) set device alarms to alert the care team to critical changes in patient; (9) assure that a designated individual other than the practitioner performing the procedure is present to monitor the patient throughout the procedure; and (10) the individual responsible for monitoring the patient should be trained in the recognition of apnea and airway obstruction and be authorized to seek additional help. The consultants, ASA members, and ASDA members agree that the designated individual may assist with minor, interruptible tasks once the patient’s level of sedation/analgesia and vital signs have stabilized, provided that adequate monitoring for the patient’s level of sedation is maintained; the AAOMS members strongly agree with this recommendation.
Recommendations for Patient Monitoring

Monitoring Patient Level of Consciousness

- Periodically (e.g., at 5-min intervals) monitor a patient’s response to verbal commands during moderate sedation, except in patients who are unable to respond appropriately (e.g., patients where age or development may impair bidirectional communication) or during procedures where movement could be detrimental
- During procedures where a verbal response is not possible (e.g., oral surgery, restorative dentistry, upper endoscopy), check the patient’s ability to give a “thumbs up” or other indication of consciousness in response to verbal or tactile (light tap) stimulation; this suggests that the patient will be able to control his airway and take deep breaths if necessary#

Monitoring Patient Ventilation and Oxygenation

- Continually*** monitor ventilatory function by observation of qualitative clinical signs
- Continually monitor ventilatory function with capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment
  - For uncooperative patients, institute capnography after moderate sedation has been achieved
- Continuously monitor all patients by pulse oximetry with appropriate alarms

Monitoring Hemodynamics

- Determine blood pressure before sedation/analgesia is initiated unless precluded by lack of patient cooperation
- Once moderate sedation/analgesia is established, continually monitor blood pressure (e.g., at 5-min intervals) and heart rate during the procedure unless such monitoring interferes with the procedure (e.g., magnetic resonance imaging where stimulation from the blood pressure cuff could arouse an appropriately sedated patient)
- Use electrocardiographic monitoring during moderate sedation in patients with clinically significant cardiovascular disease or those who are undergoing procedures where dysrhythmias are anticipated

Contemporaneous Recording of Monitored Parameters

- Record patients’ level of consciousness, ventilatory and oxygenation status, and hemodynamic variables at a frequency that depends on the type and amount of medication administered, the length of the procedure, and the general condition of the patient
  - At a minimum, this should occur (1) before the administration of sedative/analgesic agents†††; (2) after administration of sedative/analgesic agents; (3) at regular intervals during the procedure; (4) during initial recovery; and (5) just before discharge
- Set device alarms to alert the care team to critical changes in patient status

Availability of an Individual Responsible for Patient Monitoring

- Assure that a designated individual other than the practitioner performing the procedure is present to monitor the patient throughout the procedure
  - The individual responsible for monitoring the patient should be trained in the recognition of apnea and airway obstruction and be authorized to seek additional help
  - The designated individual should not be a member of the procedural team but may assist with minor, interruptible tasks once the patient’s level of sedation/analgesia and vital signs have stabilized, provided that adequate monitoring for the patient’s level of sedation is maintained

Supplemental Oxygen

Literature Findings. Meta-analysis of RCTs indicate that the use of supplemental oxygen versus no supplemental oxygen is associated with a reduced frequency of hypoxemia‡‡‡ during procedures with moderate sedation (category A1-B evidence). The literature is insufficient to examine which methods of supplemental oxygen administration (e.g., nasal cannula, face mask, or specialized devices) are more effective in reducing hypoxemia.

Survey Findings. The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendation to use supplemental oxygen during moderate procedural sedation/analgesia unless specifically contraindicated for a particular patient or procedure.

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#A response limited to reflex withdrawal from a painful stimulus is not considered a purposeful response and thus represents a state of general anesthesia.


†††For rare uncooperative patients (e.g., children with autism spectrum disorder or attention deficit disorder), recording oxygenation status or blood pressure may not be possible until after sedation.

‡‡‡Reported by authors as oxygen desaturation to at most 95% or oxygen desaturation more than 5 or 10% below baseline.
Recommendations for Supplemental Oxygen

- Use supplemental oxygen during moderate procedural sedation/analgesia unless specifically contraindicated for a particular patient or procedure.

Emergency Support

Emergency support strategies include (1) the presence of pharmacologic antagonists; (2) the presence of age and weight appropriate emergency airway equipment (e.g., different types of airway devices, supraglottic airway devices); (3) the presence of an individual capable of establishing a patent airway and providing positive pressure ventilation and resuscitation; (4) the presence of an individual to establish intravenous access; and (5) the availability of rescue support.

Literature Findings. Although it is established clinical practice to provide access to emergency support, the literature is insufficient to assess the benefits or harms of keeping pharmacologic antagonists or emergency airway equipment available during procedures with moderate sedation and analgesia. The literature is insufficient to assess whether the presence of an individual capable of establishing a patent airway, positive pressure ventilation, and resuscitation will improve outcomes. In addition, the literature is insufficient to determine the benefits of keeping an individual present to establish intravenous access during procedures with moderate sedation/analgesia. Finally, the literature is insufficient to determine the benefits of rescue support availability during moderate procedural sedation/analgesia.

Survey Findings. The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendation to assure that (1) pharmacologic antagonists for benzodiazepines and opioids are immediately available in the procedure suite or procedure room; (2) an individual is present in the room who understands the pharmacology of the sedative/analgesics administered and potential interactions with other medications and nutraceuticals the patient may be taking; (3) appropriately sized equipment for establishing a patent airway is available; (4) at least one individual capable of establishing a patent airway and providing positive pressure ventilation is present in the procedure room; (5) suction, advanced airway equipment, positive pressure ventilation, and supplemental oxygen are immediately available in the procedure room and in good working order; (6) a member of the procedural team is trained in the recognition and treatment of airway complications (e.g., apnea, laryngospasm, airway obstruction), opening the airway, suctioning secretions, and performing bag-valve-mask ventilation; (7) a member of the procedural team has the skills to establish intravascular access; (8) a member of the procedural team has the skills to provide chest compressions; (9) a functional defibrillator or automatic external defibrillator is immediately available in the procedure area; (10) an individual or service is immediately available with advanced life support skills; and (11) members of the procedural team are able to recognize the need for additional support and know how to access emergency services from the procedure room.

Recommendations for Emergency Support

- Assure that pharmacological antagonists for benzodiazepines and opioids are immediately available in the procedure suite or procedure room.
- Assure that an individual is present in the room who understands the pharmacology of the sedative/analgesics administered (e.g., opioids and benzodiazepines) and potential interactions with other medications and nutraceuticals the patient may be taking.
- Assure that appropriately sized equipment for establishing a patent airway is available.
- Assure that at least one individual capable of establishing a patent airway and providing positive pressure ventilation is present in the procedure room.
- Assure that suction, advanced airway equipment, a positive pressure ventilation device, and supplemental oxygen are immediately available in the procedure room and in good working order.
- Assure that a member of the procedural team is trained in the recognition and treatment of airway complications (e.g., apnea, laryngospasm, airway obstruction), opening the airway, suctioning secretions, and performing bag-valve-mask ventilation.
- Assure that a member of the procedural team has the skills to establish intravascular access.
- Assure that a member of the procedural team has the skills to provide chest compressions.
- Assure that a functional defibrillator or automatic external defibrillator is immediately available in the procedure area.
- Assure that an individual or service (e.g., code blue team) with advanced life support skills (e.g., tracheal intubation, defibrillation, resuscitation medications) is immediately available.
- Assure that members of the procedural team are able to recognize the need for additional support and know how to access emergency services from the procedure room (e.g., telephone, call button).

Sedative/Analgesic Medications Not Intended for General Anesthesia

For these guidelines, sedatives not intended for general anesthesia include benzodiazepines (e.g., midazolam, diazepam, etc.).

Refer to table 4 for examples of emergency support equipment and pharmaceuticals.

“Immediately available in the procedure room” refers to easily accessible shelving, cabinetry, and other measures to assure that there is no delay in accessing medications and equipment during the procedure.

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flunitrazepam, lorazepam, or temazepam) and dexmedetomidine. Analgesics administered with sedatives include opioids such as fentanyl, alfentanil, remifentanil, meperidine, morphine, and naltobuphine. This section of the guidelines addresses the following topics: (1) benzodiazepines and dexmedetomidine, (2) sedative/opioid combinations, (3) intravenous versus nonintravenous sedatives/analgesics not intended for general anesthesia, and (4) titration of sedatives/analgesics not intended for general anesthesia.

**Literature Findings.** Meta-analysis of RCTs comparing midazolam combined with opioids versus midazolam alone report equivocal findings for pain and discomfort, hypoxemia, and patient recall of the procedure (category A1-E evidence). When midazolam combined with opioids is compared with opioids alone, RCTs report equivocal findings for patient recall, pain during the procedure, frequency of hypoxemia, hypercarbia and respiratory depression (category A2-E evidence).

One RCT comparing dexmedetomidine with midazolam reports equivocal outcomes for recovery time, oxygen saturation levels, apnea, and bradycardia (category A3-E evidence). Another RCT reports a longer recovery time for dexmedetomidine compared with midazolam (category A3-H evidence), with equivocal findings for analgesia scores, oxygen saturation levels, respiratory rate, blood pressure, and pulse rate (category A3-E evidence). One RCT reports a lower frequency of hypoxemia when dexmedetomidine is combined with an opioid analgesic compared with midazolam combined with an opioid analgesic (category A3-B evidence). One RCT reports deeper sedation (i.e., higher sedation scores) and a lower frequency of hypoxemia when dexmedetomidine combined with midazolam and meperidine is compared with midazolam combined with meperidine (category A3-B evidence).

One RCT comparing intravenous midazolam with intramuscular midazolam reports equivocal findings for oxygen saturation levels, respiratory rate, and heart rate (category A3-E evidence). One RCT comparing intravenous midazolam with intranasal midazolam reports equivocal findings for sedation efficacy (category A3-E evidence), but discomfort from the nasal administration was reported for all intranasal patients with no nasal discomfort from the intravenous patients (category A3-B evidence). One RCT comparing intravenous diazepam with rectal diazepam reports lower recall for the intravenous method (category A3-B evidence); findings were equivocal for sedative effect, anxiety, and crying (category A3-E evidence). One RCT comparing intravenous with intranasal dexmedetomidine reported equivocal findings for sedation time, duration of the procedure, and the frequency of rescue doses of midazolam administered (category A3-E evidence).

One RCT comparing titration (i.e., administration of small, incremental doses of intravenous midazolam combined with meperidine until the desired level of sedation and/or analgesia is achieved) of midazolam combined with an opioid compared with a single, rapid bolus reports higher total physician times, medication dosages, frequencies of hypoxemia, and somnolence scores for titration (category A3-H evidence).

**Survey Findings.** The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendation that combinations of sedative and analgesic agents may be administered as appropriate for the procedure and the condition of the patient. The consultants, ASA members, and ASDA members agree that dexmedetomidine may be administered as an alternative to benzodiazepine sedatives on a case-by-case basis; the AAOMS members report equivocal regarding this recommendation. The consultants, ASA members, AAOMS members, and ASDA members strongly agree that in patients who have received sedation/analgesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of reestablishing intravenous access on a case-by-case basis. Finally, the consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendation to administer intravenous sedative/analgesic drugs in small, incremental doses, or by infusion, titrating to the desired endpoints.

**Recommendations for Sedative or Analgesic Medications Not Intended for General Anesthesia**

- Combinations of sedative and analgesic agents may be administered as appropriate for the procedure and the condition of the patient
- Administer each component individually to achieve the desired effect (e.g., additional analgesic medication to relieve pain; additional sedative medication to decrease awareness or anxiety)
- Dexmedetomidine may be administered as an alternative to benzodiazepine sedatives on a case-by-case basis

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***All routes of administration were considered, including oral, nasal, intramuscular, rectal, transdermal, sublingual, iontophoresis, and nebulization.

****Reported by authors as oxygen desaturation to less than 94, 93, or 90%.

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Practice Guidelines
• In patients receiving intravenous medications for sedation/analgesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression.
• In patients who have received sedation/analgesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of reestablishing intravenous access on a case-by-case basis.
• Administer intravenous sedative/analgesic drugs in small, incremental doses, or by infusion, titrating to the desired endpoints.
  ○ Allow sufficient time to elapse between doses so the peak effect of each dose can be assessed before subsequent drug administration.
• When drugs are administered by nonintravenous routes (e.g., oral, rectal, intramuscular, transmucosal), allow sufficient time for absorption and peak effect of the previous dose to occur before supplementation is considered.

Sedative/Analgesic Medications Intended for General Anesthesia

For these guidelines, sedatives intended for general anesthesia include propofol, ketamine and etomidate.‡‡‡‡ Sedatives not intended for general anesthesia (e.g., benzodiazepines, nitrous oxide, chloral hydrate, barbiturates, and antihistamines) are included either as comparison groups or in combination with sedatives intended for general anesthesia. Analgesics (e.g., opioids, nonsteroidal antiinflammatory drugs, and local anesthetics) are included either in comparison groups or in combination with sedatives intended for general anesthesia. This section of the guidelines addresses the following topics: (1) propofol versus other sedative/analgesics, (2) ketamine versus other sedative/analgesics, (3) etomidate versus other sedative/analgesics, (4) combinations of sedatives intended for general anesthesia versus other sedatives/analgesics, alone or in combination, (5) intravenous versus nonintravenous sedatives/analgesics intended for general anesthesia, |||| and (6) titration of intravenous sedatives/analgesics intended for general anesthesia.

Literature Findings. Literature comparing propofol with other sedative/analgesic medications, either alone or in combination, report the following findings: (1) Meta-analysis of RCTs report faster recovery times for propofol versus midazolam after procedures with moderate sedation (category A1-B evidence), 95–99 with equivocal findings for patient recall, 95,100–103 and frequency of hypoxemia (category A1-E evidence). 96,100,102,103 One RCT reports shorter sedation time, a lower frequency of recall and higher recovery scores for propofol versus diazepam (category A3-B evidence). 104 (2) RCTs comparing propofol versus benzodiazepines combined with opioid analgesics report shorter sedation and recovery times for propofol alone (category A2-B evidence), 105,106 with equivocal findings for pain, oxygen saturation levels, and blood pressure (category A2-E evidence). 107–109 (3) RCTs comparing propofol combined with benzodiazepines versus propofol alone report equivocal findings for recovery and procedure times, pain with injection, and restless (category A2-E evidence). 110–112 One RCT comparing propofol combined with midazolam versus propofol alone reports deeper sedation levels and more episodes of deep sedation for the combination group (category A3-H evidence). 112 RCTs comparing propofol combined with opioid analgesics versus propofol alone report lower pain scores for the combination group (category A2-B evidence). 113,114 with equivocal findings for sedation levels, oxygen saturation levels, and respiratory and heart rates (category A2-E evidence). 113–116 (4) One RCT comparing propofol combined with remifentanil versus remifentanil alone reports deeper sedation, less recall (category A3-B evidence), and more respiratory depression (category A3-H evidence) for the combination group. 117 (5) RCTs comparing propofol combined with sedatives/analgesics not intended for general anesthesia versus combinations of sedatives/analgesics not intended for general anesthesia report equivocal findings for outcomes including sedation time, patient recall, pain scores, recovery time, oxygen saturation levels, blood pressure, and heart rate (category A2-E evidence). 118–119 (6) RCTs comparing propofol with ketamine report equivocal findings for sedation scores, pain during the procedure, recovery, oxygen saturation levels, respiratory rate, blood pressure, and heart rate (category A2-E evidence). 117,118–119 (7) One RCT comparing propofol versus ketamine combined with midazolam reports equivocal findings for recovery agitation, oxygen saturation levels, respiratory rate, blood pressure, and heart rate (category A3-E evidence). 119,120 (8) One RCT comparing propofol versus ketamine combined with fentanyl reports shorter recovery times and less recall for propofol alone (category A3-E evidence). 121 (9) RCTs comparing propofol combined with ketamine versus propofol alone report deeper sedation for the combination group (category A3-B evidence). 121 with more respiratory depression and a greater frequency of hypoxemia.‡‡‡‡‡ (category A3-H evidence). 122

Literature comparing ketamine with other sedative/analgesic medications, either alone or in combination, report the following findings: (1) RCTs comparing ketamine with midazolam report equivocal findings for sedation scores, recovery time, and oxygen saturation levels (category A2-E evidence). 87,143,144 (2) One RCT comparing ketamine versus nitrous oxide reports longer sedation times and higher levels of sedation (i.e., deeper sedation levels) for ketamine (category A3-H evidence). 145 (3) One RCT comparing ketamine with midazolam combined with fentanyl reports a lower

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‡‡‡‡Note that these guidelines do not address education, training, or certification requirements for practitioners who provide moderate procedural sedation with these drugs.

