SESLHD PROCEDURE COVER SHEET

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FUNCTIONAL GROUP(S)	Cardiac and Respiratory Care
KEY TERMS	Sedation: Level 3 Procedure; Non-anaesthetist led procedural sedation, Safe sedation.
SUMMARY	This document outlines the process to follow to ensure that every episode of procedural sedation across SESLHD facilities is safely performed. This document also outlines the process for the assessment, administration, monitoring and recovery of patients receiving procedural sedation/ analgesia outside Operating Suites in the absence of an anaesthetist. Exclusions: Patients sedated by a qualified anaesthetist; Intubated patients receiving intravenous sedation/ analgesia for diagnostic or therapeutic procedures

	Paediatric patients < 16 years; It does not include sedation in Intensive Care, Emergency Department or Mental Health Settings.

Sedation: Procedural Sedation (Adults, Ward, Clinic and Imaging Areas)

SESLHDPR/528

1. POLICY STATEMENT

Within SESLHD only minimal and moderate sedation can be administered by non-anaesthetists. Deep sedation requires the involvement of anaesthetic personnel. Intravenous propofol must not be administered by the proceduralist, assistant or airway monitor.

Procedures involving the use of sedation are categorised as **Procedure Safety Checklist level 3** procedures and are required to meet the criteria set out in NSW Ministry of Health Policy Directive PD2025_006 - Clinical Procedure Safety.

This document should be read in conjunction with the following: Minimum Standards for Safe Procedural Sedation - ACI (2015), and Australian and New Zealand College of Anaesthetists (ANZCA) PG09 (G) Guideline on procedural sedation 2023.

2. BACKGROUND

This procedure outlines the minimum standards required for the safe delivery of procedural sedation outside operating theatres in the absence of an anaesthetist.

Sedation involves the use of medications that can affect brain centres controlling breathing and circulation. Safety relies on appropriate patient selection, safe medication use, and immediate access to staff skilled in life support.

The purpose of procedural sedation is to reduce consciousness sufficiently so that patients can tolerate moderately painful or uncomfortable procedures, while still responding appropriately to verbal or light tactile stimulation.

Clinicians should be aware that sedation exists on a continuum. Patients can transition from moderate sedation to deep sedation or anaesthesia more quickly than expected, and individual responses to medications are variable. This means that loss of consciousness and protective reflexes can occur suddenly *(Adapted from ANZCA PG09(G) 2023).*

Accordingly, clinicians who administer and monitor sedation must:

- understand the risks associated with sedative medicines,
- be able to recognise the different depths of sedation, and
- respond promptly and appropriately if the patient deteriorates.

3. GLOSSARY

Airway Monitor	A clinician (not the proceduralist) with competency-based training, whose sole role is to monitor the patient's level of consciousness, airway, and cardio-respiratory status throughout the procedure (NSW Health PD2025_006).

Analgesia	Relief of pain through local or systemic actions. Local agents work by blocking nerve conduction, while systemic agents act on the central nervous system to reduce pain perception. Examples include methoxyflurane and nitrous oxide (*Adapted from ANZCA PS09 2014*).
Anxiolysis (minimal sedation)	A drug-induced state in which patients respond normally to verbal commands. Cognitive function and coordination may be impaired, but airway reflexes, ventilation, and cardiovascular function remain unaffected.
Continuum of Sedation	The progressive range of sedation levels, from minimal sedation (anxiolysis) to general anaesthesia. Patients may move along this continuum unpredictably, and deeper levels of sedation can occur rapidly. Continuous monitoring and readiness to manage airway and cardiorespiratory changes are essential (*Adapted from ANZCA PG09(G) 2023*).
Levels of Sedation	**Minimal:** Patients respond normally to verbal or light tactile stimulation. Airway reflexes and spontaneous breathing are maintained, although there may be mild impairment in cognition or coordination. **Moderate:** Patients are drowsier but respond purposefully to verbal or light tactile stimulation. Airway reflexes, ventilation, and cardiovascular function are generally preserved, but some assistance may occasionally be required. **Deep:** Patients are not easily aroused and may only respond to painful stimulation. Airway maintenance, ventilation, and cardiovascular function may be impaired. Deep sedation can quickly progress to general anaesthesia. (*Adapted from ANZCA PG09(G) 2023*)
Capnography	Continuous monitoring of carbon dioxide (CO_2) in exhaled breath, providing a waveform and numerical end-tidal CO_2 value. Capnography is used to assess ventilation, detect hypoventilation or airway obstruction early, and monitor the patient's respiratory status during sedation or anaesthesia (*Adapted from ANZCA PG09(G) 2023*).
Designated Recovery Area	A staffed and equipped area suitable for the safe recovery of patients following procedures.
Proceduralist	The clinician performing the procedure. Where more than one is involved, the senior proceduralist holds overall responsibility (NSW Health PD2025_006).
A Level 3 Procedure	Requires at least one proceduralist and a team, always requires written consent, involves procedural sedation, and is generally undertaken in dedicated procedural suites such as operating theatres, endoscopy, radiology, or cardiac catheterisation laboratories (NSW Health PD2025_006).

