

SESLHD PROCEDURE COVER SHEET



NAME OF DOCUMENT	Procedural Sedation (Adults, Ward, Clinic and Imaging areas)
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/528
DATE OF PUBLICATION	February 2020
RISK RATING	High
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 4 - Medication Safety; Standard 6 – Clinical Handover; Standard 9 - Recognising Responding to Clinical Deterioration in Acute Health Care
REVIEW DATE	February 2022
FORMER REFERENCE(S)	Nil
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Dr Greg Cranney Cardiac Respiratory Stream Director
AUTHOR	SESLHD Safe Sedation Working Party
POSITION RESPONSIBLE FOR THE DOCUMENT	Suzanne Schacht Cardiac Respiratory Stream Manager Suzanne.schacht@health.nsw.gov.au
KEY TERMS	Level 3 Procedure, non-anaesthetist led Procedural Sedation, safe sedation
SUMMARY	<p>This document outlines the process to follow to ensure that every episode of procedural sedation across SESLHD facilities is safely performed.</p> <p>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.</p> <p><u>Exclusions:</u> 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.</p>

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

**This Procedure is intellectual property of South Eastern Sydney Local Health District.
Procedure content cannot be duplicated.**

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. ⁴

Procedures involving the use of sedation are categorised as Level 3 procedures and are therefore required to meet the criteria set out in [NSW Ministry of Health Policy - PD2017_032 Clinical Procedure Safety](#) ²

This document should be read in conjunction with the following: Minimum Standards for Safe Procedural Sedation - Agency for Clinical Innovation (2015) ¹
<https://www.aci.health.nsw.gov.au/resources/anaesthesia-perioperative-care/sedation/safe-sedation-resources>

When medical practitioners are providing sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures, the Medical Board of Australia¹ recommends medical practitioners to follow the Australian and New Zealand College of Anaesthetists, *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures Professional Standards document PS09 (2014) –and PS18 2017 Guidelines on Monitoring during Anaesthesia*
<http://www.anzca.edu.au/resources/endorsed-guidelines>

2. BACKGROUND

The document outlines the minimum standards required for the delivery of safe procedural sedation outside operating suites in the absence of an anaesthetist.

Sedation involves the use of medications which can affect the parts of the brain which control the patient's breathing and circulation. A safe environment for sedation is underpinned by risk stratification, safe medication use and access to life support skills.

The goal of procedural sedation is to depress consciousness so the patient is able to tolerate moderately uncomfortable or painful stimuli but still respond purposefully to verbal or light tactile stimulation.

It is important for clinicians to be aware that it is possible for patients to rapidly progress along the continuum of sedation from moderate to deep sedation/anaesthesia. In addition it is not always possible to predict the effects of sedation as the patient's response will vary between individuals.

Sedating patients carries serious associated risks including airway obstruction, hypoxia, hypoventilation, apnoea and cardiopulmonary arrest ³ (PS09 2014).

Therefore clinicians who administer sedation and monitor patients during procedural sedation must:

- be aware of the risks associated with the administration of sedatives

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

SESLHDPR/528

- have the skills to monitor and recognise different levels of sedation
- be able to appropriately respond to patient deterioration.