‡‡‡‡‡Reported by author as oxygen desaturation to less than 94%.
depth of sedation for ketamine (category A3-B evidence), with equivocal findings for recall, pain scores and frequency of hypoxemia (category A3-E evidence).\(^\text{146}\) (4) RCTs comparing ketamine combined with midazolam versus ketamine alone or midazolam report equivocal findings for sedation scores, sedation time, recovery, and recovery agitation (category A2-E evidence).\(^\text{143,147,148}\) (5) One RCT comparing ketamine combined with midazolam versus midazolam combined with alfentanil reports a lower frequency of hypoxemia (category A3-B evidence) and increased disruptive movements, longer recovery times, and longer times to discharge for ketamine combined with midazolam (category A3-H evidence).\(^\text{149}\) (6) RCTs comparing ketamine with propofol report equivocal findings for sedation scores, pain during the procedure, oxygen saturation levels, and recovery scores (category A2-E evidence).\(^\text{137,138}\) RCTs comparing ketamine with etomidate report less airway assistance required and lower frequencies of myoclonus with ketamine (category A2-B evidence).\(^\text{150,151}\) (7) RCTs comparing ketamine combined with propofol versus propofol combined with fentanyl report equivocal findings for recovery times, oxygen saturation levels, respiratory rate, and heart rate (category A3-H evidence).\(^\text{152-154}\)

Literature comparing etomidate with other sedative/analgesic medications, either alone or in combination, report the following findings: (1) One RCT comparing etomidate with midazolam reports shorter sedation times for etomidate (category A3-B evidence), with equivocal findings for recovery agitation, oxygen saturation levels, and apnea (category A3-E evidence).\(^\text{155}\) (2) One RCT comparing etomidate with pentobarbital reports shorter sedation times for etomidate (category A3-B evidence), with equivocal findings for recovery agitation and hypotension (category A3-B evidence).\(^\text{156}\) (3) One RCT comparing etomidate combined with fentanyl versus midazolam combined with fentanyl reports deeper sedation (i.e., higher sedation scores) for the combination group (category A3-B evidence), with equivocal findings for sedation times, recovery times, frequency of oversedation, and oxygen saturation levels (category A3-E evidence), and a higher frequency of myoclonus (category A3-H evidence).\(^\text{157}\) (4) One RCT comparing etomidate combined with morphine and fentanyl versus midazolam combined with morphine and fentanyl reports shorter sedation times for the etomidate combination (category A3-B evidence), with equivocal findings for oxygen saturation levels, apnea, hypotension, and recovery agitation (category A3-E evidence), and a higher frequency of patient recall and myoclonus (category A3-H evidence).\(^\text{158}\)

One RCT reports shorter sedation onset times, shorter recovery times, and fewer rescue doses administered for intravenous ketamine when compared with intramuscular ketamine (category A3-B evidence), with equivocal findings for sedation efficacy, respiratory depression, and time to discharge (category A3-E evidence).\(^\text{159}\) One RCT comparing intravenous versus intramuscular ketamine with or without midazolam reports equivocal findings for sedation time, recovery agitation, and duration of the procedure (category A3-E evidence).\(^\text{148}\)

Observational studies reporting titrated administration of sedatives intended for general anesthesia report the frequency of hypoxemia ranging from 1.7 to 4.7% of patients,\(^\text{14,160-163}\) with oversedation occurring in 0.13%-0.2% of patients.\(^\text{14,161}\)

**Survey Findings.** The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendations to (1) provide care consistent with that required for general anesthesia when moderate procedural sedation with sedative or analgesic medications intended for general anesthesia by any route is intended; (2) assure that practitioners administering these drugs are able to reliably rescue patients from unintended deep sedation or general anesthesia; (3) maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression for patients receiving intravenous sedatives intended for general anesthesia; (4) determine the advisability of reestablishing intravenous access on a case-by-case basis in patients who have received sedatives intended for general anesthesia by nonintravenous routes or whose intravenous line has become dislodged or blocked; and (5) administer intravenous sedative/analgesic drugs intended for general anesthesia in small, incremental doses, or by infusion, titrating to the desired endpoints.

**Recommendations for Sedative/Analgesic Medications Intended for General Anesthesia**

- When moderate procedural sedation with sedative/analgesic medications intended for general anesthesia by any route is intended, provide care consistent with that required for general anesthesia
- Assure that practitioners administering sedative/analgesic medications intended for general anesthesia are able to reliably identify and rescue patients from unintended deep sedation or general anesthesia
- For patients receiving intravenous sedative/analgesic medications intended for general anesthesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression
- In patients who have received sedative/analgesic medications intended for general anesthesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of reestablishing intravenous access on a case-by-case basis
- Administer intravenous sedative/analgesic medications intended for general anesthesia in small, incremental doses or by infusion, titrating to the desired endpoints
  - Allow sufficient time to elapse between doses so the peak effect of each dose can be assessed before subsequent drug administration

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• When drugs intended for general anesthesia are administered by nonintravenous routes (e.g., oral, rectal, intramuscular, transmucosal), allow sufficient time for absorption and peak effect of the previous dose to occur before supplementation is considered.

**Reversal Agents: Naloxone and Flumazenil**

**Literature Findings.** One placebo-controlled RCT reports that naloxone effectively reverses the effects of meperidine as measured by increasing alertness scores and respiratory rate (category A3-B evidence).\(^{166}\) Reversal of respiratory depression, apnea, and oxygen desaturation after naloxone administration in other practice settings is also reported by observational studies (category B3-B evidence)\(^{165,166}\) and case reports (category B4-B evidence).\(^{167-170}\)

Meta-analysis of double-blind placebo-controlled RCTs indicates that flumazenil effectively antagonizes the effects of sedation within 15 min for patients who have been administered benzodiazepines (category A1-B evidence).\(^{171-178}\)

Placebo-controlled RCTs also indicate that flumazenil administration is associated with shorter recovery times for benzodiazepine sedation (category A2-B evidence).\(^{176,179-181}\)

Meta-analysis of placebo-controlled RCTs indicate that flumazenil effectively antagonizes the effects of benzodiazepines when combined with opioids (category A1-B evidence).\(^{182-186}\)

**Survey Findings.** The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendations to (1) assure that specific antagonists are immediately available in the procedure room whenever opioid analgesics or benzodiazepines are administered for moderate procedural sedation/analgesia, regardless of route of administration; (2) encourage or physically stimulate patients to breathe deeply if patients become hypoxic or apneic during sedation/analgesia; (3) administer supplemental oxygen if patients become hypoxic or apneic during sedation/analgesia; (4) provide positive pressure ventilation if spontaneous ventilation is inadequate when patients become hypoxic or apneic during sedation/analgesia; (5) use reversal agents in cases where airway control, spontaneous ventilation, or positive pressure ventilation is inadequate; (6) administer naloxone to reverse opioid-induced sedation and respiratory depression; (7) administer flumazenil to reverse benzodiazepine-induced sedation and respiratory depression; (8) after pharmacologic reversal, observe and monitor patients for a sufficient time to ensure that sedation and cardiorespiratory depression does not recur once the effect of the antagonist dissipates; and (9) not use sedation regimens that are intended to include routine reversal of sedative or analgesic agents.

**Recommendations for Reversal Agents**

• If patients develop hypoxemia, significant hyperventilation or apnea during sedation/analgesia: (1) encourage or physically stimulate patients to breathe deeply, (2) administer supplemental oxygen, and (3) provide positive pressure ventilation if spontaneous ventilation is inadequate.

• Use reversal agents in cases where airway control, spontaneous ventilation or positive pressure ventilation are inadequate.
  - Administer naloxone to reverse opioid-induced sedation and respiratory depression.
  - Administer flumazenil to reverse benzodiazepine-induced sedation and respiratory depression.

• After pharmacologic reversal, observe and monitor patients for a sufficient time to ensure that sedation and cardiorespiratory depression does not recur once the effect of the antagonist dissipates.

• Do not use sedation regimens that are intended to include routine reversal of sedative or analgesic agents.

**Recovery Care**

Patients receiving moderate procedural sedation may continue to be at risk for developing complications after their procedure is completed. Decreased stimulation from the proceduralist delayed drug absorption after nonintravenous administration, and slow drug elimination may contribute to residual sedation and cardiorespiratory depression during the recovery period. When sedation/analgesia is administered to outpatients, medical supervision may not be available once the patient leaves the medical facility. This section of the guidelines addresses the following recovery care topics: (1) continued observation and monitoring until discharge and (2) predetermined discharge criteria.

**Literature Findings.** Although it is well accepted clinical practice to continue patient observation until discharge, the literature is insufficient to evaluate the impact of postprocedural observation and monitoring. The literature is also insufficient to evaluate the effects of using predetermined discharge criteria on patient outcomes.

**Survey Findings.** The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendations to (1) observe and monitor patients in an appropriately staffed and equipped area until they are near their baseline level of consciousness and are no longer at increased risk for cardiorespiratory depression, (2) monitor oxygenation continuously until patients are no longer at risk for hypoxemia, (3) monitor ventilation and circulation at regular intervals until patients are suitable for discharge, and (4) design discharge criteria to minimize the risk of central pulmonary edema.

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Practitioners are cautioned that acute reversal of opioid-induced analgesia may result in pain, hypertension, tachycardia, or pulmonary edema.
nervous system or cardiorespiratory depression after discharge from observation by trained personnel.

**Recommendations for Recovery Care**

- After sedation/analgesia, observe and monitor patients in an appropriately staffed and equipped area until they are near their baseline level of consciousness and are no longer at increased risk for cardiorespiratory depression.
- Monitor oxygenation continuously until patients are no longer at risk for hypoxemia.
- Monitor ventilation and circulation at regular intervals (e.g., every 5 to 15 min) until patients are suitable for discharge.
- Design discharge criteria to minimize the risk of central nervous system or cardiorespiratory depression after discharge from observation by trained personnel.

**Creation and Implementation of Patient Safety Processes**

Patient safety processes include quality improvement and preparation for rare events.

**Literature Findings.** Regarding quality improvement, one observational study reported that use of a presedation checklist compared to no checklist use may improve safety documentation in emergency department sedations (category B1-B evidence).187

**Survey Findings.** The consultants, ASA members, AAOMS members, and ASDA members strongly agree with the recommendations to (1) create and implement a quality improvement process based upon established national, regional, or institutional reporting protocols; (2) strengthen patient safety culture through collaborative practices; and (3) create an emergency response plan.

**Recommendations**

- Create and implement a quality improvement process based upon established national, regional, or institutional reporting protocols, (e.g., adverse events, unsatisfactory sedation).
- Periodically update the quality improvement process to keep up with new technology, equipment or other advances in moderate procedural sedation/analgesia.
- Strengthen patient safety culture through collaborative practices (e.g., team training, simulation drills, development and implementation of checklists).
- Create an emergency response plan (e.g., activating “code blue” team or activating the emergency medical response system: 911 or equivalent).

Appendix I: Summary of Recommendations

**Patient Evaluation**

- Review previous medical records and interview the patient or family to identify:
  - Abnormalities of the major organ systems (e.g., cardiac, renal, pulmonary, neurologic, sleep apnea, metabolic, endocrine)
  - Adverse experience with sedation/analgesia, as well as regional and general anesthesia
  - History of a difficult airway
  - Current medications, potential drug interactions, drug allergies, and nutraceuticals
  - History of tobacco, alcohol or substance use or abuse
  - Frequent or repeated exposure to sedation/analgesic agents
- Conduct a focused physical examination of the patient (e.g., vital signs, auscultation of the heart and lungs, evaluation of the airway, and when appropriate to sedation, other organ systems where major abnormalities have been identified)
- Review available laboratory test results
  - Order additional laboratory tests guided by a patient’s medical condition, physical examination, and the likelihood that the results will affect the management of moderate sedation/analgesia
  - Evaluate results of these tests before sedation is initiated
- If possible, perform the preprocedure evaluation well enough in advance (e.g., several days to weeks) to allow for optimal patient preparation†
- Reevaluate the patient immediately before the procedure.

**Preprocedure Patient Preparation**

- Consult with a medical specialist (e.g., physician anesthesiologist, cardiologist, endocrinologist, pulmonologist, nephrologist, pediatrician, obstetrician, or otolaryngologist), when appropriate before administration of moderate procedural sedation to patients with significant underlying conditions.
- If a specialist is needed, select a specialist based on the nature of the underlying condition and the urgency of the situation.
- For severely compromised or medically unstable patients (e.g., ASA status IV, anticipated difficult airway, severe obstructive pulmonary disease, coronary artery disease, or congestive heart failure) or if it is likely that sedation to the point of unresponsiveness will be necessary to obtain adequate conditions, consult with a physician anesthesiologist.