4. RESPONSIBILITIES

4.1 Service Managers / Line Managers will ensure:

- Clinical staff have access to training and education to enable skill development to safely perform their designated clinical role
- Adequate staff numbers with the appropriate skill mix are available to fulfil the role of dedicated airway monitor
- Clinical staff, overseeing the recovery of patients post procedure, have appropriate skills in the management of patients with a decreased level of consciousness
- All necessary monitoring equipment is available and in working order
- Any sedation-related incidents are documented and reviewed at department morbidity and mortality meetings, reported in IMS+ and where required escalated to Special Committee Investigating Deaths Under Anaesthesia (SCIDUA).

4.2 The Proceduralist will ensure:

- Sedation risk assessment is performed prior to the commencement of the procedure. An assessment must be made as to whether an anaesthetist is required to assess and manage the patient. Patients with physical status American Society of Anesthesiologists (ASA) ≥3 should have an anaesthetic consult, Minimum Standards for Safe Procedural Sedation - ACI (2015) p.11 and Australian and New Zealand College of Anaesthetists (ANZCA) PG09(G) Guideline on procedural sedation 2023, Appendix II). This assessment and decision must be documented in the patient's health care record
- Airway risk assessment is performed prior to the commencement of the procedure. If this assessment indicates a significant airway risk, then an anaesthetist must be present before sedation is given. Refer to Emergency Care Institute NSW Procedural Sedation - ED Sedation Procedure patient assessment specific for airway, including Mallampati score. This assessment and decision must be documented in the patient's health care record
- Anaesthetic consultation occurs for patients with physical status ASA ≥3 including identified with a significant airway risk or who have had previous anaesthetic/ sedation airway difficulties or identified to be high risk due to severe or multiple co-morbidities
- An Airway Monitor is present throughout the procedure
- Target level of Sedation, for the intended procedure, is determined and documented prior to the start of the procedure
- Sedation-related Incidents are documented and reviewed at department morbidity and mortality meetings, reported in IMS+ and where required escalated to Special Committee Investigating Deaths Under Anaesthesia (SCIDUA). See Audit section of this document (Section 9) for suggested audit criteria.

4.3 The Airway monitor will:

- Comply with education requirements (see Section 5)
- Perform the role of dedicated airway monitor

- Monitor the patient's level of consciousness and cardiorespiratory status during the procedure
- Immediately alert the procedural team if the patient enters a deeper level of sedation than intended or if the patient's airway, respiratory or cardiovascular system becomes compromised
- Respond immediately if resuscitation is required including activating a Code Blue (ext. 2222)
- Must remain with the patient throughout the procedure.

