Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Conscious Sedation		Nursing Practice	07-020-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		8
APPLIES TO:			
Community Health Nurses			

Conscious sedation is to be performed for those clients who must undergo painful or difficult procedures where cooperation and/or comfort will be difficult or impossible without pharmacologic support.

POLICY:

Only physicians have the authority to administer pharmacologic agents to achieve desired levels of sedation. The physician must be qualified to rescue clients from deep sedation, and must be competent to manage a compromised airway and provide adequate oxygenation and ventilation.

The physician performing the conscious sedation is responsible for reviewing the risks, options and benefits of the selected pharmacologic agents with the client, parent and/or guardian; and documenting the client, parent or guardian's informed consent in the health record.

The registered nurse may be given the responsibility of administration and maintenance of conscious sedation in the presence of and on the order of a physician. The nurse is responsible for verifying that informed consent has been obtained before initiating the procedure for sedation. The nurse will be trained in basic EKG and current BCLS certification. Emergency resuscitation equipment will be readily available.

DEFINITIONS:

Conscious Sedation provides a minimally reduced level of consciousness in which the client retains the ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

PRINCIPLES:

- The Registered Nurse must have education, knowledge of medications used and skills to assess, diagnose and intervene in the event of complications. The nurse functions within the limitation of facility policies and scope of practice.

- The nurse is responsible for continuously monitoring the client with assessment findings being documented every five (5) minutes for the first 15 minutes then every fifteen (15) until the procedure is completed.

- Monitoring includes:
  1. Physical assessment
  2. Blood pressure
  3. Heart rate
  4. Respirations (frequency and volume)
  5. Oxygen saturation
  6. Cardiac monitoring
  7. Skin color
  8. Level of consciousness (sedation scale)

- A second Registered Nurse may be required to assist during complex technical procedures or in procedures that are complicated due to the severity of the client's illness.

- The Physician will screen the risk factors for each client by utilizing the American Society of Anesthesiology (ASA) Physical Status Classification (see reference sheet 07-020-02) Clients considered appropriate for moderate and deep sedation in the community health centre are ASA Class I and Class II. Clients who fall into ASA Class III or Class IV present special problems which necessitate a consultation by an anesthesiologist.

- Common agents like midazolam and fentanyl cause dose-related suppression of airway protective reflexes and ventilatory drive; therefore may provoke airway compromise, hypoventilation and hypotension. Clinicians employing these agents should be comfortable with airway management and familiar with the pertinent reversal agents, flumazenil and naloxone.
- In the low doses, ketamine induces dissociative sedation, where airway protective reflexes are preserved, ventilatory response to carbon dioxide is maintained, respirations are generally adequate and the eyes often remain open. Ketamine can, cause adverse effects, including hypersalivation, laryngospasm and apnoea.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guidelines 07-020-01	Conscious Sedation Guidelines
Reference Sheet 07-020-02	Sedation – Physical Status Classification
Template 07-020-03	Conscious Sedation Record

REFERENCES:

Canadian Society of Gastroenterology Nurses and Associates (n.d.). *Conscious Sedation: Responsibilities of the Registered Nurse Related to Conscious Sedation*.

The Child Health Network for the Greater Toronto Area (2002). *Practice Guideline: Management of Children Receiving Conscious or Deep Sedation.*

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

GUIDELINES 07-020-01

Conscious Sedation Guidelines

1. The physician assesses the risk factors for each client using the American Society of Anesthesiology (ASA) Physical Status Classification (see reference sheet 07-020-02) Clients considered appropriate for moderate and deep sedation in the community health centre are ASA Class I and Class II.

2. The attending physician explains to the client and caregiver(s) the need for the procedure, the effects of medications being used, and the associated risks. Verbal consent is obtained.

