

## Minimum requirements for safe conscious sedation of adult patients in the A&E department

Conscious sedation should be used to alleviate patient anxiety, distress and pain associated with procedures in the A&E department. It should only be used once other methods of managing the patient have been excluded. It should **NEVER** be used for operator convenience.

**Conscious sedation** is defined as:

“A technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which **verbal contact with the patient is maintained throughout the period of sedation.** The drugs and techniques used to provide conscious sedation ...should carry a margin of safety wide enough to render loss of consciousness unlikely.”<sup>1</sup>

The benefits of conscious sedation must always be weighed against the risks of the procedure including hypoxia, aspiration of gastric contents and death.

### **Indications for conscious sedation in the A&E department**

Reduction of dislocated shoulder, elbow, patella, ankle, TMJ  
Reduction of displaced distal radial fractures  
Cardioversion

If conscious sedation in the A&E department is contemplated for indications other than those on this list, permission must be gained from the duty A&E consultant.

## 1. Consent

Informed consent must be gained from all patients in whom conscious sedation is contemplated. Dedicated consent forms must be used.

## 2. Environment

Conscious sedation must be performed in a suitable environment. Resuscitation equipment must include suction, basic airway adjuncts and a self inflating bag and mask. Intubation equipment must also be immediately available. Oxygen must be administered throughout the procedure if Entonox is not used.

There must be adequate space for the administration of sedation, performance of the procedure and the management of any complications.

There must also be easy access to additional staff, ideally without the need for any caregiver to leave the patient.

Conscious sedation must only be performed in the **RESUSCITATION ROOM**.

## 3. Personnel

There must be a minimum of **two medically qualified staff** with the patient once sedation is initiated. The doctor responsible for sedation should not have any involvement with the performance of the procedure. The presence of a third member of staff is recommended.

The doctor responsible for sedation must have sufficient training and experience to be competent in its use. This competence includes but is not limited to the indications, contraindications and the administration of the sedative drug(s) and the **recognition and management of any complications** of the drug(s) used<sup>2</sup>. The doctor **must** be able to manage airway obstruction and respiratory depression.

The presence of a middle grade or consultant is strongly recommended. When conscious sedation is planned, the doctor in charge of the department must always be informed. The doctor in charge should also be notified at the start of the procedure.

## 4. Drugs

A comprehensive assessment of the suitability of conscious sedation for the patient should be made. This should include co-morbidity, current medication and drug sensitivity. If doubt exists as to the appropriateness of conscious sedation, advice should be sought from the consultant in A&E or an anaesthetist.

The use of multiple drugs increases the risk of complications hence the utilisation of a single sedative agent is recommended. If patients have already received analgesia prior to the sedation the increased effect of the sedative should be accounted for in the rate of titrated administration.

The choice of sedative agent is the responsibility of the doctor in charge of the sedation. The doctor must have adequate experience and training in the use of that drug and it should also be appropriate for that particular patient. Drugs such as propofol and etomidate should only be used by doctors who have undergone additional training in anaesthesia.

Sedative agents must be **TITRATED SLOWLY**. They must **NEVER** be given in large boluses.

It must be recognised that the titrated amounts do not exert their effects instantaneously but take some time for their effect. Time must be allowed for this to occur prior to the use of further boluses. Familiarity with all aspects of the drug chosen is an essential part of the safe administration of conscious sedation.

ENTONOX must only be delivered by the patient's own inspiratory effort activating the flow. Staff must not override the demand valve to allow continuous delivery of the gas. If Entonox is not used, continuous **high flow oxygen** must be provided.

## 5. Access

Secure intravenous access must be gained **prior** to the administration of any sedation.

## 6. Monitoring

All patients undergoing conscious sedation must have 3 lead ECG, oxygen saturation and non-invasive blood pressure monitoring.

The heart rate, oxygen saturation and blood pressure should be recorded at five minute intervals until full wakefulness is attained.

## 7. Post procedure observation

The completion of the procedure is usually accompanied in a dramatic reduction in the patient's pain. This reduction of stimulation may lead to a diminution in the conscious level once the procedure ends.

Patients must not leave the resuscitation room until they have regained full wakefulness. The use of the post procedural sedation protocol on Ward 1 / CDU is strongly recommended.

Antagonists (eg Flumazenil, Naloxone) should rarely be necessary. Their use mandates a more prolonged period of observation in the Resuscitation room and a longer overall stay in the A&E department.

## 8. Discharge

The patient must only be discharged from the A&E department when the procedure has been successfully completed, follow up arranged and full recovery from the sedation has occurred.

The patient must be given appropriate post sedation instructions including advice regarding driving and be discharged to the care of a competent person in the community. If the procedure is performed in the evening or night, an overnight admission on Ward 1 / CDU should be considered.

Especially care should be taken when managing elderly patients both during the procedure and when contemplating discharge arrangements.

Comprehensive notes should be made of the entire procedure including the names of all personnel involved.

## References

1. Implementation and ensuring Safe Sedation Practice. Report of an Intercollegiate Working Party chaired by the Royal College of Anaesthetists.
2. American College of Emergency Physicians: Clinical Policy for Procedural Sedation and Analgesia in the Emergency Department. *Ann Emerg Med* 1998;31:663-667.
3. Chudnofsky C, Lozon M. Sedation and Analgesia for Procedures. Rosen's Emergency Medicine 5<sup>th</sup> ed. Mosby. St Louis. 2002.