Cooperative Wide Nursing Procedure

Number: 22 (Also HS-408.3)

Equipment

Procedure

Discontinuation of Post-Procedure Observation

Discharge to a Nursing Unit

Discharge to Home

Documentation Requirements

Quality Monitoring

Quality Monitoring: Tracking and Reporting - Conscious Sedation

Note: The following procedure is for Moderate sedation. Items specific only to deep sedation are in red and italics.

New in this Update:

- Aldrete Scoring Update

I. EQUIPMENT

All areas in which conscious sedation is performed will have the following equipment immediately available:

A. Oxygen delivery system with age-appropriate breathing/ventilation devices, e.g., airways, bags, and masks.
B. Source of suction (portable or wall mounted), with age appropriate suction catheters.
C. Emergency crash cart.
D. Pulse oximeter (audible and digital).
E. Non-invasive blood pressure monitor.
F. ECG monitor (as needed) (Note: Required for Deep Sedation.)
G. Appropriate medications, including reversal agents. See Adult and Adolescent Drug Chart for triggering conscious sedation policy in adults.

Note: All equipment will be checked and documented for appropriate functioning prior to use where conscious sedation is performed. Equipment will be stocked, inventoried and maintained in accordance with organizational policy.

II. PROCEDURE
A. Pre-procedure: All patients receiving conscious sedation will have the following documented in their charts:

1. Informed consent, both for the procedure and for conscious sedation, is documented in the medical record according to GHC policy, and includes the following: potential benefits and drawbacks, potential problems related to recuperation, the likelihood of success, the possible result of non-treatment, and significant alternatives.

2. History and Physical (H & P): An age-appropriate physical assessment completed. For a patient scheduled for a procedure, the history and physical may be obtained in advance of the procedure, but must be performed and documented within 30 days prior to the date of the procedure. The history and physical must be updated within 7 days prior to the procedure. This update is required regardless of change or no change in the patient's status. The signed and dated update note is called the "interval note." Although an H&P examination is completed and recorded in the patient's medical record, the patient is re-evaluated immediately before the procedure and sedation is initiated. The practitioner directly determines that the patient is a candidate for the planned sedation and documents this in the medical record.

3. The H&P will include all of the following:
   a. Age and weight
   b. Allergies and previous adverse drug reactions
   c. Current medications
   d. Relevant diseases and anomalies
   e. Prior relevant hospitalizations
   f. History of sedation or general anesthesia and any complications
   g. History of tobacco, alcohol, or substance use or abuse
   h. Relevant family history
   i. NPO status for planned procedures

   Adults: No solids for 8 hours prior to procedure. May have clear liquids up until 2 hours prior to procedure.

   Children < 13 years: No solids for 8 hours prior to procedure. No non-human formula for 6 hours prior to procedure. No breast milk for 4 hours prior to procedure. May have clear liquids up until 2 hours prior to procedure.

   In urgent or emergency situations, an individual determination will be made of risk/benefits of procedural timing, intake of food, and degree of sedation/analgesia to be achieved.

   j. Pregnancy status
   k. Deep Sedation: Level of consciousness - refer to Aldrete Scoring
l. Physical exam pertinent to procedure and underlying health status. *Deep Sedation: to include examination of the heart, lungs, and airway.*
m. ASA physical status classification (see Table I)

<table>
<thead>
<tr>
<th>ASA class</th>
<th>Description</th>
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<tbody>
<tr>
<td>I</td>
<td>No organic disease</td>
</tr>
<tr>
<td>II</td>
<td>Mild or moderate systemic disease without functional impairment, age &gt; 70</td>
</tr>
<tr>
<td>III</td>
<td>Organic disease with definite functional impairment</td>
</tr>
<tr>
<td>IV</td>
<td>Severe disease that is life-threatening</td>
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<tr>
<td>V</td>
<td>Moribund patient, not expected to survive</td>
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4. Pre-procedure diagnosis.
5. *Deep Sedation: Sedation plan and evidence of its discussion with the patient/family.*
6. All patients receiving IV sedation will have established intravenous access (with administration of IV fluids per physician's order). It is recommended that physician's consider establishing IV access in pediatric patients receiving drugs by other routes.
   a. A privileged provider will select, order, and sign the written order for the medication to produce conscious sedation.
   b. Baseline BP, pulse and respiratory rates, O2 saturation (on room air unless the patient arrives with O2), level of consciousness (LOC), and Aldrete score (below) will be documented on a Moderate Sedation Flowsheet following the Moderate Sedation Flowsheet Guideline.