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See table 2 for additional information related to airway assessment.
†This may not be feasible for urgent or emergency procedures, interventional radiology or other radiology settings.
• Before the procedure, inform patients or legal guardians of the benefits, risks, and limitations of moderate sedation/analgesia and possible alternatives, and elicit their preferences\
• Inform patients or legal guardians before the day of the procedure that they should not drink fluids or eat solid foods for a sufficient period of time to allow for gastric emptying before the procedure
• On the day of the procedure, assess the time and nature of last oral intake
  ◦ Evaluate the risk of pulmonary aspiration of gastric contents when determining (1) the target level of sedation and (2) whether the procedure should be delayed
• In urgent or emergent situations where complete gastric emptying is not possible, do not delay moderate procedural sedation based on fasting time alone

Patient Monitoring

Monitoring Patient Level of Consciousness

• Periodically (e.g., at 5-min intervals) monitor a patient’s response to verbal commands during moderate sedation, except in patients who are unable to respond appropriately (e.g., patients where age or development may impair bidirectional communication) or during procedures where movement could be detrimental
• During procedures where a verbal response is not possible (e.g., oral surgery, restorative dentistry, upper endoscopy), check the patient’s ability to give a “thumbs up” or other indication of consciousness in response to verbal or tactile (light tap) stimulation; this suggests that the patient will be able to control his airway and take deep breaths if necessary

Monitoring Patient Ventilation and Oxygenation

• Continually# monitor ventilatory function by observation of qualitative clinical signs

Continually monitor ventilatory function with capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment
  • For uncooperative patients, institute capnography after moderate sedation has been achieved
• Continuously monitor all patients by pulse oximetry with appropriate alarms

Monitoring Hemodynamics

• Determine blood pressure before sedation/analgesia is initiated unless precluded by lack of patient cooperation
• Once moderate sedation/analgesia is established, continually monitor blood pressure (e.g., at 5-min intervals) and heart rate during the procedure unless such monitoring interferes with the procedure (e.g., magnetic resonance imaging where stimulation from the blood pressure cuff could arouse an appropriately sedated patient)
• Use electrocardiographic monitoring during moderate sedation in patients with clinically significant cardiovascular disease or those who are undergoing procedures where dysrhythmias are anticipated

Contemporaneous Recording of Monitored Parameters

• Record patients’ level of consciousness, ventilatory and oxygenation status, and hemodynamic variables at a frequency that depends on the type and amount of medication administered, the length of the procedure, and the general condition of the patient
  • At a minimum, this should occur: (1) before the administration of sedative/analgesic agents,** (2) after administration of sedative/analgesic agents, (3) at regular intervals during the procedure, (4) during initial recovery, and (5) just before discharge
• Set device alarms to alert the care team to critical changes in patient status

Availability of an Individual Responsible for Patient Monitoring

• Assure that a designated individual other than the practitioner performing the procedure is present to monitor the patient throughout the procedure
  • The individual responsible for monitoring the patient should be trained in the recognition of apnea and airway obstruction and be authorized to seek additional help

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#This may not be feasible for urgent or emergency procedures.

§See table 3 and/or refer to: American Society of Anesthesiologists. Practice guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: Application to healthy patients undergoing elective procedures. An updated report. Anesthesiology 2017; 126:376–93

‖A response limited to reflex withdrawal from a painful stimulus is not considered a purposeful response and thus represents a state of general anesthesia.


**For rare uncooperative patients (e.g., children with autism spectrum disorder or attention deficit disorder) recording oxygenation status or blood pressure may not be possible until after sedation.
Supplemental Oxygen

- Use supplemental oxygen during moderate procedural sedation/analgesia unless specifically contraindicated for a particular patient or procedure.

Emergency Support

- Assure that pharmacologic antagonists for benzodiazepines and opioids are immediately available in the procedure suite or procedure room††
- Assure that an individual is present in the room who understands the pharmacology of the sedative/analgesics administered (e.g., opioids and benzodiazepines) and potential interactions with other medications and nutraceuticals the patient may be taking.
- Assure that appropriately sized equipment for establishing a patent airway is available.
- Assure that suction, advanced airway equipment, a positive pressure ventilation device, and supplemental oxygen are immediately available in the procedure room and in good working order.
- Assure that a member of the procedural team is trained in the recognition and treatment of airway complications (e.g., apnea, laryngospasm, airway obstruction), opening the airway, suctioning secretions, and performing bag-valve-mask ventilation.
- Assure that a member of the procedural team has the skills to establish intravascular access.
- Assure that a member of the procedural team has the skills to provide chest compressions.
- Assure that a functional defibrillator or automatic external defibrillator is immediately available in the procedure area.
- Assure that an individual or service (e.g., code blue team, paramedic-staffed ambulance service) with advanced life support skills (e.g., tracheal intubation, defibrillation, resuscitation medications) is immediately available.
- Assure that members of the procedural team are able to recognize the need for additional support and know how to access emergency services from the procedure room (e.g., telephone, call button).

Sedative or Analgesic Medications Not Intended for General Anesthesia

- Combinations of sedative and analgesic agents may be administered as appropriate for the procedure and the condition of the patient‡‡:
  - Administer each component individually to achieve the desired effect (e.g., additional analgesic medication to relieve pain; additional sedative medication to decrease awareness or anxiety).
  - Dexmedetomidine may be administered as an alternative to benzodiazepine sedatives on a case-by-case basis.
  - In patients receiving intravenous medications for sedation/analgesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression.
  - In patients who have received sedation/analgesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of reestablishing intravenous access on a case-by-case basis.
  - Administer intravenous sedative/analgesic drugs in small, incremental doses, or by infusion, titrating to the desired endpoints.
  - Allow sufficient time to elapse between doses so the peak effect of each dose can be assessed before subsequent drug administration.
  - When drugs are administered by nonintravenous routes (e.g., oral, rectal, intramuscular, transmucosal), allow sufficient time for absorption and peak effect of the previous dose to occur before supplementation is considered.

Sedative/Analgesic Medications Intended for General Anesthesia

- When moderate procedural sedation with sedative/analgesic medications intended for general anesthesia by any route is intended, provide care consistent with that required for general anesthesia.
- Assure that practitioners administering sedative/analgesic medications intended for general anesthesia are able to reliably identify and rescue patients from unintended deep sedation or general anesthesia.
- For patients receiving intravenous sedative/analgesics intended for general anesthesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression.

††“Immediately available in the procedure room” refers to accessible shelving, unlocked cabinetry, and other measures to assure that there is no delay in accessing medications and equipment during the procedure.

‡‡The propensity for combinations of sedative and analgesic agents to cause respiratory depression and airway obstruction emphasizes the need to appropriately reduce the dose of each component as well as the need to continually monitor respiratory function. Knowledge of each drug’s time of onset, peak response, and duration of action is important. Titration of drug to effect is an important concept; one must know whether the previous dose has taken full effect before administering additional drug.
• In patients who have received sedative/analgesic medications intended for general anesthesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of reestablishing intravenous access on a case-by-case basis
• Administer intravenous sedative/analgesic medications intended for general anesthesia in small, incremental doses, or by infusion, titrating to the desired endpoints
  ◦ Allow sufficient time to elapse between doses so the peak effect of each dose can be assessed before subsequent drug administration
• When drugs intended for general anesthesia are administered by nonintravenous routes (e.g., oral, rectal, intramuscular, transmucosal), allow sufficient time for absorption and peak effect of the previous dose to occur before supplementation is considered

Reversal Agents
• Assure that specific antagonists are immediately available in the procedure room whenever opioid analgesics or benzodiazepines are administered for moderate procedural sedation/analgesia, regardless of route of administration
• If patients develop hypoxemia, significant hypventilation or apnea during sedation/analgesia: (1) encourage or physically stimulate patients to breathe deeply, (2) administer supplemental oxygen, and (3) provide positive pressure ventilation if spontaneous ventilation is inadequate
• Use reversal agents in cases where airway control, spontaneous ventilation, or positive pressure ventilation is inadequate
  ◦ Administer naloxone to reverse opioid-induced sedation and respiratory depression
  ◦ Administer flumazenil to reverse benzodiazepine-induced sedation and respiratory depression
• After pharmacologic reversal, observe and monitor patients for a sufficient time to ensure that sedation and cardiorespiratory depression does not recur once the effect of the antagonist dissipates
• Do not use sedation regimens that are intended to include routine reversal of sedative or analgesic agents

Recovery Care
• After sedation/analgesia, observe and monitor patients in an appropriately staffed and equipped area until they are near their baseline level of consciousness and are no longer at increased risk for cardiorespiratory depression
• Monitor oxygenation continuously until patients are no longer at risk for hypoxemia
• Monitor ventilation and circulation at regular intervals (e.g., every 5 to 15 min) until patients are suitable for discharge
• Design discharge criteria to minimize the risk of central nervous system or cardiorespiratory depression after discharge from observation by trained personnel

Creation and Implementation of Patient Safety Processes
• Create and implement a quality improvement process based upon established national, regional, or institutional reporting protocols (e.g., adverse events, unsatisfactory sedation)
  ◦ Periodically update the quality improvement process to keep up with new technology, equipment or other advances in moderate procedural sedation/analgesia
• Strengthen patient safety culture through collaborative practices (e.g., team training, simulation drills, development and implementation of checklists)
• Create an emergency response plan (e.g., activating “code blue” team or activating the emergency medical response system: 911 or equivalent)

Appendix 2: Methods and Analyses
For these guidelines, a systematic search and review of peer-reviewed published literature was conducted, with scientific findings summarized and reported below and in the document. Assessment of conceptual issues, practicality and feasibility of the guideline recommendations was also evaluated, with opinion data collected from surveys and other sources. Both the systematic literature review and the opinion data are based on evidence linkages, or statements regarding potential relationships between interventions and outcomes associated with moderate procedural sedation. The evidence model below guided the search, providing inclusion and exclusion information regarding patients, procedures, practice settings, providers, clinical interventions, and outcomes. After review of all evidentiary information, the task force placed each recommendation into one of three categories: (1) provide this intervention or treatment, (2) this intervention or treatment may be provided to the patient based on circumstances of the case and the practitioner’s clinical judgment, or (3) do not provide this intervention or treatment. The policy of the ASA Committee on Standards and Practice Parameters is to update practice guidelines every 5 yr. The ASA Committee on Standards and Practice Parameters reviews all practice guidelines at the ASA annual meeting and determines update and revision timelines.

Evidence Model

Patients
• Inclusion criteria:
  ◦ Any patient having a diagnostic or therapeutic procedure for which moderate sedation is planned
• Exclusion criteria:
  ◦ Patients in whom the level of sedation cannot reliably be established

Discharge criteria examples are noted in table 5.
▪ Patients who do not respond purposefully to verbal or tactile stimulation (e.g., stroke victims, neonates)
▪ Patients in whom determining the level of sedation interferes with the procedure

Procedures
▪ Inclusion criteria:
  ◦ Elective and urgent/emergent procedures
  ◦ Diagnostic and therapeutic procedures
  ▪ Principal procedures (e.g., upper endoscopy, colonoscopy, radiology, ophthalmology, cardiology, dentistry, plastics, orthopedic, urology, podiatry)
  ▪ Diagnostic imaging (radiological scans, endoscopy)
  ▪ Minor surgical procedures in all care areas (e.g., cardiodversion)
  ▪ Pediatric procedures (e.g., suture of laceration, setting of simple fracture, lumbar puncture, bone marrow with local, magnetic resonance imaging or computed tomography scan, routine dental procedures)
  ▪ Pediatric cardiac catheterization (e.g., cardiac biopsy after transplantation)
  ▪ Obstetric procedures (e.g., labor and delivery)
▪ Exclusion criteria:
  ◦ Procedures using minimal sedation (e.g., anxiolysis for insertion of peripheral nerve blocks, local or topical anesthesia)
  ◦ Procedures where deep sedation is intended
  ◦ Procedures where general anesthesia is intended
  ◦ Procedures using major conduction anesthesia (i.e., neuraxial anesthesia)
  ◦ Procedures using sedatives in combination with regional anesthesia
  ◦ Nondiagnostic or nontherapeutic procedures (e.g., postoperative analgesia, pain management/chronic pain, critical care, palliative care)

Practice Settings
▪ Inclusion criteria:
  ◦ Settings where procedural moderate sedation may be administered
    ▪ Hospitals
    ▪ Ambulatory procedural centers
    ▪ Office practices
      □ Hospital connected
      □ Free-standing
      □ Dental office
      □ Urology office
      □ Ophthalmology office
    ▪ Emergency settings
    ▪ Endoscopy suite
    ▪ Plastic surgery suite
    ▪ Radiology suite (magnetic resonance imaging, computed tomography, invasive)
▪ Oral and maxillofacial surgery suite
▪ Cardiac catheterization laboratory
▪ Oncology clinics
▪ Electrophysiology laboratory
▪ Interventional radiology laboratory
▪ Neurointerventional laboratory
▪ Echocardiology laboratory
▪ Evoked auditory testing laboratory
▪ Exclusion criteria: (none indicated)

Providers
▪ Inclusion criteria:
  ◦ All providers who deliver moderate procedural sedation in any practice setting
    ▪ Physician anesthesiologists and anesthetists
    ▪ Cardiologists
    ▪ Dentists
    ▪ Dentist anesthesiologists
    ▪ Emergency physicians
    ▪ Gastroenterologists
    ▪ Hospitalists
    ▪ Nurse anesthetists
    ▪ Nursing personnel who perform monitoring tasks
    ▪ Oncologists
    ▪ Oral/maxillofacial surgeons
    ▪ Pulmonologists
    ▪ Radiologists
    ▪ Sedation nurses
    ▪ Supervised physicians and dentists in training
    ▪ Surgeons
▪ Exclusion criteria: (none indicated)

Interventions
▪ Inclusion criteria:
  ◦ Preprocedure patient evaluation and preparation
    ▪ Medical records review (patient history/condition)
      □ Underlying medical problems
        ◦ Abnormalities of major organ systems
        ◦ Obstructive sleep apnea
        ◦ Respiratory distress syndrome
        ◦ Allergies
        ◦ Intestinal inflammation
        ◦ Obesity
      □ Sedation history
      □ Anesthesia history
      □ Surgical history
      □ Problems pertaining to cooperation
      □ Current medications
      □ Extremes of age
      □ Psychotropic drug use
      □ Nonpharmaceutical (e.g., nutraceutical) use
      □ Family history

Practice Guidelines

- Focused physical examination (e.g., heart, lungs, airway)
- Consultation with a medical specialist (e.g., physician anesthesiologist, cardiologist, endocrinologist, pulmonologist, nephrologist, obstetrician)
- Preparation of the patient (e.g., preprocedure instruction, medication usage, counseling, fasting)

- Patient monitoring
  - Level of consciousness (e.g., responsiveness)
  - Breathing/ventilation
    - Observation (color when the procedure allows)
    - Auscultation, chest excursion
    - Continual end tidal carbon dioxide monitoring (e.g., capnography, capnometry) versus observation or auscultation
    - Plethysmography
      - Plethysmography versus observation or auscultation
      - Plethysmography versus capnography
  - Oxygenation
    - Pulse oximetry
  - Hemodynamic monitoring
    - Blood pressure
    - Heart rate
    - Electrocardiography
  - Contemporaneous recording of monitored parameters
    - Presence of an individual dedicated to patient monitoring
    - Creation and implementation of quality improvement processes

- Supplemental oxygen
  - Supplemental oxygen versus room air or no supplemental oxygen
    - Method of oxygen administration (e.g., nasal cannula, face masks, specialized devices (e.g., high-flow cannula)

- Emergency support
  - Presence of individual(s) capable of establishing a patent airway, positive pressure ventilation and resuscitation (i.e., advanced life-support skills)
  - Presence of emergency and airway equipment
    - Types of airway devices (e.g., nasal cannula, face masks, specialized devices (e.g., high-flow cannula)
    - Supraglottic airway (e.g., laryngeal mask airway)
    - Presence of an individual to establish intravenous access
    - Intravenous access versus no intravenous access

