Sedation-Analgesia
Patient Evaluation
Getting Started

A health care provider with current privileges to administer sedation-analgesia must conduct a pre-procedure evaluation, and obtain informed consent for sedation-analgesia.

Only patients reasonably expected to meet discharge criteria (as specified elsewhere) shall receive sedation-analgesia.

A standard sedation-analgesia order form must be placed on the chart, filled out and signed by the licensed independent practitioner prior to initiating sedation-analgesia.
Consider excluding patients who may not cooperate:

- Organic Brain Syndrome (Demented, Senile)
- Other diagnoses of psychiatric disease
- Intoxication (alcohol, illicit drugs)
- Unable to communicate (language barrier, deaf, mute, etc.)
- Unable to understand (reduced mental abilities)
- Decreased level of consciousness
Consider an Anesthesiology Consult for...

- Patients with severe alterations in critical organ function (heart, lungs, brain, kidney)
- Full stomach (despite NPO status likely to have residual contents)
- Abnormal or potentially difficult to manage airway
Examples for considering an Anesthesiology Consult …

- Morbidly obese patients or history of severe snoring or obstructive sleep apnea
- Extremes of age
- An ASA III or higher physical status
- Severe renal, hepatic or cardiopulmonary disease
- Prior adverse response to sedation-anesthesia
- Severe symptomatic gastroesophageal reflux disease
- Pregnant patients
- A difficult airway exam
ASA Physical Status Classification

I There is no organic, physiological, biochemical, or psychiatric disturbance (i.e., totally healthy)

II Mild to moderate systemic disturbance caused either by the condition to be treated or by other pathophysiologic processes (e.g., HTN, DM)

III Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability (e.g., CAD)

IV Indicative of the patient with severe systemic disorder already life-threatening, not always correctable by the operative procedure (e.g., unstable angina, ongoing myocardial ischemia, recent heart attack, uncompensated congestive heart failure, recent or evolving stroke, acute bronchospasm, etc.)

V The moribund patient who has little chance of survival but is submitted to operation in desperation
Pre-Sedation Assessment

- Informed consent for the planned procedure
- History that includes:
  - Allergies and previous adverse drug reactions
  - Current medications
  - Diseases, disorders, and abnormalities
  - Prior hospitalizations
    - Previous procedures/anesthetics and notation of any problems
  - Pertinent family history of diseases and disorders
  - FULL review of systems with concentration on cardiopulmonary function
    - EXTREME CAUTION with history of severe snoring or sleep apnea
  - Pertinent lab or other test results
  - Physical Exam
Pre-Sedation Assessment (cont.)

- Physical examination specific to the procedure being performed, including:
  - Height and weight
  - Vital signs
  - Baseline oxygen saturation by pulse oximeter
  - Airway assessment
  - Chest and cardiac examination
  - Level of consciousness
Pre-Sedation Airway Assessment

Prior to sedation-analgesia patients should have a documented airway assessment including...

- **Body Habitus**
  - (significant obesity or deformities, especially involving the neck and facial features)

- **Head and neck**
  - (short neck, limited neck extension, decreased hyoid-mental distance, neck mass, cervical spine disease or trauma, tracheal deviation, previous surgery and/or radiation)

- **Mouth**
  - (small opening, protruding incisors, removable dentures, loose or capped teeth, high arched palate, macroglossia, tonsillar hypertrophy, non-visible uvula)

- **Jaw**
  - (small or receding jaw, trismus, beard – can hide abnormalities)
Pre-Sedation Assessment

- Aspiration risk (e.g., GERD, bowel obstruction, hiatal hernia)
- Time since last PO intake
- Assessment/Plan
The following must be documented pre-procedure to allow risk assessment:

- Patient weight and height
- Complete History and Physical
- Patient’s medications and allergies
- NPO status
- ASA physical status
- Patient airway assessment
Pre-Procedure Assessment

➢ Pre-sedation vital signs:
  • Blood pressure
  • Heart rate
  • Respiratory rate
  • Baseline pulse oximetry saturation
  • Temperature

➢ Pertinent lab results
The PAR Score
(Post Anesthesia Recovery)

- The PAR score is a numerical scoring system, which assists in the documentation of easily observed signs of physical and physiological recovery from sedation/analgesia/anesthesia.

- A PAR score must be documented:
  - Pre-procedure
  - Post-procedure
  - On discharge
### PAR Score

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Points</th>
<th>Definition of Point Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity command</td>
<td>2</td>
<td>Able to move all extremities voluntarily on command</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Able to move 2 or more extremities voluntarily or on command</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>Able to move 0 extremities voluntarily or on command</td>
</tr>
<tr>
<td>Respiration</td>
<td>2</td>
<td>Able to breathe deep and cough freely</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Dyspnea or limited breathing</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>Apnea</td>
</tr>
<tr>
<td>Circulation</td>
<td>2</td>
<td>BP +/- 20% of pre-anesthetic level</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>BP +/- 20 to 50% of pre-anesthetic level</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>BP +/- 50% of pre-anesthetic level</td>
</tr>
<tr>
<td>Consciousness</td>
<td>2</td>
<td>Fully Awake</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Patient arouses on calling</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>Not responsive</td>
</tr>
<tr>
<td>Color</td>
<td>2</td>
<td>Pink</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Pale/Dusky/Blotchy/Jaundice/Other</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>Cyanotic</td>
</tr>
</tbody>
</table>

**Total PAR Score:**
NPO Status

- NPO status must be documented
- Patient must be NPO for eight hours prior to procedure
- The responsible licensed independent provider may document an exception in the event of an emergency and after discussion of risks vs. benefits of sedation options with patient or consenting individual
Females of childbearing age must have a negative urinary pregnancy test documented within the prior 10 days or a signed refusal of pregnancy testing.

Anesthesiology consultation should be considered for all pregnant patients.