Hospital Sisters HEALTH SYSTEM

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SYSTEM: Hospital Sisters Health System	**MANUAL(S): Executive Manual**
TITLE: Sedation Policy	**ORIGINATING DEPARTMENT: Quality and Physician Relations**
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* As required by CMS Regulation §482.12 A-0043 Conditions of Participation: Governing Body, the following hospitals and entities are included as HSHS Entities: ILLINOIS: (1) HSHS St. John's Hospital – Springfield (2) HSHS St. Mary's Hospital – Decatur, (3) HSHS St. Francis Hospital – Litchfield, (4) HSHS Good Shepherd Hospital – Shelbyville, (5) HSHS St. Anthony's Memorial Hospital – Effingham, (6) HSHS St. Joseph's Hospital – Highland, (7) HSHS St. Joseph's Hospital – Breese, (8) HSHS St. Elizabeth's Hospital – O'Fallon, (9) HSHS Holy Family Hospital – Greenville, (10) HSHS Medical Group, (11) Prairie Cardiovascular Consultants WISCONSIN: (1) HSHS St. Vincent Hospital – Green Bay, (2) HSHS St. Mary's Hospital Medical Center – Green Bay, (3) HSHS St. Clare Memorial Hospital – Oconto Falls, (4) HSHS St. Nicholas Hospital - Sheboygan, (5) HSHS Sacred Heart Hospital – Eau Claire, (6) HSHS St. Joseph's Hospital – Chippewa Falls, (7) HME Home Medical, (8) Libertas Treatment Center – Green Bay and Marinette, (9) HSHS Wisconsin Medical Group.

I. POLICY:

Sedation/Analgesia will be provided in a safe manner by individuals credentialed to administer moderate or deep sedation by their individual institution. These personnel will be available and assume responsibility for monitoring and assessing patients pre-procedurally, intra-procedurally, and during the recovery period.

II. PURPOSE:

To provide guidelines on the administration and monitoring of patients receiving moderate or deep sedation by non-anesthesia providers in accordance with nationally recognized professional organizations. To maximize safety, emotional and physical comfort of patients undergoing procedural sedation.

III. SCOPE:

This policy is applicable to all HSHS hospitals* where sedation is administered. Providers, Organizations, and operating entities including their employees, agents and medical staff, and employed providers of an HSHS Medical Group.

IV. DEFINITIONS:

'Sedation/Analgesia utilizing sedative, hypnotic and/ or narcotic agents' is defined as a depressed level of consciousness and reduced anxiety. Within the continuum of sedation/analgesia, are the following:

Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, spontaneous ventilation and cardiovascular functions are unaffected. Minimal sedation occurs following the administration of medication to reduce anxiety or pain and allows the patient to maintain normal respiration, eye movement, and protective reflexes (ASA, 2018).

Moderate Sedation/Analgesia: A drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained (ASA, 2018).

Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain spontaneous ventilation may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained (American Society of Anesthesiologists [ASA], 2018).

Sedation Medications: Due to the potential for rapid changes in the depth of sedation and the lack of reversal agents, medications for procedural sedation that are more likely to result in deep sedation include: propofol, etomidate, methohexital and pentobarbital. Medications such as lorazepam, midazolam, fentanyl, ketamine and other narcotics still pose a significant risk and should be used with caution, especially when given at higher doses. (American Association of Nurse Anesthetists, 2004).

Immediately Present: Is defined by- the qualified provider is present within the procedure room in which sedation is being administered. During a deep sedation procedure, the qualified provider, immediately present, is not engaged in activities that could prevent them from immediately intervening and conducting hands-on interventions if the patient's condition requires.

Immediately Available: Is defined by- the qualified provider is in a physical proximity that allows the provider to establish direct contact with the patient to meet medical needs and address any urgent or emergent problems. If the sedating nurse has patient concerns, they could reasonably request that the provider be present within the procedure room for the entire sedation process.

Pediatric Patients: 18 years old and younger. It is recognized, however, that developmental status in individual cases may be considered in determining which set of recovery criteria are most applicable.

Rescue Capacity: Refers to the provider's ability to recognize and intervene to abnormal and physiological changes. Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Further, there may be no clear boundary between sedation levels. "Rescue" from a deeper level of sedation than intended may require an intervention. The qualified provider corrects adverse physiologic consequences of the deeper-than- intended level of sedation and returns the patient to the originally intended level of sedation.

