Conscious Sedation Policy

PURPOSE

Provide guidelines to ensure safe and consistent process for patient selection, administration, monitoring and discharge care of patients receiving conscious sedation.

Conscious sedation refers to combinations of pharmacological agents administered by one or more routes to produce a minimally depressed level of consciousness and satisfactory analgesia while retaining the ability to independently and continuously maintain an airway and respond to physical stimulation and verbal commands.

POLICY

Patient must independently and continuously maintain a patent airway, protective reflexes and respiratory stability as well as respond appropriately to physical stimuli and/or verbal commands.

Conscious Sedation may easily be converted into deep sedation and/or loss of consciousness because of the unique characteristics of the medications used. Deep sedation refers to a medically controlled state of depressed consciousness in which protective reflexes may not be maintained, patient may not maintain a patent airway independently, patient is unable to appropriately respond to physical stimulation or verbal command.

Conscious sedation is administered by a physician order and in the presence of a licensed, trained and approved physician. Conscious sedation for adult patients can be administered and monitored by a licensed, trained and approved registered nurse on patients assigned an ASA 1 or 2 classification.

Outcome:

Patients of all ages will receive the same standard of care regardless of location.

The guidelines for care have been established in accordance with the ASPAN/AORN standards of care. These guidelines apply to patients who receive narcotics, benzodiazepines, barbiturates, or other ancillary agents during procedures by most commonly an intravenous route, although oral, transmucosal, rectal, intramuscular or inhalation routes may also be used.

Exceptions:
These guidelines do not apply in:

- The treatment of pain, anxiety or agitation that is unrelated to the accomplishment of a specific diagnostic or therapeutic procedure.
- When drugs are used as premedication.
- Life-threatening emergencies (i.e., intubations).

Location:

The locations that have been approved by the Medical Staff and the hospital for elective administration of anesthesia/sedation and analgesia includes but is not limited to the Main OR, Post Anesthesia Recovery Room, Labor and Delivery room, Emergency Room, and Radiology. Administration of conscious sedation will not be permitted in the long term care unit or medical surgical unit.

All anesthetizing locations must have the following:

- A functioning suction apparatus.
- The availability of (at least two) qualified individual(s) for monitoring and emergency purposes.
- The availability of a self-inflating AMBU bag with at least 15 L/min flow for the immediate initiation of positive pressure ventilation.
- A functioning oxygen source that is capable of delivering positive pressure oxygen greater than 90% for at least 60 minutes.
- Availability of a “crash cart” (including an EKG monitor and a defibrillator) in the room/department.
- Patient draping techniques to allow ready access and exposure to assess color and/or perfusion at any time.

Administration of Conscious Sedation:

All staff involved in the conscious sedation process shall demonstrate annual satisfactory passing of competencies and maintain current ACLS certification prior to administration of conscious sedation.

The Nursing office shall maintain a list of qualified registered nurses approved to administer conscious sedation. In addition, a list of approved providers will be maintained in the credentialing files.

Only a physician is qualified to prescribe, order or select the medication(s) to be used to achieve conscious sedation.
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All documentation for patients receiving conscious sedation will be completed in the patient’s electronic medical record.

Physician- Medical Staff
- Physician must be privileged for conscious sedation
- Must be updated and evaluated in conscious sedation annually and demonstrate competency.
- Must obtain informed patient consent for procedure, including conscious sedation and risks involved.
- Must assign an ASA status prior to the start of the procedure.
- Must be present during the administration of conscious sedation

Registered Nurses
Registered Nurses who are properly trained are authorized to administer narcotics, tranquilizers, sedative and inhalation per the prescribed route – IV, IM, oral, transmucosal or rectal, under the direction of a physician to achieve conscious sedation.
- The RN administering medications is responsible to continually assess the patient and shall have no other responsibilities during the procedure that would leave the patient unattended or compromise the continuous monitoring. This individual may assist with minor, interruptible tasks.
- RN must perform an initial assessment and history of the patient
- RN may be responsible for pre, intra and post procedure monitoring for patients 16 years of age and older assigned an ASA classification 1 or 2.

Certified Registered Nurse Anesthetist (CRNA)/Anesthesiologist
- CRNA or anesthesiologist will be responsible for the monitoring of all patients with an ASA classification of 3 or 4, or for situations as determined by the attending physician.
- CRNA or anesthesiologist will be responsible for the care pediatric patients under the age of 16 years that require conscious sedation.