5. EDUCATION / TRAINING REQUIREMENTS (refer to Appendix 1)

Airway Monitor:

- Advanced Life Support (ALS level1) training is the recommended minimum training for nursing or medical staff performing the role of airway monitor
- Refer to Deteriorating Patient Education Strategy, Version 4, December 2024: Mandatory deteriorating patient training by professional group (Tier 1 and Tier 2 only)
- Understand the pharmacology of sedative medications and reversal agents used (including actions, interactions, and adverse reactions)

Recovery Staff:

- Completion and proficiency in basic life support
- Have the appropriate training and skill set to detect and respond to patient instability or patient deterioration post sedation. Refer to Deteriorating Patient Education Strategy, Version 4, December 2024: Mandatory deteriorating patient training by professional group (Tier 1 and Tier 2 only)
- Understand the pharmacology of any sedative medications (including other options such as Methoxyflurane inhaler or Nitrous Oxide 50%/Oxygen 50% mix) and reversal agents used (including actions, interactions, and adverse reactions).

6. EQUIPMENT

The following equipment must be immediately available, functional, and appropriate for the patient population and clinical setting:

- **Monitoring**: Pulse oximetry with audible alarms, continuous cardiac monitoring, automated non-invasive blood pressure (NIBP) device, and a manual sphygmomanometer (to confirm accuracy or if automated monitoring fails).
- **Capnography**: End-tidal carbon dioxide monitoring is recommended for all sedated patients and is essential for high-risk patients or environments where patient observation may be limited (e.g. angiography or MRI suites).
- **Airway and breathing**:
    - A reliable source of high-pressure suction with tubing and suction tips.

- An adequate oxygen supply and appropriate delivery devices for spontaneously breathing patients.
- Equipment for assisted ventilation (e.g. self-inflating bag and mask).
- A range of airway adjuncts, including oropharyngeal, nasopharyngeal, and supraglottic devices (e.g. laryngeal mask).

- **Resuscitation**: A fully stocked emergency trolley that complies with local policy requirements.
- **Reversal agents**: Immediate access to medications that reverse benzodiazepines and opioids.
- **Emergency response**: A reliable system for summoning urgent assistance, such as a phone to activate Code Blue (ext. 2222) or an emergency buzzer.

(*Adapted from ANZCA PG09(G) 2023, p.7*)

7. PROCEDURE:

7.1 PRE-PROCEDURE: PATIENT ASSESSMENT AND RISK STRATIFICATION

7.1.1 Risk Stratification:

Prior to procedural sedation, clinicians must perform a comprehensive assessment, including a review of medical history, sedation history, and airway risk.

- Patients with an ASA physical status ≥3 should be referred for anaesthetic support.
- A documented assessment must be included in the patient's health care record. Examples of airway-focused assessments, including Mallampati scoring, can be found in the Emergency Care Institute NSW Procedural Sedation - ED Sedation Procedure

7.1.2 Key elements of assessment include:

- Past medical, surgical, and sedation history.
- Anatomical or physical factors that could affect the procedure or sedation (e.g., airway abnormalities, limited access).
- History of airway or anaesthetic complications.
- Risk factors for respiratory compromise, including obstructive sleep apnoea or reports of loud snoring.
- Chronic conditions such as cardiac, respiratory, gastrointestinal, neuromuscular, metabolic disorders, or rare syndromes.
- Patient weight and height.
- History of laryngospasm or current upper respiratory tract infection.
- Behavioural or cooperation challenges, including procedural distress.
- Neurodevelopmental conditions, including autism spectrum disorder or ADHD.
- Ability to undergo the planned procedure at the intended sedation depth.
- Special considerations for pregnant patients, such as avoiding aortocaval compression.

- Allergies.

7.1.3 Relative contraindications or barriers to intravenous sedation include:

- Communication difficulties (e.g., language barriers) that prevent effective consent or monitoring.
- Previous complications with sedation or anaesthesia.
- Known medication allergies.
- Poorly controlled medical conditions that could be optimised before sedation.
- Advanced age or frailty.
- Obstructive sleep apnoea or other conditions increasing airway risk.

(Adapted from ANZCA PG09(G) 2023, pp.8–10)

7.1.4 Consent

- Consent patient as per NSW Health Consent to Medical and Healthcare Treatment Manual.

