

Niagara Health Procedural Sedation Policy

To begin documenting bedside procedural sedation:

- a. Obtain Prescriber Orders/applicable PowerPlan (i.e ED/ICU Bedside Procedural Sedation)
- b. Navigate to Interactive View and I&O
- c. Select the Procedure Sedation Med Admin band.
- Document baseline assessment in the Procedure System Assessment/Procedure Sedation Monitoring sections, including baseline Richmond Agitation Sedation Scale (RASS), Pain and Ramsay Sedation Scale (RSS).
- e. Perform and document the procedure time out in the Pre-Procedure Time-out section.

Interactive View and I&O Orders Interactive View and I&O		ED Adult Procedures ED Lines and Devices Intake And Output		09/Oct/2024 14:40
Notes	+ Add	Blood Product Administration	Procedure System Assessment	
Allergies	+ Add	Vertice Admin	Sedation Monitoring Phase	
Diagnoses and Problems		Procedure System Assessment	Weight Measured	kg
Diagnoses and Problems		Preprocedure Time-Out	Weight Estimated	kg
Histories		Procedure Sedation Monitoring	Height/Length Measured	cm
Medication List	+ Add	Post Sedation Discharge Criteria	Height/Length Estimated	cm
Documentation	+ Add	Peripheral IV	Last Oral Intake	
Come Decision		Central Line	Temperature Temporal Artery	Deg C
Form Browser		Cardioversion	Temperature Oral	Deg C
Describe Descience				



To administer medications for the procedure, launch the Medication Administration Wizard by clicking the

Medication Administration icon (**Medication Administration Wizard, MAW for short**) from the Organizer Toolbar within PowerChart or FirstNet. Once selected, the window for the Medication Administration (MAW) will populate (below). Complete the following steps within the MAW:

- a. Scan the patient ID band
- b. Scan the barcode on the medication vial/ampoule that is to be administered







Once scanning of the ID Band and medication barcode confirms, you will note a blue checkmark next to the selected medication. This indicates that the right medication has been selected for the correct patient. By clicking on the medication name in the Results column seen in the image below, the dosage, route and who administered the medication can be modified.

		Nurse	Review	Create order and document	Last Refresh at 15:0	7 EDT
HOH Male	Ο, ΤΙΜΜΥ	MRN: 11001539 FIN#: 22-001669	DOB: 09/Aug Age: 72 years	/1952 * ** Alle	Loc: SC2 rgies, No Known Medication /	B13; A Allergies **
		2024-Oct-24 1	3:52 EDT - 2024-(Oct-24 16:22 EDT		
	Scheduled	Mnemonic	Details		Result	^
⊽ 🖌 ♦	🕑 词 24/Oct/2024 15:02	midazolam	2 mg =	2 mL, IV, INJ, Once, First D	ose midazolam 2 mg, IV	-
- I	PRN	dimenhyDRINA	TE 25 mg =	0.5 mL, IV, INJ, q4h, PRN na	ause	
	PRN 🔁	heparin	3,000 un	iit(s) = 3 mL, IV, INJ, as direc	ted,	
		heparin (hepar	in (bolusHeparin	BOLUS dose if PTT is less th	an o	
	PRN	salbutamol salbutamol (sa	5 mg = . Ibutamol	5 mL, INHALE, NEBULE, q4h,	PRN	
	Continuous	fentaNYL fentaNYL (addi	Total Vo tive) 1,00	lume (mL): 100, IV-CONTINU	OUS	
۲ I	🐨 🔁 Continuous	fentaNYL	Total Vo	lume (mL): 100, IV-CONTINU	OUS	
		fentaNYL (addi	tive) 1,00 0 to 200	mcg/hr Target Richmond A	gitat	
	Continuous	fentaNYL	Total Vo	lume (mL): 100, IV-CONTINU	IOUS	
		fentaNYL (addi	tive) 1,00			
	🐨 🔁 Continuous	heparin	Total Vo	lume (mL): 500, IV-CONTINU	IOUS	~
Deedeet	Continuous	heparin	Total Vo	lume (mL): 500, IV-CONTINU	OUS	

A window will open which will allow the user to modify parameters such as who administered the medication and the dose. Other pertinent information may also be verified such as the route of administration. Click Ok at the bottom of the window as seen below to advance to the medication administration.

