LOUISIANA STATE BOARD OF NURSING
3510 NORTH CAUSEWAY BOULEVARD
SUITE 501
METAIRIE, LOUISIANA 70002

MINUTES OF THE JULY 15, 2003 LSBN TASK FORCE ON RN SCOPE OF PRACTICE REGARDING PAIN MANAGEMENT

Call to Order: Deborah Ford, Chairperson, called the meeting of the LSBN Task Force on RN Scope of Practice Regarding Pain Management to order at 12:20 p.m. on Tuesday, July 15, 2003 in Suite 601 Conference Room of the Board's office.

Roll Call: Present:

Task Force Members:
Deborah Ford, MSN, RN, Chairperson
Frankie Rosenthal, MSN, RN, CNS, CNA, Committee Member
Pat Brandon, RN Ochsner Clinic Foundation
Carol J. Ratcliffe, MSN, CNOR, CHE, RN, CHRISTUS St. Patrick Hospital
Lisa Lauve, RN, VP, Nursing CHRISTUS St. Francis Cabrini Hospital
Charlene Brouillette, CRNA, MS, APRN, LANA
Kathy Wren, CRNA, PhD, LSUHSC

Absent:
Ginger Broussard, RN, Director, Breast Center
Connie Brown, RN, LSBPNE
Sylvia Oats, MHA, RN, OCN, Lafayette General Medical Center
Linda Pullig, RN, Director Anesthesia/Pain Management

Staff:
Barbara Morvant, MN, RN, Executive Director
Cynthia Morris, MN, RN, Assistant Executive Director
Pat Ladner, MN, RN, Nursing Consultant for Practice

Guests:
Patsy Bourgeois, MN, RN, LSBN, Board Member
Shelia Dufuene, RN, Ochsner
Gwendolyn George, LANP
Linda Horn-Thompson, BSN, RN, Woman's Hospital, Baton Rouge
Karen Loden, MN, RN, LSNA
Virginia Shirado, BSN, RN, Woman's Hospital
Becky Stein, RN, CHRISTUS St. Patrick Hospital
Cathryn Wright, LANP

Minutes: The minutes of the June 12, 2003 meeting were reviewed.

Motion: by P. Brandon, seconded by F. Rosenthal to accept the minutes with editorial changes: F. Rosenthal, Yes; C. Brouillette, Yes; K. Wren, Yes; C. Ratcliffe, Yes: P. Brandon, Yes; L. Lauve, Yes.

Staff Report: Reviewed the Task Force mailing: Agenda for July 15, 2003 meeting; revised Task Force member list to include A. Pitt, LANA; revised minutes of the May 6, 2003; revised agenda for the June 12, 2003 meeting; minutes of the June 12, 2003 meeting.

Old Business: D. Ford informed the guests that this meeting is the Task Force on Pain Management and that the Practice Committee would resume after the Task Force meeting.

5.1 Review of Literature: conscious sedation. Additional information was distributed regarding the review of the literature, additional articles and review of the position statements from other agencies. L. Lauve addressed the first article: "Conscious sedation": Time for this oxymoron to go away! This article sums up the argument for what is happening in practice, addresses safe practices. Should be called "procedural sedation" since many procedures require a sedation level that does not allow the patient to speak.

The second article, "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists" addresses guidelines that assure patients are appropriately screened for sedation. With this screening adverse events seldom occur.

These articles discern between moderate and deep sedation and recommend better teaching of advanced cardiac life support (ACLS) and monitoring to include capnography and pulse oximetry. These monitoring devices provide data to alert the practitioners when the level of patient consciousness is deepening.

C. Ratcliffe reviewed the other articles that address recommended guidelines: ASA guidelines, anesthesia classification; JCAHO standards; physical exam, having appropriate emergency equipment on hand and educational materials regarding emergency drug reversal in case of excessive respiratory depression.