The person administering or monitoring conscious sedation patients are required to:
- Be familiar with proper dosages, administration, adverse reactions and interventions for adverse reactions and overdoses.
- Know how to recognize an airway obstruction and demonstrate skills in basic life support.
- Assess total patient care requirements or parameters, including but not limited to, respiratory rate, oxygen saturation, blood pressure, cardiac rate, and level of consciousness; and
- Have the knowledge and skills to intervene in the event of complications.
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PROCEDURE

Prior to the administration of conscious sedation, it is necessary to:

1. Obtain a history and physical. Factors to be considered include age, weight, pregnancy, potential airway problems, medication, allergies, NPO status, and problems with anesthesia / sedatives.
2. Suggested fasting guidelines include 6 – 8 hours NPO (solids/non-clear liquids) and 2-3 hours (clear liquids) in patients not meeting NPO guidelines or in other situations where gastric emptying is impaired (morbid obesity, diabetic gastropesis, etc), the potential for aspiration of gastric contents must be considered in determining the timing of the intervention and the degree of sedation/analgesia used.
3. Obtain baseline assessment of patient’s mental status, level of consciousness, heart rate, blood pressure, respiratory rate and oxygen saturation level.
4. Emergency drugs and equipment must be available including defibrillator, suction device, oxygen, airways, emergency drugs (to include reversal agents such as Narcan (nalaxone) and Romazicon (flumazenil), intubation equipment, and ECG monitor.
5. To assure hemodynamic stability throughout the period of anesthesia/sedation:
   • All patients must have an IV access initiated prior to anesthesia and maintained throughout the recovery period. All IV fluid (both type and amount) must be part of the documentation.
   • All patients will be monitored continuously by EKG and pulse oximetry.
   • Blood pressure, HR, oxygen saturation, level of consciousness and respiration will be documented at interval no greater than 15 minutes (or more frequently as clinically indicated).
   • Any adverse or untoward event, including hypersensitivity reaction, resulting from the administration must also be documented in the patient’s chart.
   • The provider, or designees, must remain available to provide care in case of emergency.
   • Supplemental oxygen should be administered if hypoxemia is anticipated or develops.

Post Procedure Assessment:

The patient is continuously monitored during the post sedation phase. The RN is responsible for patient monitoring and documentation after procedure completion.
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Documented monitoring includes vital signs, oxygen saturation, skin color, level of consciousness and presence of protective reflexes.

Continuous physical assessment (at least every 15 minutes) is maintained until the patient returns to the pre-sedation level of consciousness with regard to:
   a. Airway, breathing and circulation;
   b. Ability to respond appropriately to verbal stimuli;
   c. Absence of discomfort as physiologic stability allows.

Patients will be observed for a minimum of two vital sign assessments taken at 15 minute intervals after the stimulation of procedure ceases. If reversal agents are given, the patient will be observed for a minimum of 1 hour.

PROCEDURE

The nurse will evaluate and document on the conscious sedation flowsheet on an ongoing basis to determine fulfillment of the following criteria:

1. Respiratory Status
   a. Patient, unassisted airway, reflexes present;
   b. Breath sounds equal and clear;
   c. Rate approximate for age;
   d. Pulse oximetry >90% on room air or achieved with supplemental O2 as ordered;
   e. Color is maintained.

2. Cardiovascular Status:
   a. Pulse and blood pressure readings approximate to normal pre-operative values;
   b. Absence of persistent bleeding;
   c. Absence of unexplained cardiac irregularities.

3. Neurologic Status:
   a. Responds appropriately to verbal stimuli.

4. Patient Comfort:
   a. Absence of discomfort as physiologic stability allows.

Discharge Home:

The physician care provider is responsible for determining the suitability for patient’s discharge. If the provider is not personally present to make the decision, the RN
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may initiate discharge of the patient if the discharge criteria is met with a score of 9 or greater.

Physician order for discharge must be obtained.

Outpatients will receive written and oral home care instructions, providing a 24-hour emergency phone contact number. Instructions will be pertinent to the patient’s needs and their level of understanding. The patient and/or patient representative will sign an acknowledgment of these written instructions.

Discharge:

All ambulatory or outpatients must be discharged from the hospital accompanied by a designated responsible adult.

