**Document Title:** SAFE CONSCIOUS SEDATION FOR EMERGENCY PROCEDURES IN THE EMERGENCY DEPARTMENT

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<th>Document Reference/Register no:</th>
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<th>Version Number:</th>
<th>2.0</th>
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<td>11, 12</td>
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<td>Emergency Care</td>
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</tr>
<tr>
<td><strong>Author/Contact:</strong> (Asset Administrator)</td>
<td>Dr Ahmad Aziz, Consultant Emergency Medicine</td>
<td></td>
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<td>✓ MEHT</td>
<td>□ BTUH</td>
<td>□ SUH</td>
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<td><strong>Approval Group / Committee(s):</strong></td>
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<td><strong>Professionally Approved by:</strong> (Asset Owner)</td>
<td>Dr. Tim Lightfoot, Divisional Director Medicine and Emergency Care</td>
<td><strong>Date:</strong></td>
<td>16th November 2018</td>
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<td><strong>Date:</strong></td>
<td>28th November 2018</td>
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<td>Date: December 2018</td>
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Dr. Ajay Thomas | Consultant EM | 15 February 2018
Dr. Pallav Bhatnagar | Consultant EM | 15 February 2018
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Hilary Bowring | ADoN | November 2018
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Related Trust Policies (to be read in conjunction with)
- 06054 Safe Conscious sedation for Adults
- 04080 Consent policy
- 08086 Clinical Record Keeping Standards
- 05129 Medicines Policy

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<table>
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<td>Ahmad Aziz</td>
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<td>05/08/2013</td>
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1 Purpose

1.1 To standardise/improve patients care.

1.2 This guideline is to help the clinicians (Emergency Medicine or other specialties) safely deal with adults who need procedures requiring sedation in the emergency department e.g. joint reduction, fracture manipulation.

2 Scope

2.1 Adult patients requiring procedural sedation in the emergency department age 18 or over.

2.2 Procedural sedation is contraindicated if any one of these applies:

- Procedures involving stimulation of the posterior pharynx
- Procedures that are more appropriately performed under general anaesthesia or in sterile operating theatre conditions
- History of airway instability, tracheal surgery, or tracheal stenosis or abnormal facial anatomy
- Active pulmonary infection or disease (including upper-respiratory infection, but with the exception of asthma)
- Head injury associated with loss of consciousness, altered mental status, or vomiting
- Central nervous system masses, abnormalities, or hydrocephalus
- Poorly controlled seizure disorder
- Acute Glaucoma or acute globe injury
- Fluids within the last 2 hours or solids within the last 6 hours for deep sedation (for minimal sedation eg Nitrous oxide or moderate sedation where verbal contact is maintained, no starvation period is required)

2.3 Sedation may only take place in appropriately equipped areas where full monitoring and resuscitation facilities are available. There should be a tilting trolley, suction, oxygen, and equipment for advanced airway management.

2.4 The use of Entonox as a sole agent or Intranasal Diamorphine is outside the scope of this guideline.

3 Staffing and Training

3.1 Sedation is always a 3 person team: 2 doctors and a dedicated nurse.
- All procedural sedation should be supervised by a consultant or a lead middle grade
- Procedural Doctor (Consultant or middle grade)
- Sedation Doctor (Consultant or middle grade)
- Registered Nurse – for entire sedation and recovery period
- Staff should be familiar with the drugs used; especially dose calculation and potential side effects.
- All staff undertaking a procedural sedation should have had training in advanced airway skills.
4 Introduction

4.1 Procedural sedation is a common practice in Emergency departments and is often performed in conjunction with clinicians from other specialties. The aims are to relieve anxiety, reduce pain, facilitate a procedure and provide amnesia. Sedation can produce a continuum of states, ranging from minimal sedation (anxiolysis) through to general anaesthesia. This guideline specifically applies to moderate sedation (i.e. “conscious sedation”) and deep sedation.

4.2 Conscious Sedation is a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and technique used to provide conscious sedation should carry a margin of safety wide enough to render loss of consciousness unlikely.

4.3 If verbal responsiveness is lost the patient requires a level of care identical to that needed for general anaesthesia.

5 Overview of Process

5.1 All potential sedation cases MUST be discussed with the consultant/ the Lead Middle Grade and Sister in charge prior to sedation taking place.

5.2 Sedation may only take place in appropriately equipped areas where full monitoring and resuscitation facilities are available.