C. Ratcliffe reviewed the articles by Sipe and Natale regarding procedural sedation for adults having defibrillator implantation and endoscopy. These authors addressed the safe administration of drugs for deep sedation such as Propofol by endoscopists without anesthesia specialist in attendance. Current procedures require a deeper level of sedation than moderate sedation. Natale's article is based on a study to prove the safety of non-anesthetists sedating for these procedures. Most of the articles are very specific in regards to providing deep sedation; the agency must have an ACLS nurse whose sole purpose is to monitor the patient and the sedation level. Most of these articles address deep sedation in the acute care setting where it is safer because of the resource available if an adverse reaction should occur as compared with non-acute care settings such as a dentist's office.

C. Ratcliffe also addressed the literature review of pediatric patients receiving Chloral Hydrate and how agencies are trying to get away from this "not so safe practice" by following national standards for both children and adults. C.

Ratcliffe presented what CHRISTUS is doing to get away from the practice of having parents administer Chloral Hydrate at home. Chloral Hydrate does not taste good and the child has the tendency to spit out the medication. Since the child does not take the full dose the parents re-dose. The current practice at CHRISTUS is to administer Versed (Midazolam) when dosing pediatric patients. C. Ratcliffe recognized that CHRISTUS' policy is not part of the literature review but she wanted to point out the agency's commitment to safe best practices.

C. Ratcliffe addressed the difficulty in securing anesthesiologists for (dental to be replaced with radiology at the request of C. Ratcliffe, on August 27, 2003) procedures because they are not being reimbursed for the procedure. When a high-risk patient at CHRISTUS is identified, they have to wait for the availability of scheduling with an anesthesiologist.

Discussion focused on the literature distributed at the last meeting regarding moderate/deep sedation and the "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists" that addresses the different requirements for deep sedation, the additional nurse training, and the nurse not having any other responsibilities during the procedures. It was pointed out from the literature review that anyone who administers a drug that may cause deep sedation must be qualified to rescue a patient from a state of general anesthesia, disqualifying RNs from administering these drugs. The ASA guidelines were discussed without group consensus regarding the role of the registered nurse and non-anesthesiologist. A second set of ASA guidelines were copied and distributed to the members.

C. Ratcliffe clarified that CHRISTUS is not asking the Board for RNs to administer the anesthetic drugs; the purpose of the Board opinion request was in regards to the scope of registered nurse practice monitoring the patient receiving deep sedation. Rescue teams are available to respond to emergency situations at CHRISTUS.

K. Wren requested clarification of the original request. The letter dated September 12, 2002, from C. Ratcliffe to P. Ladner, was read regarding the ability by licensure of a nurse (non-CRNA) to assess, monitor and care for a patient that is receiving Diprivan (Propofol) or other anesthetic or analgesic in which the intended sedation level ranges from deep sedation to anesthesia. The medications are administered by the physician (non-anesthesiologist) performing the procedure. It was stated that the request is not asking for RNs to administer anesthetic agents but to monitor the patient receiving deep sedation. The petitioner's request was read. "We want a clear definition of the nurse's scope of practice regarding:

1. Monitoring of a patient in a controlled setting receiving IV Conscious Sedation which may on occasion progress to deep sedation for a short period of time, when administered by a physician."

It was clarified that the petition was not asking to allow RNs to administering medications in conflict with RS 37:930 but to monitor patients that are receiving procedural sedation that may progress to deep sedation.

The role of the physician performing the procedure and the person administering the anesthesia was discussed as described in the ASA guidelines and the JCAHO standards. Discussion also included the role of anesthesia personnel in the dentist's office, insurance versus reimbursement.

K. Wren addressed the articles previously reviewed by C. Ratcliffe stating that only one article addressed "procedural sedation" while the second article did not mention procedural sedation; K. Wren requested that: "the first article is shown as a "commentary" it is not research article". Wren stated that "the author (Cote) did not promote the use of nurses providing deep sedation what he is saying is that it is time to give the pediatric patients the same kind of attention we give adults". Discussion continued on what this author was addressing in the article with no agreement on who should be doing what.