- Sedative or analgesic medications not intended for general anesthesia
  - Sedatives (all routes of administration)
    - Benzodiazepines
    - Dexmedetomidine versus other sedatives or analgesics
  - Sedative/opioid combinations (all routes of administration)
    - Benzodiazepines combined with opioids versus benzodiazepines
    - Benzodiazepines combined with opioids versus opioids
    - Dexmedetomidine combined with other sedatives or analgesics versus dexmedetomidine
    - Dexmedetomidine combined with other sedatives or analgesics versus other sedatives or analgesics (alone or in combination)
  - Intravenous versus nonintravenous sedative/analgesics not intended for general anesthesia (all non-IV routes of administration, including oral, nasal, intramuscular, rectal, transdermal, sublingual, iontophoresis, nebulized)
  - Titration versus single dose, repeat bolus, continuous infusion

- Sedative/analgesic medications intended for general anesthesia
  - Propofol
    - Propofol alone versus non–general anesthesia sedative/analgesics alone
    - Propofol alone versus non–general anesthesia sedative/analgesic combinations
    - Propofol combined with non–general anesthesia sedative/analgesics versus propofol alone
    - Propofol combined with non–general anesthesia sedative/analgesics versus non–general anesthesia sedative/analgesics (alone or in combination)
    - Propofol alone versus other general anesthesia sedatives (alone or in combination)
    - Propofol combined with sedatives intended for general anesthesia versus other sedatives intended for general anesthesia (alone or in combination)
    - Propofol combined with other sedatives intended for general anesthesia versus propofol (alone or in combination)
  - Ketamine
    - Ketamine alone versus non–general anesthesia sedative/analgesics alone
    - Ketamine alone versus non–general anesthesia sedative/analgesic combinations
    - Ketamine combined with non–general anesthesia sedative/analgesics versus ketamine alone
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▫ Ketamine combined with non–general anesthesia sedative/analgesics versus non–general anesthesia sedative/analgesics (alone or in combination)
▫ Ketamine alone versus other general anesthesia sedatives (alone or in combination)
▫ Ketamine combined with sedatives intended for general anesthesia versus other sedatives intended for general anesthesia (alone or in combination)
▫ Ketamine combined with other sedatives intended for general anesthesia versus ketamine (alone or in combination)

▪ Etomidate
▫ Etomidate alone versus non–general anesthesia sedative/analgesics alone
▫ Etomidate alone versus non–general anesthesia sedative/analgesic combinations
▫ Etomidate combined with non–general anesthesia sedative/analgesics versus etomidate alone
▫ Etomidate combined with non–general anesthesia sedative/analgesics versus non–general anesthesia sedative/analgesics (alone or in combination)
▫ Etomidate alone versus other general anesthesia sedatives (alone or in combination)
▫ Etomidate combined with sedatives intended for general anesthesia versus other sedatives intended for general anesthesia (alone or in combination)
▫ Etomidate combined with other sedatives intended for general anesthesia versus etomidate (alone or in combination)

▪ Intravenous versus nonintravenous sedatives intended for general anesthesia
▪ Titration of sedatives intended for general anesthesia

▫ Reversal agents
▪ Naloxone for reversal of opioids with or without benzodiazepines
▫ Naloxone versus placebo
▫ Intravenous versus nonintravenous naloxone
▪ Flumazenil for reversal or benzodiazepines with or without opioids
▫ Flumazenil versus placebo
▫ Intravenous versus nonintravenous flumazenil

▫ Recovery care
▪ Continued observation and monitoring until discharge
▪ Predetermined discharge criteria

▪ Exclusion criteria:
▫ Minimal sedation
▫ Deep sedation
▫ General anesthesia
▫ Patient-controlled sedation/analgesia
▫ Major conduction anesthetics (i.e., neuraxial anesthesia)
▫ Sedatives combined with regional anesthesia
▫ Premedication administered before general anesthesia
▫ Interventions without sedatives (e.g., hypnosis, acupuncture)
▫ New or rarely administered sedative/analgesics (e.g., fospropofol)
▫ Automated sedative delivery systems
▫ New or rarely used monitoring or delivery devices
▫ Bispectral index monitoring

Outcomes

▪ Expected benefits:
▫ Sedation efficacy
▪ Induction time
▪ Duration of sedation
▪ Successful procedure
▪ Patient/family satisfaction
▪ Proceduralist satisfaction
▫ Improved pain management (i.e., pain during a procedure)
▫ Speed of recovery
▪ Time to recovery
▪ Time to discharge-ready
▫ Reduced frequency/severity of sedation-related complications
▪ Unintended deep sedation or general anesthesia
▪ Conversion to deep sedation or general anesthesia
▪ Undersedation
▪ Unplanned hospitalization and/or intensive care unit admission
▪ Unplanned emergency department visits
▪ Unplanned use of rescue agents (naloxone, flumazenil)
▪ Resedation after discharge criteria met
▪ Postprocedure neurologic function
▪ Need to change planned procedure or technique
▪ Respiratory depression
▪ Hypoxemia
▪ Oxygen desaturation
▪ Upper airway obstruction
▪ Airway support required
▪ Intubation required
▪ Airway adjunct required
▪ Pulmonary aspiration
▪ Hypotension
▪ Arrhythmias
▪ Cardiac arrest
▪ Bradycardia
Results for each pertinent outcome were summarized, and when sufficient numbers of RCTs were found, study grading and meta-analyses were conducted. The literature relating to six evidence linkages contained enough studies with well defined experimental designs and statistical information to conduct formal meta-analyses. These seven evidence linkages are: (1) capnography versus blinded capnography, (2) supplemental oxygen versus no supplemental oxygen, (3) midazolam combined with opioids versus midazolam alone, (4) propofol versus midazolam, (5) flumazenil versus placebo for benzodiazepine reversal, and (6) flumazenil versus placebo for reversal of benzodiazepines combined with opioids (table 6). Fixed and random-effects odds ratios are reported for dichotomous outcomes, and raw and standardized mean differences are reported for findings with continuous data. An acceptable significance level was set at $P < 0.01$. No search for unpublished studies was conducted, and no reliability tests for locating research results were done.

Interobserver agreement among task force members and two methodologists was obtained by interrater reliability testing of 36 randomly selected studies. Agreement levels using a $\kappa$ statistic for two-rater agreement pairs were as follows: (1) research design, $\kappa = 0.57$ to 0.92; (2) type of analysis, $\kappa = 0.60$ to 0.75; (3) evidence linkage assignment, $\kappa = 0.76$ to 0.85; and (4) literature inclusion for database, $\kappa = 0.28$ to 1.00. Three-rater $\kappa$ values were: (1) research design, $\kappa = 0.70$; (2) type of analysis, $\kappa = 0.68$; (3) linkage assignment, $\kappa = 0.79$; and (4) literature database inclusion, $\kappa = 0.43$. These values represent moderate to high levels of agreement.

Consensus-based Evidence. Consensus was obtained from multiple sources, including: (1) survey opinion from consultants† who were selected based on their knowledge or expertise in moderate procedural sedation and analgesia; (2) survey opinions from a randomly selected sample of active members of the ASA, AAOMS, and ASDA‡; (3) testimony from attendees of publicly held open forums at national anesthesia meetings§; (4) internet commentary; and (5) task force opinion and interpretation. The survey rate of return was 81% ($n = 129$ of 159) for consultants. For membership respondents, survey data were collected from 69 ASA members, 104 AAOMS members, and 104 ASDA members. The results of the surveys are reported in tables 7–10 and are summarized in the text of the guidelines.

*Consultants were drawn from the following specialties where moderate procedural sedation/analgesia are commonly administered: anesthesiology, cardiology, dentistry, emergency medicine, gastroenterology, oral and maxillofacial surgery, pediatrics, radiology, and surgery.

‡All participating organizations were invited to participate in this survey.


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Hemodynamic support or rescue required
Assistance request
Neurologic injury
Death

Evidence Collection

• Literature inclusion criteria:
  ◦ Randomized controlled trials
  ◦ Prospective nonrandomized comparative studies (e.g., quasiexperimental, cohort)
  ◦ Retrospective comparative studies (e.g., case-control)
  ◦ Observational studies (e.g., correlational or descriptive statistics)
  ◦ Case reports, case series

• Literature exclusion criteria (except to obtain new citations):
  ◦ Editorials
  ◦ Literature reviews
  ◦ Meta-analyses
  ◦ Abstracts greater than 5 yr old
  ◦ Unpublished studies
  ◦ Studies in non–peer-reviewed journals
  ◦ Newspaper articles

• Survey evidence:
  ◦ Expert consultant survey
  ◦ ASA membership survey
  ◦ Other participating organization surveys
  ◦ Reliability survey
  ◦ Feasibility survey

State of the Literature. For the systematic review, potentially relevant clinical studies were identified via electronic and manual searches. Healthcare database searches included PubMed, EMBASE, Web of Science, Google Books, and the Cochrane Central Register of Controlled Trials. The searches covered a 15.6-yr period from January 1, 2002, through July 31, 2017. Accepted studies from the previous guidelines were also reviewed, covering the period of August 1, 1976, through December 31, 2002.1 Only studies containing original findings from peer-reviewed journals were acceptable. Editorials, letters, and other articles without data were excluded. A literature search strategy and PRISMA® flow diagram are available as Supplemental Digital Content 2, http://links.lww.com/ALN/B597.

In total, 4,349 new citations were identified, with 1,428 articles assessed for eligibility. After review, 1,140 were excluded, with 288 new studies meeting the above stated criteria. These studies were combined with 209 pre-2002 articles used in the previous guidelines, resulting in a total of 497 articles accepted as evidence for these guidelines. In this document, 187 are referenced, with a complete bibliography of articles used to develop these guidelines, organized by section, available as Supplemental Digital Content 3, http://links.lww.com/ALN/B595.

• Prefered reporting items of systematic reviews and meta-analyses.
Consultants were asked to indicate which, if any, of the evidence linkages would change their clinical practices if the guidelines were instituted. The rate of return was 34.6% (n = 55 of 159). The percent of responding consultants expecting no change associated with each linkage were as follows: (preprocedure patient evaluation – 9%); preprocedure patient preparation – 93.75%; patient preparation – 87.5%; patient monitoring – 68.75%; supplemental oxygen – 93.75%; emergency support – 87.5%; sedative or analgesic medications not intended for general anesthesia – 87.5%; sedative or analgesic medications intended for general anesthesia – 75.0%; availability/use of reversal agents – 87.5%; recovery care – 75%; and creation and implementation of patient safety processes – 56.25%. Forty-four respondents (84.62%) indicated that the guidelines would have no effect on the amount of time spent on a typical case with the implementation of these guidelines. Seven respondents (13.46%) indicated that there would be an increase in the amount of time, with four of these respondents estimating an increase ranging from 5 to 15 min. One respondent (1.92%) estimated a decrease in the amount of time they would spend on a typical case.

Research Support
Support was provided solely from institutional and/or departmental sources in the American Society of Anesthesiologists.

Competing Interests
The authors declare no competing interests.

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Address correspondence to the American Society of Anesthesiologists: 1061 American Lane, Schaumburg, Illinois 60173. jeffa@dacc.uchicago.edu. These updated Practice Guidelines, and all ASA Practice Parameters, may be obtained at no cost through the Journal Web site, www.anesthesiology.org.

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Table 1. Continuum of Depth of Sedation, Definition of General Anesthesia, and Levels of Sedation/Analgesia

<table>
<thead>
<tr>
<th>Responsiveness</th>
<th>Minimal Sedation (Anxiolysis)</th>
<th>Moderate Sedation/Analgesia (Conscious Sedation)</th>
<th>Deep Sedation/Analgesia</th>
<th>General Anesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway</td>
<td>Unaffected</td>
<td>No intervention required</td>
<td>Intervention may be required</td>
<td>Intervention often required</td>
</tr>
<tr>
<td>Spontaneous ventilation</td>
<td>Unaffected</td>
<td>Adequate</td>
<td>May be inadequate</td>
<td>Frequently inadequate</td>
</tr>
<tr>
<td>Cardiovascular function</td>
<td>Unaffected</td>
<td>Usually maintained</td>
<td>May be impaired</td>
<td></td>
</tr>
</tbody>
</table>

Minimal Sedation (Anxiolysis) indicates 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. Moderate Sedation/Analgesia (Conscious Sedation) indicates 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. Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully* after 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. 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.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia (Conscious Sedation) should be able to rescue patients who enter a state of Deep Sedation/Analgesia, whereas those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia. (Developed by the American Society of Anesthesiologists: Approved by ASA House of Delegates on October 13, 1999 and last amended on October 15, 2014. Available at: http://www.asahq.org/quality-and-practice-management/practice-guidance-resource-documents/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedation-analgesia. Accessed on August 21, 2017.)

*Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

Table 2. Airway Assessment Procedures for Sedation and Analgesia

Positive pressure ventilation, with or without tracheal intubation, may be necessary if respiratory compromise develops during sedation/analgesia. This may be more difficult in patients with atypical airway anatomy. Also, some airway abnormalities may increase the likelihood of airway obstruction during spontaneous ventilation. Some factors that may be associated with difficulty in airway management are listed below.

History
- Previous problems with anesthesia or sedation
- Stridor, snoring, or sleep apnea
- Advanced rheumatoid arthritis
- Chromosomal abnormality (e.g., trisomy 21)

Physical examination
- Habitus: significant obesity (especially involving the neck and facial structures)
- Head and neck: short neck, limited neck extension, decreased hyoid-mental distance (< 3 cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation, dysmorphic facial features (e.g., Pierre–Robin syndrome)
- Mouth: small opening (< 3 cm in an adult); edentulous; protruding incisors; loose or capped teeth; dental appliances; high, arched palate; macrognathia; tonsillar hypertrophy; nonvisible uvula
- Jaw: micrognathia, retrognathia, trismus, significant malocclusion
### Table 3. Summary of American Society of Anesthesiologists Recommendations for Preoperative Fasting and Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures

<table>
<thead>
<tr>
<th>Ingested material</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear liquids†</td>
<td>2-h minimum fasting period*</td>
</tr>
<tr>
<td>Breast milk</td>
<td>4-h minimum fasting period*</td>
</tr>
<tr>
<td>Infant formula</td>
<td>6-h minimum fasting period*</td>
</tr>
<tr>
<td>Nonhuman milk‡</td>
<td>6-h minimum fasting period*</td>
</tr>
<tr>
<td>Light meal§</td>
<td>6-h minimum fasting period*</td>
</tr>
<tr>
<td>Fried foods, fatty foods, or meat</td>
<td>Additional fasting time (e.g., 8 h or more) may be needed</td>
</tr>
</tbody>
</table>

Pharmacologic recommendations (medication type and common examples)

<table>
<thead>
<tr>
<th>Gastrointestinal stimulants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Metoclopramide</td>
<td>May be used/no routine use</td>
</tr>
<tr>
<td>Gastric acid secretion blockers</td>
<td></td>
</tr>
<tr>
<td>Cimetidine</td>
<td>May be used/no routine use</td>
</tr>
<tr>
<td>Famotidine</td>
<td>May be used/no routine use</td>
</tr>
<tr>
<td>Ranitidine</td>
<td>May be used/no routine use</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>May be used/no routine use</td>
</tr>
<tr>
<td>Lansoprazole</td>
<td>May be used/no routine use</td>
</tr>
</tbody>
</table>

Antacids                                    |

| Sodium citrate                             | May be used/no routine use |
| Sodium bicarbonate                         | May be used/no routine use |
| Magnesium trisilicate                       | May be used/no routine use |

Antiemetics                                 |

| Ondansetron                                 | May be used/no routine use |

Anticholinergics                            |

| Atropine                                    | No use                    |
| Scopolamine                                 | No use                    |
| Glycopyrrolate                              | No use                    |
| Combinations of the medications above      | No routine use            |

These recommendations apply to healthy patients who are undergoing elective procedures. They are not intended for women in labor. Following the guidelines does not guarantee complete gastric emptying.