Reversal Agents: Medications used to antagonize or reverse the untoward or undesired effects of previously administered medications.

V. PERSONNEL REQUIREMENTS

The minimum number of available personnel for any procedure employing sedation/analgesia shall be two:
Personnel #1 – An individual that can intervene with supportive or resuscitative measures if needed
Personnel #2 – A monitor (an assistant trained to monitor appropriate physiologic parameters and to assist in any supportive or resuscitative measures required). A provider could fulfill this role.
The provider must be present during the administration of deep sedation and available during administration of moderate sedation. This personnel requirement applies until the patient demonstrates progress in the recovery process. The monitor may not have other duties or responsibilities that would prevent appropriate monitoring of the patient and may assist with minor interruptible tasks once sedation level is maintained. Procedures requiring intended deep sedation will require the presence of a provider with skills in advanced airway management.

VI. CREDENTIALS

Medical staff and Allied Medical staff members are credentialed to direct moderate sedation or deep sedation according to medical staff services policy.

VII. GUIDELINES/PROCEDURE

A. This policy applies to privileged employed or contracted providers, allied medical staff, and nursing staff who are involved in moderate or deep sedation procedures.

B. This policy does not apply to:
   1. Pharmaceutical therapies used to treat pain or sleep that are not part of a therapeutic or diagnostic procedure.
   2. The use of sedative medications to assist with intubations or other emergency situations (examples: acute uncontrolled agitation, imminent self-harm or harm to others).
   3. The use of sedative medications for mechanically ventilated patients.
   4. General anesthesia, regional anesthesia, MAC anesthesia, topical or local anesthesia and minimal sedation.

C. To administer moderate or deep sedation, the following must occur:
   1. Location:
      a. The location in which the procedure will be conducted must contain the necessary age-appropriate equipment to monitor patient response and appropriately manage emergent situations including rescue capacity.
      b. For all deep sedation cases, ETCO2 monitoring or continuous pretracheal auscultation is mandatory due to high risk of hypoventilation/apnea.
   2. Provider
      a. The ordering provider must be available as per Definitions Immediately Available and Immediately Present.
      b. Moderate or deep sedation medications are only to be ordered and used by personnel with moderate or deep(respectively) sedation privileges due to the high potential for required airway intervention with these medications.
   3. Registered Nurse:
      a. Registered nurses will have documented education and competencies to administer sedation.
      b. Registered nurses administering moderate sedation must be under the supervision of a provider who has been granted privileges to conduct procedural sedation.
      c. For a deep sedation procedure, the provider credentialed in Deep Sedation will be physically present at the patient's bedside at all times and will either personally administer the medication (required in Illinois, optional in Wisconsin), or direct a nurse (optional in Wisconsin).

D. Pre-procedure

   1. Before the procedure, a pre-sedation assessment must be performed and documented by the medical staff member or allied health professional, and include elements listed in **Appendix 1**.

   2. Signed consent form including an attestation from the provider that he/she explained the planned procedure including benefits, options, and risks of sedation and the sedation plan to the patient/family/legal representative.

   3. Pregnancy test (urine or blood) on all females between menarche and menopause on the day of procedure unless any of the following:
      - D&C for miscarriage
      - Patient is pregnant
      - Tested in past 72 hrs (result on chart)
      - Prior history of sterilization
      - Currently menstruating
      - Presence of sterilization device, ie, Essure, etc

- If patient states has had a tubal ligation/hysterectomy and this is documented within the patient's chart
- Attending provider waives the test and documents this rationale pre-procedure

4. For severely compromised or medically unstable patients (e.g., ASA status IV, anticipated difficult airway, severe obstructive pulmonary disease, coronary artery disease, or congestive heart failure) or if it is likely that sedation to the point of unresponsiveness will be necessary to obtain adequate conditions, consultation with an anesthesiologist is recommended. In an emergency situation where procedural benefits outweigh the risk of potential delay for Anesthesia Consultation, the sedation provider is encouraged to proceed with the least amount of sedation/analgesia necessary.
5. Nursing Colleagues shall perform a focused patient assessment as required by the type of procedure to be performed and document the findings in the EHR or patient record, as applicable.
6. Nursing Colleagues shall instruct patients that are scheduled for procedures requiring sedation/analgesia regarding any pre-procedure instructions from the provider, the NPO status, medications that may be taken even if NPO according to the provider's orders. Patients that are scheduled for elective outpatient procedures requiring sedation/analgesia shall also be instructed that the patient must be accompanied at discharge by a responsible adult and that the patient should not drive for a minimum of 12 hours post-sedation. If a provider wants to extend this restriction, it should be communicated to the patient/responsible adult and documented within the EHR.
7. The medical staff member or allied health professional credentialed in procedural sedation shall perform an evaluation of the patient immediately prior to beginning the procedure (attest that patient is or is not a candidate for moderate or deep sedation).
8. Nursing Colleagues shall initiate pre-procedure orders pursuant to a provider's order.
9. The credentialed medical staff or allied health professional directing sedation may consider referring to the Department of Anesthesiology any patient including those meeting the criteria in **Appendix 2**.