3. GLOSSARY

Airway Monitor	A dedicated clinician (who is not the proceduralist) with appropriate competency-based training, whose primary responsibility is to monitor the patient’s level of consciousness, airway and cardio-respiratory status throughout the procedure. (PD2017_036)																									
Analgesia	An agent that reduces or eliminates the perception of pain. Analgesia can act locally by interfering with nerve conduction or systemically by depressing the pain perception in the central nervous system. (PS09 – 2014)																									
Anxiolysis	A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected. Also known as minimal sedation.																									
Continuum of Sedation	<table border="1" style="width: 100%; text-align: center;"> <tr> <td></td> <td>Minimal sedation</td> <td>Moderate sedation/analgesia</td> <td>Deep sedation/analgesia</td> <td>General anesthesia</td> </tr> <tr> <td></td> <td>↓</td> <td>↓</td> <td>↓</td> <td>↓</td> </tr> <tr> <td>Response</td> <td>Responds normally to verbal commands</td> <td>Responds purposefully to verbal commands/or light touch</td> <td>Responds to pain</td> <td>No response</td> </tr> <tr> <td>Airway</td> <td>Maintained</td> <td>Maintained</td> <td>May require support</td> <td>Requires support</td> </tr> <tr> <td>CV support</td> <td>Not needed</td> <td>Not needed</td> <td>May be needed</td> <td>May be needed</td> </tr> </table>		Minimal sedation	Moderate sedation/analgesia	Deep sedation/analgesia	General anesthesia		↓	↓	↓	↓	Response	Responds normally to verbal commands	Responds purposefully to verbal commands/or light touch	Responds to pain	No response	Airway	Maintained	Maintained	May require support	Requires support	CV support	Not needed	Not needed	May be needed	May be needed
	Minimal sedation	Moderate sedation/analgesia	Deep sedation/analgesia	General anesthesia																						
	↓	↓	↓	↓																						
Response	Responds normally to verbal commands	Responds purposefully to verbal commands/or light touch	Responds to pain	No response																						
Airway	Maintained	Maintained	May require support	Requires support																						
CV support	Not needed	Not needed	May be needed	May be needed																						
Levels of Sedation	<p>Conscious sedation: drug induced depression of consciousness where the patient is able to respond to verbal commands or light tactile stimulation. All conscious sedation techniques should provide a margin of safety that is wide enough to render loss of consciousness unlikely.</p> <p>Deep levels of sedation: depression of consciousness that can readily progress to a loss of consciousness. The patient will only respond to painful stimulation. It is associated with inability to maintain an airway, inadequate spontaneous ventilation and/or impaired cardiovascular function. It has similar risks to general anaesthesia. (PS09 – 2014)</p>																									

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

SESLHDPR/528

Designated Recovery Area	An area staffed with the appropriate skill mix and staff number equipped with resources to ensure the safe recovery of patients post procedure
Proceduralist	A clinician who is performing the procedure. There may be more than one proceduralist involved in a procedure. The senior proceduralist takes overall responsibility for the case ² (PD2017_036)
Level 3 Procedure	<ul style="list-style-type: none"> • Requires at least one proceduralist and a procedural team • Always requires written consent • Involves procedural sedation • Usually performed in formal procedural suites such as operating theatres, endoscopy suites, radiology units and cardiac catheterisation laboratories (PD2017_036)

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 Incident Information Management System (IIMS) and where required escalated to Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)².

4.2 The Proceduralist will ensure a:

- 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. This assessment and decision must be documented in the patient’s health care record (2)
- 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. This assessment and decision must be documented in the patient’s health care record (2)
- Anaesthetic Consultation occurs for patients 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

- Airway Monitor is present throughout the procedure^{1, 2}
- 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 Incident Information Management System (IIMS) and where required escalated to Special Committee Investigating Deaths Under Anaesthesia (SCIDUA). See Audit section of this document (Section 9) for audit criteria.

4.3 The Airway monitor will:

- Comply with education requirements (see Section 5)
- Perform the role of dedicated airway monitor (if an anaesthetist is not present). Monitor the patient's level of consciousness and cardiorespiratory status during the procedure^{2 3}
- 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 Blue/Cardiac arrest call (ext. 2222).
- Must remain with the patient throughout the procedure.

5. EDUCATION / TRAINING REQUIREMENTS (see Appendix 1)

Airway Monitor:

- Advanced Life Support training is the recommended minimum training for nursing or medical staff performing the role of airway monitor (SGH and TSH Level 1 ALS; local ALS course at POWH)
- Understand the pharmacology of any sedative drugs and reversal agents used (including actions, interactions and adverse reactions). Refer to Appendix for related policies and teaching packages.

Recovery Staff:

- Completion and proficiency in basic life support training
- Have the appropriate training and skill set to detect and respond to patient instability or patient deterioration post sedation
- Understand the pharmacology of any sedative drugs (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 ^{2, 3, 5}

The following monitoring and emergency equipment must be immediately available and functioning:

- Pulse oximetry (with audible patient alarms), cardiac monitor, automated BP machine and a manual sphygmomanometer (in case of machine malfunction and to confirm accuracy of NIBP)

SESLHD PROCEDURE

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

SESLHDPR/528

- End tidal carbon dioxide monitoring is recommended for all patients receiving sedation and must be available for use in high risk patients/environments (i.e. patients with severe or multiple co-morbid disease/illnesses or in situations where there is poor lighting or minimal access to patient i.e. Angiography Suites / Magnetic Resonance Imaging Units)
- A source of high pressure suction (wall or portable), yankauer suction tip and tubing
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient (ANZCA PS09 2014 p.5)
- A means of inflating the lungs with oxygen, for example a self-inflating bag and mask (ANZCA PS09 2014 p.5)
- Ready access to a range of equipment for airway management, including Guedel's, nasopharyngeal airway and laryngeal mask, ANZCA PS09 2014 p.5)
- A fully stocked emergency trolley
- Drugs for the reversal of benzodiazepines and opioids (ANZCA PS09 2014 p.5)
- A means of summoning emergency assistance such as an accessible phone to activate arrest/code blue (ext. 2222) or an emergency buzzer.