3. The client is placed on NPO status. The registered nurse documents a pre-sedation assessment on the *Conscious Sedation Record* (Template07-020-03)

   Physical and baseline assessment parameters include, but are not limited to:

   - Level of consciousness
   - Anxiety level
   - Vital signs, including temperature
   - Skin color and condition
   - Sensory defects
   - Current medications and allergies
   - Relevant medical surgical history
   - Client perceptions regarding procedure and moderate sedation

4. The client is connected to an ECG monitor, oxygen saturation monitor and automated blood pressure monitor. Oxygen is applied by mask or nasal cannula.

5. The resuscitation cart is brought to the bedside. Oral airway, bag-valve-mask, suction, and reversal drugs are made immediately available.

6. IV access is established. Fluid type and rate is determined by the physician.

7. Medications are administered. The choice of agent and route of administration is at the discretion of the attending physician.

8. Vital signs are recorded every five (5) minutes for the first 15 minutes then are performed every fifteen (15) minutes until the client meets the discharge criteria. One-to-one nursing care is maintained during the monitoring period.

9. Untoward reactions or sudden/significant changes in monitoring parameters should be immediately reported to the physician.

Conscious Sedation Guidelines (cont'd)

10. Post procedure, the client should be place in the recovery position until fully awake.

11. Clients should continue to be monitored for a minimum of one (1) hour post procedure with vital signs recorded every 15-30 minutes. Readiness for discharge is assessed according to the discharge criteria key (see *Conscious Sedation Record*). Clients must achieve a score of 7 prior to discharge.

12. The entire procedure is documented on the *Conscious Sedation Record*.

13. Written and verbal after-care instructions are given to the client's caregiver prior to discharge and documented in the client's health record.

EQUIPMENT

- Oxygen and nasal cannula
- Suction
- Emergency crash cart with defibrillator
- Cardiac monitor
- Pulse oximeter
- Blood pressure monitor

EMERGENCY INTERVENTIONS

Initiate emergency interventions when the following client conditions are identified:

1. **Decreased Oxygen Saturation** < 94% (or based on individual baseline oxygen saturation) with minimal respiratory distress that does not return to baseline
   - Look, listen and feel
   - Assess colour and chest wall movement
   - Check for proper placement of oxygen saturation probe
   - Check airway patency and reposition (airway/jaw holding) if necessary
   - Apply oxygen by facemask at 100 %, and notify M.D.

2. **Dyspnea or Cyanosis**
   - Determine patency of airway and reposition, suction if necessary
   - Apply oxygen per mask or ambu-bag at highest concentration (e.g., 100%)
   - Notify M.D.
   - Call additional nursing or medical staff for assistance if condition does not improve

3. **Inability to Maintain Patient Airway Related to Copious Secretions**
   - Suction patient
   - Oral airway
   - Notify physician

4. **Laryngospasm**
   - Determine airway patency
   - Reposition, head tilt/chin lift, jaw thrust
   - Apply oxygen per mask at 100% when airway patent
   - Provide artificial ventilation with a bag and mask if necessary
   - Call physician and additional nursing staff STAT, anticipate intubation

5. **Respiratory Depression**
   - Reposition airway, head tilt/chin lift, jaw thrust
   - Ventilate with ambu-bag using 100% oxygen
   - If no response, call additional nursing and medical staff and initiate advanced life support measures
   - Anticipate use of reversal agent

6. **Symptomatic Bradycardia**
   - Ensure patent airway
   - Ventilate with ambu-bag with 100% oxygen
   - If not corrected or leads to asystole, initiate CPR and advanced life support measures

7. **Excessive Sedation**
   - Inability to rouse easily
   - Support airway by jaw holding and bagging if no air exchange
   - Notify physician STAT

8. **Persistent Agitation**
   - Paradoxical response
   - If client is agitated remain at bedside and constantly assess airway and level of consciousness, protect client from injury
   - Notify physician (e.g., possibility of using a reversal agent)

REFERENCES:

Canadian Society of Gastroenterology Nurses and Associates (n.d.). *Conscious Sedation: Responsibilities of the Registered Nurse Related to Conscious Sedation*.

