Safe sedation matters:

Why anaesthetists should care, and what you can do.

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Sedation is a walk in the park for most anaesthetists- management of unconscious or semi-conscious patients is, after all, our core business. We have good recognition and understanding of risk factors for procedural sedation (even if it's *"just a smidge of midazolam"*), we have high level airway skills, and excellent crisis management training. We know how to avoid problems, but, if they occur, we are well skilled and well trained to resuscitate.

But here's the thing- in almost every public hospital across Australia, and also in many private settings, there is a lot of procedural sedation happening, and there is often no anaesthetist in the room (and sometimes, not even in the building). In radiology departments, cardiac catheterisation labs, emergency departments, for bone marrow biopsies, for many endoscopies, dental work, taking out and putting in drains and catheters, to enable distressing or uncomfortable procedures, and any number of other procedures- a lot of patient sedation for procedures happens every day.

There aren't enough anaesthetists to be present at all of these sites, and mostly it is not the sort of work where we feel we are necessary. Most of the time, sedation happens without serious (or indeed, any) problem. This activity is often identified as "proceduralist-directed sedation" and there should be a member of staff nominated and supported to manage the patient's airway.

ANZCA's professional document PS09 describes the requirements to safely provide patient sedation in the absence of an anaesthetist, and includes guidelines covering patient assessment, monitoring, staffing, equipment, documentation, training and audit. The guidelines are available at:- http://www.anzca.edu.au/getattachment/resources/professional-documents/ps09-2014-guidelines-on-sedation-and-or-analgesia-for-diagnostic-and-interventional-medical-dental-or-surgical-procedures.pdf

PS09 is "co-badged" by a number of specialist medical colleges. However the extent of non-anaesthetist sedation administration is vast, and many doctors who practice safe sedation may be unaware of PS09, as they do not belong to one of the Colleges who have co-badged PS09. Examples include cardiologists, haematologists, and the many skilled GPs who staff some rural or regional emergency departments.

Many anaesthetists may be aware of proceduralist-directed sedation happening in their own hospitals. Sometimes this awareness comes about as a result of responding to an emergency call, or being asked to help review a critical incident. In these situations our response may be along the lines of "You did what? On who? What on earth were you thinking??". But a more effective conversation can be framed in terms of how things went wrong, and how to ensure the systems and processes of the hospital or department/unit can align with ANZCA PS09, and with safe contemporary practice.

Often the proceduralist, or the department nursing staff (who manage much of the administrative and clinical detail for these patients) won't know where to start to ensure their unit's practice is sound. Sometimes they "don't know what they don't know". Most commonly, when there has been a critical incident, hospitals, departments and individual clinicians will be very keen to explore and implement solutions.

Some recent work by the NSW Agency for Clinical Innovation established Minimum Standards for Safe Procedural Sedation (aligned with ANZCA PS09), and developed audit and implementation tools to assist procedural departments who wish to review their sedation practice. These resources are available here: https://www.aci.health.nsw.gov.au/resources/anaesthesia-perioperative-care/sedation/safe-sedation-resources

In many of the procedural units where these resources have been employed, the biggest needs identified have been (1) the development of agreed triage processes to recognise and refer high risk patients, with support to further assess manage these patients appropriately (usually from departments of anaesthesia); and (2) airways skills training and support for nursing staff who act in the role of patient airway monitor.

We all want to be proud of the work done in our own institutions. We all want to ensure safety for patients and communities. As anaesthetists, we share at least some responsibility for practice which falls within our own area of expertise. We cannot turn a blind eye to units which are struggling. Sometimes we need to initiate difficult conversations with clinical colleagues, to better support patient safety.