7. PROCEDURE:

7.1 Pre Procedure: Patient Assessment and Risk Stratification

Risk Stratification:

- Conduct a comprehensive medical history including, sedation risk assessment and airway risk assessment. If a significant airway risk is identified the patient must be referred for anaesthetic support²
- Clinical indicators indicating a sedation risk include (but not limited to):
 - Airway or aspiration risk
 - A prior adverse event associated with sedation or anaesthesia
 - Obstructive sleep apnoea
 - Morbid obesity
 - Patients with limited functional reserve
 - Frailty
 - Age¹

Consent

- Consent patient as per [NSW Ministry of Health Policy - PD2005 406 Consent to Medical Treatment - Patient Information](#)

Patient Preparation

- Ensure all patients undergoing elective procedures with planned sedation fast for six hours for solids and two hours for clear fluids ⁷
- Ensure the patient has IV access
- Record patient's weight. **NB:** an accurate weight is essential to accurately calculate sedation dose

SESLHD PROCEDURE

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

SESLHDPR/528

- 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.

Patient Monitoring

- Record baseline respiratory rate, oxygen saturation (on room air), blood pressure, heart rate.

Procedure Safety Checklist Stage 1 (Sign In)

- *Clinical procedure safety checklist level 3* must be conducted as per [NSW Ministry of Health Policy - PD2017_032 Clinical Procedure Safety](#) Complete Stage 1 of the Level 3 Procedure Safety Checklist (sign in).

7.2 Intra Procedure:

Procedure Safety Checklist Stage 2

- Complete Stage 2 of the Safety Checklist immediately before commencing the procedure (final patient identification and procedure verification).

Monitoring^{3, 5}

- **Confirm the target sedation level and safe limits for vital signs** has been documented
- **Attach monitoring:** pulse oximetry, ECG, NIBP and capnography. Ensure alarm limits are appropriately set and audible³
- Once sedation has been administered, **maintain constant visual observation** of the patient's 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. Check BP every two minutes³
- See Appendix 3 for the University of Michigan Sedation Scale
- 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.

Supplemental Oxygen

- Administer supplemental oxygen to maintain the patient's baseline oxygen saturations⁵ or as ordered by the proceduralist
- Continue to administer oxygen until the patient has returned to their pre-procedure state of consciousness.

Administration of Sedation and Reversal Agents

- Adhere to all relevant policies, procedures, clinical business rules, medication product information and regulations pertaining to S4D/S8 when prescribing and administering sedative agents
- Calculate sedative/analgesic dose based on the patient's age, weight and clinical condition

- Administer sedative in small incremental doses and titrate to required affect
NB: there can be a synergistic effect between the sedative, benzodiazepines (such as midazolam) and opioid (such as Fentanyl) drugs. Even small doses of these drugs may result in loss of consciousness in some patients (ANZCA PS09 2014 p.5)
- Reversal agents (such as naloxone, flumazenil) must be immediately available
- Document all drugs used, dosages and timing of administration on the eMEDS, SESLHD IV Sedation chart SEI130.040 or Anaesthetic Record.

Critical Events and Escalation

- If at any point the patient’s condition deteriorates (see examples of clinical triggers below) the Airway Monitor must escalate this immediately by advising the proceduralist and other members of the procedural team
- The procedure must be stopped. All team members should be aware of the escalation plan to follow, should the patient deteriorate. All members of the procedural team must devote their entire attention to treating and monitoring the patient until recovery³
- If the procedural team are not able to manage the clinical situation or if the patient breaches Code Blue criteria a Code Blue/cardiac arrest call must be activated (ext. 2222).

<p>NB: Clinical Triggers for Recognising a Deteriorating Patient ³</p>
<ul style="list-style-type: none"> • Obstructed or partially obstructed airway (i.e. Snoring or noisy breathing) • Respiratory rate ≤ 8 • Cardiorespiratory insufficiency (hypotension) • Loss of Consciousness/loss of patient response to light tactile stimulation or verbal commands (indicates potential loss of airway reflexes and respiratory and cardiovascular depression) • Unexpected reduction in the patient’s conscious level beyond the target sedation level • Agitation

7.3 Post Procedure: Post Procedure Care and Discharge Planning

Procedure Safety Check list (Level 3)²

- Complete Stage 3 of the Procedure Safety Checklist (sign out) before the patient /procedural team leave the procedural area.

