Pre-Procedure

- Informed consent for treatment obtained and documented
- Order for sedation established and documented
  - Targeted level of sedation indicated
- Baseline assessment completed and documented
  - Airway assessment completed and documented by the authorized prescriber
- Required monitoring equipment/supplies assembled
  - Medications including antagonists are present
  - All equipment tested and functioning
  - Cardiac monitoring established and documented - electrocardiogram monitoring is not required for all patients though strongly advised in patients where underlying cardiopulmonary disease (e.g., previous myocardial infarction or dysrhythmias may impact the patient outcomes during or post-procedure)
- Authorized prescriber present
- Roles for administering, monitoring and documenting are established within the team
- Communication strategy for administration and monitoring established within the team including the plan for unexpected events or complications
- Appropriate number of competent health care professionals present
  - 2 for moderate, 3 for deep

Intra-Procedure

- The prescriber and team verbally confirm:
  - Order for sedation
  - Target level of sedation
  - Roles
  - Correct initial dose confirmed and written
  - Route of medications confirmed
  - Method for order changes/additions and titration including initial dose established
  - IV access established
  - Communication strategy for administration and monitoring
  - Appropriate number of competent health care professionals present
  - 2 for moderate, 3 for deep
- Place patient on continuous oximetry
- Patient is monitored closely at all times:
  - Cardiac monitoring (3 lead) if cardiac history may negatively impact outcomes
  - BP, HR and RR monitored and recorded
  - O₂ saturation monitored and recorded
  - ETCO₂ (capnography) - where available
  - Level of Consciousness /Responsiveness
  - General Status
- Patient is monitored for unanticipated events including (but not limited to):
  - Overshoot/undershoot of sedation
  - Airway compromise
  - Cardiac complications
  - Pain
- Document all assessment data every 15 min (moderate sedation) or 5 min (deep sedation) or more frequently as needed dependent on the patient’s condition and immediately following procedure:
  - Vital signs
  - Medication used in sedation
  - Patient’s responses to both the procedure and sedation

Post-Procedure

- Complete and document recovery from sedation, post procedure in the health record
- For target of moderate or deep sedation:
  - Monitor and document BP, HR and RR every 15 minutes for a minimum of 30 minutes and patient achieves:
    - Aldrete recovery of ≥ 8 or
    - Patient’s baseline level at pre-procedure assessment
- If patient experienced intra-procedural complications and/or received reversal agents during the procedure, patient must be monitored in an appropriate clinical area for a minimum of 2 hours (and achieve Aldrete ≥ 8 or pre-procedure baseline status)
- If transferred to inpatient unit or external facility:
  - Ensure that the health professional/worker receiving the patient has accurate and complete documentation on the patient’s discharge status and any issues requiring further monitoring
- If discharged home with family/caregiver support (whenever possible):
  - Provide instructions and contact information for post procedure complications
  - Advise re: driving, and heavy equipment operation restriction and caution against major decision making for an 8 hour period
- Patients with Obstructive Sleep Apnea and treated with Continuous Positive Airway Pressure (CPAP) or Bilateral Positive Airway Pressure (BiPAP) are to employ devices in any setting where they may fall asleep for a 24 hour period post procedure

Adapted from the AHS Procedural Sedation Checklist