30 May 2023

Vanessa Hille
Policy Officer – Professional Documents
ANZCA
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Dear Vanessa,

Re: Feedback on PG09(G) Guideline on procedural sedation 2022 PILOT

About the New Zealand Society of Anaesthetists (NZSA)

The NZSA is a professional medical society which represents over 800 Anaesthetists and Specialist Pain Medicine Physicians (SPMP) in New Zealand. Our members include Specialist and Trainee Anaesthetists and SPMPs in public and private practice. Our key roles are advocacy, facilitating and promoting education, and strengthening networks of anaesthetists nationwide.

Overview

The NZSA welcomes the opportunity to provide feedback on the ANZCA PG09 Guideline on Procedural Sedation.

PG09 is a comprehensive document covering all aspects of minimal and moderate sedation. Although we were initially concerned about the removal of deep sedation, removal of this is a pragmatic approach, and leaves those performing deep sedation to work within the scope of their own college and society guidelines.

We have collated feedback received from our Executive Committee and New Zealand anaesthetists during the pilot phase.

Comments

ASA classification and staffing requirements

The body of the guideline and background paper discusses staffing levels, acknowledging the balance of keeping patients safe but not limiting access to sedation.

We are concerned that the requirement for a second doctor/sedationist or anaesthetist present for patients who are ASA 3, as indicated in Appendix III, could inhibit access to care in New Zealand.

In New Zealand, ASA 3 patients routinely undergo PSA without a dedicated sedationist. The proceduralist makes an assessment and if there are concerns will refer to anaesthesia. However, this does not include all ASA 3 patients as ASA 3 covers a wide cohort of patients, as discussed in the Background Paper. Nor do many proceduralists use ASA as a classification system. (Please also see our joint letter with EGGNZ further relating to this).

The competencies dictate that a sedationist should be able to identify when

> '*patients at high risk of adverse sedation-related events should be referred to a specialist anaesthetist'.*

But there is no reference to requiring the use of the ASA classification for this. The only reference to this staffing requirement comes in Appendix III. It is not discussed in the body of the Guideline or the Background Paper, so no nuance or variation can be inferred or considered. This was considered in the review of the document as indicated in the Background Paper with reference to 'stable ASA 3' considered to be a similar risk as ASA 2. However, the background paper specifically indicates the decision not to use this subclassification of ASA 3.

Section 7.2 states:

> *An assistant to the sedationist is required to be exclusively available at induction of, and emergence from sedation, and as required during the procedure.*

If this also included: 'This assistant may be required for the entirety of the procedure in a high-risk case', or similar, it would cover those sicker patients without requiring the use of the ASA classification.

Reference to ASA could then be removed from Appendix III, with a qualifying statement in the four-person staffing model. This would allow the asterisked comment about ASA 4 patients and cardiology to also be removed. As demonstrated in Fig 1 below.

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APPENDIX III

Recommended personnel for procedural sedation – refer Table 1 for description of requisite competencies and skills.

Scenario 1: Minimal sedation achieved solely using a single dose of oral anxiolytic or nitrous oxide/oxygen or methoxyflurane

- Proceduralist/sedationist with requisite competencies for minimal sedation
- Assistant
- For children a third person may be advisable
- ~~ASA 1-2 patients~~

Scenario 2: Minimal sedation achieved using multiple doses or multiple agents or agents administered intravenously

- Proceduralist with requisite sedation competencies
- Assisting practitioner with requisite competencies
- Assistant to both
- ~~ASA 1-2 and ASA 3~~

or

- Proceduralist
- Sedationist with requisite sedation competencies
- Assistant to both
- ~~ASA 1-2 and ASA 3~~

Scenario 3: Moderate sedation

- Proceduralist with requisite sedation competencies
- Assisting practitioner with requisite competencies
- Assistant to both
- ~~ASA 1-2*~~

or

- Sedationist with requisite competencies and skills
- Proceduralist
- Assistant to assist both
- ~~ASA 1-2 and ASA 3~~* **For example high risk patient/case**
- Anaesthetist may be the sedationist

~~*It is acknowledged that some cardiology patients requiring procedural sedation are ASA 4~~

Proceduralist/Sedationist	Proceduralist	Sedationist	Assisting practitioner	Assistant (or PS08)	Anaesthetist

Figure 1. Demonstration of the removal of ASA classification in Appendix III

Capnography

We commend the inclusion of a strong recommendation for capnography. Although this will require work to achieve, it is something we should be striving for, and this document will help facilitate this.

Audit

The document indicates the requirement for audit of practice. It may be useful to suggest topics that are regularly audited as a guide, for example, these below that are included in the Academy of Medical Royal Colleges document:

- the number of procedures performed under sedation by location and operator
- the sedation techniques and drugs used
- the monitoring used during sedation
- the occurrence of adverse events such as:
    - sustained decrease in oxygen saturation to <90%
    - hypotension (systolic blood pressure <90 mmHg in adults)
    - the use of reversal agents such as naloxone and flumazenil
    - unplanned admission to hospital
    - cardiac or respiratory arrest.

Grammatical suggestions

In section 4.1 of the Background Paper there is a minor grammatical error, some unnecessary commas:

> **4.1 Scope of the document and sedationist competencies**
>
> After the extensive second round of consultation, it was decided to narrow the scope of PG09(G) to minimal and moderate sedation but exclude deep sedation. Managing patients under general anaesthesia is complex, high-risk and requires extensive training. As deep sedation can rapidly progress to, general anaesthesia, it is unreasonable to expect any practitioner who has not completed such training to manage general anaesthesia.

Many thanks for the opportunity to provide feedback on this valuable guideline.

Ngā mihi,

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