SEDATION IN THE EMERGENCY DEPARTMENT AT THE PRINCESS ROYAL HOSPITAL (INTERIM POLICY)

Ref No: 2013

Lead Clinician	:	Dr A Marsh, Consultant in Emergency Medicine
Care Group	:	Unscheduled Care (Emergency Assessment)
Implemented	:	February 2014
Last updated	:	February 2014
Last reviewed	:	March 2014
Planned review	:	March 2015
Keywords	:	sedation
Comments	:	

This interim policy sets out the standards required for sedation in the Emergency Department at the Princess Royal Hospital.

Sedation is a continuum, and it is not always possible to maintain patients at a pre-determined sedation depth. This document recognises a clear distinction between lighter levels of sedation (minimal and moderate, or conscious, sedation) and deeper levels (including the dissociative state caused by ketamine). Deeper levels of sedation are indistinguishable from general anaesthesia, and should be treated as such. This is reflected in a series of recommendations for staff numbers and competencies, alongside the required environment and equipment, which are required for each target sedation depth.

Because maintenance of the airway is essential, for deep and dissociative sedation in low risk patients the sedating practitioner should have successfully completed the initial assessment of competence of the Royal College of Anaesthetists and been accredited through a local training programme. Additional supervised practice and competence assessment are required to undertake unsupervised rapid sequence induction of anaesthesia and tracheal intubation in the Emergency Department, and these additional skills are not included within the scope of this document.

The use of continuous capnography is mandatory wherever deep sedation, dissociative sedation or general anaesthesia occurs, and is also recommended at lighter levels of sedation. A skilled assistant must be present for all levels of sedation beyond minimal. Prior patient consent should be obtained wherever possible, and standard documentation, within a robust system of clinical governance, put in place along with post-sedation and discharge advice.

Fasting is not needed for minimal sedation or moderate sedation where verbal contact is maintained. For deeper levels of sedation the fasting rules for general anaesthesia form an accepted baseline. For an emergency procedure in the absence of fasting any decision to proceed should be based on urgency and the target depth of sedation coupled with a careful assessment of aspiration risk.

Sedation is not a substitute for adequate explanation or analgesia.

MINIMAL SEDATION WITH ENTONOX

Time of day: Anytime

Staffing: One physician

Competencies: ALS

Location: Anywhere in the ED

Monitoring: Pulse oximetry

MODERATE SEDATION (CONSCIOUS SEDATION)

Time of day: Within working hours only

Staffing: One physician as seditionist and one physician as operator and one nurse

Competencies: ALS certification and local sign off for sedation training.

Location: Resuscitation room only.

Monitoring: ECG, NIBP, pulse oximetery (+/- capnography)

Outside normal working hours then the patient should be reffered to the relevant speciality and the anaesthetic team. The procedure and sedation will then occur in theatres.

DEEP SEDATION AND DISSOCIATIVE SEDATION

Time of day: Within working hours only

Staffing: One physician as seditionist and one physician as operator and one nurse

Competencies: ALS certification, local sign off for sedation training and Royal College of Anaesthetists initial assessment of competence

Location: Resuscitation room only.

Monitoring: ECG, NIBP, pulse oximetery and capnography

Outside normal working hours then the patient should be reffered to the relevant speciality and the anaesthetic team. The procedure and sedation will then occur in theatres.

If a complication occurs in the resuscitation room then the on-call anaesthetic senior doctor or consultant should be contacted for assistance.