Competency Verification Record (CVR)
UVA Health
RN Procedural Sedation

Employee Name:________________________________**Employee ID #:**__________________**Date Due**:__________________

Disclaimer: Competency Verification Records (CVR) are temporarily stored in the Department's competency filing system until completion has been recorded on a permanent competency form (e.g., OCA, ACR). The CVR requires a validator's signature.

Transfer of CVR to Permanent Record: With this record of a validated competency, the preceptor, Dept. NEC, manager, or their designee locates the matching competency statement on the Annual Competency Record (ACR), Orientation Competency Assessment (OCA) Regional Competency Assessment (RCA), or Department Specific Competency (DSC) form. *(If the statement is not present, it can be written-in*.) The competency statement is then initialed and dated as complete.

Competency Statement:	**Demonstrates monitoring of patients receiving moderate/deep procedural sedation.** *(This statement should be added to the Department Specific form)*
Validator(s):	RN competent in moderate/deep sedation monitoring
Validator Documentation Instructions:	Validator documents method of validation (below) and initials each skill box once completed **and** places their full name, signature, and completion date at the end of the document.
Method of Validation: (Place any required methods for this competency in bold)	**(DO)** Direct Observation – Return demonstration or evidence of daily work. T – Test: Written or oral assessments, surveys or worksheets, passing grade on a CBL test. **S** – Simulation C – Case Study/ Scenarios: Create/share a story of a situation then ask questions that capture the nature of the competency that is being referenced. D – Discussion: Identify questions related to a competency and ask orientee to provide an example of their real-life experiences. R – Reflection: A debriefing of an actual event or a discussion of a hypothetical situation. QI – Quality Improvement Monitoring: Audits or compliance checks on actual work or documentation to ensure the competency is completed. N/A – If the specific product or process step is not used in the respective area or by the respective role, then this step is deemed N/A.
Validation Instructions:	• Sign-off of satisfactory performance (in the role of operator or monitor) of 3 procedures observed by a competency-validated operator or monitor • A manager (for monitors), or residency director or department chair (for LIP) may sign off an experienced staff or faculty member for all procedures at one time if competency was previously determined based on observed experience

Demonstrated Skill Behaviors for Competency (Critical Behaviors in Bold)	Method of Validation	#1	#2	#3
Locates current "Moderate and/or Deep Sedation by Non- Anesthesiology Providers" Medical Policy as a guide in caring for patients undergoing procedural sedation. This policy includes documentation requirements, care expectations during and after the procedure, and training specifications.				

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Demonstrated Skill Behaviors for Competency (Critical Behaviors in Bold)	Method of Validation	#1	#2	#3
Demonstrates knowledge of the Medical Center Policy and responsibility of the RN role as sedation monitor according to Moderate and /Deep Sedation by Non-Anesthesiology Providers and has completed all of the following before competency: Demonstrates competency in cardiac monitoring, in accordance with unit specific proficiency requirements • Current BLS Certification • Current ALS Certification (ACLS, PALS, NRP, ATLS) per Policy: Emergency Response Training Medical Policy (*unless anesthesiologists are present and immediately available to respond*) • Successful completion of online training module (digital course) "Procedural Sedation Moderate and/or Deep Sedation by Non-Anesthesiologist Providers: Roles and Responsibilities of Sedation Monitors, Proceduralists, and Sedation Providers "				
Preparation Pre-Procedure:				
Prepares the procedural area by ensuring all required equipment is present and ready for use <u>in the ROOM</u> where moderate procedural sedation occurs: • Oxygen delivery system • Suction • Manual ventilation bag and mask • Blood pressure monitor • Pulse oximetry • End Tidal CO2 monitoring (capnography) unless unadvisable per LIP • Cardiac Monitor and/or ability to monitor heart rate				
Prepares the procedure area by ensuring the following additional equipment is present and ready for use <u>in the AREA</u> where moderate procedural sedation occurs: • Ventilation box* • Emergency resuscitation medications* • Code care (or equivalent) and defibrillator **these items shall be in room if deep sedation is intended*				
Confirms that in a non-emergent situation, the following occurs prior to procedure according to responsible personnel: • *LIP History & Physical documented* • *LIP pre-sedation assessment documented day-of procedure* • *LIP Re-evaluation immediately prior to procedure* • *The LIP serving as "sedation provider" must order sedation and/or pain control medication—individualized to the patient based on the pre-sedation assessment, procedure, and intended level of sedation.* • RN must <u>obtain and administer</u> these ordered medications **at the location where the procedure will be performed** • RN completes the Pre-Procedure Checklist in the EHR				
Demonstrates Pre – Procedure Requirements: • Initiates and documents the Pre-procedure/Sedation Assessment in EHR • Initiates continuous cardiac monitor • Obtains and documents baseline temperature, BP, pulse, RR, LOC, oxygen saturation, and Aldrete Score • Pain level assessment that is developmentally appropriate				