E. Intra-procedure

1. A qualified professional shall be present to continuously monitor the patient and should not have other duties or responsibilities that would prevent appropriate monitoring of the patient. The qualified professional may assist with minor interruptible tasks once sedation level is maintained.
2. Procedure Team: Conduct a time-out prior to beginning the procedure—for verification of the correct patient, correct procedure, and the correct site. Provider shall mark the site, if indicated. Refer to your local policies and procedures on site marking.
3. A qualified professional shall monitor and document blood pressure, heart rate, ETCO2 (if available), respiratory rate, SpO2, pain, and level of consciousness at least every 5 minutes in the electronic health record (EHR) or on applicable paper forms (if EHR documentation is not available). Electrocardiogram (ECG) is monitored during deep sedation or during any procedure in which arrhythmia is likely. Immediately notify the provider of abnormal findings and document abnormal ECG with a cardiac strip. If signs of respiratory compromise occur, such as alteration in ETCO2 or significant oxygen desaturation, notify provider immediately and request order to administer supplemental oxygen. Contact Rapid Response Team or Anesthesia, if complications and/or requested by the provider.
    a. For patients in MRI receiving sedation, check the heart rate, respiratory rate, BP, and level of consciousness at least every 5 minutes. If available, MRI safe continuous pulse oximetry and ETCO2 monitoring should be utilized. Visualization of the patient should occur throughout the procedure. If the patient experiences any change in condition, the procedure is stopped, and the patient is removed from the MRI scanner. He/she will be reassessed by the provider or registered nurse prior to the continuation of the procedure.
4. It is recommended that all patients receiving moderate or deep sedation receive supplemental oxygen unless specifically contraindicated for a patient or procedure.
5. All medications will be administered pursuant to the provider's verbal orders and will be documented accordingly.

F. Post-sedation
   1. The utilization of pulse oximetry and/or supplemental oxygen should be considered when transporting patients post-sedation that have higher respiratory risks such as, COPD, morbid obesity, etc.
   2. For patients that have received moderate sedation:
      a. All patients shall be monitored post-procedure for a minimum of 30 minutes or to the achievement of baseline parameters.
      b. All patients receiving moderate sedation who experience a complication shall be monitored post-procedure for a minimum of 1 hour to assess the resolution of the complication.
      c. All patients that have received a reversal agent shall be monitored post-procedure for a minimum of 2 hours and to the achievement of baseline parameters.
      d. For any patient experiencing complications during the procedure or requiring a reversal agent, the procedural provider or a sedation-credentialed provider will perform a focused patient assessment within 48 hours of the procedure by the type of procedure performed and document the findings in the EHR or patient record, as applicable, to include at a minimum respiratory function, cardiovascular function, mental status, temperature, pain, nausea and vomiting, and post-procedural hydration status.
   3. For patients that have received deep sedation:
      a. All patients shall be monitored post-procedure for a minimum of 1 hour or to the achievement of baseline parameters.
      b. All patients that have received a reversal agent shall be monitored post-procedure for a minimum of 2 hours and to the achievement of baseline parameters.
      c. The procedural provider or a sedation-credentialed provider/partner will perform a focused post-deep sedation patient assessment as required within 12 hours after the procedure by the type of procedure performed. Findings of the assessment are to be documented within the EHR or patient record, as applicable, to include (at a minimum); respiratory function, cardiovascular function, mental status, temperature, pain, nausea and/or vomiting if present, and post-procedural hydration status.
   4. Monitoring parameters:
      a. **For adults and patients ≥ 14 years of age who have NOT received reversal agents:** At a minimum, two Aldrete criteria scores of 8 or more at least 15 minutes apart and documentation of the patient's return to pre-sedation status are required for sedation/analgesic recovery period to be complete. These criteria are required before releasing the patient from the procedural recovery area. If outpatient, the same criteria are required before the patient is discharged.
      b. **For pediatric patients < 14 years who have NOT received reversal agents:** The patient must meet all the requirements of the American Academy of Pediatrics (AAP) discharge criteria. **Appendix 3**.
      c. **For all patients, regardless of age, who HAVE received reversal agents:** Post-procedure monitoring shall be for a minimum of two hours from administration of last dose of reversal agents.
         i. Monitoring for adult patients ≥14 years, who have received reversal agents, shall consist of assessment of airway patency, BP, pulse, respirations, O2 saturation at least every 15 minutes x 4, then every 30 minutes x 2 and at least two Aldrete criteria scores of 8 or more and return to pre-sedation status at least 15 minutes apart and will be documented in the medical record for the patient to be released from the procedural area or discharged, if outpatient.
         ii. Monitoring for pediatric patients <14 years, who have received reversal agents, shall consist of assessment of airway patency, BP, pulse, respirations, O2 saturation at least every 15 minutes x 4, then every 30 minutes x 2 and must meet all of the requirements of the AAP discharge criteria and return to pre-sedation status at least 15 minutes apart and will be documented in the medical record for the patient to be released from the procedural/recovery area (or discharged if outpatient).
      d. ETCO2 and/or pulse oximetry monitoring is required for those who have received reversal agents and for patients requiring high-flow oxygen or with significant pre-existing pulmonary disease for the duration of their post-sedation monitoring period.