The Chair requested the members to complete discussion on one article before addressing another article. The Chair cited Cote's commentary:
~ AAP (American Academy of Pediatrics) guidelines,
~ "(8) A separate observer to monitor deeply sedated patients who might not be able to maintain their airways independently" doesn't really identify "who" the practitioner is, just that there is a separate observer.
~ ASA Task Force changes from "conscious sedation" to "sedation/analgesia"
~ JCAHO new terminology (1) minimal sedation/analgesia (anxiolysis), (2) moderate sedation/analgesia, (3) deep sedation/analgesia (the patient may require airway intervention), and (4) general anesthesia.
It was noted that the members do not have a full article; page 16 is missing.
The following statement was read from Cote's article, "I assume that rescue from a state of general anesthesia means that the individual supervising deep sedation must be skilled in bag-mask ventilation, opening of obstructed airways, treatment of laryngospasm, and hy-".

It was clarified that the petitioner has removed the drug propofol from the opinion request. The issue is that of the RN monitoring the patient receiving conscious sedation progressing to deep sedation.

The JCAHO standards were addressed. The following standards were read from standard TX.2 Moderate or deep sedation and anesthesia are provided by qualified individuals:
~ "B. Practitioners who have appropriate credentials and are permitted to administer deep sedation are qualified to rescue patients from general anesthesia and are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation."

"Sufficient numbers of qualified personnel (*in addition* to the licensed independent practitioner performing the procedure) are present during procedures using moderate or deep sedation and anesthesia to:
appropriately evaluates the patient prior to beginning moderate or deep sedation and anesthesia;
provides the moderate or deep sedation and anesthesia;
performs the procedure;
monitor the patient; and

recovers and discharges the patient either from the postsedation or postanesthesia recovery area or from the organization."

"Appropriate equipment for care and resuscitation is available for monitoring vital signs including heart and respiratory rates and oxygenation using pulse oximetry equipment. Heart rate and oxygenation are continuously monitored by pulse oximetry. Respiratory frequency and adequacy of pulmonary ventilation are continually monitored. Blood pressure is measured at regular intervals. EKG is monitored in patients with significant cardiovascular disease or when dysrhythmias are anticipated or detected."

"The patient's response to care provided throughout the sedation-supported procedure is documented in the patient's record. Outcomes of patients undergoing moderate and deep sedation are collected and analyzed in the aggregate in order to identify opportunities to improve care."

The organization determines the number of qualified personnel who are present during the procedure. TX.2.a.was cited, "practitioners who have appropriate credentials and are permitted to administer moderate sedation are qualified to rescue patients from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation."

The Chair determined that these standards appropriately address *qualified personnel*. C. Wren stated that JCAHO has never condoned that the person giving the anesthesia and the person doing the procedure is an appropriate combination of skills, same person doing both. The Chair questioned where this is stated in the standards. C. Wren indicated that she needed a complete copy of the standards to document her statement. This information needs to be provided for the record. There was disagreement among the members regarding a JCAHO standard that required one person to administer the sedation/anesthesia and another person to perform the procedure. Until the standards are identified, the minutes will not reflect concurrence.

Second article, Gross, J. B. (2002) "House of Delegates Adopts Updated 'Guidelines for Sedation and Analgesia by Nonanesthesiologists'. Task Force on Sedation and Analgesia by Nonanesthesiologists." "The impetus for updating the guidelines in 2001 was fourfold:

1) in 1999, the ASA House of Delegates adopted formal definitions of levels of sedation and analgesia, including levels of sedation ranging from minimal sedation (anxiolysis) through general anesthesia {Table 1}; the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has incorporated these definitions into its 2001 standards for sedation and anesthesia;
2) there have been a large number of questions regarding the use of rapidly acting anesthetic induction agents (especially propofol and ketamine) for moderate ("conscious") and deep sedation by nonanesthesiologists; and
3) ASA practice guidelines require re-evaluation at five-year intervals.

