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Adult Procedural Sedation Record

Physician Assessment

Anaesthesia MD: _____ Procedure MD: _____ P: _____ B/P: _____ RR: _____

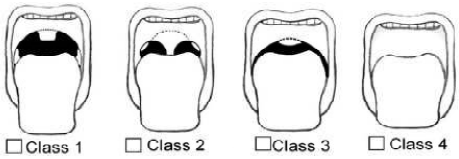
Procedure: _____ Wt: _____ O_2Sat: _____ Ht: _____

Pre–Procedure Assessment

Airway:

Face and Dentures: ☐ NAD OR

Mallampati Score:



☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4

3–3–2 Abnormality: ☐ NAD OR

Abnormal Neck Mobility: ☐ NAD OR

Obstruction or abnormal upper airway: ☐ NAD OR

ASA Classification: ☐ **E** ☐ **I** ☐ **II** ☐ **III** ☐ **IV** ☐ **V**

Medical/Anaesthesia Assessment:

Relevant Medical Hx: ☐ None OR

Medication: ☐ None OR ☐ Reviewed in Chart

Previous Anaesthesia: ☐ No ☐ Yes, Any problems?

Relevant Allergies: ☐ None OR

NPO status:

Respiratory and Cardiovascular Exam: ☐ NAD OR

Procedural Preparation

☐ Discussed Risks and Benefits
☐ Patient Consented as required
☐ sodium chloride 0.9% IV running
☐ RT/2nd MD/Airways Designee

Monitors and Equipment
☐ O_2Sat ☐ B/P ☐ Suction ☐ Age appropriate equipment accessible
☐ $ETCO_2$ ☐ ECG ☐ O_2 / BVM handy

Procedural Notes

Start Time (hhmm) _____ End Time (hhmm) _____ Date (dd/mm/yyyy) _____ MD Signature _____

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Nursing Documentation

Date (dd/mm/yyyy): _____ Test / Procedure: _____

Sedation Ordered By: _____ Sedation Provided By: _____

Nursing Assessment Time (hhmm): _____ Signature: _____

Height (cm) _____ Weight (kg) _____ Temp _____ RR _____ O_2 Sat _____ HR _____ BP _____

Last consumption of Solids _____ AND Last consumption of Liquids _____

Informed consent for sedation obtained by physician (including review of risks, benefits and alternatives) ☐ Review of consent and patient education by RN ☐

Additional Comments:

Current Medications (include time of last dose): ☐ Best Possible Medication History (ORD37)

Allergies or Drug Reactions: _____

Cardiac Assessment: ☐ Pacemaker or Defibrillation ☐ Peripheral Vascular Disease ☐ Congestive Heart Failure ☐ Hypertension ☐ Other: _____

Respiratory Assessment: ☐ Smoker ☐ Asthma / COPD ☐ Obstructive Sleep Apnea ☐ CPAP ☐ Other: _____

Neurological Assessment: ☐ Seizures ☐ Dementia ☐ Other: _____

Anaesthetic History: ☐ No Previous Anaesthetic ☐ No Previous Sedation ☐ Difficult Intubation ☐ Malignant Hyperthermia

Other: ☐ Pregnant ☐ Substance Use ☐ Kidney Dysfunction ☐ Dialysis ☐ Diabetes ☐ Thyroid Disorder ☐ _____

Intravenous Access: ☐ **Not Applicable** ☐ **Saline Lock** ☐ **IV Infusing**

Size: _____ Site: _____ Solution: _____ Rate: _____

Sedation Materials Check ☐ Sedation Medication ☐ Reversal Agents ☐ Airway / Resuscitation Equipment ☐ Monitoring Equipment

Procedure Start Time (hhmm): _____ Procedure End Time (hhmm): _____

Monitoring every 5 minutes intra–procedure. Post–procedure every 5 minutes x3 and then every 15 minutes (unless otherwise indicated more frequently)

Time	Pre–Procedure Assessment																									
Respirations																										
SpO_2 Saturation																										
End–Tidal CO_2																										
ECG Rhythm																										
Ramsay Sedation Score																										
Pain Score																										
NH Discharge Criteria Score																										
BP Cuff Location																										
Systolic / **Diastolic** / **Pulse X** (280, 260, 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20, 0)																										
Initials																										

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Sedation Results	☐ Adequate Sedation	☐ Adverse Effects	☐ Inadequate / Failed Sedation

Adverse Effects – where "Yes" is checked please see interdisciplinary notes			**Comments**
Desaturation	☐ No	☐ Yes	
Airway Obstruction	☐ No	☐ Yes	
Apnea	☐ No	☐ Yes	
Aspiration	☐ No	☐ Yes	
Hypotension	☐ No	☐ Yes	
Bradycardia	☐ No	☐ Yes	
Prolonged / Excessive Sedation	☐ No	☐ Yes	
Excessive Irritability	☐ No	☐ Yes	
Other	☐ No	☐ Yes	

Discharge Criteria		
Discharge criteria score is ≥9 or the patient has returned to the pre–procedure baseline status	☐ Yes	☐ No
Vital signs within 5–10% of baseline and airway patent	☐ Yes	☐ No
Patient is easily is awake and orientated	☐ Yes	☐ No
Patient can communicate appropriately	☐ Yes	☐ No
Patient can sit up unaided (if appropriate)	☐ Yes	☐ No
Pre–sedation level of responsiveness	☐ Yes	☐ No
Patient drinking and tolerating fluids – (minimal or no nausea and vomiting at time of discharge)	☐ Yes	☐ No
Pain, if present, rated as less than 5	☐ Yes	☐ No
ECG at pre–procedure baseline (excluding cardioversions)	☐ Yes	☐ No
Where "No" is checked, patient is not suitable for discharge – contact the physician (an interdisciplinary note is required)		

Discharge	Time (hhmm):_____		
IV Discontinued	☐ Intact	IV Site _____	Initials _____
Discharge Instructions Provided	☐ Verbally	☐ Written	Given To _____
Discharged To	☐ Home	☐ Unit	☐ Other _____
Name: _____		Signature: _____	

Reference Tools for Patient Monitoring (Page 1)

NH Discharge Criteria Score	**Score**
Nausea / Vomiting	
Minimal	2
Moderate	1
Severe	0
Respiration	
Breathes, coughs freely	2
Dyspnea	1
Apnea	0
Circulation	
Blood pressure ± 20 mmHg of baseline	2
Blood pressure > 20 – 50 mmHg difference from baseline	1
Blood pressure > 50 mmHg difference from baseline	0
Ambulation and Mental Status	
Oriented x 3 and has a steady gait	2
Oriented x 3 or has a steady gait	1
Neither	0
O_2 Saturation	
SpO_2 > 92% on room air	2
SpO_2 > 92% on supplemental oxygen	1
SpO_2 < 92% on oxygen	0
Total score must be **greater than or equal to 8** for discharge **TOTAL**	

Ramsay Sedation Scale	
Response	**Score**
Anxious or restless or both	1
Cooperative, orientated and tranquil	2
Responding to commands	3
Brisk response to stimulus	4
Sluggish response to stimulus	5
No response to stimulus	6

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Date / Time (dd/mm/yyyy hhmm)	**Focus**	**DARE** (Data – Action – Response – Evaluation)