Yukon-Kuskokwim HEALTH CORPORATION

Nursing Flowsheet for Procedural Sedation and Analgesia Outside the OR

PROCEDURE MONITORING

HR, RR, SpO_2, LOC (level of consciousness), and Modified Aldrete Score to be monitored and recorded Q5 minutes until fifteen minutes after last administration of sedating medication, then Q15 minutes x1 hour, then Q1h until returned to pre-sedation baseline. Respiratory status should be monitored continuously.

PRESENT IN ROOM (NAME AND ROLE)

____

____

____

____

TIME OUT PERFORMED

□ Correct patient
□ Correct procedure
□ Correct site

Time __________ Initials __________

EQUIPMENT READINESS

In room:
□ Cardiopulmonary monitor with three lead ECG, RR, and BP cuff
□ Pulse-oximeter
□ Supplemental oxygen
□ BVM
□ Suction
□ End-tidal CO_2 monitoring

Readily accessible:
□ Crash cart
□ Reversal agents

RESPIRATORY EFFORT QUALITY

N = normal
S = shallow
D = deep
L = labored
R = regular
I = irregular

PRE-SEDATION IV ACCESS

IVF __________ Site __________

Gauge _______ Rate _________

LOC SCALE

5 = awake and alert
4 = sleeping intermittently
3 = asleep but responds to voice
2 = responds to painful stimuli
1 = unresponsive

POST-SEDATION EVALUATION

□ VS and SpO_2 stable and patient has returned to pre-sedation baseline.
□ LOC at pre-sedation baseline.
□ Airway protective reflexes intact or at pre-sedation baseline.
□ Patient tolerates oral intake.
□ Ambulation at baseline.

MODIFIED ALDRETE SCORE

Activity	
Able to move four extremities voluntarily on command.	2
Able to move two extremities voluntarily on command.	1
Unable to move.	0
Respiration	
Able to breathe deeply and cough freely.	2
Dyspnea or limited breathing.	1
Apnea.	0
Circulation	
BP and HR ± 20% of pre-sedation level.	2
BP and HR ± 20-50% of pre-sedation level.	1
BP and HR ± 50% of pre-sedation level.	0
Consciousness	
Fully awake and able to answer questions.	2
Arousable only to calling.	1
Unresponsive.	0
Oxygenation	
SpO_2 >90% on room air.	2
Requires supplemental oxygen to maintain SpO_2 >90%.	1
SpO_2 <90% despite supplemental oxygen.	0

DISPOSITION

□ Discharged to home.
  □ Responsible adult present to accompany patient.
  □ Written instructions given and reviewed.
□ Transferred to _________ via (circle one) stretcher wheelchair ambulance
  □ Report given to _________.

OUTCOMES AND MONITORING

Check all that apply:
□ Apnea > 15 seconds.
□ Intubation or positive pressure ventilation.
□ Desaturation with SpO_2 <90% for >90 seconds.
□ Vomiting.
□ HR, CP, or RR change 30% from baseline.
□ Emergency consultation with CRNA after start of procedure.
□ No complications.

PROCEDURE SUMMARY

Date of procedure: __________
Procedure start time: __________
Procedure end time: __________
Time last sedating medication was given: __________
Deepest level of sedation achieved: __________
IVF received (type and total volume): __________

SIGNATURES

Provider performing sedation: ____

Monitoring RN: ____

Provider performing procedure: ____

Place patient ID sticker here.

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Nursing Flowsheet for Procedural Sedation and Analgesia Outside the OR

TIME	BP	HR	RR	RESPIRATORY EFFORT QUALITY	SpO_2	OXYGEN (L/min)	LOC	MODIFIED ALDRETE SCORE	MEDICATION AND DOSE	COMMENTS	INITIALS

SIGNATURES

Monitoring RN(s):____

____

Place patient ID sticker here.

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Provider Flowsheet for Procedural Sedation and Analgesia Outside the OR

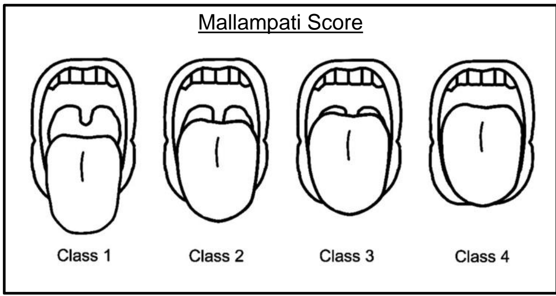
PROCEDURE INFORMATION		
Date:		
Procedure:		
Procedure performed by:		
Sedation performed by:		
PATIENT INFORMATION		
Age:	Weight (kg):	Last meal (time):
Allergies:		
Previous reaction to sedative/anesthetic:		
□ Armband/ID confirmed.		
□ Objectives, associated risks, and benefits of sedation have been discussed.		
□ Written consent obtained from patient guardian (circle one).		
TO BE COMPLETED BY PROVIDER PERFORMING SEDATION		

PRE-SEDATION ASSESSMENT

Airway History:
□ No stridor.
□ No obstructive sleep apnea.
□ No history of rheumatoid arthritis or ankylosing spondylitis with cervical spine involvement.
□ No history of Trisomy 21.
□ No active respiratory tract infection.
□ No history of difficult intubation.

Airway Exam:
Mallampati (circle one) Class 1 Class 2 Class 3 Class 4

□ Patient can open mouth completely and temporomandibular joint function is normal.
□ No micrognathia.
□ No dysmorphic facial features or craniofacial abnormalities.
□ No loose teeth.
□ Patient is able to extend neck > 70°.



ASA CLASSIFICATION

□ ASA I – normal healthy patient
□ ASA II – patient with mild systemic disease
□ ASA III – patient with severe systemic disease that is limiting but not incapacitating
□ ASA IV or greater – patient with severe systemic disease that is life-threatening → patient does not meet criteria for procedural sedation at YKHC.

SIGNATURES

Provider performing sedation: ________________________________

Monitoring RN: ________________________________

Provider performing procedure: ________________________________

Place patient ID sticker here.