Ta midazolam Mg = 2 mj, IV, INJ, Once, First Dose: 10/24/24 15:02:00 EDT, Stop Date: 10/24/24 15:02:00 EDT, URGENT						
*Performed date / time : 24/0ct/2024						
*Performed by: NHS Test03, Nurse - Critical Care						
Witnessed by :						
*midazolam: 2 mg v Volume: 2 ml						
*Route: IV V Site: V						
Total Volume : 2 Infused Over : 0 minute(s) v						
◆ 2024-Oct-24 2024-Oct-24 2024-Oct-24 2024-Oct-24 2024-Oct-24 2024-Oct-24 1400 EDT 1500 EDT 1600 EDT 1700 EDT 1800 EDT 1900 EDT →						
2						
Not Given						
Reason : 🗸						
Comment						

OK Cancel

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After clicking Ok, note that where the **Next** button was in the MAW window now says **Sign**. Clicking the Sign button will document that the medication has been administered.

		Nurse F	leview	Create order and do	ocument.	Last Refresh at	15:18 EDT	ſ
HOHO, TII ^{Nale}	ММҮ	MRN: 11001539 FIN#: 22-001669	DOB: 09/A Age: 72 ye	ug/1952 ars	** Allergies, N	Loc: S Io Known Medicati	C2B1	3; A jies *
		2024-Oct-24 14	1:03 EDT - 202	4-Oct-24 16:33 EDT				
Se	heduled	Mnemonic	Deta	ils		Result		1
1 🖌 🔶 🗑 24	/Oct/2024 15:18	midazolam	2 mg	= 2 mL, IV, INJ, Once	, First Dose	midazolam 2 m	q, IV ▼	
🗍 📷 PR	N	dimenhyDRINAT	TE 25 m	g = 0.5 mL, IV, INJ, q4h	, PRN nause			
l 🐨 🖿 PR	N.	heparin heparin (hepari	3,000 n (bolusHepa	unit(s) = 3 mL, IV, INJ, rin BOLUS dose if PTT	as directed, is less than o			
PR	N	salbutamol salbutamol (sall	5 mg butamol	= 5 mL, INHALE, NEBU	JLE, q4h, PRN			
) 🐨 Co	ontinuous	fentaNYL fentaNYL (addit	Total ive) 1,00	Volume (mL): 100, IV-C	ONTINUOUS			
] 🐚 🔁 Co	ontinuous	fentaNYL fentaNYL (addit	Total ive) 1,00 0 to 2	Volume (mL): 100, IV-C :00 mcg/hr Target Ricl	ONTINUOUS hmond Agitat			ł
) 🐨 Co	ontinuous	fentaNYL fentaNYL (addit	Total ive) 1,00	Volume (mL): 100, IV-C	ONTINUOUS			1
🛯 🔹 📴 Co	ontinuous	heparin	Total	Volume (mL): 500, IV-C	ONTINUOUS			

After medication has been administered and documented:

a. Document intraprocedural vitals and assessments per policy in the **Procedure Sedation Monitoring** section. If the patient is connected to BMDI, right click in the blue row (under the date/time) and select 'Add Result' to transfer vitals into the chart.

	Find Item V Critical	High Low	Abnormal	🗌 Unauth 🔄 Flag	⊖ Ar
	Result	Comments Flag	Date	Performed By	
	×-		10/0 +/2024		
			08:54		
	Procedure Sedation Monitoring				
	Procedure Start Time			Add Result	
	Procedure Stop Time				
	SBP/DBP Cuff	mmHg		Clear Unsigned Results	
1	Mean Arterial Pressure, Cuff	mmHg			
	Peripheral Pulse Rate	bpm			
	Heart Rate Automatic	bpm			
	Cardiac Rhythm				
	Respirations				
	Bachiraton: Data	hr/min		1	

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b. Once the procedure is completed, document vitals and assessments in the **Procedure System Assessment** section. Ensure to update that the Sedation Monitoring Phase is now in the Post-procedure phase, as seen in the image below.