7.1.5 Patient Preparation

- Ensure all patients undergoing elective procedures with planned sedation fast as per facility preoperative/procedure fasting CBRs
- Ensure the patient has a reliable and patent intravenous access
- Record patient's weight. **NB:** an accurate weight is essential to accurately calculate sedation dose
- For outpatients only - check that arrangements have been made to ensure the patient is accompanied home post procedure with a responsible adult (i.e. capable of summoning help in an emergency) and who will stay with the patient overnight.

7.1.6 Patient Monitoring

- Record baseline respiratory rate, oxygen saturation (on room air), blood pressure, heart rate
- Confirm the target sedation level and safe limits for vital signs has been documented.

7.1.7 Procedure Safety Checklist level 3, Stage 1

- Complete sign in, Procedure Safety Checklist Level 3, stage 1 as per NSW Health Policy Directive PD2025_006 - Clinical Procedure Safety.

7.2 INTRA PROCEDURE:

7.2.1 Procedure Safety Checklist level 3, Stage 2

Complete final patient identification and procedure verification immediately before commencing the procedure as per Procedure Safety Checklist, level 3, stage 2 as per NSW Health Policy Directive PD2025_006 - Clinical Procedure Safety.

7.2.2 Monitoring

- Confirm the target sedation level and safe limits for vital signs has been documented

- Monitoring equipment: pulse oximetry, ECG, NIBP and capnography. Ensure alarm limits are appropriately set and audible
- Once sedation has been administered, the airway monitor must maintain constant visual observation of the patient and assess level of consciousness (patient's response to verbal commands or light tactile stimulation), airway patency, respirations, oxygen saturation levels, nausea, and pain levels throughout the procedure
- Maintain verbal contact to ensure the patient is receiving adequate analgesia and is rousable
- Record vital signs at least every five minutes throughout the procedure, refer to Appendix 3.

7.2.3 Supplemental Oxygen

- Administer supplemental oxygen to maintain the patient's baseline oxygen saturations or as ordered by the proceduralist
- Continue to administer oxygen until the patient has returned to their pre-procedure state of consciousness.

7.2.4 Administration of Sedation and Reversal Agents

Clinicians must adhere to all relevant policies, procedures, and regulations regarding the storage, prescribing, and administration of sedative and analgesic medications, including Schedule 4D and Schedule 8 drugs. Refer to NSW Health Policy Directive PD2022_032 - Medication Handling for guidance. Key requirements include:

- **Dose calculation:** Determine sedative and analgesic doses based on the patient's age, weight, and clinical condition.
- **Caution with multiple medications:** When using more than one sedative or analgesic, be aware that effects may interact synergistically, increasing the risk of deeper sedation or prolonged duration.
- **Incremental dosing:** Administer medications in small, titrated doses at appropriate intervals until the desired sedation effect is achieved. This reduces the risk of cardiorespiratory complications, which are the most common adverse events during sedation.
- **Availability of reversal agents:** Naloxone (for opioids) and flumazenil (for benzodiazepines) must be immediately accessible in case of over-sedation.
- **Documentation:** Record all medications administered, including dose and timing, on the eMEDS system, the SESLHD IV Sedation Chart (SEI130.040), Anaesthetic Record, or other department-specific sedation documentation *(Adapted from ANZCA PG09(G) 2023, pp.2, 6 & 11).*

7.2.5 Escalation and Management of Deteriorating Patients

- All members of the procedural team must be familiar with the escalation plan in the event of patient deterioration.
- If a patient shows signs of clinical deterioration (see clinical triggers below), the Airway Monitor must promptly notify the proceduralist and the rest of the team. The procedure should be paused immediately, and the team must focus entirely on stabilising and monitoring the patient.
- If the team cannot manage the situation, or if the patient meets Code Blue criteria, a **Code Blue** must be activated by calling **ext. 2222**.