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.

SESLHD PROCEDURE

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

SESLHDPR/528

Handover to Recovery Staff

- Provide a written and verbal handover to the receiving ward/unit, using ISBAR principles (Introduction/Situation/Background/Assessment/Recommendation)
- 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 procedural instructions.

Monitoring Requirements

- Monitor vital signs as per post procedure instructions and according to the clinical condition of the patient
 - **NB** If over sedated or 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 of the sedation). An extended recovery period plus additional monitoring is required for any patient who receives a reversal agent (as per the facility Naloxone or other reversal agent clinical business rule).
- Continue to monitor until the patient has fully recovered according to the following criteria:
 - Able to maintain own airway
 - Conscious and alert
 - Oxygen saturations have returned to baseline levels
 - Respiratory rate > 10 breaths/minute
 - Blood pressure and heart rate are within 20% of baseline levels

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 unstable patient requires transfer a MO and RN/RM must escort the patient
- Continuously monitor patient's oxygen saturation and heart rate during transfer and patient's BP via NIBP
- Ensure appropriate resuscitation equipment i.e. oxygen, suction, resuscitation bag and mask and Guedel's airway is transferred with the patient.

Handover to Ward/Unit

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

Additional Requirements for Outpatients

- Outpatients must remain under observation for a minimum of two hours after the last dose of sedative/ opioid medication and meet the unit's discharge criteria such as the

Procedural Sedation (Adults, Ward, Clinic and Imaging Areas)**SESLHDPR/528**

Modified Chung's Post Anaesthetic or the Modified Aldrete discharge criteria (see Appendix 4)^{4 5}

- 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
- Prior to discharge patients should have voided and be tolerating fluids.

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.
- Who to contact in the event of complications
- Instructions should be given verbally and in written format.

8. ADVERSE EVENTS/ CRITICAL INCIDENTS REPORTING

- Report any adverse events via IIMS and if applicable to SCIDUA
 - Link to IIMS: http://seslnweb/Clinical_Governance/Incident_Management/IIMS/default.asp
 - Link to SCIDUA: <http://www.cec.health.nsw.gov.au/incident-management/mortality-review-committees/scidua>
- Review at Department's Morbidity and Mortality meetings.

9. AUDIT

Clinical departments that regularly perform procedural sedation should 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 Committees².

- Abandoned procedures
- The need for emergency assistance such as Blue/Cardiac Arrest call
- 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-Post Procedural Handover
- Clinical Procedural Checklist Level 3
- Consent
- NIMC /eMEDs / SESLHD IV Sedation chart SE1130.040 or Anaesthetic Record
- Patient Sedation Assessment Tool (to be developed)
- SAGO or BFT in eMR2

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

SESLHDPR/528

- Discharge against medical advice

11. REFERENCES

1. *Agency for Clinical Innovation Minimum Standards for Safe Procedural Sedation Produced by: ACI Anaesthesia Perioperative Care Network*
ACI Trim Reference: ACI/D14/2115SHPN (ACI) 140149ISBN 978-1-74187-006-0
<https://www.aci.health.nsw.gov.au/resources/anaesthesia-perioperative-care/sedation/safe-sedation-resources>
2. Australian and New Zealand College of Anaesthetists *PS09 2014 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures* <http://www.anzca.edu.au/resources/endorsed-guidelines>
3. (4). Australian and New Zealand College of Anaesthetists *PS18 2017 Guidelines on Monitoring during Anaesthesia* <http://www.anzca.edu.au/resources/endorsed-guidelines>
4. (5). The Sydney Children’s Hospitals Network – Procedural Sedation /C/11:9017-01:01
5. Australian and New Zealand College of Anaesthetists *PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation* <http://www.anzca.edu.au/resources/endorsed-guidelines>

Ministry of Health (MOH) Policy Directives

[NSW Ministry of Health Policy - PD2017_032 Clinical Procedure Safety](#)
[NSW Ministry of Health Policy - PD2005_406 Consent to Medical Treatment - Patient Information](#)

Agency for Clinical Innovation Guidelines

Agency for Clinical Innovation Minimum Standards for Safe Procedural Sedation Produced by: ACI Anaesthesia Perioperative Care Network
ACI Trim Reference: ACI/D14/2115SHPN (ACI) 140149ISBN 978-1-74187-006-0
<https://www.aci.health.nsw.gov.au/resources/anaesthesia-perioperative-care/sedation/safe-sedation-resources>