If a patient does not meet discharge criteria, this should be communicated to the physician for a decision to either retain the patient in the unit for further observation and intervention, or transfer to an ICU or PACU for continued care. If criteria for discharge is not met, the patient will be admitted to 23-hour observation or inpatient status by order of the physician.

Outpatient Transfer:

An RN may assume care of the patient with a normal patient load when outpatient transfer criteria have been met. Transfer orders must be written by the physician ordering the conscious sedation. A report will be given to the receiving nurse or unit consisting of pre-procedure, intra and post procedure history. The following criteria must be met prior to a patient transfer:

1. Temperature above 97 degrees Fahrenheit (ax) or below 100 degrees Fahrenheit (ax) and approaching normal.
2. Blood pressure within 20% of normal or pre-sedation value.
   a. Pulse not below 60 or above 100 BPM (except where pre-sedation values are below 60 or above 100)
3. Respirations not below 12 or above 30
4. Patient is awake, can call for assistance, and is oriented if so disposed prior to sedation.
5. Post sedation Aldrete score of 7-10, considering baseline.

Continuing Quality Improvement:

Occurrence Reports are generated when there is a breach in protocol or an adverse patient outcome*. All such reports will be reviewed by the Hospital and Medical Staff.

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*ADVERSE PATIENT OUTCOMES*

Laryngospasm / Airway Obstruction
Death
Cardiac Arrest
Acute MI
Acute CHF / Pulmonary Edema
Angina / Myocardial Ischemia
Significant BP Instability
Hemo, Significant Dysrhythmias
Bronchospasm

Pulmonary Aspiration / ARDS
Unplanned Resp. Arrest / Depression
CNS Injury
Seizures
Post Operative Delirium / Confusion
Equipment Failure
Wrong Medication
Allergic Reaction

ADDENDUM
CONSCIOUS SEDATION

Definitions:

1. **Conscious Sedation:** A minimally depressed level of consciousness that retains the patient’s ability to maintain a patent airway independently and continuously and to respond appropriately to physical stimulation and verbal commands. The drugs, doses, and techniques used, regardless of the route of administration, are not intended to produce the loss of consciousness.

2. **Deep Sedation:** A controlled state of depressed consciousness or unconsciousness from which patients are not easily aroused and are unable to respond purposefully to physical stimulation or verbal commands. This may be accompanied by partial or complete loss of protective reflexes and an inability to maintain a patent airway independently.

3. **General Anesthesia:** A controlled state of consciousness accompanied by a loss of protective reflexes, including the loss of the ability to maintain a patent airway independently or to respond purposefully to physical stimulation or verbal commands.