7.2.6 Recognition of a Deteriorating Patient

Clinicians must monitor patients continuously during sedation and be able to identify early signs of deterioration. Key indicators include:

- **Airway and breathing:** Obstruction, abnormal respiratory patterns, hypoventilation, or apnoea.
- **Aspiration risk:** Evidence of inhaled gastric contents or other airway compromise.
- **Oxygenation:** Desaturation observed clinically or via age-appropriate pulse oximetry.
- **Capnography changes:** Abnormalities in waveform where capnography is used.
- **Sedation depth:** Unexpected changes in responsiveness to verbal or light tactile stimuli.
- **Cardiovascular changes:** Alterations in heart rate, rhythm, or blood pressure.
- **Allergic reactions:** Including anaphylaxis.
- **Respiratory distress:** Complaints of chest pain or shortness of breath.
- **Behavioural changes:** Agitation or unusual restlessness.

(Adapted from ANZCA PG09(G) 2023, p.21)

7.3 POST PROCEDURE: POST PROCEDURE CARE AND DISCHARGE PLANNING

7.3.1 Procedure Safety Check list, Level 3, Stage 3

- Complete sign out, Procedure Safety Checklist level 3, stage 3 before the patient procedural team leaves the procedural area. Link to NSW Health Policy Directive PD2025_006 - Clinical Procedure Safety.

7.3.2 Designated Recovery Area

- Recover the patient in a recovery area that has the appropriate staff number and skill mix (i.e. by a RN/RM or MO appropriately trained in the management of patients with a decreased level of consciousness)
- Ensure resources are readily available to ensure the safe recovery of the patient

7.3.3 Handover to Recovery Staff

- Provide a written and verbal handover to recovery staff using ISBAR principles (Introduction/Situation/Background/Assessment/Recommendation). Refer to SESLHDPR/303 - Clinical Handover: Implementation of ISBAR Framework and Key Principles

- Include the type of procedure, name/dose of the medications administered, the patient's cardiorespiratory status during and following the procedure, any complications and post procedure instructions.

7.3.4 Monitoring Requirements

- Monitor vital signs as per post procedure instructions and/or according to the clinical condition of the patient
- Continue to monitor until the patient has fully recovered according to the following criteria:
    - Ability to maintain own airway
    - Fully conscious and alert. Sedation score should be 0 for a patient who is fully recovered, refer to Appendix 3
    - Oxygen saturations returned to baseline levels
    - Respiratory rate > 10 breaths/minute
    - Blood pressure and heart rate within 20% of baseline levels and in Between the Flags.

NB: If the patient is given a reversal agent there is a risk of rebound sedation (due to the half-life of the reversal agent being shorter than the half-life opioid or benzodiazepine medications). Additional monitoring is required for all patients who receives a reversal agent (as per the facility Naloxone or other reversal agent clinical business rule). An extended recovery period maybe required. Refer to Medicine Guideline SESLHDMG/142 - Naloxone for treatment of opioid induced over-sedation and respiratory depression

7.3.5 Additional Requirements for Outpatients

- Patient discharge from the recovery area should be authorised by the treating medical team and the patient must meet the unit's discharge criteria, refer to Appendix 4
- Outpatients must remain under observation for a minimum of two hours after the last administered dose of reversal medication to ensure that the effects of reversal agents have worn off and there is no rebound sedation prior to discharge.
- Prior to discharge patients should have voided and/or be tolerating oral fluids
- If a reversal agent was used or a clinical adverse event occurred during the procedure, the MO must be consulted prior to discharging the patient home.

7.3.6 Transfer to Higher Level Care

- If the patient remains unresponsive to voice, requires airway support or is hemodynamically unstable, the patient must be assessed to determine if transfer to higher level care is required for ongoing management
- If an unrousable or haemodynamically unstable patient requires transfer, a MO and RN/RM with appropriate advanced life support skills must escort the patient
- Continuously monitor patient's oxygen saturation and heart rate during transfer and intermittent BP monitoring via NIBP

- Ensure appropriate resuscitation equipment i.e. oxygen, suction, resuscitation bag and mask and Guedel airway adjuncts are available throughout the patient's transfer.

7.3.7 Handover to Ward/Unit

- Provide a written and verbal handover to the receiving ward/unit, using ISBAR principles, link to SESLHDPR/303 - Clinical Handover: Implementation of ISBAR Framework and Key Standard Principles
- Include the type of procedure, name/dose of medications administered and patient's cardiorespiratory status during and following the procedure. Ensure any complications and post procedure instructions are communicated to the receiving staff.