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Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

REFERENCE SHEET 07-020-02

The Physician will screen the risk factors for each client by utilizing the American Society of Anesthesiology (ASA) Physical Status Classification. Clients considered appropriate for moderate and deep sedation in the community health centre are ASA Class I and Class II. Clients who fall into ASA Class III or Class IV present special problems which necessitate a consultation by a member of the Anesthesia Department.

ASA PHYSICAL STATUS CLASSIFICATION:

Class I	No organic, physiologic, biochemical or psychiatric disturbance. Normal, healthy client.
Class II	Mild systemic disturbance; may or may not be related to reason for surgery. (Examples: controlled hypertension, controlled diabetes mellitus)
Class III	Severe systemic disturbance, but not incapacitating. (Examples: heart disease, poorly controlled hypertension)
Class IV	Life threatening systemic disturbance. (Examples: congestive heart failure, persistent angina pectoris)
Class V	Moribund client. Little chance for survival. (Examples: uncontrolled bleeding, ruptured abdominal aortic aneurysm)
Class E	Client requires emergency procedure. (Examples: appendectomy, D&C for uncontrolled bleeding)

REFERENCES:

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Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

TEMPLATE 07-020-03

When conscious sedation procedure is to be performed in the community health centre, the *Conscious Sedation Record* shall be used to document the event. Once the form is completed, the form shall be filed in the client's health record.

Adopted from:

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

CONSCIOUS SEDATION RECORD

GUIDELINES: (Initials)

1. _____ Client is NPO
2. _____ Client weight is obtained
3. _____ Baseline TPR and BP done
4. _____ Baseline oxygen saturation done
5. _____ Oral airway, bagging unit, oxygen, suction, pulse oximeter done
6. _____ Crash cart with cardiac monitor is readily available
7. _____ Vital signs post procedure:
   Q 5 minutes for 15 minutes
   Q 15 minutes for 45 minutes or until meets discharge criteria
8. _____ Discharge criteria are met prior to criteria

Procedure: _____

Time Begin:_____ Time End:_____

PRE-SEDATION ASSESSMENT

Airway	Breathing	Colour	Skin	Vital Signs	Oxygen Rate	IV access
□ Own □ Mask □ _____	□ Nasal □ Normal □ Shallow □ Rapid □ Laboured	□ Normal □ Pale □ _____	□ Moist □ Warm □ Dry □ Cool	BP_____ HR_____ RR_____ O2 Sat_____ T _____	□ N/A □ Cannula □ Mask □ _____ Flow:_____ Time started:_____ Discontinued:_____	□ N/A □ Saline Lock □ Peripheral IV Site_____ Solution_____ Time started:_____ Discontinued:_____

VITAL SIGNS: DURING AND POST PROCEDURE

Time									
BP									
HR									
RR									
O2 Sat									

MEDICATION

TIME	Medication	Dose	Route	Initials

DISCHARGE CRITERIA

Activity								
Breathing								
Circulation								
Consciousness								
Total Scores								

COMMENTS: (Document pre-procedure information given to client/parent)

DISCHARGE CRITERIA KEY

1. **ACTIVITY**
   0 = Unable to lift head or move extremities Voluntarily or on command
   1 = Lifts head spontaneously & moves extremities voluntarily or on command
2. BREATHING
   0 = Apneic
   1 = Dyspnea or shallow, irregular breathing
   2 = Able to breathe deeply and cough on command
3. CIRCULATION
   0 = Systolic BP < 80mmHg
   1 = Systolic BP > 100mmHg
   2 = Systolic BP within normal limits for client
4. CONSCIOUSNESS
   0 = Not responding, or responding only to painful stimuli
   1 = Responds to Verbal stimuli but falls asleep readily

	2 = Awake, alert and oriented to time, person, place (child to name, parent) **TOTAL SCORE PRIOR TO DISCHARGE MUST BE SEVEN**
Verbal/written discharge instructions given to: □Client □ Parent/guardian □ Other Initials:	Signature:_____ Initials:_____ Signature:_____ Initials:_____