4. **Local Anesthesia:** The introduction of a local anesthetic agent by injection in subcutaneous tissue(s), in close proximity to a nerve, or applied topically in such a manner as to avoid intravascular injection. All local anesthetics possess both excitatory and depressant CNS effects in sufficient blood levels and may additionally have profound effects on the cardiovascular system. There may also be interactive effects between local anesthetic agents and sedative medications.
<table>
<thead>
<tr>
<th>AGENTS</th>
<th>DOSING GUIDELINES</th>
<th>PHARMACOKINETICS</th>
<th>ADVERSE DRUG REACTIONS</th>
<th>REVERSAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ativan</td>
<td>0.04mg/kg to 2mg IVP 20-30 minutes prior to procedure</td>
<td>Onset: 3-7 minutes Peak Effect: 10-20 minutes Duration of Action: 6-8 hours</td>
<td>Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation.</td>
<td>Romazicon (Flumazenil) IV 0.2mg over 15 seconds, may repeat at 1 min as needed</td>
</tr>
<tr>
<td>Versed</td>
<td>1-2mg up to 15mg (recommended to wait at least 2 minutes between increments to assess sedation)</td>
<td>Onset: 3-7 minutes Peak Effect: 5-7 minutes Duration of Action: 20-30 minutes</td>
<td>Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation.</td>
<td>Romazicon (Flumazenil) IV 0.2mg over 15 seconds, may repeat at 1 min as needed</td>
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<tr>
<td>Valium</td>
<td>Adults: 2.5-5mg IV every 5 minutes to a max dose of 20mg. In elderly (&gt;65) and those with COPD max dose is 10mg</td>
<td>Onset: 1-5 minutes Duration of Action: 1-8 hours</td>
<td>Respiratory and cardiovascular depression may occur. May also cause ataxia, dizziness, hypotension, bradycardia, blurred vision, and paradoxical agitation.</td>
<td>Romazicon (Flumazenil) IV 0.2mg over 15 seconds, may repeat at 1 min as needed</td>
</tr>
<tr>
<td>Morphine</td>
<td>Adults: 5-20mg IM;</td>
<td>Onset: 2-3 minutes Peak Effect: 20 minutes Duration of Action: 2-4 hours</td>
<td>Hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash</td>
<td>Narcan (Naxolone), May give IV, IM, SC. Recommend IV in emergency situations. Dose: 0.1-0.4mg at 2-3 minute intervals until desired response is achieved</td>
</tr>
<tr>
<td>Sublimaze</td>
<td>Adults: 25-100mcg IV</td>
<td>Onset: 1-2 minutes Peak Effect: 10-15 minutes Duration of Action: 30-60 minutes</td>
<td>Hypotension, bradycardia, respiratory depression, nausea, vomiting, constipation, biliary spasm, and skin rash</td>
<td>Narcan (Naxolone), May give IV, IM, SC. Recommend IV in emergency situations. Dose: 0.1-0.4mg at 2-3 minute intervals until desired response is achieved</td>
</tr>
<tr>
<td>Amidate</td>
<td>Adults: 0.1-0.3mg/kg IV over 15-30 seconds <strong>Note: has NO analgesic effect</strong>*</td>
<td>Onset: 10-20 seconds Duration: 10-30 minutes</td>
<td>Hypo/hypertension, tachy/bradycardia, apnea, laryngospasm</td>
<td>None</td>
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<tr>
<td>Propofol</td>
<td>Adults: IV 5mcg/kg/min (may increase in 5 - 10mcg/kg/min every 5-10 min) IV Bolus: 1mg/kg (may titrate by 0.5mg/kg every 3-5 minutes as needed)</td>
<td>Onset: 30-60 seconds Duration of Action: 10-15 minutes</td>
<td>Hypotension, heart block, asystole and other arrhytthmias, bradycardia. Allergic reactions in patients with a history of an egg allergy</td>
<td>None</td>
</tr>
</tbody>
</table>
## ADDENDUM

### CONSCIOUS SEDATION

<table>
<thead>
<tr>
<th>ASA Classification</th>
<th>Description of Patient</th>
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</thead>
<tbody>
<tr>
<td>ASA Physical Status 1</td>
<td>A normal healthy patient</td>
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<tr>
<td>ASA Physical Status 2</td>
<td>A patient with mild systemic disease</td>
</tr>
<tr>
<td>ASA Physical Status 3</td>
<td>A patient with severe systemic disease</td>
</tr>
<tr>
<td>ASA Physical Status 4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
</tr>
<tr>
<td>ASA Physical Status 5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
</tr>
<tr>
<td>ASA Physical Status 6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
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</table>
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CONSCIOUS SEDATION (SEDATION / ANALGESIA)

General Nursing Conscious Sedation Flowsheet

Date: __________ Allergies: __________________________________________

Planned Procedure: ________________________________________________
MD: ________________

Pre-Procedure Checklist Requirements:

____ Patient identified using 2 patient identifiers from two sources
____ Consent signed to include Conscious Sedation Consent
____ Documented Nursing Assessment
____ Documented Physician Assessment
____ Appropriate Emergency equipment at bedside: oxygen: __ suction: __ bag valve mask: __

Pre-Procedure Assessment Requirements:

Age: _______ Height: _______ Weight: _______ Pre-procedure Aldrete Score: _____

NPO for _______ hours (alert physician if less than 6 hours)

Pain level (1-10): _______ Location/description of pain: __________________________

Significant medical history: ________________________________________________

Temp: ____ Pulse: ____ Respirations: ____ BP: _______ SPO2: ______

Lung sounds: ____________________________________________________________

Supplemental oxygen: ________________________ via: ________________________

Comments: ____________________________________________________________

______________________________________________________________

______________________________________________________________

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**Conscious Sedation Policy**

Pre-procedure
RN: ___________________________ Date: ____________ Time: ____________