5. Transfer/Discharge
    a. For inpatients, nurse-to-nurse report will be given by the sedation/procedural RN to the RN on the receiving unit prior to patient transfer.
    b. For outpatients,
        i. Patients may be discharged if the minimum discharge criteria score (≥ 14 years of age) or AAP discharge criteria (< 14 years of age) is attained as described above, and a discharge order is obtained from the provider who performed procedure.
        ii. Perform discharge planning/teaching in accordance withprovider's orders and plan of care and document in the medical record. Provide written instructions to the patient and/or responsible adult regarding sedation, possible side effects, and after care at home. Ensure that the patient/responsible adult accompanying the patient has prescriptions, if applicable.

In the event that the patient requires transfer to a higher level of care, appropriate monitoring will continue until criteria are met. The names of the transferring and receiving clinics/units and individuals responsible for patient monitoring will be documented in the patient's medical record.

- Monitoring and documentation will include but not be limited to:
    - Level of consciousness
    - Vital signs (HR, RR, NBP, SPO2)
    - ETCO2 may be considered but is not required
    - Oxygen flow rate if applicable
    - Any unusual occurrences
    - Medications administered
    - Interventions instituted and patient response
    - Medical staff member or allied health professional post sedation note

Patients with an Aldrete score of ≥ 8 **and** either a Ramsay Scale score of 1-3 or a UMSS of 0-2 (**Appendix 4**) may be transported from the procedural area with oxygen as required, and a pulse oximeter. Patients meeting post-sedation recovery discharge criteria may be transported without specific monitoring.

Post Sedation Recovery discharge criteria unit are:

- Aldrete Score of ≥ 8 or pre-sedation score, whichever is less.
- For adult patients (18 years of age or above), oxygen saturation of > 92% (on room air) or return to pre-sedation saturation levels.
- For pediatric patients < 18 years, oxygen saturation of > 92% (on room air) or return to pre-sedation saturation levels.
- Developmental level of the patient will be taken into consideration when determining recovery criteria are met.

Patients may be discharged from post procedure area if discharge criteria are not met upon specific order of a provider only.

Discharge from hospital may occur for outpatients when they meet all the following criteria:

- They have met post procedure recovery discharge criteria
- DEEP SEDATION: At least 60 minutes have passed since the last sedation was administered
- MODERATE SEDATION: At least 60 minutes have passed since the last sedation was administered
- 120 minutes have passed since the last reversal agent was administered
- Pain is adequately controlled
- Nausea and vomiting have been controlled

- Written instructions have been conveyed to the patient and a responsible adult
- A responsible person must accompany patients discharged following sedation.