*The fasting periods noted above apply to all ages. †Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee. ‡Because nonhuman 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. Additional fasting time (e.g., 8 h or more) may be needed in these cases. Both the amount and type of foods ingested must be considered when determining an appropriate fasting period.

### Table 4. Emergency Equipment for Sedation and Analgesia

<table>
<thead>
<tr>
<th>Intravenous equipment (age- and size-appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gloves</td>
</tr>
<tr>
<td>• Tourniquets</td>
</tr>
<tr>
<td>• Alcohol wipes</td>
</tr>
<tr>
<td>• Sterile gauze pads</td>
</tr>
<tr>
<td>• Intravenous catheters</td>
</tr>
<tr>
<td>• Intravenous tubing</td>
</tr>
<tr>
<td>• Intravenous fluid</td>
</tr>
<tr>
<td>• Assorted needles for drug aspiration, intramuscular injection</td>
</tr>
<tr>
<td>• Intraosseous access kit</td>
</tr>
<tr>
<td>• Appropriately sized syringes</td>
</tr>
<tr>
<td>• Tape</td>
</tr>
</tbody>
</table>

Basic airway management equipment (age- and size-appropriate)

<table>
<thead>
<tr>
<th>Advanced airway management equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supraglottic airway devices</td>
</tr>
<tr>
<td>• Laryngoscope handles (tested)</td>
</tr>
<tr>
<td>• Laryngoscope blades</td>
</tr>
<tr>
<td>• Endotracheal tubes</td>
</tr>
<tr>
<td>• Stylet</td>
</tr>
</tbody>
</table>

Pharmacologic antagonists

<table>
<thead>
<tr>
<th>Emergency medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Naloxone</td>
</tr>
<tr>
<td>• Flumazenil</td>
</tr>
<tr>
<td>• Epinephrine</td>
</tr>
<tr>
<td>• Ephedrine</td>
</tr>
<tr>
<td>• Vasopressin</td>
</tr>
<tr>
<td>• Atropine</td>
</tr>
<tr>
<td>• Nitroglycerin (tablets or spray)</td>
</tr>
<tr>
<td>• Amiodarone</td>
</tr>
<tr>
<td>• Lidocaine</td>
</tr>
<tr>
<td>• Glucose (IV or oral)</td>
</tr>
<tr>
<td>• Diphenhydramine</td>
</tr>
<tr>
<td>• Benzodiazepines</td>
</tr>
<tr>
<td>• β blocker</td>
</tr>
<tr>
<td>• Adenosine</td>
</tr>
</tbody>
</table>

Appropriate emergency equipment should be available whenever sedative or analgesic drugs capable of causing cardiorespiratory depression are administered. This table should be used as a guide, which should be modified depending upon the individual practice circumstances.

*IV = intravenous.
Table 5. Recovery and Discharge Criteria after Sedation and Analgesia

General principles
- Medical supervision of recovery and discharge after moderate sedation is the responsibility of the operating practitioner or a licensed physician.
- The recovery area should be equipped with or have direct access to age and size appropriate monitoring and resuscitation equipment.
- Patients receiving moderate sedation should be monitored until appropriate discharge criteria are satisfied. The duration and frequency of monitoring should be individualized depending upon the level of sedation achieved, the overall condition of the patient, and the nature of the intervention for which sedation/analgesia was administered. Oxygenation should be monitored until patients are no longer at risk for respiratory depression.
- Level of consciousness, vital signs, and oxygenation (when indicated) should be recorded at regular intervals.
- A nurse or other individual trained to monitor patients and recognize complications should be in attendance until discharge criteria are fulfilled.
- An individual capable of managing complications (e.g., establishing a patent airway, administering a reversal medication when appropriate, and providing positive pressure ventilation) should be immediately available until discharge criteria are fulfilled.

Guidelines for discharge
- Patients should be alert and oriented; infants and patients whose mental or physical status was initially abnormal should have returned to their baseline status.
- Patients should be advised to avoid making life-changing decisions and activities that may impact their safety (e.g., operate a vehicle or heavy equipment) until the effects of the sedatives have worn off.
- Cardiovascular function, airway patency, and protective airway reflexes are satisfactory.
- Practitioners and parents must be aware that pediatric patients are at risk for airway obstruction should the head fall forward while the child is secured in a child safety seat.*
- Vital signs should be stable and within acceptable limits.
- Use of scoring systems may assist in documentation of fitness for discharge.
- Sufficient time (up to 2 h) should have elapsed after the last administration of reversal agents (naloxone, flumazenil) to ensure that patients do not become resedated after reversal effects have worn off.
- Outpatients should be discharged in the presence of a responsible adult who will accompany them home or to a care facility and be able to report any postprocedure complications.
- Outpatients and their escorts should be provided with written instructions regarding postprocedure diet, medications, activities, and a phone number to be called in case of emergency.

Each patient-care facility in which sedation/analgesia is administered should develop recovery and discharge criteria that are suitable for its specific patients and procedures. Some of the basic principles that might be incorporated in these criteria are enumerated in the table.

*Drugs with long durations of action (e.g., chloral hydrate, intramuscular pentobarbital, phenothiazines) will require longer periods of observation even after the child achieves currently used recovery and discharge criteria. This concept is particularly important for infants and toddlers transported in car safety seats who are at risk of resedation after discharge because of residual prolonged drug effects with the potential for airway obstruction.
Table 6. Meta-analysis Summary

<table>
<thead>
<tr>
<th>Evidence Linkages*</th>
<th>N†</th>
<th>Odds Ratio (CI)‡</th>
<th>Z Value</th>
<th>P Value</th>
<th>Odds Ratio (CI)§</th>
<th>Z Value</th>
<th>P Value</th>
<th>Heterogeneity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient monitoring</strong>&lt;br&gt;(capnography versus blinded capnography)&lt;br&gt;Hypoxemia ($O_2 &lt; 90%$)&lt;sup&gt;30-34&lt;/sup&gt;</td>
<td>6</td>
<td>0.68 (0.51–0.90)</td>
<td>−3.53</td>
<td>&lt; 0.001</td>
<td>0.70 (0.47–1.02)</td>
<td>−2.44</td>
<td>0.015</td>
<td>0.110</td>
</tr>
<tr>
<td><strong>Supplemental oxygen</strong>&lt;br&gt;(supplemental oxygen vs. placebo)&lt;br&gt;Hypoxemia ($O_2 &lt; 95%$)&lt;sup&gt;65-71&lt;/sup&gt;</td>
<td>7</td>
<td>0.15 (0.09–0.24)</td>
<td>−10.49</td>
<td>&lt; 0.001</td>
<td>0.24 (0.07–0.81)</td>
<td>−3.01</td>
<td>&lt; 0.001</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td><strong>Sedative/analgesics not</strong>&lt;br&gt;intended for general anesthesia (midazolam combined with opioids vs. midazolam)&lt;br&gt;Pain/discomfort during procedure&lt;sup&gt;72-77&lt;/sup&gt;</td>
<td>6</td>
<td>0.57 (0.33–1.00)</td>
<td>−2.57</td>
<td>0.010</td>
<td>0.48 (0.16–1.43)</td>
<td>−1.73</td>
<td>0.084</td>
<td>0.061</td>
</tr>
<tr>
<td><strong>Sedative/analgesics intended</strong>&lt;br&gt;for general anesthesia (propofol vs. midazolam)&lt;br&gt;Recall&lt;sup&gt;95,99-102&lt;/sup&gt;</td>
<td>5</td>
<td>0.49 (0.25–0.97)</td>
<td>−2.67</td>
<td>0.008</td>
<td>0.40 (0.07–2.21)</td>
<td>−1.38</td>
<td>0.168</td>
<td>0.002</td>
</tr>
<tr>
<td><strong>Sedation recovery</strong>&lt;br&gt;(awakening time)&lt;sup&gt;95-99&lt;/sup&gt;</td>
<td>5</td>
<td>0.90 (0.47–1.70)</td>
<td>−0.431</td>
<td>0.666</td>
<td>0.92 (0.48–1.78)</td>
<td>−0.32</td>
<td>0.752</td>
<td>0.638</td>
</tr>
<tr>
<td><strong>Reversal agents (flumazenil vs. placebo [reversal of benzodiazepines])</strong>&lt;br&gt;Recovery within 15 min&lt;sup&gt;171-178&lt;/sup&gt;</td>
<td>8#</td>
<td>11.67 (6.47–21.05)</td>
<td>10.72</td>
<td>&lt; 0.001</td>
<td>14.07 (5.59–35.45)</td>
<td>7.37</td>
<td>&lt; 0.001</td>
<td>0.064</td>
</tr>
<tr>
<td><strong>Reversal agents (flumazenil vs. placebo [reversal of benzodiazepines combined with opioids])</strong>&lt;br&gt;Recovery within 30 min&lt;sup&gt;182-186&lt;/sup&gt;</td>
<td>5</td>
<td>7.13 (4.49–11.32)</td>
<td>10.94</td>
<td>&lt; 0.001</td>
<td>7.13 (4.49–11.32)</td>
<td>10.94</td>
<td>&lt; 0.001</td>
<td>0.538</td>
</tr>
</tbody>
</table>

Statistics for individual studies and forest plots are available as supplemental digital content 4, http://links.lww.com/ALN/B596.

*Evidence linkage with references for included studies.
†Number of studies included in the meta-analysis.
‡Mantel–Haenszel or Peto fixed-effects analysis (99% CI); using Comprehensive Meta-analysis software, version 3.3.070, November 20, 2014. Licensed to Richard T. Connis, Ph.D., March 20, 2017.
‖Statistical significance values for homogeneity/heterogeneity of effect size; a $P$ value of < 0.01 indicates that the studies are significantly heterogeneous.
#Double-blind studies only.
### Table 7. Consultant Survey Responses

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>N*</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Equivocal</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient evaluation</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Review previous medical records and interview the patient or family</td>
<td>129</td>
<td>87.6*</td>
<td>10.1</td>
<td>2.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>2. Conduct a focused physical examination of the patient</td>
<td>129</td>
<td>86.0*</td>
<td>13.2</td>
<td>0.8</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>3. Review available laboratory test results and order additional laboratory tests when needed</td>
<td>129</td>
<td>71.3*</td>
<td>21.7</td>
<td>6.2</td>
<td>0.8</td>
<td>0.0</td>
</tr>
<tr>
<td>4. If possible, perform the preprocedure evaluation well enough in advance (e.g., several days to weeks) to allow for proper patient preparation</td>
<td>129</td>
<td>35.7</td>
<td>35.7*</td>
<td>19.4</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>5. Reevaluate the patient immediately before the procedure</td>
<td>127</td>
<td>80.3*</td>
<td>18.1</td>
<td>0.8</td>
<td>0.0</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Preprocedure patient preparation</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. Consult with a medical specialist, when appropriate, before administration of moderate procedural sedation to patients with significant underlying conditions</td>
<td>127</td>
<td>51.2*</td>
<td>22.8</td>
<td>15.7</td>
<td>5.5</td>
<td>4.7</td>
</tr>
<tr>
<td>7. When feasible before the procedure, inform patients or legal guardians of the benefits, risks, and limitations of moderate sedation/analgesia and possible alternatives and elicit their preferences</td>
<td>129</td>
<td>75.2*</td>
<td>20.2</td>
<td>1.6</td>
<td>2.3</td>
<td>0.8</td>
</tr>
<tr>
<td>8. Before the day of the procedure, inform patients or legal guardians that they should not drink fluids or eat solid foods for a sufficient period of time to allow for gastric emptying</td>
<td>128</td>
<td>71.9*</td>
<td>14.1</td>
<td>4.7</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>9. On the day of the procedure, assess the time and nature of last oral intake</td>
<td>128</td>
<td>82.0*</td>
<td>13.3</td>
<td>2.3</td>
<td>1.6</td>
<td>0.8</td>
</tr>
<tr>
<td>10. In urgent or emergent situations where complete gastric emptying is not possible, do not delay moderate procedural sedation based on fasting time alone</td>
<td>128</td>
<td>38.3</td>
<td>25.0*</td>
<td>17.2</td>
<td>10.2</td>
<td>9.4</td>
</tr>
<tr>
<td><strong>Monitoring patient level of consciousness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Periodically monitor a patient’s response to verbal commands during moderate sedation, except in patients who are unable to respond appropriately or during procedures where movement could be detrimental clinically</td>
<td>129</td>
<td>46.5</td>
<td>37.2*</td>
<td>9.3</td>
<td>4.7</td>
<td>2.3</td>
</tr>
<tr>
<td>12. During procedures where a verbal response is not possible, check the patient’s ability to give a “thumbs up” or other indication of consciousness in response to verbal or tactile stimulation</td>
<td>128</td>
<td>39.1</td>
<td>38.3*</td>
<td>16.4</td>
<td>4.7</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Monitoring patient ventilation and oxygenation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Continuously monitor ventilatory function by observation of qualitative clinical signs</td>
<td>126</td>
<td>76.2*</td>
<td>19.8</td>
<td>2.4</td>
<td>1.6</td>
<td>0.0</td>
</tr>
<tr>
<td>14. Continuously monitor ventilatory function by capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment</td>
<td>127</td>
<td>67.7*</td>
<td>14.2</td>
<td>10.2</td>
<td>4.7</td>
<td>3.1</td>
</tr>
<tr>
<td>15. Monitor all patients by pulse oximetry with appropriate alarms</td>
<td>127</td>
<td>85.8*</td>
<td>14.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Monitoring hemodynamics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Determine blood pressure before sedation/analgesia is initiated unless precluded by lack of patient cooperation</td>
<td>127</td>
<td>74.8*</td>
<td>22.0</td>
<td>0.0</td>
<td>2.4</td>
<td>0.8</td>
</tr>
<tr>
<td>17. Once moderate sedation/analgesia is established, continually monitor blood pressure and heart rate during the procedure unless such monitoring interferes with the procedure</td>
<td>127</td>
<td>69.3*</td>
<td>23.6</td>
<td>1.6</td>
<td>2.4</td>
<td>3.1</td>
</tr>
<tr>
<td>18. Use electrocardiographic monitoring during moderate sedation in patients with clinically significant cardiovascular disease or those who are undergoing procedures where dysrhythmias are anticipated</td>
<td>127</td>
<td>76.4*</td>
<td>15.7</td>
<td>3.1</td>
<td>0.8</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>Contemporaneous recording of monitored parameters</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Record level of consciousness, ventilatory and oxygenation status, and hemodynamic variables at a frequency that depends on the type and amount of medication administered, the length of the procedure, and the general condition of the patient</td>
<td>126</td>
<td>60.3*</td>
<td>24.6</td>
<td>4.8</td>
<td>7.9</td>
<td>2.4</td>
</tr>
<tr>
<td>20. Set device alarms to alert the care team to critical changes in patient availability of an individual responsible for patient monitoring</td>
<td>126</td>
<td>75.4*</td>
<td>21.4</td>
<td>3.2</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>21. Assure that a designated individual other than the practitioner performing the procedure is present to monitor the patient throughout the procedure</td>
<td>126</td>
<td>78.6*</td>
<td>18.3</td>
<td>0.8</td>
<td>0.8</td>
<td>1.6</td>
</tr>
</tbody>
</table>

(Continued)
Table 7. (Continued).