C. Ratcliffe noted that anesthesiologist recognize that there are other physicians administering these drugs for moderate and deep sedation.

C. Ratcliffe reviewed the *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists*. # 11. Anesthetic induction agents for sedation/analgesia (propofol, methohexital, ketamine) was read:
"The literature suggests that when administered by non-anesthesiologists, propofol and ketamine can provide satisfactory moderate sedation, and suggests that methohexital can provide satisfactory deep sedation. The literature is insufficient to evaluate the efficacy of propofol or ketamine administered by non-anesthesiologists for deep sedation." C. Ratcliffe was requested to read the next sentence: "There is insufficient literature to determine whether moderate or deep sedation with propofol is associated with a different incidence of adverse outcomes than similar levels of sedation with midazolam. The consultants are equivocal regarding whether use of these medications affects the likelihood of producing satisfactory moderate sedation, while agreeing that using them increases the likelihood of satisfactory deep sedation. However, the consultants agree that avoiding these medications decreases the likelihood of adverse outcomes during moderate sedation, and are equivocal regarding their effect on adverse outcomes during deep sedation." "The Task Force cautions practitioners methohexital and propofol can produce rapid, profound decreases in level of consciousness and cardiorespiratory function, potentially culminating in a state of general anesthesia."

C. Wren stated that they have no qualms regarding the efficacy or desirability of these drugs; the issue here is the training of practitioners administering these drugs and patient safety and outcomes. The level of practitioners was questioned. Response was "no need to muddle thru a bunch of information about what an efficacy technique this is. That is not what we see as the issue. What the issue is is the delivery of the technique by personnel with the appropriate expertise, which would be related to patient safety and patient outcomes." The Chair questioned C. Wren regarding whom she was defining with appropriate training. From C. Wren point of view, deep sedation would be trained in anesthesia. It was then questioned where in the literature that this is it determined as an unsafe practice. C. Wren, "we will wait and see."

For the record, it is the opinion for the practitioners that administering or for monitoring or both? (For the record, it is noted that LANA representatives did not answer this question). Discussion went back to clarification of the petitioner's request: monitoring or rescue for anesthetic drugs for deep sedation; administering non- anesthetic drugs for moderate sedation.

C. Wren insisted that the Chair "go back to specifically what is the request here because it keeps changing; well now we wanted to change it to deep sedation, well now we want to say deep sedation with versed but not propofol and this and that and I really must insist that we must have a specific request and we stick to it, every time we turn around it changes". The Chair re-read the request before the Practice Committee, it is on page two, agenda item 6.1, request for a declaratory statement, advisory opinion:
"We want a clear definition of the nurse's scope of practice regarding:
Monitoring of a patient in a controlled setting receiving IV Conscious Sedation which may on occasion progress to deep sedation for a short period of time, when administered by a physician."

Discussion continued regarding the request, we are not trying to focus on drugs but a level of sedation. The request is to monitor for deep sedation, then we hear that I want to give versed for deep sedation, this is not the request.

The Chair clarified the role of the Task Force, the actual scope of practice of what the RN will be allowed to do will be a recommendation by the Practice Committee to the Board and the Board will determine the RN's scope of practice. We need to work on the question that is before us and whatever the literature supports or doesn't support in practice. C. Wren stated that she needs to know what to address. The Chair advised that if she has any information that refutes what is in the literature that it needs to be addressed by the members.

The Chair questioned if the members were finished discussing the guidelines, anyone wants to make a motion to support or not support the guidelines. The members were reminded that all materials reviewed would become a permanent part of the record. C. Ratcliffe clarified that the guidelines were presented to show that the Task Force of anesthesiologists have recognized that there has been a evolution in practice and that there are others out there other than them that are giving these medications for the intent of moderate and deep sedation. That was the sole purpose of this article.

