

CH CONSCIOUS SEDATION

Summary:

It is the policy of Carondelet Health that moderate conscious sedation of patients will be undertaken with appropriate evaluation and monitoring.

Effective Date:	9/4/04
Revision History:	8/10/06, 12/22/04;10/28/04; SJHC 3/04/03
Facilities:	CH
Approved By:	President/CEO, General Counsel
Policy Impacts:	RNs, Physicians, Pharmacy; Anesthesiology

DEFINITION OF SEDATION:

1. MODERATE SEDATION/ANALGESIA (CONSCIOUS SEDATION)- A drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

2. DEEP SEDATION/ANALGESIA- A drug induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

PURPOSE:

To provide guidelines for the safe care of patients during the delivery of medications for sedation and analgesia by non-anesthetists during procedures. To provide minimum requirements for administering and monitoring conscious sedation. Department specific policies for conscious sedation guidelines may be more, but not less, restrictive. (This policy does not apply to care such as sedation in the ICU [i.e., patients on ventilators], pain control, or when agents are given with the intent to provide anxiety relief.)

PROCEDURE:

1. Only personnel who have completed the required competencies or met credentialing criteria for conscious sedation will provide care to patients receiving moderate (conscious) sedation.

2. Medication may only be administered by a physician or RN and dosing should be titrated. No drug, with the potential for producing moderate (conscious) sedation, should be administered in the absence of immediate resuscitation capability.
3. Anesthesia presence is required for deep sedation.
4. **(St. Mary's only)** Scheduling of patients ages 12 and below for GI procedures will be coordinated between the OR and the GI Lab. The procedure will be performed in the OR. The patient will be cared for pre and post op by PACU.
5. Pre-assessment of post procedure needs for patient placement or discharge is completed prior to conscious sedation. Education is initiated for any post-procedure needs identified.

PRE-PROCEDURE:

1. A recent (within last 30 days) patient history and physical evaluation must be in the medical of record prior to the procedure on all patients receiving sedation; to include, at a minimum, documentation of:
 - a. Medication history, including current medication and dosage.
 - b. Adverse or allergic drug reactions, including any anesthetics or sedatives.
 - c. Co morbid conditions, i.e., cardiac history, pulmonary history, diabetes, etc.
 - d. Time of last food and fluid intake. (The patient shall be NPO for at least four hours prior to procedure for non-urgent/non-emergent procedures.){Exception: P.O. Medication.}
 - e. Baseline vital signs (heart rate, blood pressure, respiratory rate) and O2 saturation and 3 lead telemetry tracing (If vital signs are not within normal limits, Physician will be notified immediately. If the 3 lead telemetry tracing is not within normal limits, a 12 Lead EKG will be obtained and the Physician will be notified immediately).
 - f. Assessment of level of consciousness.
 - g. Examination specific to procedure to be performed.
 - h. Examination of heart and lungs by auscultation.
 - i. Indications/symptoms of procedure requiring IV sedation.
 - j. Weight.
 - k. Assessment of patient's ability to open and close mouth and extend neck.
2. Before the procedure can begin, there must be documentation on the CH Informed Consent form identifying the use of conscious sedation (mark box #8) and demonstrating that the risks and alternatives of this type of sedation have been explained to the patient (or patient's legal representative) with the Physician's signature on the form.
3. Immediately prior to administration of sedation a reassessment of the patient is to take place and be documented.
4. Pre-procedure Aldrete or baseline to be completed .

INTRA-PROCEDURALLY:

1. Final verification of the correct patient and procedure is communicated and documented as a timeout. **Timeout consists of:** confirming right patient with two identifiers,

confirming procedure, confirming allergies, verifying completions of H&P and assessment by Physician, confirming that risks and benefits have been reviewed and CH Informed Consent Form signed by Physician and Patient before procedure begins.

2. Continuous monitoring of pulse oximetry, pulse, respiratory status, level of consciousness and EKG monitoring.
3. Documentation of vital signs (heart rate, blood pressure, respiratory rate) and O₂ saturation every **5 minutes**. (Automatic device may be used to document.)
4. Venous access (either a running infusion or saline lock) prior to sedation and maintained until discharge criteria are met.
5. Supplementary oxygen available by nasal prongs/mask/tracheal access is immediately available as well as a ventilatory device.
6. A monitoring RN or personnel whom have completed sedation competency will be with patient at all times and may not engage in tasks that would compromise continuous monitoring during the procedure.
7. Monitoring RN will monitor patient's level of comfort and act as liaison between patient and doctor.
8. The patient is continuously monitored for potential adverse reaction to the medication(s) being administered. Any signs and symptoms are promptly reported immediately to the physician and documented.
9. Maintain dignity and privacy of patient.

MEDICATIONS:

1. The patient's physician or qualified anesthesia provider selects and orders any medications utilized.
2. The physician must be present during the initial and continued administration of IV sedation or the procedure will not be started.
3. An RN may not administer medications classified as anesthetics including, but not limited to, Sodium Pentathol, Ketamine, Methohexital and Propofol except in situations outlined in department-specific policies.
4. All medications are to be titrated to the desired effect based upon individual response.
5. Clear and complete documentation must be presented in the procedure record of all drugs used, by specific name, doses and route administered, and time administered, both in increments and in total.

