TIP SHEET

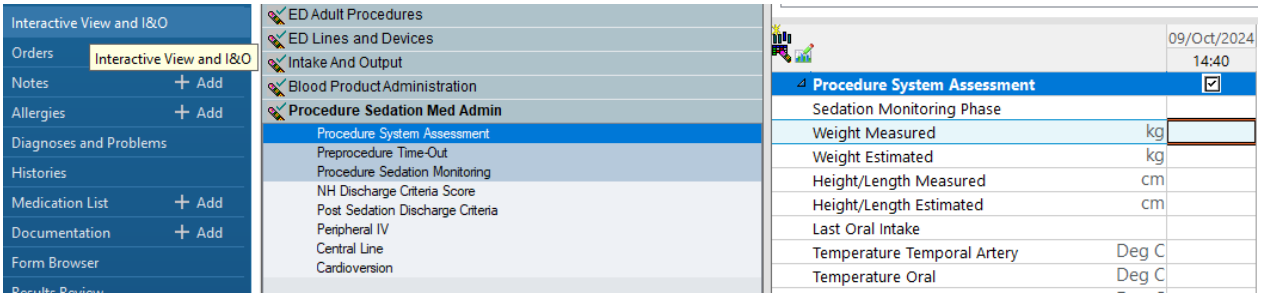
HOSPITAL INFORMATION SYSTEM (HIS)

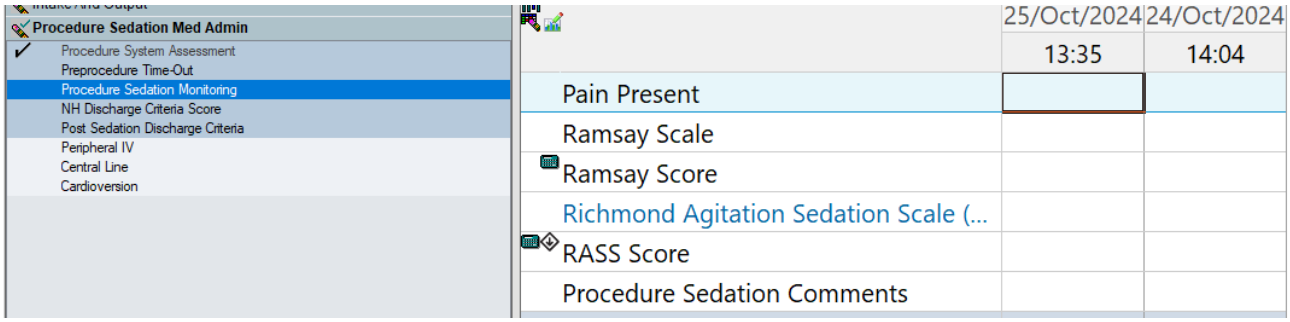
BEDSIDE PROCEDURAL SEDATION

<u>Niagara Health Procedural Sedation Policy</u>

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.
d. 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.

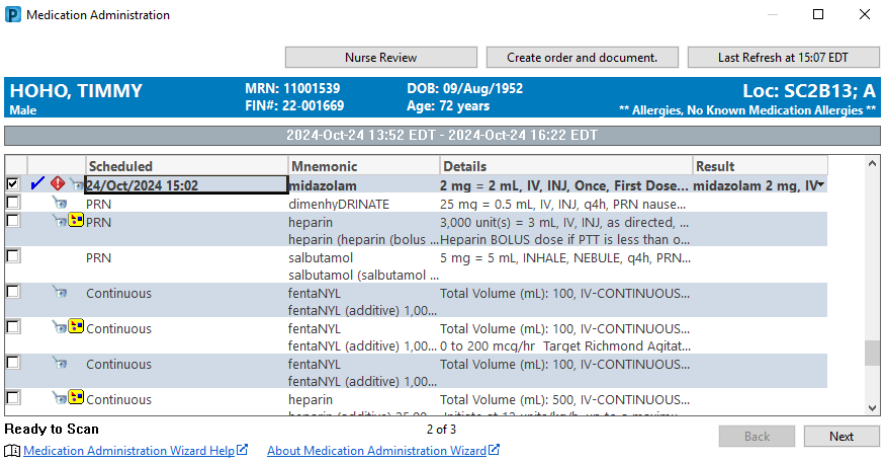




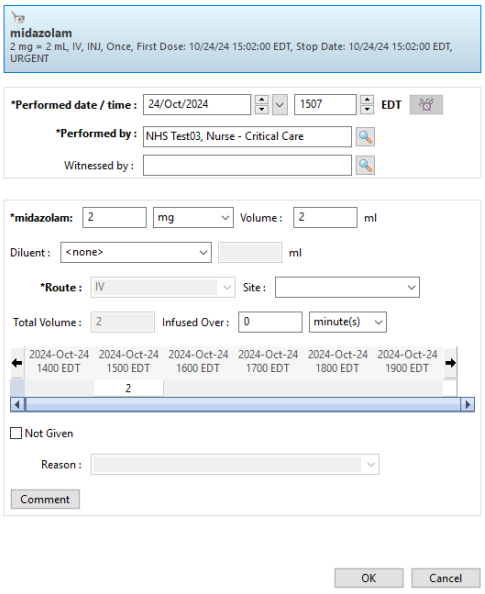
To administer medications for the procedure, launch the Medication Administration Wizard by clicking the Medication Administration icon (**Medication Administration Wizard, MAW for short)** from the Organizer Toolbar within PowerChart or FirstNet. Once selected, the window for the Medication Administration (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