5.3 Ensure pre-sedation assessment and consent.

5.4 Give supplemental oxygen and use Capnography during the procedure and post procedure observation period.

5.5 Use only agents with which you are familiar and trained to use.

5.6 Full monitoring is required until the patient is fully recovered.

5.7 Document episode in ED notes and fill out sedation record.

6 Patient Assessment

6.1 Clinical Assessment prior to sedation should include a full history specifically:

- events leading to current problem
- co-morbidities
- past medical history
- past surgical and anaesthetic history
• fasting time
• medications/recreational drugs
• Allergies

7 Examination and Observation

7.1 The Trust has adopted the grading system used by the ASA (American Society of Anaesthesiologists) and a grade should be given to each patient and documented in the ED medical record.

• ASA 1 (Fit & healthy, no systemic disease)
• ASA 2 (A patient with mild systemic disease)
• ASA 3 (A patient with severe systemic disease)
• ASA 4 (A patient with severe systemic disease that is a constant threat to life)
• ASA 5 (A moribund patient who is not expected to survive without the operation)

➢ ASA grades 4 and 5 should only be sedated in the ED in dire emergencies.
➢ ASA grade 3 patients considered after discussion with the ED Consultant.

7.2 A focused physical examination including auscultation of the heart and lungs.

7.3 Vital signs: 3 lead ECG, BP, HR, SpO2 and Capnography

7.4 The patient’s AIRWAY should be assessed to identify features associated with increased risk of difficult intubation and/or ventilation such as;

• Obesity
• Short neck
• limited neck movements,
• dysmorphic face, small jaw
• small mouth opening, protruding incisors, large tongue

7.4.1 The LEMON score can be used to assess the airways;
7.4.2

**LEMON Airway assessment method**

<table>
<thead>
<tr>
<th>Class 1</th>
<th>Class 2</th>
<th>Class 3</th>
<th>Class 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Obstruction: Presence of any condition like epiglotitis, Peritonsillar abscess, trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Neck Mobility (Limited neck mobility)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mallampati scores (see below); should be assessed with patient sitting up, opposite and on the same level as the examiner. Best assessed with the tongue protruding

Class 3 and 4 are associated with difficult intubation

8 **Patient Monitoring**

8.1 Observations must be recorded pre-sedation, during sedation and post sedation every 5 minutes.

8.2 Clinical observation of the patient's appearance, respiratory rate, perfusion and behaviour must be maintained throughout the procedure in conjunction with other monitoring.

8.3 The following observations are mandatory in all patients:

- Pulse rate
- respiratory rate
- Oxygen saturation
- blood pressure
- ECG
- end tidal CO2 (Capnography)

8.4 The routine use of supplemental oxygenation may allow SpO2 to remain satisfactory but hide the fact that there is significant hypoventilation and the patient may be on the cusp of losing their airway.
8.5 Level of consciousness, using the ASA guidelines (see table 1) will need regular communication with the patient to assess.

<table>
<thead>
<tr>
<th>Table 1. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Responsiveness</td>
</tr>
<tr>
<td>Airway</td>
</tr>
<tr>
<td>Spontaneous ventilation</td>
</tr>
<tr>
<td>Cardiovascular function</td>
</tr>
</tbody>
</table>

9 Consent

9.1 Informed consent for sedation and procedure must be obtained. Verbal consent is sufficient but must be documented.

9.2 In the event that the Patient has an impairment of, or a disturbance in the functioning of, their mind or brain and assessment shows that the Patient lacks capacity then a “best interest” decision is required and Family/Friends/Carers all need to be consulted and involved in the decision making process. Completion of MCA documentation is required.

9.3 Where the Patient is deemed to be vulnerable i.e. any issues arising surrounding Learning disabilities/autism/elderly/dementia/mental health, then additional support can be gained by contacting the Lead Nurses in these areas.

10 Commonly Used Drugs

10.1 Intravenous sedative/analgesic drugs should be given in small, incremental doses that are titrated to the desired end-point of analgesia and sedation

10.2 Familiarity with effect of the drug(s) used and their potential side effects is most important.

10.3 In general single agents are safer than polypharmacy though no one agent or regime is conclusively more effective than another.

10.4 Specific antagonists for the drug(s) given should be at hand. (i.e. Naloxone and Flumazenil)

10.5 Doses in table 2 are a guide; care is required in old age, poor clinical condition etc.

10.6 Allow peak drug effect to occur before titrating further doses or other agents.
Table 2: Intravenous sedative/analgesic drugs commonly used