7.3.8 Post Sedation Instructions for Day Stay/Outpatients

- Patients should be advised that they may experience drowsiness or dizziness, therefore should **not** undertake the following within the next 24 hours:
    - Drive a motor vehicle or operate machinery
    - Sign legal documents
    - Consume alcohol
- Advise the patient who to contact in the event of complications
- Provide written and verbal postoperative instructions to both the patient and the accompanying adult.

8. ADVERSE EVENTS/ CRITICAL INCIDENTS REPORTING

- Report any adverse events via IMS+ and if applicable to SCIDUA
- Review at Department's Morbidity and Mortality meetings.

9. AUDIT

Clinical departments that regularly perform procedural sedation must collect data on the following indicators and conduct regular reviews of any adverse outcomes. The results of reviews should be tabled at facility Patient Safety Committees.

- Abandoned procedures
- The need for emergency assistance such as Code Blue
- Unplanned overnight admission or unplanned admission to ICU/HDU related to over sedation
- Use of reversal agents
- Adverse outcomes including death following sedation.

10. DOCUMENTATION

- SES090.002 Pre and Post Procedural Handover
- Clinical Procedural Checklist Level 3
- Consent patient as per NSW Health Consent to Medical and Healthcare Treatment Manual
- NIMC /eMEDs / SESLHD IV Sedation chart SEI130.040 or Anaesthetic Record

- Standard Adult General Observation Chart (SAGO) Between the Flag form in eMR2
- Discharge against medical advice.

11. REFERENCES

NSW Ministry of Health Policy Directives

- NSW Health Policy Directive PD2025_006 - Clinical Procedure Safety
- NSW Health Consent to Medical and Healthcare Treatment Manual (2020)

Agency for Clinical Innovation Guidelines

- Safe sedation | Agency for Clinical Innovation

Australian and New Zealand College of Anaesthetists College (ANZAC) Guidelines

- PS09-2014 Guidelines on sedation and or analgesia for diagnostic and interventional medical dental or surgical procedures
- PG07BP Guideline on pre-anaesthesia consultation and patient preparation - Background Paper 2024
- PG09(G) 2023 Guideline on procedural sedation
- PG18 Guideline on monitoring during anaesthesia 2025

NSW Emergency Care Institute

- Emergency Care Institute NSW Procedural Sedation - ED Sedation Procedure

Clinical Excellence Commission

- Deteriorating Patient Education Strategy, Version 4, December 2024

SESLHD Procedures

- SESLHDPR/697 - Management of the deteriorating ADULT inpatient (excluding maternity)
- SESLHDPR/705 - Management of the deteriorating MATERNITY woman
- SESLHDPR/303 - Clinical Handover: Implementation of ISBAR Framework and Key Standard Principles
- SESLHDGL/049 - SESLHD Post Anaesthetic Care Unit (PACU) Discharge Guidelines, Post-Operative Adult and Maternity

Other References

- The Sydney Children's Hospitals Network – Procedural Sedation /C/11:9017-01:01

12. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
June 2017	Draft	Draft for Comment
October 2017	Draft	Draft for Comment

December 2017	Draft	Processed by Executive Services prior to progression to SESLHD Drug and Quality Use of Medicine Committee
February 2018	Draft	Approved by DQUM Committee and Clinical and Quality Council
March 2019	0	Published following endorsement by DQUM and Clinical and Quality Council
February 2020	1	Executive Sponsor approved Executive Services to facilitate a minor update – specifically the removal of PACE references.
3 August 2023	2	Major review. Extensive revision and update with contributions from Gary Holland – Nurse Educator SGH, Beatrice Kidenya - Clinical Nurse Educator: Safety & Risk POWH, Director Anaesthetics POWH. Approved at SESLHD Drug and Therapeutic Committee and SESLHD Clinical and Quality Council.
21 October 2025	2.1	Minor review in lieu of review of the ACI Sedation recommendations. Links updated. Reworked narrative that removed the need for direct quotes from ANZCA, PG09 (G) 2023. Removed Table 1 and included link to Deteriorating Patient Education Strategy, Version 4, December 2024. Appendix 2 removed. Appendix 5 and Appendix 6 removed and included reference to the Emergency Care Institute NSW Procedural Sedation - ED Sedation Procedure. Approved at SESLHD Drug and Therapeutics Committee.