C. Wren pointed out the following in the practice guidelines by the House of Delegates, ASA:

~ Page 11, there should be someone "to rescue patients who enter a state of deep sedation"
~ Page 8, monitoring level of consciousness, "Patients whose only response is reflex withdrawal from painful stimuli are deeply sedated, approaching a state of general anesthesia, and should be treated accordingly."
~ Page 11, *recommendation*. "However, during moderate sedation, this 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." F. Rosenthal read the first part of the recommendation; "A designated individual, other than the practitioner performing the procedure, should be present to monitor the patient throughout procedures performed with sedation/analgesia. During deep sedation, this individual should not have any other responsibilities."
~ Page 14, # 11, *recommendation*. "Even if moderate sedation is intended, patients receiving propofol or methohexital by any route should receive care consistent with that required for deep sedation." These practitioners should be qualified to rescue patients from any level of sedation including general anesthesia.
~Page 17, # 15, for deep sedation the consultants agree that the immediate availability of such an individual (postgraduate training in anesthesiology increases the likelihood of a satisfactory outcome) improves the likelihood of satisfactory sedation and that it will decrease the likelihood of adverse outcomes.

Recommendations: "Whenever possible, appropriate medical specialist should be consulted prior to administration of sedation to patients with significant

underlying conditions. The choice of specialists depends on the nature of the underlying condition and the urgency of the situation. For severely compromised or medically unstable patients (e.g., 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, practitioners who are not trained in the administration of general anesthesia should consult an anesthesiologist."

C. Brouillette reviewed the following materials:

~ Blumenreich, G. A. (2003). *Legal Briefs*. ANNA Journal.
The article cites cases where a non-anesthesia provider gives sedation (deep); the outcomes led to litigation, the nurse was found liable for what occurred. "In the anesthesiologist's expert opinion, the surgeon had violated the standard of care by not having an anesthesiologist or a nurse anesthetist administer the anesthesia." It was pointed out that this case describes a complication "air embolism". Discussion ensued regarding the fact that the anesthesiologist did not in fact give testimony because he was not in the geographical area.

~ The Administration and Monitoring of Diprivan, the PDR definition. If Diprivan is given for deep sedation, it should only be given by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/diagnostic procedure, patients should be continuously monitored. C. Ratcliffe reported that she contacted the company that manufactures Diprivan and specifically questioned them about non-anesthesia personnel administering their drug and they referred her back to the drug insert and advised that those drugs should not be given by non-anesthesia personnel. Physicians do not always follow the manufactures warnings.

~ The ASA guidelines that were previously discussed.

~The Louisiana State Board of Medical Examiners revised rules regarding office-based surgery, page 2, "*Deep sedation, monitored sedation, general anesthesia* – a drug induced loss of consciousness that results in the partial or complete loss of ability to independently maintain an airway, ventilatory, neuromuscular or cardiovascular function and during which patients are arousable, even by painful stimulation."
~ The ASA House of Delegates, levels of sedation, definitions.
~The JCAHO standards, previously reviewed, TX.2, "Sufficient numbers of qualified personnel (in addition to the licensed independent practitioner performing the procedure) are present during procedures using moderate or deep sedation and anesthesia to…" Discussion focused on the physician administering the drug and then performing the procedure versus having a second person to administer the drug while the physician performs the procedure. The intent is to have sufficient numbers of qualified personnel.
~ Baptist Health, Baptist Medical Center. A case describing what was given and the response from the Florida Board of Nursing. Hold till statements from other Boards are discussed.

