Kaleida Health

PRIVILEGE TO ADMINISTER DEEP SEDATION and/or PROPOFOL

CRITERIA LOG

Provider Name: _____ **Medical Staff ID # _____**

Service: _____ **Date: _____**

The use of deep sedation with or without the use of propofol, is to render the patient insensible to pain and emotional distress during selected medical or surgical procedures. Deep sedation is a drug induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The patient's ability to independently maintain ventilator function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation. Cardiovascular function is usually maintained. The individual performing the procedure cannot be the individual monitoring deep sedation.

By virtue of their training, physicians who graduated from an ACGME accredited Emergency Medicine Residency program since 1997 have met the requirements for Deep Sedation Privileges.

By virtue of their training, physicians who graduated from an ACGME accredited Anesthesia Residency program have met the requirements for Deep Sedation Privileges.

Sedation Training: Must meet following criteria:

_____ Possess MODERATE (CONSCIOUS) SEDATION privilege
(The training is available at www.kaleidahealth.org/moderatesedation.)

Advanced Patient management Skills: Must meet **one** of the following criteria:

_____ Emergency Medicine Level 1 Privileges (Adult)
Emergency Medicine Level 3 Privileges (Peds)

_____ Current ACLS Certification
(Patients equal or greater than 14 years of age)

AND/OR

Neonatal Resuscitation Training or Current PALS Certification
(Patients less than 14 years of age)

Advanced Airway Management: Must meet **one** of the following criteria:

_____ Emergency Medicine Level 1 Privileges (Adult)
Emergency Medicine Level 3 Privileges (Peds)

_____ Successful completion of advanced airway management in five proctored deep sedation / anesthestitized patients by a credentialed member of the Kaleida Health Department of Anesthesia Medical Staff or a senior credentialed NICU attending.

Kaleida Health

AIRWAY ATTESTATION FORM

To: Chief of Service and Credentials Committee

From: _____

Title: _____

Date: _____

Name of Proctored Provider: _____

The above named Provider has demonstrated successful advanced airway management skills with five patients as noted below. This letter serves as attestation of meeting the standard for airway management in deep sedation procedures.

Signed,

PLUE Label or Pt.Name / Med Rec #	Proctoring Provider Signature	Airway Adjuncts Utilized
		Oral Airway/Ambu LMA Intubation
		Oral Airway/Ambu LMA Intubation
		Oral Airway/Ambu LMA Intubation
		Oral Airway/Ambu LMA Intubation
		Oral Airway/Ambu LMA Intubation