EMERGENCY MANAGEMENT:

1. Emergency resuscitative equipment is immediately available on site.

2. Personnel skilled in airway management are immediately available.
3. Specific antagonists (reversal agents such as Flumazenil or Naloxone) should be available at bedside. If a reversal agent is used, recovery monitoring should continue beyond the duration of the reversal agent in order to monitor for re-sedation. (At least 90 minutes after administration of reversal agent.)

POST PROCEDURE:

1. Aldrete score documented in start of recovery.
2. Vital signs with O2 saturation taken initially and recorded every 5 minutes for the first 15 minutes then checked every 5 minutes or more frequently if indicated, recording every 15 minutes unless otherwise indicated until patient reaches discharge criteria. Prior to discontinuing the post-procedure monitoring, patient's vital signs must be stable compared to baseline (pre-procedure readings).
3. Significant variations in physiologic parameters are reported to the physician immediately. These include, but are not limited to, a variation of 20% or greater in BP or pulse, serious arrhythmia, O2 saturation greater than or equal to 5% below baseline, dyspnea, apnea or hypoventilation, diaphoresis, inability to arouse the patient, the need to maintain the patient's airway mechanically and other untoward unexpected patient responses.

DISCHARGE CRITERIA:

1. Aldrete score is documented for post-recovery. Patient may be discharged when score is equal to or varies no more than one point lower than pre-procedure score.
2. RN reviews both written and verbal discharge instructions with patient and person accompanying patient at dismissal.
3. Patient is discharged with a designated driver and instructed not to drive.
4. Discharge instructions are documented.
5. If Aldrete score varies from pre-procedure score by greater than one point, physician is notified to re-evaluate patient prior to discharge/transfer.

APPROVED BY: CH Standard Policy Signatures

CH INFORMED CONSENT TO OPERATION OR OTHER MEDICAL PROCEDURES

1. I, _____, do hereby authorize Dr. _____ and/or such other physicians or assistants as may be designated and supervised by him/her to perform the following operation(s)/procedure(s):

I understand that my doctors, their assistants and anesthesia personnel are not employees or agents of this hospital.

2. The doctor has discussed with me the nature and purpose of the proposed operation(s)/procedure(s). I have also been informed of risks associated with the procedure. I have been informed of the possible or likely consequences of the procedure, as well as the chance that the procedure may not accomplish the desired objective. Feasible alternative treatments, if any, have been discussed with me.

3. I am aware that, in addition to the risks specifically described above and any potential problems related to recuperation, there are other risks such as infection, severe loss of blood, cardiac arrest, etc. that attend the performance of any surgical procedure.

4. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me regarding the results of the proposed treatment.

5. I have had sufficient opportunity to discuss my condition and treatment with my doctor and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to make an informed decision to consent to the proposed treatment.

6. I consent to the performance of operations and procedures in addition to or different from those described above that the named doctor and his/her associates may deem necessary or advisable during the course of the presently authorized procedure due to any unforeseen conditions.

7. I impose no specific limitations or prohibitions regarding treatment other than those stated here (or enter "none"):

8. This procedure may require use of intravenous or oral medications to produce **conscious sedation** by or under the direction of _____.

9. Any organs, body parts, or tissues surgically removed may be examined and retained by St. Mary's Medical Center **OR** St Joseph Medical Center for medical, scientific, or educational purposes. I consent to the disposal of these organs, body parts, and tissues by St. Mary's Medical Center **OR** St Joseph Medical Center in accordance with customary practices, except as noted here (or enter "none"): _____.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, THAT THE EXPLANATIONS REFERRED TO WERE MADE, AND THAT ALL BLANKS OR STATEMENTS WERE COMPLETED AND ANY APPLICABLE PARAGRAPHS STRICKEN BEFORE I SIGNED.

Patient Signature

Date and Time

Witness Signature

Witness Name and Status (Please Print)

TO BE COMPLETED IF PATIENT LACKS AUTHORITY OR CAPACITY TO CONSENT

_____ is unable to agree to the above described operation or Medical Procedure

(Name of Patient)

due to: _____. I am the Patient's _____ (Parent, Legal Guardian or Agent pursuant to a Durable Power of Attorney for Health Care) and am legally authorized to consent on

behalf of the patient. Accordingly, I hereby give my consent to the above described operation or Medical Procedure to be performed on the patient.

Signature

Date and Time

Witness Signature

Witness Name and Status (Please Print)

TO BE COMPLETED BY PHYSICIAN:

I, _____, have explained to the above patient the nature and purpose of the proposed treatment, the expected outcome and likelihood of success, the material risks, the alternatives, and the effect of no treatment or procedure, including the effect on the prognosis and the material risks associated with no treatment.

Physician Signature

Date and Time