Barash, P. G., Cullen, B. F., & Stoeling, R. K. (2001) *Clinical Anesthesia*, Chapter 47, Monitored Anesthesia Care, Simon C. Hillier. "The ASA specifically states that those patients whose only response is reflex withdrawal from a painful stimulus are sedated to greater degree than encompassed by the term sedation/analgesia. Significant inter-patient variability in dose response will cause some patients intended to receive sedation/analgesia to be rapidly sedated to a level much deeper than intended. Indeed, some patients may have no movement in response to painful stimulus (general anesthesia). This situation compromises patient safety and may increase morbidity and mortality."
"Monitored anesthesia care implies the potential for a deeper level of sedation than that provided by sedation/analgesia and is always administered by an anesthesiologist provider. The standards for preoperative evaluation, intraoperative monitoring, continuous presence of a member of the anesthesia care team, etc. are no different from those for general or regional anesthesia."
"Monitored anesthesia care is a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure."
Discussion regarding MAC addressed the usage of the term and "billing" implications. "Monitored anesthesia care often includes the administration of doses of which loss of normal protective reflexes or loss of consciousness is likely. Monitored anesthesia care refers to those clinical situations in which the patient remains able to protect the airway for the majority of the procedure. If, for an extended period of time, the patient is rendered unconscious and/or loses normal protective reflexes, then anesthesia care shall be considered a general anesthesia." The patient is compromised when there is no response to painful stimuli.

C. Ratcliffe cited (page 1244), Propofol, use for conscious sedation, the short half-life of the drug. "The quality of recovery and the low incidence of nausea and vomiting make propofol particularly well suited to ambulatory conscious sedation procedures. A significant body of experience with the use of propofol for conscious sedation has emerged." C. Wren restated that their concern does not deal with the efficacy of the drug. The half-life of propofol is long enough to require rescue from airway and cardiovascular alterations. "Although anesthesiologists have specific training and expertise to provide sedation and analgesia, in clinical practice these services are frequently provided by nonanesthesiologists. The specific reasons for nonanesthesiologist involvement differ from institution to institution and from case to case. Putative causes include: convenience, availability, and scheduling issues; perceived lack of anesthesiologist enthusiasm; perceived cost issues; and a perceived lack of benefit concerning patient satisfaction and safety when sedation/analgesia is provided by anesthesiologists. Despite our frequent noninvolvement in these cases, anesthesiologists can be directly involved in the care of these patients by participating in the development of institutional policies and procedures for analgesia and sedation. To assist anesthesiologists in this process, an ASA task force has developed practice guidelines for sedation and analgesia by nonanesthesiologists. Practice guidelines are recommendations that can be adopted, modified, exceeded, or rejected according to local institutional demands and resource" (p. 1251 & 1252). This documents that practice has evolved and other persons are administering sedation/analgesia. "The ASA practice

guidelines define specifically the desired level of sedation that should be achieved by nonanesthesiologist providers. The term "sedation and analgesia" is used in preference to "conscious sedation": "Sedation and analgesia describes a state that allows patients to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal command and/or tactile stimulation" (p. 1252).

C. Wren, "The practice guidelines specifically state that the patient whose only response is reflex withdrawal is sedated to a greater degree than defined by the term "sedation and analgesia." Excessive sedation may result in cardiorespiratory compromise. If cardiorespiratory compromise is not immediately diagnosed and treated appropriately, hypoxic brain damage or death may occur" (p. 1252).

For the record, the JCAHO standard TX...2.2.b. was cited regarding the practitioners who have appropriate credentials and are permitted to administer deep sedation are qualified to rescue patients from general anesthesia and manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.

Next Meeting: The Task Force is scheduled to meet on August 27, 2003, 11:00 am to 3:30 pm in conference room 601, Board's office.

Announcements/ Communications: The Chair announced that a fourth arena might come before the Task Force for consideration. The Practice Committee made a recommendation to the Board to forward the request for an opinion regarding epidurals for the laboring patient to the Task Force.

Adjournment: The meeting of the Task Force adjourned at 2:30 p.m.

Submitted: Pat Ladner, MN, RN Date: July 25, 2003

Approved: Date: