Conscious Sedation Pre-assessment

In order to be in compliance with UWHC sedation policy, we need to ensure that the minimum required patient assessment is completed and signed/co-signed by the responsible sedation credentialed MD. Please see below excerpt from the sedation policy related to this. In review of these requirements we identified that we were not in compliance related to documentation of a Mallampati classification score for airway assessment. In order to remedy this, we have added the mallampati score to the HealthLink template for the Pre-cath H&P that is utilized by the Fellows and NP’s. They will complete this as part of the pre-procedure assessment. This needs to be completed on all patients, both inpatients and outpatients, prior to sedation. This is a change in our current workflow as we were not requiring an additional pre-procedure physical assessment for inpatients with a completed H&P documented by the inpatient team. Moving forward, we need to maintain compliance with the sedation policy by documenting appropriateness for sedation, including an airway assessment. This means that, prior to sedation administration, a fellow, NP or attending MD will need to complete a pre-procedure note that addresses sedation and airway. The Health Link pre-procedure note template should be utilized for this unless the individual completing the note has their own preferred template that includes the required airway assessment.

I have attached a reference sheet that diagrams the mallampati classification. This airway classification should be communicated during the timeout so that all participating in the case are aware of any airway risks related to sedation.

Please let me know if you have any questions related to this procedure.

1. HEALTH ASSESSMENT
   An attending staff physician/Nurse Practitioner must supervise the performance and documentation of a health assessment of the patient. The purpose of the pre-procedure assessment is to determine baseline status of the patient and identify factors that may increase the patient's risk during the period of sedation. No patient shall receive sedation until a pre-sedation assessment has been completed and documented, and the physician has attested to the patient's appropriateness to receive sedation as evidenced by his/her signature on an appropriate documentation form. The person administering the sedative agent shall verify that the required documentation is completed prior to any sedation being given. A procedure will be delayed or canceled until all pre-procedure documentation is completed.

   Minimal assessment required before sedation includes, but is not limited to, the determination and documentation of:
   
   a. Age and weight.
   b. Drug allergies.
   c. Current medication use (including recent narcotics and sedatives within the past 24 hours).
   d. Previous problems with anesthesia/sedation.
   e. Heart rate, blood pressure, and respiratory rate.
   f. Oxygen saturation.
   g. Level of awareness (consider mental status/orientation).
   h. Time of last PO intake (see Appendix B).
   i. Respiratory and cardiovascular status which may include findings from heart and lung auscultation and other physical findings as appropriate.

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j. **Assessment for risk of airway compromise. (Mallampati Classification)**

k. Baseline assessment of pain, where appropriate.

l. Baseline Modified Aldrete Sedation Score (minimum score of 8 recommended for moderate sedation).

m. Marking of surgical site involving right/left distinction, multiple structures (such as fingers or toes) or levels (such as spine). Teeth do not require marking.