

### **Adult Procedural Sedation Record**

### **Physician Assessment**

Anaesthesia MD:	Procedure I	MD:	P:	B/P:	RR:						
Procedure:		-	Wt:	O₂Sat:	Ht:						
	Pre-Proced	dure Assessment									
Airway:		Medical/Anaesthesia Assessment:									
Face and Dentures: NAD OR		Relevant Medical Hx: None	OR								
Mallampati Score:	) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	Medication: None OR Reviewed in Chart									
3–3–2 Abnormality: NAD OR		Previous Anaesthesia: No Yes, Any problems?									
Abnormal Neck Mobility: NAD OR		Relevant Allergies: None OR									
		NPO status:									
Obstruction or abnormal upper airway: NAD O	R	Respiratory and Cardiovascular Exam: NAD OR									
ASA Classification: E I I II III		-									
		dural Preparation									
□ Discussed Risks and Benefits       Monitors and         □ Patient Consented as required       □ O <sub>2</sub> Sat         □ sodium chloride 0.9% IV running       □ ETCO2         □ RT/2 <sup>nd</sup> MD/Airways Designee       □ Monitors and			] Age appropi	iate equipme	nt accessible						

#### **Procedural Notes**

Rev. 05/2016 (v3)

Start Time (hhmm)

End Time (hhmm)

Date (dd/mm/yyyy)

MD Signature



Chart Copy – Do Not Destroy

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Sedation Results	Adequate	Sedation	Ad	verse Effe	cts	Inadequate / Failed Seda	tion				
Adverse Effects - where "Yes" is c	hecked pleas	e see interdiscip		Comments							
Desaturation	□ No	Yes									
Airway Obstruction	□ No	Ves									
Apnea		Ves									
Aspiration		Ves									
Hypotension											
Bradycardia	No No	Ves									
Prolonged / Excessive Sedation	No No	Ves									
Excessive Irritability	🗌 No	Yes		-							
Other	🗌 No	Yes									
Discharge Criteria											
Discharge criteria score is ≥9 or the p			e-procedure	baseline s	statu	IS		Yes		No	
Vital signs within 5–10% of baseline		atent						Yes	<u> </u>	No	
Patient is easily is awake and orienta								Yes	$\mathbf{H}$	No	
Patient can communicate appropriate Patient can sit up unaided (if appropr								Yes Yes	+	No No	
Pre-sedation level of responsiveness							Η	Yes	⊢	No	
Patient drinking and tolerating fluids -		or no nausea	and vomit	ing at tin	ne (	of discharge)	Η	Yes	H	No	
Pain, if present, rated as less than 5	Innina			ing at th		si discharge)	Η	Yes	Η	No	
ECG at pre-procedure baseline (exc	luding cardiov	versions)					Π	Yes	П	No	
Where "No" is checked, patient is not	suitable for c	discharge – cont	act the phys	ician (an i	nter	disciplinary note is required)					
Discharge Tim											
IV Discontinued		Intact		IV S	Site _	Initials					
Discharge Instructions Provided		Verbally		Writ							
Discharged To			Unit	Other	ner .						
Name: Signature:											
		Reference	ce Tools for	Patient N	loni	toring (Page 1)					
NH Discharge	Critoria Sco		Score		Ramsay Sedati	on	Scale				
Nausea / Vomiting			00016		Response		ocale			Score	
Minimal			2		Anxious or restless or both					1	
Moderate				1		Cooperative, orientated and tranquil					2
Severe			0		Responding to commands					3	
Respiration				Brisk response to stimulus					4		
Breathes, coughs freely				2		Sluggish response to stimulus					5
Dyspnea Apnea						No response to stimulus					6
Circulation				0							
Blood pressure <u>+</u> 20 mmHg of baseling	ne			2							
Blood pressure > $20 - 50$ mmHg diffe		aseline	1								
Blood pressure > 50 mmHg differenc			0								
Ambulation and Mental Status											
Oriented x 3 and has a steady gait											
Oriented x 3 or has a steady gait Neither											
O <sub>2</sub> Saturation				0							
$SpO_2 > 92\%$ on room air											
SpO <sub>2</sub> > 92% on supplemental oxygen											
SpO <sub>2</sub> < 92% on oxygen											
Total score must be greater than or	equal to 8 fo	r discharge									
			TOTAL								