Verocedure Sedation Med Admin	N 🖬		24/000/2024	
Procedure System Assessment			15:30	
Procedure Sedation Monitoring	Procedure System Assessmen	t		
Post Sedation Discharge Criteria Post Sedation Discharge Criteria	Sedation Monitoring Phase		Sedation Monitoring Phase ×	
Central Line Cardioversion	Weight Measured	kg	Presedation baseline	
	Weight Estimated	kg	Pre-procedure baseline	
	Height/Length Measured	cm	Procedure	
	Height/Length Estimated	cm	Post-procedure	
	Last Oral Intake			
	Temperature Temporal Artery	Deg C		
	Temperature Oral	Deg C		
	Temperature Tympanic	Deg C		
	Peripheral Pulse Rate	bpm		
	Heart Rate Automatic	bpm		
	Respiratory Rate	br/min		
	Systolic Blood Pressure	mmHg		
	Diastolic Blood Pressure	mmHg		
	Mean Arterial Pressure, Cuff	mmHg		
Continuous Renal Replacement Therapy	SpO2	%		
× The second second				

c. Ensure that the patient's Richmond Agitation Sedation Score (RASS) and Ramsay Sedation Score (RSS) are obtained **post-procedure**. Remember the patient must meet an RSS equal to or less than 3 prior to transfer to the post procedural care area (area/procedure specific). Refer to the Procedural Sedation Policy linked in the beginning of this tip sheet as needed.

Vertice Admin		R 🖬	23/001/2024 24/001/2024		
ř	Procedure System Assessment Preprocedure Time-Out		13:35	14:04	
	Procedure Sedation Monitoring NH Discharge Criteria Score Post Sedation Discharge Criteria Peripheral IV Central Line Cardioversion	Ramsay Scale			
		Ramsay Score			
		Richmond Agitation Sedation Scale (
		[■] RASS Score			
		Procedure Sedation Comments			

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d. If patient is expected to be discharged from hospital, a **NH Discharge Criteria Score** must be obtained. Once the assessment is completed in the **NH Discharge Criteria Score** section, a score will be calculated as seen in the image below. A **Post Sedation Discharge Criteria** assessment must also be documented as seen below. Prior to discharge, the patient must obtain a NH Discharge Criteria Score of greater than or equal to 9 AND has returned to the pre-procedure baseline status regarding the listed post sedation discharge criteria. Refer to the Procedural Sedation Policy linked in the beginning of this tip sheet as needed.

MAR Summary		C ED Aduit Interventions View				
Interactive View and I&O		C ED Adult Procedures				
Orders + Add		X ED Lines and Devices			09/Oct/2024	
		🗙 Intake And Output		15:19	14:40	
Notes	+ Add	Second Product Administration	4 NH Discharge Criteria Score			
Allergies	+ Add	Y Procedure Sedation Med Admin	Nausea/Vomiting		Minimal	
Diagnoses and Proble	ms	 Procedure System Assessment 	Respiration		Breathes, coughs freely	
- ongrioses and ricone		Preprocedure Time-Out	Circulation		Blood pressure +/- 20mmHg of	
Histories		Procedure Sedation Monitoring	Ambulation and Mental Status		Returned to baseline level of ori	
Medication List	+ Add	Post Sedation Discharge Criteria	O2 Saturation		SpO2 > 92% on room air	
Documentation	+ Add	Peripheral IV	Discharge Criteria Score		10	
Form Browser		Central Line	△ Post Sedation Discharge Criteria			
		Lardioversion	Pt Returned to Pre Procedure Baseline		Yes	
Results Review			Vitals 5-10% of Baseline, Airway Patent			
Patient Information			Patient Awake and Oriented			
Growth Chart			Patient Communicates Appropriately			
Clinical Media	+ Add		Patient Sits Up Unaided			
	1 //44		Pre-sedation Level of Responsiveness			
Clinical Connect			Patient Drinking and Tolerating Fluids			
Oncology			Pain Rating Less than 5			
Trauma Documentati	on		ECG at Pre-Procedure Baseline		Yes	

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