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>N*</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Equivocal</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. The individual responsible for monitoring the patient should be trained in the recognition of apnea and airway obstruction and be empowered to seek additional help</td>
<td>127</td>
<td>87.4*</td>
<td>11.8</td>
<td>0.0</td>
<td>0.8</td>
<td>0.0</td>
</tr>
<tr>
<td>23. The designated individual may assist with minor, interruptible tasks once the patient's level of sedation/analgesia and vital signs have stabilized, provided that adequate monitoring for the patient's level of sedation is maintained</td>
<td>127</td>
<td>47.2</td>
<td>30.7*</td>
<td>10.2</td>
<td>9.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Supplemental oxygen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Use supplemental oxygen during moderate procedural sedation/analgesia unless specifically contraindicated for a particular patient or procedure</td>
<td>126</td>
<td>54.0*</td>
<td>29.4</td>
<td>11.1</td>
<td>4.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Emergency support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Assure that pharmacologic antagonists for benzodiazepines and opioids are immediately available in the procedure room</td>
<td>127</td>
<td>68.5*</td>
<td>20.5</td>
<td>6.3</td>
<td>3.1</td>
<td>1.6</td>
</tr>
<tr>
<td>26. Assure that an individual is present in the room who understands the pharmacology of the sedative/analgesics administered and potential interactions with other medications and nutraceuticals the patient may be taking</td>
<td>127</td>
<td>78.0*</td>
<td>16.5</td>
<td>3.9</td>
<td>1.6</td>
<td>0.0</td>
</tr>
<tr>
<td>27. Assure that appropriately sized equipment for establishing a patient airway is available</td>
<td>124</td>
<td>88.7*</td>
<td>10.5</td>
<td>0.8</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>28. Assure that at least one individual capable of establishing a patient airway and providing positive pressure ventilation is present in the procedure room</td>
<td>126</td>
<td>84.9*</td>
<td>12.7</td>
<td>1.6</td>
<td>0.8</td>
<td>0.0</td>
</tr>
<tr>
<td>29. Assure that suction, advanced airway equipment, positive pressure ventilation, and supplemental oxygen are immediately available in the procedure room and in good working order</td>
<td>126</td>
<td>84.1*</td>
<td>11.9</td>
<td>3.2</td>
<td>0.8</td>
<td>0.0</td>
</tr>
<tr>
<td>30. Assure that a member of the procedural team is trained in the recognition and treatment of airway complications, opening the airway, suctioning secretions, and performing bag-valve-mask ventilation</td>
<td>127</td>
<td>87.4*</td>
<td>10.2</td>
<td>0.8</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>31. Assure that a member of the procedural team has the skills to establish intravenous access</td>
<td>127</td>
<td>80.3*</td>
<td>14.2</td>
<td>0.8</td>
<td>3.9</td>
<td>0.8</td>
</tr>
<tr>
<td>32. Assure that a member of the procedural team has the skills to provide chest compressions</td>
<td>127</td>
<td>84.3*</td>
<td>13.4</td>
<td>0.8</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>33. Assure that a functional defibrillator or automatic external defibrillator is immediately available in the procedure area</td>
<td>127</td>
<td>77.2*</td>
<td>17.3</td>
<td>3.9</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>34. Assure that an individual or service is immediately available with advanced life support skills</td>
<td>127</td>
<td>77.2*</td>
<td>13.4</td>
<td>7.1</td>
<td>2.4</td>
<td>0.0</td>
</tr>
<tr>
<td>35. Assure that members of the procedural team are able to recognize the need for additional support and know how to access emergency services from the procedure room</td>
<td>127</td>
<td>89.0*</td>
<td>11.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Sedative or analgesic medications not intended for general anesthesia</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>36. Combinations of sedative and analgesic agents may be administered as appropriate for the procedure and the condition of the patient</td>
<td>124</td>
<td>65.3*</td>
<td>32.3</td>
<td>0.8</td>
<td>1.6</td>
<td>0.0</td>
</tr>
<tr>
<td>37. Dexmedetomidine may be administered as an alternative to benzodiazepine sedatives on a case-by-case basis</td>
<td>124</td>
<td>30.6</td>
<td>37.9*</td>
<td>21.0</td>
<td>9.7</td>
<td>0.8</td>
</tr>
<tr>
<td>38. In patients receiving intravenous medications for sedation/analgesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression</td>
<td>124</td>
<td>83.1*</td>
<td>12.9</td>
<td>3.2</td>
<td>0.8</td>
<td>0.0</td>
</tr>
<tr>
<td>39. In patients who have received sedation/analgesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis</td>
<td>124</td>
<td>48.4</td>
<td>40.3*</td>
<td>1.6</td>
<td>6.5</td>
<td>3.2</td>
</tr>
<tr>
<td>40. Administer intravenous sedative/analgesic drugs in small, incremental doses or by infusion, titrating to the desired endpoints</td>
<td>124</td>
<td>71.0*</td>
<td>26.6</td>
<td>1.6</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Sedative or analgesic medications intended for general anesthesia</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>41. When moderate procedural sedation with sedative or analgesic medications intended for general anesthesia by any route is intended, provide care consistent with that required for general anesthesia</td>
<td>122</td>
<td>65.6*</td>
<td>18.9</td>
<td>4.9</td>
<td>4.9</td>
<td>5.7</td>
</tr>
</tbody>
</table>

(Continued)
42. Assure that practitioners administering these drugs are able to reliably rescue patients from unintended deep sedation or general anesthesia

43. For patients receiving intravenous sedatives intended for general anesthesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression

44. In patients who have received sedatives intended for general anesthesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis

45. Administer intravenous sedative/analgesic drugs intended for general anesthesia in small, incremental doses, or by infusion, titrating to the desired endpoints

**Reversal agents**

46. Assure that specific antagonists are immediately available in the procedure room whenever opioid analgesics or benzodiazepines are administered for moderate procedural sedation/analgesia regardless of administration route

47. If patients become hypoxemic or apneic during sedation/analgesia, encourage or physically stimulate patients to breathe deeply

48. If patients become hypoxemic or apneic during sedation/analgesia, administer supplemental oxygen

49. If patients become hypoxemic or apneic during sedation/analgesia, provide positive pressure ventilation if spontaneous ventilation is inadequate

50. Use reversal agents in cases where airway control, spontaneous ventilation, or positive pressure ventilation is inadequate

51. Administer naloxone to reverse opioid-induced sedation and respiratory depression

52. Administer flumazenil to reverse benzodiazepine-induced sedation and respiratory depression

53. After pharmacologic reversal, observe and monitor patients for a sufficient time to ensure that sedation and cardiorespiratory depression does not recur once the effect of the antagonist dissipates

54. Do not use sedation regimens that include routine reversal of sedative/analgesic agents

**Recovery care**

55. After sedation/analgesia, observe and monitor patients in an appropriately staffed and equipped area until they are near their baseline level of consciousness and are no longer at increased risk for cardiorespiratory depression

56. Monitor oxygenation continuously until patients are no longer at risk for hypoxemia

57. Monitor ventilation and circulation at regular intervals until patients are suitable for discharge

58. Design discharge criteria to minimize the risk of central nervous system or cardiorespiratory depression after discharge from observation by trained personnel

**Creation and implementation of patient safety processes**

59. Create and implement a quality improvement process based upon national, regional, or institutional reporting protocols

60. Strengthen patient safety culture through collaborative practices (e.g., team training, simulation drills, development and implementation of checklists)

61. Create an emergency response plan (e.g., activating “code blue” team or activating the emergency medical response system: 911 or equivalent)

*Table 7. (Continued)*

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>N*</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Equivocal</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>42. Assure that practitioners administering these drugs are able to reliably rescue patients from unintended deep sedation or general anesthesia</td>
<td>122</td>
<td>87.7*</td>
<td>9.8</td>
<td>0.8</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>43. For patients receiving intravenous sedatives intended for general anesthesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression</td>
<td>123</td>
<td>85.4*</td>
<td>9.8</td>
<td>1.6</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>44. In patients who have received sedatives intended for general anesthesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis</td>
<td>121</td>
<td>51.2*</td>
<td>24.8</td>
<td>4.1</td>
<td>13.2</td>
<td></td>
</tr>
<tr>
<td>45. Administer intravenous sedative/analgesic drugs intended for general anesthesia in small, incremental doses, or by infusion, titrating to the desired endpoints</td>
<td>122</td>
<td>73.0*</td>
<td>21.3</td>
<td>2.5</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>46. Assure that specific antagonists are immediately available in the procedure room whenever opioid analgesics or benzodiazepines are administered for moderate procedural sedation/analgesia regardless of administration route</td>
<td>123</td>
<td>74.0*</td>
<td>17.1</td>
<td>5.7</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>47. If patients become hypoxemic or apneic during sedation/analgesia, encourage or physically stimulate patients to breathe deeply</td>
<td>120</td>
<td>82.5*</td>
<td>16.7</td>
<td>0.0</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>48. If patients become hypoxemic or apneic during sedation/analgesia, administer supplemental oxygen</td>
<td>124</td>
<td>84.7*</td>
<td>10.5</td>
<td>3.2</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>49. If patients become hypoxemic or apneic during sedation/analgesia, provide positive pressure ventilation if spontaneous ventilation is inadequate</td>
<td>122</td>
<td>82.8*</td>
<td>13.1</td>
<td>1.6</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>50. Use reversal agents in cases where airway control, spontaneous ventilation, or positive pressure ventilation is inadequate</td>
<td>124</td>
<td>69.4*</td>
<td>19.4</td>
<td>7.3</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>51. Administer naloxone to reverse opioid-induced sedation and respiratory depression</td>
<td>118</td>
<td>61.9*</td>
<td>25.4</td>
<td>8.5</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>52. Administer flumazenil to reverse benzodiazepine-induced sedation and respiratory depression</td>
<td>123</td>
<td>58.5*</td>
<td>23.6</td>
<td>12.2</td>
<td>4.1</td>
<td></td>
</tr>
<tr>
<td>53. After pharmacologic reversal, observe and monitor patients for a sufficient time to ensure that sedation and cardiorespiratory depression does not recur once the effect of the antagonist dissipates</td>
<td>120</td>
<td>87.5*</td>
<td>10.8</td>
<td>0.0</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>54. Do not use sedation regimens that include routine reversal of sedative/analgesic agents</td>
<td>123</td>
<td>78.9*</td>
<td>13.0</td>
<td>3.3</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>55. After sedation/analgesia, observe and monitor patients in an appropriately staffed and equipped area until they are near their baseline level of consciousness and are no longer at increased risk for cardiorespiratory depression</td>
<td>123</td>
<td>85.4*</td>
<td>14.6</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>56. Monitor oxygenation continuously until patients are no longer at risk for hypoxemia</td>
<td>123</td>
<td>87.8*</td>
<td>10.6</td>
<td>0.0</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>57. Monitor ventilation and circulation at regular intervals until patients are suitable for discharge</td>
<td>122</td>
<td>83.6*</td>
<td>13.9</td>
<td>2.5</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>58. Design discharge criteria to minimize the risk of central nervous system or cardiorespiratory depression after discharge from observation by trained personnel</td>
<td>123</td>
<td>83.7*</td>
<td>16.3</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
</tbody>
</table>

* N = the number of consultants who responded to each item. An asterisk beside a percentage score in the columns to the right indicates the median.
### Table 8. ASA Membership Survey Responses

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>N*</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Equivocal</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient evaluation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Review previous medical records and interview the patient or family</td>
<td>444</td>
<td>91.0*</td>
<td>7.0</td>
<td>1.4</td>
<td>0.5</td>
<td>0.2</td>
</tr>
<tr>
<td>2. Conduct a focused physical examination of the patient</td>
<td>445</td>
<td>85.2*</td>
<td>13.5</td>
<td>0.9</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>3. Review available laboratory test results and order additional laboratory tests when needed</td>
<td>441</td>
<td>77.6*</td>
<td>19.0</td>
<td>2.7</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td>4. If possible, perform the preprocedure evaluation well enough in advance (e.g., several days to weeks) to allow for proper patient preparation</td>
<td>441</td>
<td>37.6</td>
<td>34.7*</td>
<td>18.4</td>
<td>7.0</td>
<td>2.3</td>
</tr>
<tr>
<td>5. Reevaluate the patient immediately before the procedure</td>
<td>444</td>
<td>83.8*</td>
<td>14.0</td>
<td>1.6</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Preprocedure patient preparation</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Consult with a medical specialist, when appropriate, before administration of moderate procedural sedation to patients with significant underlying conditions</td>
<td>445</td>
<td>61.3*</td>
<td>29.7</td>
<td>7.4</td>
<td>1.3</td>
<td>0.2</td>
</tr>
<tr>
<td>7. When feasible before the procedure, inform patients or legal guardians of the benefits, risks, and limitations of moderate sedation/analgesia and possible alternatives and elicit their preferences</td>
<td>443</td>
<td>74.9*</td>
<td>19.9</td>
<td>4.1</td>
<td>0.7</td>
<td>0.5</td>
</tr>
<tr>
<td>8. Before the day of the procedure, inform patients or legal guardians that they should not drink fluids or eat solid foods for a sufficient period of time to allow for gastric emptying</td>
<td>443</td>
<td>89.2*</td>
<td>9.0</td>
<td>1.4</td>
<td>0.0</td>
<td>0.5</td>
</tr>
<tr>
<td>9. On the day of the procedure, assess the time and nature of last oral intake</td>
<td>442</td>
<td>91.6*</td>
<td>7.2</td>
<td>0.7</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>10. In urgent or emergent situations where complete gastric emptying is not possible, do not delay moderate procedural sedation based on fasting time alone</td>
<td>440</td>
<td>27.5</td>
<td>27.5*</td>
<td>11.8</td>
<td>18.6</td>
<td>14.5</td>
</tr>
<tr>
<td><strong>Monitoring patient level of consciousness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Periodically monitor a patient's response to verbal commands during moderate sedation, except in patients who are unable to respond appropriately or during procedures where movement could be detrimental clinically</td>
<td>443</td>
<td>48.3</td>
<td>30.5*</td>
<td>13.8</td>
<td>5.4</td>
<td>2.0</td>
</tr>
<tr>
<td>12. During procedures where a verbal response is not possible, check the patient's ability to give a “thumbs up” or other indication of consciousness in response to verbal or tactile stimulation</td>
<td>444</td>
<td>43.5</td>
<td>35.1*</td>
<td>14.9</td>
<td>4.7</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Monitoring patient ventilation and oxygenation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Continually monitor ventilatory function by observation of qualitative clinical signs</td>
<td>418</td>
<td>80.6*</td>
<td>15.3</td>
<td>1.9</td>
<td>1.9</td>
<td>0.2</td>
</tr>
<tr>
<td>14. Continually monitor ventilatory function by capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment</td>
<td>419</td>
<td>75.4*</td>
<td>17.7</td>
<td>4.1</td>
<td>1.9</td>
<td>1.0</td>
</tr>
<tr>
<td>15. Monitor all patients by pulse oximetry with appropriate alarms</td>
<td>415</td>
<td>95.7*</td>
<td>4.1</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Monitoring hemodynamics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Determine blood pressure before sedation/analgesia is initiated unless precluded by lack of patient cooperation</td>
<td>415</td>
<td>84.3*</td>
<td>12.8</td>
<td>0.5</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>17. Once moderate sedation/analgesia is established, continually monitor blood pressure and heart rate during the procedure unless such monitoring interferes with the procedure</td>
<td>414</td>
<td>82.1*</td>
<td>12.6</td>
<td>1.2</td>
<td>2.4</td>
<td>1.7</td>
</tr>
<tr>
<td>18. Use electrocardiographic monitoring during moderate sedation in patients with clinically significant cardiovascular disease or those who are undergoing procedures where dysrhythmias are anticipated</td>
<td>415</td>
<td>82.2*</td>
<td>13.0</td>
<td>1.0</td>
<td>2.7</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Contemporaneous recording of monitored parameters</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Record level of consciousness, ventilator and oxygenation status and hemodynamic variables at a frequency that depends on the type and amount of medication administered, the length of the procedure, and the general condition of the patient</td>
<td>414</td>
<td>64.7*</td>
<td>26.1</td>
<td>2.7</td>
<td>4.1</td>
<td>2.4</td>
</tr>
<tr>
<td>20. Set device alarms to alert the care team to critical changes in patient</td>
<td>418</td>
<td>76.3*</td>
<td>18.7</td>
<td>3.6</td>
<td>1.2</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Availability of an individual responsible for patient monitoring</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Assure that a designated individual other than the practitioner performing the procedure is present to monitor the patient throughout the procedure</td>
<td>418</td>
<td>90.4*</td>
<td>7.9</td>
<td>1.0</td>
<td>0.2</td>
<td>0.5</td>
</tr>
</tbody>
</table>