## **Adult Procedural Sedation Record**

	Date (dd/mm/y Sedation Orde	I/mm/yyyy):         Test / Procedure:           n Ordered By:         Sedation Provided By:																								
Γ	Nursing Ass	sessment			Tim	e (hhr	nm):				_	Sigr	nature	:												
ſ	Height (cm)	Nursing Assessment         Time (hhmm):         Signature:           Height (cm)         Weight (kg)         Temp         RR         O2 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:																									
ŀ	Current Medic	ations (include ti	me of	last do	se): [	Bes	t Poss	ible M	edicati	on Hist	ory (OF	RD37)														
ŀ	Allergies or Dr	ug Reactions:																								
	Cardiac Asse	ssment:								heral V		r Disea	ase [	Col	ngestiv	/e Hea	rt Failı	ıre [	🗌 Нур	pertens	ion					
l	Respiratory A	Assessment:		Smoke	r 🗆	] Asthr	na / CO	OPD	0	bstruct	ive Sle	ep Apr	nea	🗆 СР	AP	🗌 Otl	ner:									
l	Neurological	Assessment:		Seizure	es [	Dem	nentia		Other:													_				
ĺ	Anaesthetic H	listory:	1 🗆	No Pre	vious /	Anaest	hetic	🗆 N	o Prev	ious S	edatior	n 🗆	Difficu	ılt Intul	bation		Malign	ant Hy	perthe	rmia						
	Other:		E F	Pregna	Int	Sub	stance	Use	Пĸ	(idney [	Dysfun	ction	D	ialysis		Diabe	tes	Thy	roid D	isorde	r 🗆 .					
Γ	Intravenous A	Access:			•					C Solutior		-					Ba	te:								
L	Sedation Mat	erials Check																			nitorin	- a Faui	nment			
L T		art Time (hhmm):		Jouan		lication	1			sai Ayu	1110		Airway / Resuscitation Equipment  Monitoring Equipment  Procedure End Time (hhmm):													
ŀ		5 minutes intra-pr		e. Post	-proced	dure eve	– erv 5 mi	inutes x	3 and th	nen ever	v 15 mi							entlv)								
		Time	ooodaa								<u>, io in</u>	10100 (0					e neqe	onay)								
F		TIME	Ŧ																							
			Assessment																							
			sess																						<u> </u>	
L			ure A																							
			roced																							
			Pre-Procedure																							
		<b>D</b>	а.																						<u> </u>	
ŀ		Respirations SpO <sub>2</sub> Saturation	-	-										-											──	-
ŀ		End-Tidal CO <sub>2</sub>																								
Ĺ		ECG Rhythm																								
L	Ramsay	Sedation Score																							L	
ŀ	NH Discharge	Pain Score Criteria Score																							┝──	
ľ		P Cuff Location																								
ſ		280																								
		260												-												
		240 220																								
	Custelle	220																								
	Systolic	180								]															[	
		160																							<u> </u>	
-	Diastolic	140 ——																							<b> </b>	
I		120 ——																							├──	
I	Pulse X	100																							<u> </u>	
I	FUISC A	80 •		†						+													<u> </u>			}
l		60																							<u> </u>	
I		40																								
I		20 <u> </u>																								
L		-																							<b> </b>	
L		Initials																								





### **Adult Procedural Sedation Record**

	Date / Time (dd/mm/yyyy hhmm)	Focus	DARE (Data – Action – Response – Evaluation)
3 (v3)			
/2016			
Rev. 05/2016 (v3)			
Ве			