VIII. REFERENCE

A. American Society of Anesthesiologists. (2018). Practice Guidelines for Moderate Sedation and Analgesia 2018. Anesthesiology. (2018) V128 #3 437-479

B. American Academy of Pediatrics. 2016. Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016

C. CMS State Operations Manual.

D. The Joint Commission

ORIGINATOR: Bill Cox
System Director, Quality

ACCOUNTABLE LEADER: Bill Cox
System Director, Quality

Administrative Approval: Damond Boatwright
President & CEO

APPENDIX 1: Pre-Sedation Assessment

The pre-sedation assessment documents the following:

- Current and past medical problems including recent problems potentially related to sedation such as respiratory, cardiovascular, or nervous system abnormalities.
- Past anesthetic and sedation history including problems related to anesthesia or sedation.
- Patient's current NPO status (**Appendix 5**). It is strongly recommended that patients undergoing elective procedural sedation meet these NPO recommendations.
- Medication history including allergies.
- Family History focusing on history of anesthetic/sedation problems, e.g. malignant hyperthermia or pseudocholinesterase deficiency.
- Focused physical exam to include:
  - Vital signs and weight
  - Mallampati Score (for patients age 4 and above) (**Appendix 6**)
  - Evaluation of the patient's airway: teeth, jaw, neck and pharynx
  - Heart
  - Lungs
  - ASA status classification (**Appendix 4**)

- Document a plan of care for the patient based on the pre-sedation assessment to include:
  - Suitability of the patient for the planned sedation.
  - Kind of sedation and route of administration.
  - Discussion of risks/benefits and alternatives of the planned sedation with the patient or guardian.

APPENDIX 2: Consideration for Referral to Department of Anesthesia

Criteria for consideration of referral to the Department of Anesthesia or a medical staff member credentialed for deep sedation:

- Upper airway obstruction, sleep apnea or significant snoring
- Craniofacial abnormalities, e.g. mandibular hypoplasia
- History of a difficult airway or failed intubation
- Active vomiting or history of delayed gastric emptying
- History of sedation difficulty or failure
- Pre-existing significant neurologic dysfunction or depressed level of consciousness
- History of psychiatric conditions (anxiety disorder, panic attacks, claustrophobia)
- History of abuse or tolerance to opioid medications and/or benzodiazepines
- Significant cardiovascular disease: hypovolemia, uncontrolled hypertension, uncompensated CHF, cyanotic heart disease
- Significant respiratory disease: reactive airway disease, COPD, hypoxemia
- Significant gastroesophageal reflux (GERD)
- Inadequate NPO time prior to procedure (Appendix 5)
- ASA physical status 3 (strongly recommended with ASA status 4)

***APPENDIX 3: American Academy of Pediatrics Discharge Criteria**

1. Cardiovascular function and airway patency are satisfactory and stable.
2. The patient is easily arousable, and protective airway reflexes are intact.
3. The patient can talk (if age appropriate).
4. The patient can sit up unaided (if age appropriate).
5. For a very young child or a child with disability who is incapable of the usually expected responses, the presedation level of responsiveness or level as close as possible to the normal level for that child should be achieved.
6. The state of hydration is adequate.

APPENDIX 4: Patient Status Grading Systems

ASA Physical Status Classification System

ASA Physical Status (PS) Classification System*:

ASA PS Category	Preoperative Health Status	Comments, Examples
*ASA PS classifications from the American Society of Anesthesiologists, with comments and examples from the Cleveland Clinic		
ASA PS 1	Normal healthy patient	No organic, physiologic, or psychiatric disturbance; excludes the very young and very old; healthy with good exercise tolerance
ASA PS 2	Patients with mild systemic disease	No functional limitations; has a well-controlled disease of one body system; controlled hypertension or diabetes without systemic effects, cigarette smoking without chronic obstructive pulmonary disease (COPD); mild obesity, pregnancy
ASA PS 3	Patients with severe systemic disease	Some functional limitation; has a controlled disease of more than one body system or one major system; no immediate danger of death; controlled congestive heart failure (CHF), stable angina, old heart attack, poorly controlled hypertension, morbid obesity, chronic renal failure; bronchospastic disease with intermittent symptoms
ASA PS 4	Patients with severe systemic disease that is a constant threat to life	Has at least one severe disease that is poorly controlled or at end stage; possible risk of death; unstable angina, symptomatic COPD, symptomatic CHF, hepatorenal failure
ASA PS 5	Moribund patients who are not expected to survive without the operation	Not expected to survive > 24 hours without surgery; imminent risk of death; multiorgan failure, sepsis syndrome with hemodynamic instability, hypothermia, poorly controlled coagulopathy
ASA PS 6	A declared brain-dead patient who organs are being removed for donor purposes	