(Continued)
22. The individual responsible for monitoring the patient should be trained in the recognition of apnea and airway obstruction and be empowered to seek additional help.

23. The designated individual may assist with minor, interruptible tasks once the patient's level of sedation/analgesia and vital signs have stabilized, provided that adequate monitoring for the patient's level of sedation is maintained.

Supplemental oxygen

24. Use supplemental oxygen during moderate procedural sedation/analgesia unless specifically contraindicated for a particular patient or procedure.

Emergency support

25. Assure that pharmacologic antagonists for benzodiazepines and opioids are immediately available in the procedure room.

26. Assure that an individual is present in the room who understands the pharmacology of the sedative/analgesics administered and potential interactions with other medications and nutraceuticals the patient may be taking.

27. Assure that appropriately sized equipment for establishing a patent airway is available.

28. Assure that at least one individual capable of establishing a patent airway and providing positive pressure ventilation is present in the procedure room.

29. Assure that suction, advanced airway equipment, positive pressure ventilation, and supplemental oxygen are immediately available in the procedure room and in good working order.

30. Assure that a member of the procedural team is trained in the recognition and treatment of airway complications, opening the airway, suctioning secretions, and performing bag-valve-mask ventilation.

31. Assure that a member of the procedural team has the skills to establish intravenous access.

32. Assure that a member of the procedural team has the skills to provide chest compressions.

33. Assure that a functional defibrillator or automatic external defibrillator is immediately available in the procedure area.

34. Assure that an individual or service is immediately available with advanced life support skills.

35. Assure that members of the procedural team are able to recognize the need for additional support and know how to access emergency services from the procedure room.

Sedative or analgesic medications not intended for general anesthesia

36. Combinations of sedative and analgesic agents may be administered as appropriate for the procedure and the condition of the patient.

37. Dexmedetomidine may be administered as an alternative to benzodiazepine sedatives on a case-by-case basis.

38. In patients receiving intravenous medications for sedation/analgesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression.

39. In patients who have received sedation/analgesia by non-intravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis.

40. Administer intravenous sedative/analgesic drugs in small, incremental doses or by infusion, titrating to the desired endpoints.

Sedative or analgesic medications intended for general anesthesia

41. When moderate procedural sedation with sedative or analgesic medications intended for general anesthesia by any route is intended, provide care consistent with that required for general anesthesia.

Table 8. (Continued)

| Percent Responding to Each Item |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| N*   | Strongly Agree | Agree | Equivocal | Disagree | Strongly Disagree |
| 416 | 93.8* | 5.0 | 0.2 | 0.0 | 1.0 |
| 418 | 32.5 | 28.0* | 12.0 | 17.0 | 10.5 |
| 417 | 67.9* | 21.1 | 8.6 | 1.7 | 0.7 |
| 415 | 73.6* | 19.4 | 5.5 | 1.2 | 0.2 |
| 415 | 83.1* | 14.0 | 2.7 | 0.0 | 0.2 |
| 416 | 91.6* | 7.7 | 0.2 | 0.2 | 0.2 |
| 415 | 84.8* | 12.8 | 2.4 | 0.0 | 0.0 |
| 415 | 90.4* | 8.7 | 0.5 | 0.2 | 0.2 |
| 415 | 89.6* | 9.4 | 0.7 | 0.2 | 0.0 |
| 416 | 87.0* | 11.1 | 1.7 | 0.0 | 0.2 |
| 414 | 88.9* | 10.1 | 1.0 | 0.0 | 0.0 |
| 412 | 83.5* | 13.6 | 2.2 | 0.7 | 0.0 |
| 414 | 74.6* | 17.1 | 5.6 | 2.2 | 0.5 |
| 415 | 88.4* | 11.6 | 0.0 | 0.0 | 0.0 |
| 403 | 57.8* | 37.7 | 3.2 | 0.5 | 0.7 |
| 403 | 30.5 | 40.9* | 17.4 | 8.4 | 2.7 |
| 400 | 89.8* | 9.5 | 0.3 | 0.3 | 0.3 |
| 402 | 51.2* | 33.3* | 3.7 | 6.2 | 5.5 |
| 402 | 82.1* | 16.2 | 0.5 | 0.7 | 0.5 |
| 401 | 83.5* | 11.7 | 2.2 | 1.5 | 1.0 |
42. Assure that practitioners administering these drugs are able to reliably rescue patients from unintended deep sedation/general anesthesia.

43. For patients receiving intravenous sedatives intended for general anesthesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiopulmonary depression.

44. In patients who have received sedatives intended for general anesthesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis.

45. Administer intravenous sedative/analgesic drugs intended for general anesthesia in small, incremental doses or by infusion, titrating to the desired endpoints.

46. Assure that specific antagonists are immediately available in the procedure room whenever opioid analgesics or benzodiazepines are administered for moderate procedural sedation/analgesia, regardless of administration route.

47. If patients become hypoxemic or apneic during sedation/analgesia, encourage or physically stimulate patients to breathe deeply.

48. If patients become hypoxemic or apneic during sedation/analgesia, administer supplemental oxygen.

49. If patients become hypoxemic or apneic during sedation/analgesia, provide positive pressure ventilation if spontaneous ventilation is inadequate.

50. Use reversal agents in cases where airway control, spontaneous ventilation, or positive pressure ventilation is inadequate.

51. Administer naloxone to reverse opioid-induced sedation and respiratory depression.

52. Administer flumazenil to reverse benzodiazepine-induced sedation and respiratory depression.

53. After pharmacologic reversal, observe and monitor patients for a sufficient time to ensure that sedation and cardiorespiratory depression does not recur once the effect of the antagonist dissipates.

54. Do not use sedation regimens that include routine reversal of sedative/analgesic agents.

55. After sedation/analgesia, observe and monitor patients in an appropriately staffed and equipped area until they are near their baseline level of consciousness and are no longer at increased risk for cardiorespiratory depression.

56. Monitor oxygenation continuously until patients are no longer at risk for hypoxemia.

57. Monitor ventilation and circulation at regular intervals until patients are suitable for discharge.

58. Design discharge criteria to minimize the risk of central nervous system or cardiorespiratory depression after discharge from observation by trained personnel.

59. Create and implement a quality improvement process based upon national, regional, or institutional reporting protocols.

60. Strengthen patient safety culture through collaborative practices (e.g., team training, simulation drills, development and implementation of checklists).

61. Create an emergency response plan (e.g., activating “code blue” team or activating the emergency medical response system: 911 or equivalent).

### Table 8. (Continued)

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>N*</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Equivocal</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

*N = the number of consultants who responded to each item. An asterisk beside a percentage score in the columns to the right indicates the median.
### Table 9. American Association of Oral and Maxillofacial Surgeons Member Survey Responses

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>N*</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Equivocal</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Review previous medical records and interview the patient or family</td>
<td>68</td>
<td>82.4*</td>
<td>16.2</td>
<td>1.5</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>2. Conduct a focused physical examination of the patient</td>
<td>68</td>
<td>80.9*</td>
<td>17.6</td>
<td>1.5</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>3. Review available laboratory test results and order additional laboratory tests when needed</td>
<td>68</td>
<td>76.5*</td>
<td>17.6</td>
<td>5.9</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>4. If possible, perform the preprocedure evaluation well enough in advance (e.g., several days to weeks) to allow for proper patient preparation</td>
<td>67</td>
<td>53.7*</td>
<td>28.4</td>
<td>9.0</td>
<td>9.0</td>
<td>0.0</td>
</tr>
<tr>
<td>5. Reevaluate the patient immediately before the procedure</td>
<td>69</td>
<td>78.3*</td>
<td>17.4</td>
<td>0.0</td>
<td>4.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Preprocedure patient preparation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Consult with a medical specialist, when appropriate, before administration of moderate procedural sedation to patients with significant underlying conditions</td>
<td>69</td>
<td>68.1*</td>
<td>24.6</td>
<td>5.8</td>
<td>1.4</td>
<td>0.0</td>
</tr>
<tr>
<td>7. When feasible before the procedure, inform patients or legal guardians of the benefits, risks, and limitations of moderate sedation/analgesia and possible alternatives and elicit their preferences</td>
<td>69</td>
<td>73.9*</td>
<td>23.2</td>
<td>2.9</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>8. Before the day of the procedure, inform patients or legal guardians that they should not drink fluids or eat solid foods for a sufficient period of time to allow for gastric emptying</td>
<td>68</td>
<td>86.8*</td>
<td>10.3</td>
<td>1.5</td>
<td>1.5</td>
<td>0.0</td>
</tr>
<tr>
<td>9. On the day of the procedure, assess the time and nature of last oral intake</td>
<td>68</td>
<td>89.7*</td>
<td>10.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>10. In urgent or emergent situations where complete gastric emptying is not possible, do not delay moderate procedural sedation based on fasting time alone</td>
<td>62</td>
<td>25.8</td>
<td>30.6*</td>
<td>21.0</td>
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<tr>
<td>Monitoring patient level of consciousness</td>
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<tr>
<td>11. Periodically monitor a patient’s response to verbal commands during moderate sedation, except in patients who are unable to respond appropriately or during procedures where movement could be detrimental clinically</td>
<td>67</td>
<td>40.3</td>
<td>29.9*</td>
<td>22.4</td>
<td>7.5</td>
<td>0.0</td>
</tr>
<tr>
<td>12. During procedures where a verbal response is not possible, check the patient’s ability to give a “thumbs up” or other indication of consciousness in response to verbal or tactile stimulation</td>
<td>69</td>
<td>30.4</td>
<td>36.2*</td>
<td>26.1</td>
<td>7.2</td>
<td>0.0</td>
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<tr>
<td>Monitoring patient ventilation and oxygenation</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>13. Continuously monitor ventilatory function by observation of qualitative clinical signs</td>
<td>66</td>
<td>84.8*</td>
<td>13.6</td>
<td>1.5</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>14. Continuously monitor ventilatory function by capnography unless precluded or invalidated by the nature of the patient, procedure, or equipment</td>
<td>61</td>
<td>65.6*</td>
<td>21.3</td>
<td>11.5</td>
<td>1.6</td>
<td>0.0</td>
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<tr>
<td>15. Monitor all patients by pulse oximetry with appropriate alarms</td>
<td>66</td>
<td>87.9*</td>
<td>12.1</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>Monitoring hemodynamics</td>
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<tr>
<td>16. Determine blood pressure before sedation/analgesia is initiated unless precluded by lack of patient cooperation</td>
<td>63</td>
<td>84.1*</td>
<td>14.3</td>
<td>0.0</td>
<td>1.6</td>
<td>0.0</td>
</tr>
<tr>
<td>17. Once moderate sedation/analgesia is established, continually monitor blood pressure and heart rate during the procedure unless such monitoring interferes with the procedure</td>
<td>64</td>
<td>79.7*</td>
<td>18.8</td>
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<td>1.6</td>
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<tr>
<td>19. Record level of consciousness, ventilator and oxygenation status, and hemodynamic variables at a frequency that depends on the type and amount of medication administered, the length of the procedure, and the general condition of the patient</td>
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<td>54.5*</td>
<td>24.2</td>
<td>16.7</td>
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<td>20. Set device alarms to alert the care team to critical changes in patient</td>
<td>66</td>
<td>72.7*</td>
<td>22.7</td>
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### Table 9. (Continued)

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<th>Percent Responding to Each Item</th>
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<th>Agree</th>
<th>Equivocal</th>
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<td>21. Assure that a designated individual other than the practitioner performing the procedure is present to monitor the patient throughout the procedure</td>
<td>65</td>
<td>53.8*</td>
<td>26.2</td>
<td>10.8</td>
<td>9.2</td>
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<tr>
<td>22. The individual responsible for monitoring the patient should be trained in the recognition of apnea and airway obstruction and be empowered to seek additional help</td>
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<td>63.1*</td>
<td>30.8</td>
<td>3.1</td>
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<td>23. The designated individual may assist with minor, interruptible tasks once the patient's level of sedation/analgesia and vital signs have stabilized, provided that adequate monitoring for the patient's level of sedation is maintained</td>
<td>64</td>
<td>50.0*</td>
<td>40.6</td>
<td>1.6</td>
<td>7.8</td>
</tr>
</tbody>
</table>

**Supplemental oxygen**

24. Use supplemental oxygen during moderate procedural sedation/analgesia unless specifically contraindicated for a particular patient or procedure | 64 | 78.1* | 14.1 | 4.7 | 3.1 | 0.0 |

**Emergency support**

25. Assure that pharmacologic antagonists for benzodiazepines and opioids are immediately available in the procedure room | 62 | 74.2* | 14.5 | 9.7 | 1.6 | 0.0 |
| 26. Assure that an individual is present in the room who understands the pharmacology of the sedative/analgesics administered and potential interactions with other medications and nutraceuticals the patient may be taking | 64 | 71.9* | 17.2 | 6.3 | 4.7 | 0.0 |
| 27. Assure that appropriately sized equipment for establishing a patent airway is available | 64 | 87.5* | 12.5 | 0.0 | 0.0 | 0.0 |
| 28. Assure that at least one individual capable of establishing a patent airway and providing positive pressure ventilation is present in the procedure room | 64 | 82.8* | 15.6 | 1.6 | 0.0 | 0.0 |
| 29. Assure that suction, advanced airway equipment, positive pressure ventilation, and supplemental oxygen are immediately available in the procedure room and in good working order | 64 | 81.3* | 12.5 | 3.1 | 3.1 | 0.0 |
| 30. Assure that a member of the procedural team is trained in the recognition and treatment of airway complications, opening the airway, suctioning secretions, and performing bag-valve-mask ventilation | 64 | 87.5* | 10.9 | 1.6 | 0.0 | 0.0 |
| 31. Assure that a member of the procedural team has the skills to establish intravenous access | 64 | 76.6* | 17.2 | 4.7 | 1.6 | 0.0 |
| 32. Assure that a member of the procedural team has the skills to provide chest compressions | 62 | 87.1* | 12.9 | 0.0 | 0.0 | 0.0 |
| 33. Assure that a functional defibrillator or automatic external defibrillator is immediately available in the procedure area | 64 | 78.1* | 18.8 | 1.6 | 1.6 | 0.0 |
| 34. Assure that an individual or service is immediately available with advanced life support skills | 63 | 73.0* | 19.0 | 6.3 | 1.6 | 0.0 |
| 35. Assure that members of the procedural team are able to recognize the need for additional support and know how to access emergency services from the procedure room | 64 | 85.9* | 10.9 | 1.6 | 1.6 | 0.0 |

**Sedative or analgesic medications not intended for general anesthesia**

36. Combinations of sedative and analgesic agents may be administered as appropriate for the procedure and the condition of the patient | 64 | 81.3* | 18.8 | 0.0 | 0.0 | 0.0 |
| 37. Dexmedetomidine may be administered as an alternative to benzodiazepine sedatives on a case-by-case basis | 63 | 14.3 | 17.5 | 63.5* | 4.8 | 0.0 |
38. In patients receiving intravenous medications for sedation/analgesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression.