<table>
<thead>
<tr>
<th>Drug</th>
<th>Guide Dose</th>
<th>Peak</th>
<th>Duration</th>
<th>Cautions and Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORPHINE (I.V.)</td>
<td>0.1-0.2mg/kg</td>
<td>5-30mins</td>
<td>3-4hours</td>
<td>If given with Midazolam, give morphine first and await peak effect</td>
</tr>
<tr>
<td>MIDAZOLAM (I.V.)</td>
<td></td>
<td>1-5mins</td>
<td>hours</td>
<td>Half-life is approx. 2 hours but can be up to 4 times in the elderly.</td>
</tr>
<tr>
<td></td>
<td>Adults &lt;60yrs</td>
<td>Adults ≥60 y / debilitated or chronically ill</td>
<td></td>
<td>May cause hypotension and respiratory depression, particularly when rapidly administered or given with fentanyl (consider reduced dose of Midazolam)</td>
</tr>
<tr>
<td></td>
<td>Initial dose:</td>
<td>Initial dose:</td>
<td></td>
<td>May be reversed with Flumazenil</td>
</tr>
<tr>
<td></td>
<td>2 - 2.5 mg</td>
<td>0.5 - 1 mg</td>
<td></td>
<td>Consider reduced dose if used in combination with other agents.</td>
</tr>
<tr>
<td></td>
<td>Titration doses: 1 mg</td>
<td>Titrations doses: 0.5 - 1 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total dose:</td>
<td>Total dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.5 - 7.5 mg</td>
<td>&lt; 3.5 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NITROUS &amp; OXYGEN</td>
<td>O2:nitrous oxide</td>
<td>2mins</td>
<td>minutes</td>
<td>Useful supplement to other agents</td>
</tr>
<tr>
<td></td>
<td>50:50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11 Alternative Drugs

11.1 The drugs named in the table 3 below are for use only by doctors trained in their use, currently:

- Emergency Department consultants
- Named ED registrars or middle grades
- Anaesthetists (Registrar and above)

11.2 Other specialty doctors should not use these agents without discussion with ED consultant.
## Table 3: Alternative Drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Guide Dose</th>
<th>Peak</th>
<th>Duration</th>
<th>Cautions and Notes</th>
</tr>
</thead>
</table>
| PROPOFOL| Elderly > 75 yrs 0.5 mg/kg bolus then | 1 min| 10mins   | Prolonged apnoeas may occur, especially with fentanyl  
|         | 0.25 mg/kg Adults < 75 yrs 1 mg/kg bolus then 0.5 mg/kg |      |          | Causes cardiovascular depression and hypotension  
|         |                                      |      |          | Beware using Propofol with Opioids (can cause severe respiratory and cardiovascular depression)  
|         |                                      |      |          | 1% solution contains 10mg per mL                                                                                                                   |
| KETAMINE| IM 2-4mg/kg                          | <5mins| 5-20mins | Rapid I.V. administration → apnoea/hypoventilation  
|         | IV 0.5-1mg/kg (slow)                  |      |          | Be aware of emergence phenomena & hypersalivation.  
|         |                                      |      |          | Consider adjunctive agents  
|         |                                      |      |          | Avoid in patients in whom elevation of blood pressure would be a serious hazard.  
|         |                                      |      |          | Contraindicated in patients with cardiovascular disease, thyroid disease or if agitated and sympathetically stimulated  
|         |                                      |      |          | Smaller doses (e.g. 20mg, sometimes repeated) can be used to facilitate short procedures e.g. radial fracture manipulation, where a haematoma block has already been given  |
| FENTANYL| IV 0.5-2mcg/kg                        | 2-5mins| 30-60mins| Prolonged apnoeas may occur, especially with Propofol: reduce dose or omit if long acting opiates have been given in last 30 – 40 minutes.  
|         |                                      |      |          | Action reversed by Naloxone                                                                                                                        |
### 11.3 Ketamine

- Contraindicated in patients with cardiovascular disease, thyroid disease or if agitated and sympathetically stimulated
- Beware different concentrations available

### 11.4 Smaller doses (e.g. 20mg, sometimes repeated) can be used to facilitate short procedures e.g. radial fracture manipulation, where a haematoma block has already been given.

### 11.5 Fentanyl

- A potent synthetic opiate with a rapid onset and short half life
- Stocked in 2ml ampoules of 50μg/ml
- Should be drawn up into a 2ml syringe (100μg in total) and labelled.
- Dosage intravenously of 0.5 – 1 μg/kg over 30 – 60 seconds
- May cause significant respiratory depression and hypotension
- Give at least 3 minutes before sedation
- Reduce dose or omit if longer acting opiates already given within 30 – 40 minutes

## 12 Post-sedation Management

### 12.1 Recovery area

- To remain in Emergency department Resus room until fully recovered (able to protect own airway, alert and responsive)
- Advise parents or caretakers not to stimulate patient prematurely
- Continue oxygen saturation monitoring
- Will need continuous nursing observation until fully alert and responsive – beware if the patient has required Flumazenil as may become re-sedated (Refer to Appendix 2)
12.2 **Discharge criteria**

- The discharge checklist attached to the sedation record should be completed
- Recovery depends on drug(s) used
- Full recovery is defined as the patient returning to their pre-sedation state of consciousness and cardio respiratory function.
- Normal vital signs and ability to take oral fluids
- Give discharge instructions (see advice sheet): nothing by mouth for 2 hours
- Responsible adult to accompany patient if discharged
- Not to drive for 48 hours post sedation

13 **Documentation**

13.1 The Emergency department sedation record should be completed for all patients. (Refer to Appendix 1)

13.2 Informed consent should be obtained and documented in the patient’s notes.

13.3 Patient specific record of the procedure including pre-procedure state of the patient, drugs used during the procedure, observations recorded during the sedation period and any adverse events should be recorded in the patient’s medical record.