<table>
<thead>
<tr>
<th>Aldrete Scoring</th>
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<tbody>
<tr>
<td>Points</td>
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<tr>
<td>--------</td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>1</td>
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</tbody>
</table>
B. Intra-Procedure: The monitoring assistant (*Deep sedation: Registered Nurse Monitoring Assistant*) will document the name, route, site, time of administration, dosage, and effect of all drugs administered.

The following continual quantitative monitoring will be performed and documented in the Medical Record. Individual departments may use department-specific flowsheets provided all required elements are included and documented:

1. Continuous pulse oximetry with both digital and auditory displays.
2. Pulse, respirations, BP, oxygen saturation (on room air unless patient arrives with O2) documented at 5 minutes after administration of every dose of medication, and then at least every 15 minutes and as needed.
3. Level of consciousness will be documented at least every 15 minutes and as needed.
4. Heart rate and rhythm monitoring for patients with suspected or documented cardiovascular disease through use of ECG monitor.
5. Pediatric patients - BP monitoring as needed.

**Note:** O2 supplementation should be considered when the O2 saturation level is 92% or less.

C. Post Procedure: After the procedure, the patient is assessed according to the Aldrete scoring criteria.

1. If the assessment score is less than the pre-procedural status or 10, the patient requires continuous observation following completion of the procedure, with vital signs recorded at least every 15 minutes.
2. Monitoring is continued until the Aldrete assessment score is 10 or reaches pre-procedural status, at which time the patient may be discharged from the procedure or post procedure area.
3. Pediatric patients - only final scoring interval requires BP documentation.

III. **DISCONTINUATION OF POST-PROCEDURE OBSERVATION**
A. The privileged provider is responsible for the decision to discontinue conscious or deep sedation monitoring. When he or she is not present (a) the name of the responsible practitioner must be recorded, and (b) the discharge criteria described in V.C.2 will remain the standard criteria for releasing patients who have undergone conscious sedation. 

*Deep Sedation: The discharge criteria (Aldrete assessment score is 10 or reaches pre-procedural status) will remain the standard criteria for releasing patients who have undergone deep sedation.*

B. In the absence of the privileged provider, the monitoring assistant (*Deep sedation: Registered Nurse Monitoring Assistant*) will utilize these criteria to assess the patient's readiness for discontinuation of post-procedure observation.

C. If these criteria are not met, privileged provider will assess and determine course of action.

D. In the event that the patient does not meet the criteria for discontinuation of post-procedure observation, follow-up monitoring should occur on a designated unit (one with trained staff and designated to provide recovery services).

IV. **DISCHARGE TO A NURSING UNIT**

A. Prior to transporting the patient to the nursing unit, Monitoring Technician (*Deep Sedation: Registered Nurse Monitoring Assistant*) will give a verbal report to a Registered Nurse in the receiving nursing unit.

B. If the patient has not met the Conscious or Deep Sedation Discharge Criteria, the patient shall be accompanied to the receiving unit by the Monitoring Assistant (*Deep Sedation: Registered Nurse Monitoring Assistant*) or the Privileged Provider with the following equipment:

1. Pulse oximeter
2. Oxygen tank, face mask, and self-inflating bag for ventilation
3. Emergency drug supplies
4. Oral airways
5. Suction equipment