College Guidelines - Australian and New Zealand College of Anaesthetists

PS07 Guidelines on Pre-Anaesthesia Consultation and Patient Preparation
<http://www.anzca.edu.au/resources/endorsed-guidelines>

PS09 2014 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures <http://www.anzca.edu.au/resources/endorsed-guidelines>

PS15 guidelines for the Perioperative Care of Patients Selected for Day Stay Procedures

SESLHD PROCEDURE

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

SESLHDPR/528

<http://www.anzca.edu.au/resources/endorsed-guidelines>

PS18 2017 Guidelines on Monitoring during Anaesthesia <http://www.anzca.edu.au/resources/endorsed-guidelines>

LHD Procedures/ Clinical Business Rules

[SESLHDPR/283 Deteriorating Patients - Clinical Emergency Response System for the Management of Adult and Maternity Inpatients](#)

[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](#)

St George/Sutherland Hospitals Intravenous Sedation Clinical Business Rule SGSHHS CLIN08 http://seslnweb/SGSHHS/Business_Rules/Clinical/default.asp

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

12. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
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.

SESLHD PROCEDURE

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

SESLHDPR/528

APPENDIX 1.

Education / Training Resources

Information regarding Advanced Life Support training is provided through Prince of Wales Hospital and Sydney/Sydney Eye Hospital Nursing Education and Research Unit (NERU)

St George Hospital and The Sutherland Hospital Staff Education (9113 2594)

Training in Intravenous Sedation in SESLHD is provided via Staff Education at SGH. 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: Staff Education SGH / 9113 2594

Contact Name: Garry Holland / 9113 2174

APPENDIX 2.

Physical Assessment Checklist

Physical Assessment Checklist	
	<ul style="list-style-type: none"> • Height and weight (to facilitate calculation of Body Mass Index) • Vital signs • Baseline oxygen saturation • Airway assessment/evaluation (in case there is a need for bag/ mask ventilation) e.g. checking condition of teeth, range of neck motion, ability to open mouth, Mallampati score, Sleep apnoea risk- i.e. Berlin score • Chest and cardiac status • General neurological status (e.g. assessing mental status, presence of stroke deficits) • Physical status - Physical Status Assessment (PSA)

Assessment of Physical Status

American Society of Anaesthesiologists Classification of Physical Status (PS09)	
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life
P 5	A moribund patient who is not expected to survive without the operation

SESLHD PROCEDURE

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

SESLHDPR/528

APPENDIX 3.

Sedation Scale (University of Michigan)		
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

SESLHD PROCEDURE

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

SESLHDPR/528

APPENDIX 4.

Examples of Discharge Criteria

Modified Chung's Post Anaesthetic Scoring System⁵ (Adapted from St George Hospital Day Surgery/ Endoscopy Unit) A total score of less than 5 is required for the patient to be discharged home following a procedure involving IV sedation				
Mental Status Activity 0= Orientated, steady gait, no dizziness or as pre-procedural 1= Orientated, ambulating with assistance 2= Dizziness, unable to walk	BP/ Heart rate 0= Within 20% of pre-procedural value 1=20%-40% of pre-procedural value 2=40% difference from pre-procedural value	Pain & Nausea 0= No pain/ nausea 1= Mild pain or nausea 2= Moderate pain/ nausea	Bleeding 0= Nil 1= Minimal 2= Moderate	Intake & Output 0= Has had oral fluids and voided 1= Has had oral fluids or voided 2= Has not had oral fluids and has not voided
Tally Score:				Total

Modified Aldrete Discharge Criteria (Adapted from SESLHD Post Anaesthetic Care Discharge Guidelines SESLHDGL/049) The patient can be discharge when the score total 8 or above, however the patient must NOT score a 0 in any one category. If the discharge score is below 8, the patient can be discharged with medical review and signature.				
Airway / Score	Breathing / Score	Consciousness / Score	Pain / Score	Nausea / Score
Patent = 2	Good = 2	Fully Awake = 2	Comfortable = 2	Nil = 2
Supported = 1	Obstructed/ = 1 Inadequate	Rousable = 1	Moderate = 1	Nausea = 1 (mild/moderate)
Artificial = 0	Fully/Awake = 0	Unrousable = 0	Severe = 0	Vomiting = 0
Tally Score:				Total