14 **Risk Events**

14.1 Datix/ Risk Event form must be completed in all events where this guideline has not been complied with.

14.2 Any serious complications or near misses will be reported through the hospital incident reporting system and discussed at the monthly ED clinical governance meetings.

15 **Audit and Monitoring**

15.1 The Emergency department will regularly audit the use of sedation against national standards. Compliance with this guideline will be audited once a year and presented at the weekly departmental teaching programme. It will be the responsibility of the author and the department lead for audit to make sure that recommendations from the audit are considered and implemented as necessary.
16 Implementation and Communication

16.1 It is a corporate responsibility to ensure that the guideline is uploaded to the intranet and website following ratification and to notify all staff via Staff Focus magazine.

16.2 It is the responsibility of the author to communicate locally with the ED staff any other relevant staff in the trust.

17 References


Sedation of adult patients in Emergency Department, Addenbrooke’s Hospital, Cambridge. 2008


Procedural Sedation and Anaesthesia on the Emergency Department (clinical policy); from the American college of Emergency Physicians clinical policies committee. February 2005


18 Equality Impact Assessment
(Refer to Appendix 3)
Appendix 1: Sedation Record

BROOMFIELD EMERGENCY DEPARTMENT
SEDATION RECORD

Date: ____/____/____

Planned procedure: .......................................................... .......................................................... ..........................................................

ASA Status: (circle status)
ASA 1 (Fit & healthy no systemic disease)
ASA 2 (Mild systemic disease, not debilitating)
ASA 3 (Significant systemic disease, limiting)
ASA > 2 is not suitable for sedation in the ED

Brief details of co-morbidities:

Staff involved: Procedure Doctor ................. Adjuncts to sedation:
Sedation Doctor ................. (e.g. regional block/ L.A. infiltration)
Dedicated Nurse ................. ...........................................

Checklist:
Consent † written / verbal
Procedure explained †
Patient assessed (inc. airway) †
Last meal / drink _____ hrs ago
Check equipment †

Airway Assessment (LEMON)
Look: short neck, large tongue, small jaw, buck teeth, beard
Evaluate: Mouth opening > 3 fingers, thyro-mental distance > 7cm

Page 14 of 17
Appropriate monitoring  
Drug doses calculated  
Estimated body weight  

Details of Sedation Procedure: (to be documented in notes including prescriptions)

**Observations to be documented every 2-5mins**

<table>
<thead>
<tr>
<th>Drug: (inc. Nitrous oxide)</th>
<th>Route</th>
<th>Dose</th>
<th>Time given</th>
<th>Subsequent Doses &amp; time:</th>
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<tr>
<td>1. Oxygen</td>
<td>inh</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
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<td>3.</td>
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<td>4.</td>
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<tr>
<td>5.</td>
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</tr>
</tbody>
</table>

Complications / Reversal agents used:

Discharge checklist

- Fully conscious  
- Observations normal for patient  
- No nausea and vomiting  
- Adequate analgesia  
- Follow-up arranged  
- Verbal/Written advice given  
- Discharged to care of responsible adult / Admitted  
- Copy in notes

Discharge date and time  

Signed:  
Print name:  

Call for anaesthetic advice if difficult airway
Appendix 2: Nursing Observations Sheet

<table>
<thead>
<tr>
<th>Time (5mins)</th>
<th>Initial</th>
<th></th>
<th></th>
<th></th>
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<td></td>
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</tbody>
</table>
## Equality Impact Assessment (EIA)

Title of document being impact-assessed: 12031 Safe Conscious Sedation for Emergency Procedures in ED

<table>
<thead>
<tr>
<th>Equality or human rights concern (see guidance notes below)</th>
<th>Does this item have any differential impact on the equality groups listed? Brief description of impact.</th>
<th>How is this impact being addressed?</th>
</tr>
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<tbody>
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<td>N/A</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Disability</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>Religion, faith and belief</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Sexual orientation</td>
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<tr>
<td>Carers</td>
<td>No</td>
<td>N/A</td>
</tr>
</tbody>
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Date of assessment: 07/11/18

Names of Assessor(s): Evelyn Wild