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Demonstrated Skill Behaviors for Competency (Critical Behaviors in Bold)	Method of Validation	#1	#2	#3
During Procedure:				
Demonstrates how to monitor and document the patient's clinical status and response to medications as required by policy: • Pulse rate, RR, BP, oxygen saturation and LOC **every five minutes** and **additionally PRN** according to expected timing effect of medications or change in clinical status • **Assess patient pain level** using developmentally appropriate pain scale **at intervals** throughout procedure as indicated by the patient's clinical status, the expected effects of medication administered, and the procedure being performed				
Describes interventions in the event of change in vital signs, LOC, airway compromise, decrease in oxygen saturation or adverse medication reaction				
After the Procedure:				
Demonstrates how to monitor and document the patient's clinical status and response to procedure until recovery criteria are met: • Monitoring is in an area where continuous monitoring and resuscitation equipment are available • **Aldrete score** is completed at the **beginning of recovery** period and **prior to release** from post-sedation monitoring • **The duration and frequency of monitoring** ordered by the sedation provider are communicated and are based on the level of sedation, patient's medical condition, and procedure performed (Aldrete, BP, pulse rate, RR, oxygen saturation, airway protective reflexes and pain level) • **For critically ill patients**, upon transfer back to the unit, the critical care team will determine the appropriate level of monitoring required • Aldrete score is completed prior to release from post-procedural monitoring and must be within one (1) point of the pre-procedural baseline • Patients shall not be released from post procedural monitoring for thirty (30) minutes after administering the last dose of a sedative/analgesic medication OR ninety (90) minutes after the administration of an antagonist dose for sedation or narcotic medication				

Demonstrates required documentation of criteria for patient discharge is met and the discharge order is in EHR
• Patients will receive both verbal and written discharge instructions to include:
  ○ Specific post-sedation cautions
  ○ Post-procedure care instructions
  ○ Any necessary follow-up care				

Demonstrates knowledge of Outcomes Monitoring process and reports untoward outcomes including: • Apnea for >15 seconds • Unplanned tracheal intubation or positive pressure ventilation • Oxygen desaturation for > 90 seconds to < 90% O2 sat (or >8% O2 Sat drop from baseline) • Vomiting (for non-GI procedures) • Unexpected change in HR, BP, RR to 30% above or below baseline • Unplanned use of flumazenil, or naloxone (reversal agents) • Emergency anesthesia consultation after procedure begins				

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Competency Verified by:

Procedure #1
Competency Verified by:

____Date: ____________

Validator's Name (printed) *Validator's signature*

Procedure #2
Competency Verified by:

____Date: ____________

Validator's Name (printed) *Validator's signature*

Procedure # 3
Competency Verified by:

____Date: ____________

Validator's Name (printed) *Validator's signature*

References:

Patient Care Documentation (Electronic Health Record)

Moderate and/or Deep Sedation by Non-Anesthesiology Providers

Emergency Response Training Requirements

CVR Template: Created 11/10/2018; Revised; 11/21/2018; 12/29/2022; 6/8/2023
Date CVR Created: 2008
Date CVR Revised: 2011, 2019, 9/2023 Procedural Sedation Committee
Subject Matter Expert(s): Joel Anderson PhD, RN