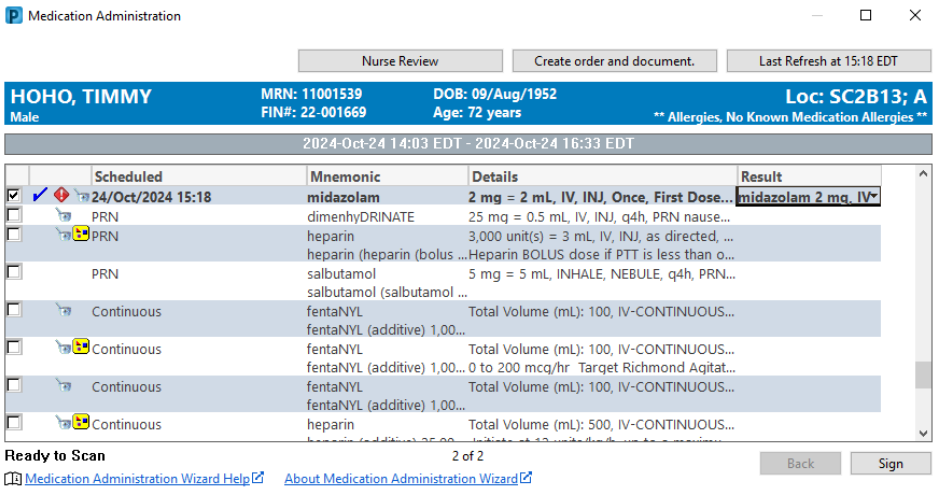
Once scanning of the ID Band and medication barcode confirms, you will note a blue checkmark next to the selected medication. This indicates that the right medication has been selected for the correct patient. By clicking on the medication name in the Results column seen in the image below, the dosage,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



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.

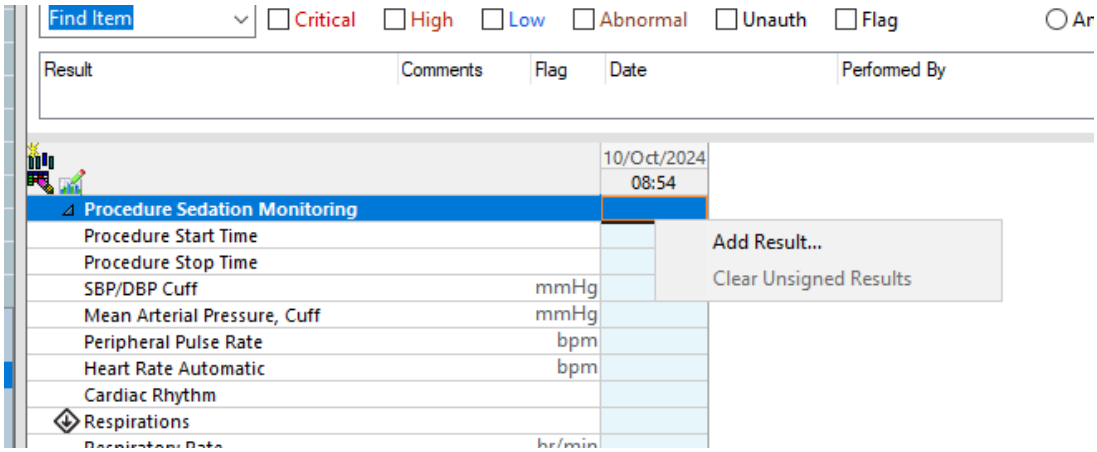


After clicking Ok, note that where the **Next** button was in the MAW window now says **Sign**. Clicking the Sign button will document that the medication has been administered.