APPENDIX 1: Education / Training Resources

Information regarding Advanced Life Support training is provided through Prince of Wales Hospital Nursing Education, Workforce and Research (NEWR) Phone: 9382 3099. Sydney/Sydney Eye Hospital Nursing Education, Research and Leadership Unit (NERLU) Phone 9382 7403. St George Hospital and The Sutherland Hospital Staff Education (9113 2594)
Training in Intravenous Sedation is provided via Staff Education at SGH. Procedural Sedation Training HETI code CSK 13833. Target: Registered Nurses/Midwives involved in the caring for patients undergoing procedures that require sedation and monitoring/recovery of patients in such procedures. Contact: Education Service St George/Sutherland Hospitals and Health Services STG: 9113 2594 TSH: 9540 8943
POWH Procedural Sedation and Analgesia for Adult patients: Learning Pathway for nursing staff working in areas where procedural sedation is used. Contact: Nursing Education, Workforce and Research Prince of Wales Hospital 9382 3099

APPENDIX 2: University of Michigan Sedation Scale

University of Michigan Sedation Scale Conscious sedation equates to 0-2 Deeper sedation equates to 3 or more		
Levels of Sedation		**Score**
Awake and alert	Awake and alert	0
Minimally sedated	Tired/sleepy, appropriate response to verbal conversation or sound	1
Moderately sedated	Somnolent/sleeping, easily aroused with light tactile stimulation or a simple verbal command	2
Deeply sedated	Deep sleep, rousable only with significant physical stimulation	3
Unrousable	Unrousable	4

Continuum of Sedation			
Level of Sedation	**Responsiveness**	**Airway**	**Ventilation**
Minimal Sedation	Normal response to verbal commands	Unaffected	Spontaneous and adequate
Moderate Sedation	Purposeful response to verbal or light tactile stimulation	May require minimal airway support	Usually adequate; spontaneous
Deep Sedation	Responds only to painful stimuli	Airway intervention may be required	Ventilation may be inadequate
General Anaesthesia	Unresponsive to verbal or painful stimuli	Airway intervention required	Ventilation frequently inadequate without support

*Adapted from **ANZCA PG09(G) Guideline on Procedural Sedation (2023)***

APPENDIX 3: Example of Discharge Criteria

Ensure that the discharge criteria are used with clinical judgement.

Modified Post – anaesthetic discharge scoring system (PADS)	
1. Vital signs (BP, P and O2)	Vital signs (BP, P and O2) Vital signs must be stable and consistent with age and preoperative baseline. 2 = Within 20% of preoperative value 1 = 20-40% of preoperative value 0 = > 40% of preoperative value
2. Ambulation	Patient must be able to ambulate at preoperative level. 2 = Steady gait, no dizziness 1 = with assistance 0 = None, dizziness
3. Nausea/vomiting	The patient should have minimal nausea and vomiting before discharge 2 = Minimal: successfully treated with oral medication 1 = Moderate: successfully treated with IM medication 0 = Severe: continues after repeated treatment
4. Pain	The patient should have minimal or no pain before discharge; the level of pain that the patient has should be acceptable to the patient; pain should be controllable by oral analgesics and the location, type, and intensity of pain should be consistent with anticipated postoperative discomfort. 2 = Minimal 1 = Moderate 0 = severe
5. Surgical bleeding	Postoperative bleeding should be consistent with expected blood loss for the procedure. 2 = Minimal: does not require a dressing change 1 = Moderate: up to 2 dressing changes required 0 = Severe: more than 3 dressing changes required.
Each of the criteria is assessed individually and assigned a score from 0–2. The total possible score is 10. Patients must have a score of 2 for the vital signs category and a cumulative score ≥ 9 to be considered fit for discharge.	