Ramsay Sedation Scale (modified)

1	Awake	Anxious, agitated, or restless
2	Awake or sedated	Cooperative, oriented, and tranquil
3	Sedated or Asleep	Responds to light tactile stimulus or commands
4	Asleep	Arouses with moderate tactile stimulus (e.g. gentle shaking) or loud auditory stimulus
5	Asleep	Arouses slowly with painful stimulus
6	Asleep	Unresponsive to painful stimulus

University of Michigan Sedation Scale (UMSS)

0 Awake and Alert
1 Minimally sedated: tired/sleepy, appropriate response to verbal conversation and/or sound
2 Moderately sedated: somnolent/sleeping, easily aroused with light tactile stimulation or a simple verbal command
3 Deeply sedated: deep sleep, arousable only with significant physical stimulation
4 Unarousable

Aldrete Score

ACTIVITY 2- Able to move 4 extremities voluntarily or on command
1- Able to move 2 extremities voluntarily or on command
0- Able to move 0 extremities voluntarily or on command

RESPIRATION 2- Able to deep breathe and cough freely
1- Dyspnea or limited breathing
0- Apneic

CIRCULATION 2- BP: $\pm$ < 20% of pre anesthetic level
1- BP: $\pm$ 20-50% of pre-anesthetic level
0- BP: $\pm$ > 50% or more of pre-anesthetic level

CONSCIOUSNESS 2- Fully awake
1- Arousable on calling
0- Not responding

OXYGENATION 2- Maintains O_2 sat > 92% on room air
1- Needs O_2 to maintain sat > 90%
0- O_2 sat < 90% with O_2 supplement

APPENDIX 5: NPO Recommendations

Below are the NPO recommendations for **elective** operative and non-operative procedures on **healthy** patients receiving moderate sedation, deep sedation or anesthesia.

The risk of doing urgent or emergent procedures in patients not fasting for these periods of time must be weighed against the risk of delaying the procedure.

NPO Recommendations:

- Solids, non-human milk and infant formula: Up until 6 hours prior to sedation
- Breast milk: Up until 4 hours prior to sedation
- Clear liquids: Up until 2 hours prior to sedation. An NPO period of 4 hours or longer for clear liquids should be allowed in patients with delayed gastric emptying including, but not limited to:
    - Diabetes Mellitus
    - End Stage Renal Disease
    - Significant neurologic disease or decreased level of consciousness
    - Patients receiving narcotics or other medications known to delay gastric emptying
    - Pregnancy

APPENDIX 6: Mallampati Score

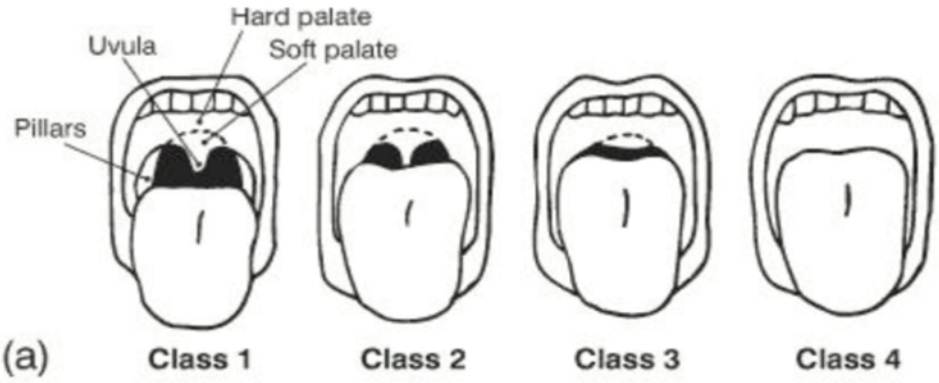

Figure 1. The Mallampati score:
Class 1. Complete visualization of the soft palate
Class 2. Complete visualization of the uvula
Class 3. Visualization of only the base of the uvula
Class 4. Soft palate is not visible at all

APPENDIX 7: Recommended Indications for Quality Review

- *Reversal agent administered*
- *Assistance from anesthesia department required*
- *Unplanned admission post procedure*
- *Deviation from hospital policy/procedure regarding procedural sedation*
- *Medical emergency or rapid response team called*
- *Any Staff request for review*