39. In patients who have received sedation/analgesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis.

40. Administer intravenous sedative/analgesic drugs in small, incremental doses or by infusion, titrating to the desired endpoints.

Sedative or analgesic medications intended for general anesthesia

41. When moderate procedural sedation with sedative or analgesic medications intended for general anesthesia by any route is intended, provide care consistent with that required for general anesthesia.

42. Assure that practitioners administering these drugs are able to reliably rescue patients from unintended deep sedation or general anesthesia.

43. For patients receiving intravenous sedatives intended for general anesthesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression.

44. In patients who have received sedatives intended for general anesthesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis.

45. Administer intravenous sedative/analgesic drugs intended for general anesthesia in small, incremental doses, or by infusion, titrating to the desired endpoints.

Reversal agents

46. Assure that specific antagonists are immediately available in the procedure room whenever opioid analgesics or benzodiazepines are administered for moderate procedural sedation/analgesia regardless of administration route.

47. If patients become hypoxemic or apneic during sedation/analgesia, encourage or physically stimulate patients to breathe deeply.

48. If patients become hypoxemic or apneic during sedation/analgesia, administer supplemental oxygen.

49. If patients become hypoxemic or apneic during sedation/analgesia, provide positive pressure ventilation if spontaneous ventilation is inadequate.

50. Use reversal agents in cases where airway control, spontaneous ventilation or positive pressure ventilation is inadequate.

51. Administer naloxone to reverse opioid-induced sedation and respiratory depression.

52. Administer flumazenil to reverse benzodiazepine-induced sedation and respiratory depression.

53. After pharmacologic reversal, observe and monitor patients for a sufficient time to ensure that sedation and cardiorespiratory depression does not recur once the effect of the antagonist dissipates.

54. Do not use sedation regimens that include routine reversal of sedative/analgesic agents.

Table 9. (Continued)

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<thead>
<tr>
<th>Percent Responding to Each Item</th>
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<th>Agree</th>
<th>Equivocal</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>38. In patients receiving intravenous medications for sedation/analgesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression</td>
<td>64</td>
<td>85.9*</td>
<td>14.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>39. In patients who have received sedation/analgesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis</td>
<td>63</td>
<td>66.7*</td>
<td>31.7</td>
<td>1.6</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>40. Administer intravenous sedative/analgesic drugs in small, incremental doses or by infusion, titrating to the desired endpoints</td>
<td>64</td>
<td>81.3*</td>
<td>15.6</td>
<td>0.0</td>
<td>3.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Sedative or analgesic medications intended for general anesthesia</td>
<td>41. When moderate procedural sedation with sedative or analgesic medications intended for general anesthesia by any route is intended, provide care consistent with that required for general anesthesia</td>
<td>61</td>
<td>82.0*</td>
<td>16.4</td>
<td>1.6</td>
<td>0.0</td>
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<tr>
<td>42. Assure that practitioners administering these drugs are able to reliably rescue patients from unintended deep sedation or general anesthesia</td>
<td>64</td>
<td>90.6</td>
<td>7.8</td>
<td>1.6</td>
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<tr>
<td>43. For patients receiving intravenous sedatives intended for general anesthesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression</td>
<td>64</td>
<td>87.5*</td>
<td>12.5</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>44. In patients who have received sedatives intended for general anesthesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis</td>
<td>61</td>
<td>73.8*</td>
<td>21.3</td>
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<tr>
<td>45. Administer intravenous sedative/analgesic drugs intended for general anesthesia in small, incremental doses, or by infusion, titrating to the desired endpoints</td>
<td>64</td>
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<td>15.6</td>
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<tr>
<td>Reversal agents</td>
<td>46. Assure that specific antagonists are immediately available in the procedure room whenever opioid analgesics or benzodiazepines are administered for moderate procedural sedation/analgesia regardless of administration route</td>
<td>63</td>
<td>77.8*</td>
<td>17.5</td>
<td>4.8</td>
<td>0.0</td>
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<tr>
<td>47. If patients become hypoxemic or apneic during sedation/analgesia, encourage or physically stimulate patients to breathe deeply</td>
<td>64</td>
<td>81.3*</td>
<td>15.6</td>
<td>3.1</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>48. If patients become hypoxemic or apneic during sedation/analgesia, administer supplemental oxygen</td>
<td>61</td>
<td>82.0*</td>
<td>16.4</td>
<td>1.6</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>49. If patients become hypoxemic or apneic during sedation/analgesia, provide positive pressure ventilation if spontaneous ventilation is inadequate</td>
<td>64</td>
<td>85.9*</td>
<td>14.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>50. Use reversal agents in cases where airway control, spontaneous ventilation or positive pressure ventilation is inadequate</td>
<td>63</td>
<td>71.4*</td>
<td>22.2</td>
<td>4.8</td>
<td>1.6</td>
<td>0.0</td>
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<tr>
<td>51. Administer naloxone to reverse opioid-induced sedation and respiratory depression</td>
<td>63</td>
<td>55.6*</td>
<td>36.5</td>
<td>3.2</td>
<td>4.8</td>
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<tr>
<td>52. Administer flumazenil to reverse benzodiazepine-induced sedation and respiratory depression</td>
<td>63</td>
<td>57.1*</td>
<td>33.3</td>
<td>6.3</td>
<td>3.2</td>
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<tr>
<td>53. After pharmacologic reversal, observe and monitor patients for a sufficient time to ensure that sedation and cardiorespiratory depression does not recur once the effect of the antagonist dissipates</td>
<td>64</td>
<td>79.7*</td>
<td>18.8</td>
<td>1.6</td>
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<tr>
<td>54. Do not use sedation regimens that include routine reversal of sedative/analgesic agents</td>
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<td>67.7*</td>
<td>22.6</td>
<td>6.5</td>
<td>3.2</td>
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</tbody>
</table>
Recovery care

55. After sedation/analgesia, observe and monitor patients in an appropriately staffed and equipped area until they are near their baseline level of consciousness and are no longer at increased risk for cardiorespiratory depression

56. Monitor oxygenation continuously until patients are no longer at risk for hypoxemia

57. Monitor ventilation and circulation at regular intervals until patients are suitable for discharge

58. Design discharge criteria to minimize the risk of central nervous system or cardiorespiratory depression after discharge from observation by trained personnel.

Creation and implementation of patient safety processes

59. Create and implement a quality improvement process based upon national, regional, or institutional reporting protocols

60. Strengthen patient safety culture through collaborative practices (e.g., team training, simulation drills, development and implementation of checklists)

61. Create an emergency response plan (e.g., activating “code blue” team or activating the emergency medical response system: 911 or equivalent)

*N = the number of consultants who responded to each item. An asterisk beside a percentage score in the columns to the right indicates the median.

Table 9. (Continued)

<table>
<thead>
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<th>Percent Responding to Each Item</th>
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Table 10. American Society of Dentist Anesthesiologists Member Survey Responses

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(Continued)
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<td>91.4*</td>
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</tr>
</thead>
<tbody>
<tr>
<td>N*</td>
</tr>
<tr>
<td>27. Assure that appropriately sized equipment for establishing a patent airway is available</td>
</tr>
<tr>
<td>28. Assure that at least one individual capable of establishing a patent airway and providing positive pressure ventilation is present in the procedure room</td>
</tr>
<tr>
<td>29. Assure that suction, advanced airway equipment, positive pressure ventilation, and supplemental oxygen are immediately available in the procedure room and in good working order</td>
</tr>
<tr>
<td>30. Assure that a member of the procedural team is trained in the recognition and treatment of airway complications, opening the airway, suctioning secretions, and performing bag-valve-mask ventilation</td>
</tr>
<tr>
<td>31. Assure that a member of the procedural team has the skills to establish intravenous access</td>
</tr>
<tr>
<td>32. Assure that a member of the procedural team has the skills to provide chest compressions</td>
</tr>
<tr>
<td>33. Assure that a functional defibrillator or automatic external defibrillator is immediately available in the procedure area</td>
</tr>
<tr>
<td>34. Assure that an individual or service is immediately available with advanced life support skills</td>
</tr>
<tr>
<td>35. Assure that members of the procedural team are able to recognize the need for additional support and know how to access emergency services from the procedure room</td>
</tr>
<tr>
<td>36. Combinations of sedative and analgesic agents may be administered as appropriate for the procedure and the condition of the patient</td>
</tr>
<tr>
<td>37. Dexmedetomidine may be administered as an alternative to benzodiazepine sedatives on a case-by-case basis</td>
</tr>
<tr>
<td>38. In patients receiving intravenous medications for sedation/analgesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression</td>
</tr>
<tr>
<td>39. In patients who have received sedation/analgesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis</td>
</tr>
<tr>
<td>40. Administer intravenous sedative/analgesic drugs in small, incremental doses or by infusion, titrating to the desired endpoints</td>
</tr>
<tr>
<td>Sedative or analgesic medications not intended for general anesthesia</td>
</tr>
<tr>
<td>42. Assure that practitioners administering these drugs are able to reliably rescue patients from unintended deep sedation or general anesthesia</td>
</tr>
<tr>
<td>43. For patients receiving intravenous sedatives intended for general anesthesia, maintain vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression</td>
</tr>
<tr>
<td>44. In patients who have received sedatives intended for general anesthesia by nonintravenous routes or whose intravenous line has become dislodged or blocked, determine the advisability of establishing or reestablishing intravenous access on a case-by-case basis</td>
</tr>
</tbody>
</table>

(Continued)
Table 10. (Continued)

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>N*</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Equivocal</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

45. Administer intravenous sedative/analgesic drugs intended for general anesthesia in small, incremental doses, or by infusion, titrating to the desired endpoints

| | 90 | 65.6* | 12.2 | 5.6 | 5.6 | 11.1 |

Reversal agents

46. Assure that specific antagonists are immediately available in the procedure room whenever opioid analgesics or benzodiazepines are administered for moderate procedural sedation/analgesia regardless of administration route

| | 90 | 82.2* | 14.4 | 1.1 | 2.2 | 0.0 |

47. If patients become hypoxemic or apneic during sedation/analgesia, encourage or physically stimulate patients to breathe deeply

| | 90 | 88.9* | 6.7 | 1.1 | 2.2 | 1.1 |

48. If patients become hypoxemic or apneic during sedation/analgesia, administer supplemental oxygen

| | 90 | 92.2* | 6.7 | 0.0 | 1.1 | 0.0 |

49. If patients become hypoxemic or apneic during sedation/analgesia, provide positive pressure ventilation if spontaneous ventilation is inadequate

| | 90 | 92.2* | 6.7 | 0.0 | 1.1 | 0.0 |

50. Use reversal agents in cases where airway control, spontaneous ventilation or positive pressure ventilation is inadequate

| | 89 | 73.0* | 16.9 | 3.4 | 3.4 | 3.4 |

51. Administer naloxone to reverse opioid-induced sedation and respiratory depression

| | 90 | 62.2* | 25.6 | 7.8 | 2.2 | 2.2 |

52. Administer flumazenil to reverse benzodiazepine-induced sedation and respiratory depression

| | 90 | 61.1* | 25.6 | 7.8 | 2.2 | 3.3 |

53. After pharmacologic reversal, observe and monitor patients for a sufficient time to ensure that sedation and cardiorespiratory depression does not recur once the effect of the antagonist dissipates

| | 90 | 91.1* | 8.9 | 0.0 | 0.0 | 0.0 |

54. Do not use sedation regimens that include routine reversal of sedative/analgesic agents

| | 90 | 84.4* | 10.0 | 2.2 | 2.2 | 1.1 |

Recovery care

55. After sedation/analgesia, observe and monitor patients in an appropriately staffed and equipped area until they are near their baseline level of consciousness and are no longer at increased risk for cardiorespiratory depression

| | 88 | 86.4* | 10.2 | 2.3 | 0.0 | 1.1 |

56. Monitor oxygenation continuously until patients are no longer at risk for hypoxemia

| | 88 | 86.4* | 13.6 | 0.0 | 0.0 | 0.0 |

57. Monitor ventilation and circulation at regular intervals until patients are suitable for discharge

| | 88 | 77.3* | 18.3 | 3.4 | 1.1 | 0.0 |

58. Design discharge criteria to minimize the risk of central nervous system or cardiorespiratory depression after discharge from observation by trained personnel

| | 88 | 84.1* | 14.8 | 1.1 | 0.0 | 0.0 |

Creation and implementation of patient safety processes

59. Create and implement a quality improvement process based upon national, regional, or institutional reporting protocols

| | 88 | 58.0* | 31.8 | 9.1 | 1.1 | 0.0 |

60. Strengthen patient safety culture through collaborative practices (e.g., team training, simulation drills, development and implementation of checklists)

| | 88 | 72.7* | 22.7 | 4.5 | 0.0 | 0.0 |

61. Create an emergency response plan (e.g., activating “code blue” team or activating the emergency medical response system: 911 or equivalent)

| | 88 | 79.5* | 18.2 | 2.3 | 0.0 | 0.0 |

*N = the number of consultants who responded to each item. An asterisk beside a percentage score in the columns to the right indicates the median.