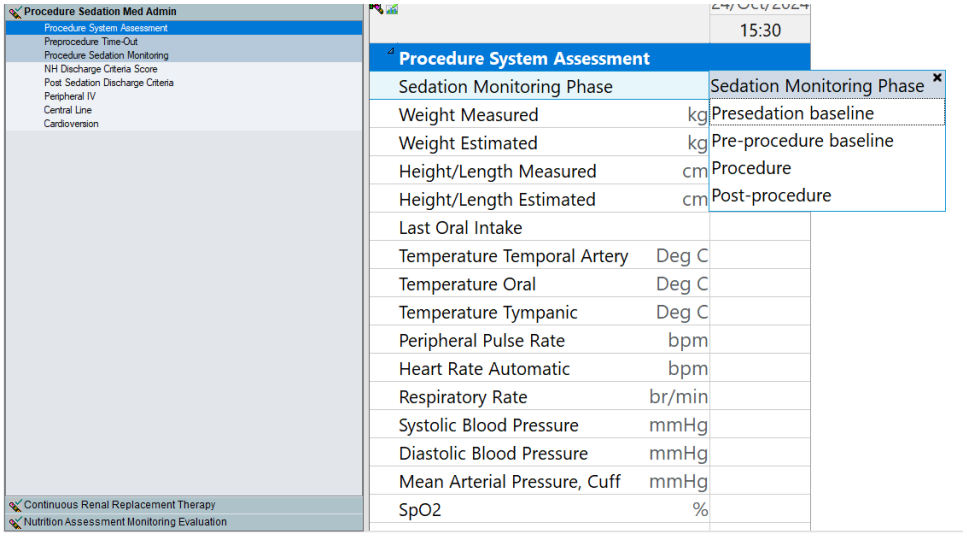


After medication has been administered and documented:

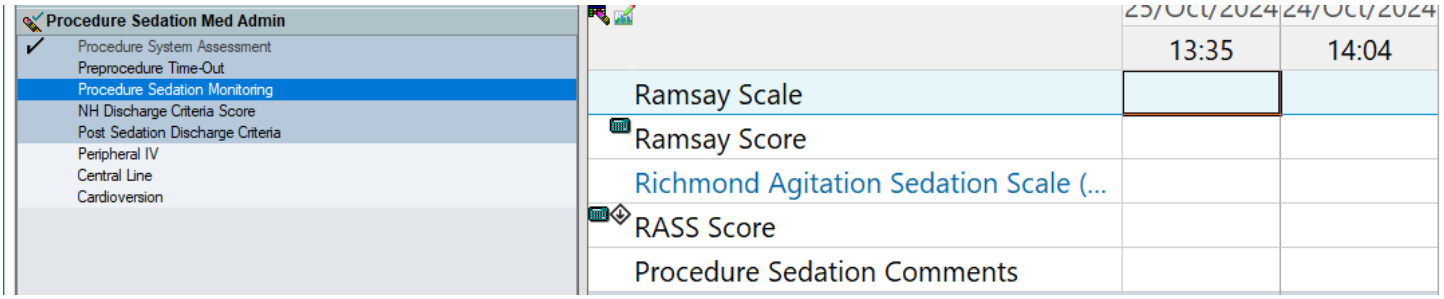
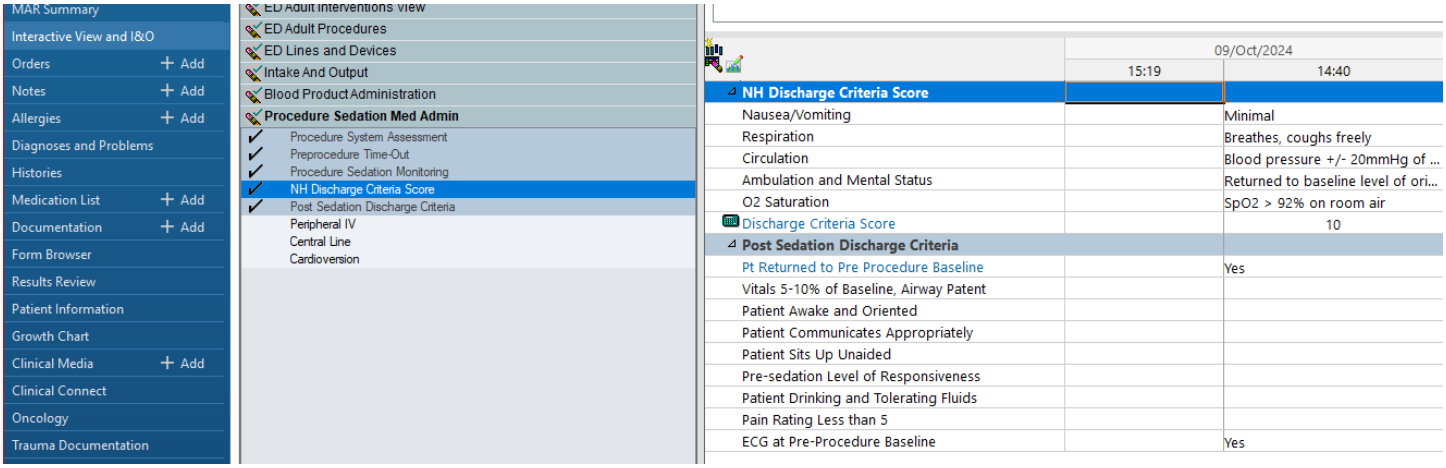
a. Document intraprocedural vitals and assessments per policy in the **Procedure Sedation Monitoring** section. If the patient is connected to BMDI, right click in the blue row (under the date/time) and select 'Add Result' to transfer vitals into the chart.



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.



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.



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.