Sedation and Analgesia during Procedures

<table>
<thead>
<tr>
<th>Sedation Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Calm, follows command</td>
</tr>
<tr>
<td>-1</td>
<td>Drowsy, will arouse to verbal (Moderate “Conscious” Sedation)</td>
</tr>
<tr>
<td>-2</td>
<td>Awakens to noxious stimuli only (Deep Sedation)</td>
</tr>
<tr>
<td>-3</td>
<td>Unarousable to any stimuli (General Anesthesia)</td>
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When does the Sedation Policy apply?

Policy for the Use of Sedation and Analgesia During Procedures Policy 1327

The policy pertains to patients receiving sedation and/or analgesia for the purpose of lessening anxiety and discomfort while undergoing procedures (e.g. endoscopy, colonoscopy, bronchoscopy, biopsy, chest tube, central line insertion, cardioversion, etc.). The term procedure shall pertain to diagnostic or therapeutic procedures, whether noninvasive or invasive.

Who is Excluded from the Sedation Policy?

1. Patients receiving a single dose of medication (standard out-patient dose, prior to procedure) – this is considered “Minimal Sedation/Anxiolysis”.
   - Patients respond normally to verbal commands, but ventilation and cardiovascular functions are not affected.
   - If additional medication is given (more than a single medication) during procedure, the policy is in effect.
   - Requires routine monitoring of VS and patient's response to sedation.

2. Patients (intubated or via trach) receiving mechanical ventilation in critical care areas during and after procedure.

3. Patients having surgery or other procedures under the direct care of anesthesia practitioners.
   - General anesthesia is a drug-induced loss of consciousness with inability to maintain a patent airway (e.g. ventilation required).
   - General anesthesia is administered only under the care of an anesthesia practitioner and exceeds the scope of the Sedation Policy.
   - Patient is NOT arousable even by painful stimulation correlates with -3 on Sedation Scale / Unarousable to any stimuli.
Policy for the Use of Sedation and Analgesia During Procedures:

1. Moderate Sedation (Conscious Sedation):  
   To administer moderate sedation, M.D. must be "privileged" to administer Moderate Sedation.
   - Minimally depressed level of consciousness.
   - (-1 on Sedation Scale / Drowsy, will arouse to verbal)
   - Patient is able to maintain patent airway independently, able to respond appropriately to verbal command e.g. "open your eyes", and to physical stimulation.
   - Requires Q15 minute documentation of VS (HR, BP, RR, Sp02, Level of Sedation, Pain).

2. Deep Sedation:  
   To administer deep sedation, MD must be "privileged" for administration of Deep Sedation.
   - Drug induced depression of consciousness in which patient is NOT easily aroused.
   - (-2 on Sedation Scale / Awakens to noxious stimuli only)
   - Patient may have partial or complete loss of protective reflexes & unable to maintain patent airway.
   - Requires Q5 minute monitoring and documentation of VS (HR, BP, RR, Sp02, Level of Sedation, Pain).

Note: Physician Privileges:
   - Sedation ordered & supervised ONLY by a physician privileged for administration of sedation and analgesia.
   - Physician with appropriate clinical privileges should be immediately available (refers to Attending Physicians only, not Fellows).
   - A physician in-training or nurse practitioner administering sedation MUST be under direct supervision a "privileged" physician.

** LOOK UP CLINICAL PRIVILEGES ON MEDNET HOME PAGE UNDER GENERAL RESOURCES- USE MEDNET EMAIL LOG IN & PASSWORD (can also look up resident competencies) http://www.mednet.ucla.edu/

Equipment needed for all Sedation Procedures:
Pulse Oximeter, Automated NIBP, Oxygen with Regulator, Emergency Cart, Ambu Bag, Airway, Mask, Suction with Regulator, Defibrillator, EKG Machine, and Warming Light (for infants < 5 kg).
REQUIRED DOCUMENTATION: (paper chart/electronic medical record)

**NPO Status** must be assessed, communicated to MD, and documented **PRIOR TO PROCEDURE**

The Role of the RN to keep the patient safe; continuous monitoring of the patient is necessary to prevent deeper sedation than was intended. Documentation requirements are based on level of risk to the patient.

1. In Doc Flowsheets, add the Conscious Sedation flowsheet and insert the required items for documentation.


3. Record BP, HR, RR, Level of Sedation and Pain and Pre-procedural Aldrete Score as a baseline assessment (see Conscious Sedation Drop down items).
   a. States that role of physician in obtaining **Informed Consent** (procedure consent and conscious sedation consent is required) and **completion of airway assessment**, Risk Stratification / ASA Classification pre-sedation, History & Physical appropriate to procedure.
   b. States NPO guidelines related to sedation and other required elements prior to sedation.
   c. Verify **intended level of sedation** with physician prior to procedure and Universal Protocol (time out).
   d. Obtains and documents baseline Aldrete Score Pre-Procedure

**Pre-procedure Sedation Documentation: Vital Signs and Pain Documentation**

![Image of a flowsheet showing patient observations and vital signs]
4. During the procedure, the RN remains at Bedside and records VS (HR, BP, RR & SpO2), Pain and Level of Sedation (see Sedation Scale):
   a. Every 15 minutes during the procedure for Moderate (Conscious) Sedation (-1 on Sedation Scale)
      i. Interruptible tasks allowed.
   b. Every 5 minutes during the procedure for Deep Sedation (-2 on Sedation Scale)
      i. No Interruptible tasks allowed.
   c. Continuous monitoring of Level of Sedation, Heart rate, Respiratory Rate, and SaO2 saturation is required for all types of sedation
5. Record all medications (time, route, site, and dose) as ordered BY MD for Sedation Procedure.

6. Post-Procedure and during Recovery Period, record VS (BP, HR, RR and Sp02), Pain, Sedation Level, and Post-Procedural “Aldrete Scores”:
   a. Every 15 minutes until patient is recovered (all physiologic variables must be stable for at least 30 minutes after last dose of medication and no airway support required).
   b. From recovery (obtain post procedural Aldrete score, patient Cardiovascular physiologic variables remain stable for at least 30 minutes after last dose of medication and returned to pre-procedural Aldrete score)
   c. For discharge to home (Patient awake, alert, oriented to person, place, time or has returned to pre-sedation level of consciousness)
Post-Procedural and during Recovery Period Documentation:
Record VS (BP, HR, RR and Sp02), Pain, Sedation Level, and Post-Procedural “Aldrete Scores”:

![Image showing a medical chart with patient information and vitals]
7. Record ANY adverse occurrences under “Outcomes”
   - Quality Improvement Indicators
   - Unplanned intubation
   - Reversal agent given
   - Deeper level sedation than intended; or
   - Failure to respond to physical stimuli
   - Sp02 <90; or drop of 5% from baseline for >1 nub
   - Decrease BP/HR requiring intervention
   - Admission to Higher level of care
   - Cardiac/Respiratory Arrest