**General Nursing Conscious Sedation Flowsheet**

**Intra-Procedure**
Pre information reviewed or report received: ___________________________

Date: ___________________________

Procedure start time: ___________________________

Allergies: ___________________________

**Document vital signs immediately prior to induction and every 5 minutes and as needed throughout procedure. Changes in vitals from baseline should be reported to physician.**

Time Out called by: ___________________________

**Sedation scale:**

- S = Sleepy, easy to arouse
- 1 = awake and alert
- 2 = Slightly drowsy, easily aroused
- 3 = Somnolent, minimal or no response to physical stimulation

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<tr>
<th>Time</th>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Response</th>
<th>Temp</th>
<th>Pulse</th>
<th>Resp</th>
<th>BP</th>
<th>SPO2/02</th>
<th>Sedation Scale</th>
<th>Initials</th>
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Sedation scale: ___________________________

Time of End of Procedure: ___________________________

Medication/Monitoring RN: ___________________________

Circulating/Assisting RN: ___________________________

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General Nursing Conscious Sedation Flowsheet

**Post-Procedure:** Vital signs every 10 minutes x3 then as needed until discharge. Patients must have an Aldrete Score of at least 8 for end of post monitoring. **To transfer a patient out, patient must have an Aldrete Score 7-10.**

<table>
<thead>
<tr>
<th>Time</th>
<th>Pain level (1-10)</th>
<th>Condition of procedure site</th>
<th>Medications given</th>
<th>Response</th>
<th>Temp</th>
<th>Pulse</th>
<th>Resp</th>
<th>BP</th>
<th>S P02/02</th>
<th>Initials</th>
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Aldrete Score: ______ Start Time: __________ Score Start 10 min 20 min 30 min 40 min 50 min 60 min

Activity: Able to move 4 extremities

Able to move 2 extremities

Able to move 0 extremities

Respiration: Deep breath, cough freely

Dyspnea, limited breathing

Apnea

Circulation: B/P +/- 20% of pre-sedation level

B/P +/- 40% of pre-sedation level

B/P +/- 60% of pre-sedation level

Color: Pink

Dusky, blotchy, pale

Cyanotic

LOC: Fully awake

Responds to name or light touch

Unresponsive

**TOTAL SCORE:**

Time recovery ended: ____________ Recovery RN: ____________________________________________________________________________________

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CONSCIOUS SEDATION (SEDATION / ANALGESIA)

Post Anesthetic Discharge Scoring System (PADS)

In order for a patient to be discharged home, the patient must have a PADS score of 9 or higher.

Start using PADS table after post monitoring is completed. Patients must be assessed using this table every 30 minutes until the patient reaches a score of 9 or higher.

<table>
<thead>
<tr>
<th>Post-Anesthetic Discharge Scoring System</th>
<th>Score</th>
<th>Start Time</th>
<th>Time</th>
<th>Time</th>
<th>Time</th>
<th>Time</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Signs:</td>
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<td>Within 20% of preop value</td>
<td>2</td>
<td>2</td>
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<td>20%-40% of preop value</td>
<td>1</td>
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<td>&gt;40% of preop value</td>
<td>0</td>
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<td>Activity &amp; Oriented x3 AND steady gait</td>
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<tr>
<td>Mental status:Oriented x3 OR has a steady gait</td>
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<td>Neither</td>
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<tr>
<td>Pain, nausea and/or vomiting: Minimal</td>
<td></td>
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<tr>
<td>Moderate, having required treatment</td>
<td>2</td>
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<tr>
<td>Severe, requiring treatment</td>
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<td>Bleeding:</td>
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<tr>
<td>Minimal</td>
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<td>Moderate</td>
<td>1</td>
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<tr>
<td>Intake &amp; Output: Has had PO fluids AND voided</td>
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<tr>
<td>Has had PO fluids OR voided</td>
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<td>2</td>
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<tr>
<td>Neither</td>
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<tr>
<td>TOTAL SCORE:</td>
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Revised: 5/15 – Board approved 6/4/15
CONSCIOUS SEDATION (SEDATION / ANALGESIA)

EFFECTIVE DATE: 1/24/2014
APPROVED BY: Pharmacy & Therapeutics Committee
REVISED: 05/05/2015
APPROVED BY: Medical Executive Committee
REVISED: 5/5/2015

DATE: 01/26/2015
DATE: 01/26/2015