V. **DISCHARGE TO HOME**

A. Each patient will be assessed for home readiness using the following criteria:

1. Patient is alert and oriented (or has returned to pre-procedure baseline level of consciousness).
2. Vital signs are stable.
3. Breathing is uncompromised (no stridor, retractions, or croup) and the patient can demonstrate adequate cough.
4. Patient has demonstrated ability to swallow (or has demonstrated gag reflex). Drinking liquids or eating food is not required for non-diabetic patients, who may electively choose to drink liquids if they desire.
5. Vomiting is controlled and nausea minimal.
6. The patient is able to ambulate consistent with preoperative status without excessive dizziness or staggering. Children are able to sit up unaided if age appropriate.
7. There is no significant oozing or bleeding from the procedure site, if applicable.
8. Circulation is not impaired, swelling is minimal, and sensation is present in the extremity where the procedure was performed, especially if casted.
9. Pain is under control.
10. IV or saline lock discontinued prior to discharge unless ordered otherwise by attending physician.
11. Responsible adult is present to assist the patient home.
12. The adult patient, and as appropriate, the accompanying responsible adult have received verbal and written discharge instructions, including: side effects, duration of sedation, diet, activity, pain relief, follow-up care, emergency contact information, technical skills for self care and awareness of potential complications to watch for and report.
13. Discharge instructions specify that the patient is not to: drive an automobile, participate in activities that need normal reflexes and coordination, or sign legal documents until the next day.
14. For children, parent/legally authorized persons are advised not to permit their child to drive, ride a bicycle, or use machinery until the next day. Play should be supervised for at least 12 hours.
15. Instructions will include and may not be limited to the following: diet, medications, activity, signs/symptoms of complications and courses of actions to take if any complication develops.

B. Patients can be discharged by the monitoring assistant or privileged provider when the above criteria are met.

VI. DOCUMENTATION REQUIREMENTS

Document on a Moderate Sedation Flowsheet following the Moderate Sedation Flowsheet Guideline. Documentation in the medical record will include both handwritten and electronically recorded documentation as follows:

A. Informed consent
B. Sedation plan and evidence of its discussion with the patient/family
C. Beginning and end time of procedure
D. Name, dose, route, time of all drugs given
E. Prior adverse drug reaction (including allergies)
F. Pre-medication, time and effect
G. All monitoring parameters listed in Section V.
H. Oxygen delivered: L/M via mask or nasal
I. Patient response to all drugs given
J. Any adverse drug reactions or untoward/significant responses, to include, but not limited to:

**Unexpected Events**

- Unplanned Admission
- Unplanned Transfer to CCU
- Use of Reversal Agents
- Hypotension Which Required Treatment
- Combativeness/Agitation
- Uncontrolled Pain or Restlessness
- Unarousable/Not Responsive to Verbal Commands
- Respiratory Compromise with O2 SAT <90% with O2
- Airway Obstruction
- Intubation
- Respiratory Arrest
- Cardiac Arrhythmias Which Required Treatment
- Cardiac Arrest
- Unexpected Death

K. Patient's baseline status will be considered when determining whether an unexpected event has occurred.

L. Deep Sedation: Discharge documentation will include documentation about discharge status and instructions and will note that all the patient's questions were answered.

VII. QUALITY MONITORING

The intent of quality monitoring of Moderate sedation is to collect, aggregate, and analyze relevant, useful, and important data. The analysis of this data results in a determination of how well Group Health Cooperative selects, prepares patients for, performs, monitors patients during, care for patients after, and educates patients and their families about conscious sedation. The following indicators will be monitored:

1. Volume, location of service, and nature of use: Number of patients, age breakdown by service, site of service, procedure-specific, unexpected events (see above), name of privileged provider, name of monitoring assistant.

2. Clinical indicators: A variety of selection, preparation, care and discharge indicators such as: completion of history and physical, evidence of informed consent for conscious sedation, documentation of baseline vital signs documented prior to procedure start, documentation of vital signs 5 minutes after med administration, and evidence of reaching pre-procedural status.

3. Practitioner-specific data: frequency of procedures by age, frequency and type of unexpected events.

The Monitoring Assistant or Department/Practice Team Manager is responsible for assuring documentation is completed on the Moderate Sedation Monitoring Log for all conscious or deep sedation procedures. The log is kept at the site where conscious sedation is performed.

For all cases where an unexpected event occurs, the Clinical Service Chief/Service Line Chief or their designee complete the Conscious/Deep Sedation Physician Case Review Form.
VIII. QUALITY MONITORING: TRACKING AND REPORTING - Conscious Sedation Only

The Department Manager/Practice Team Manager is responsible for completing a quarterly summary/report on conscious sedation including the indicators listed above in A and B and relevant recommendations, actions taken, and further evaluation/follow-up needed.

Department specific quarterly summaries/reports will be combined to analyze patterns, trends, and areas for improvement. This aggregated data will be presented to the appropriate quality committee/council.

Provider specific data about frequency of conscious sedation procedures by age, frequency and type of unexpected events will be collected. This data will be aggregated and presented to the appropriate clinical service committee/department and the appropriate quality committee/council.

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