One + all | we care

Royal Cornwall Hospitals NHS Trust

Procedural Sedation of Adult Patients Clinical Guideline

V2.0

December 2019

Summary

Pre-Procedure Checklist

Staff, Location, Equipment, Documentation

- Staffing: Minimum of three staff required for all procedural sedation. Sedation only to be performed by trained clinicians
- Location: Level 2 moderate sedation (midazolam & opiate) minors theatre or resus, endoscopy.
- Level 3 deep sedation (propofol) or dissociative sedation (ketamine) resus, ITU, theatre suite
- Equipment: Resus equipment available
- Documentation: Sedation pro-forma completed

Patient Assessment

- ASA Grade documented:
  Only ASA I, II and selected grade III patients for sedation.
  ASA complex III, IV or V patients to be sedated need discussion with senior anaesthetist
- Airway Assessment complete:
  No patient with feature of difficult airway to be sedated without discussion with senior anaesthetist or airway specialist

Pre-procedure safety checklist

During sedation

- All patients to be on continuous monitoring including ECG, NIBP, pulse oximetry, end-tidal CO2 when physically possible
- All patients to have 15L oxygen via non-rebreather mask when possible
- Documentation
- Observations every 5 minutes
- Level and depth of sedation
- Adverse events reported

Post sedation

- Criteria for discharge
- Return to normal level of consciousness
- Normal vital signs
- Pain, nausea and vomiting controlled
- Discharged with responsible adult
- Written sedation patient information

1. Aim/Purpose of this Guideline

1.1. The purpose of these guidelines is to allow clinicians to provide their patients with the benefits of sedation and analgesia while minimising risks of complications for the patient. Procedural sedation is routine practice in RCHT where patients may require procedures that will cause pain and anxiety. Such procedures may be life or limb-saving, and when performed in the ED can prevent patient admission. Procedural sedation allows patients to tolerate otherwise painful or distressing procedures by relieving anxiety and reducing pain. The drugs used during procedural sedation have the potential to cause serious and life-threatening complications.

The emphasis of these guidelines is that good multidisciplinary practice, combined with continuing professional development will help improve patient safety and quality of care. There is published guidance that has been instrumental in constructing these RCHT guidelines [2,3,4]
These guidelines apply to all RCHT employees who are involved with the care of patients who require sedation.

The patient group is young people over the age of 16 years and adults

Please see RCHT paediatric sedation guidelines for sedation practice for children.

1.2. This version supersedes any previous versions of this document.

1.3. Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can't rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team rch-tr.infogov@nhs.net

2. The Guidance

2.1. Introduction

2.1.1. Sedation techniques can enable patients to tolerate unpleasant healthcare procedures, but they also have the potential to cause life-threatening complications. Research [1] suggests that despite a positive response in improving patient monitoring and giving supplementary oxygen during sedative procedures, patient morbidity and mortality had not improved significantly. The

role of appropriate training, patient assessment, drug selection and recovery is of vital importance.

2.2. Definitions and Depth of Sedation

Sedation is a continuum ranging from normal level of level of consciousness to complete unresponsiveness. The ASA defines four levels of sedation:

- **Level 1 minimal sedation** (anxiolysis) patients respond normally to verbal commands. Cognitive function and co-ordination may be impaired. Ventilatory and cardiovascular functions are unaffected. This is usually achieved with inhaled nitrous oxide.

- **Level 2 moderate/ conscious sedation** patients respond purposefully to verbal commands either alone or accompanied by light tactile simulation. Protective airway reflexes and adequate ventilation are maintained without intervention. Cardiovascular function is usually maintained. In the ED this is achieved with a combination of opioids and benzodiazepines

- **Level 3 deep sedation** the patient cannot be easily roused but responds purposefully following repeated or painful stimulation. Assistance may be needed to ensure the airway is protected and maintain adequate ventilation. Cardiovascular function is usually maintained. In the ED this is achieved with the combination of opioids and propofol.

- **Level 4 general anaesthesia** patients are not rousable, even by painful stimulus. Require assistance to protect airway and maintain ventilation. Cardiovascular function may be impaired.

- **Dissociative sedation** is a separate sedation category produced by ketamine. Ketamine causes a trance like cataleptic state characterised by profound analgesia and amnesia with retention of protective airway reflexes, spontaneous respirations and cardiopulmonary stability. As there is loss of verbal contact with patients during ketamine sedation and because of the risk of significant (although rare) complications ketamine sedation is grouped with deep sedation (level 3).

2.3. Standards and Practice

2.3.1. The process below should be followed for patients who require sedation by a non- specialist anaesthetist, outside of the theatre environment. Adherence to the guidance is imperative to improve patient safety and quality of care.

2.3.2. The process involves patient selection, pre-assessment and preparation, fasting considerations, premedication and documentation needed.

2.3.3. This document also provides guidance on patient monitoring, drug administration, staffing levels and competency, reporting of critical incidents, recovery and discharge criteria.

2.4. Training Requirements and Personnel

2.4.1. Personnel

The minimum number of staff required for procedural sedation is three:

- One doctor, advanced nurse practitioner (ANP), emergency nurse practitioner (ENP), dentist, Physician Associate or other trained individual who performs the procedure
- One doctor or other appropriately trained individual who performs the sedation
- One nurse or other trained individual responsible for monitoring the patient

2.4.2. Training Requirements

Training requirements for clinicians performing procedural sedation are documented below:

2.4.3. Level 1 Minimal sedation using oral or inhaled agents

- Current ILS certification
- Completion of RCHT Entonox training if using nitrous oxide
- Performed minimum of 5 observed level 1 sedations
- Completion of sedation log book for evidence of practice

2.4.4. Level 2 Moderate sedation using intravenous benzodiazepines and opioids:

- Current ALS certification
- Local sign off for level 2 (moderate) sedation training
- Completed Royal College procedural sedation e-learning module or attended RCHT training
- Encouraged to attend theatres for airway management skills
- Performed minimum 5 supervised level 2 sedations. The number of supervised procedures required to be deemed competent will be at discretion of the supervising consultant.
- Completion of sedation logbook for evidence of practice

2.4.5. Level 3 Deep sedation using Propofol

- Current ALS certification
- Local sign off for level 3 (deep) sedation training
- Completed 6 months ICU/ anaesthetics
- Attendance at theatre sessions to maintain airway skills. Recommended minimum requirement 1 theatre session per year
- Completed Royal College procedural sedation e-learning module +/- attended RCHT training
- Perform 5 supervised procedural sedation cases using Propofol. The number of supervised procedures required to be deemed competent will be a discretion of the supervising ED consultant but is likely to a require a minimum of 5 supervised procedures.
- Completion of sedation logbook for evidence of practice

- Dissociative sedation using Ketamine
- Current ALS certification
- Local sign off for level 3 (deep) sedation training
- Completion of 6 months ICU/anaesthesia

- Attendance at theatre sessions to maintain airway skills. Recommended minimum requirement 1 theatre session per year Completed Royal College procedural sedation e-learning module +/- RCHT training
- Performed 5 supervised procedural sedation cases using Ketamine. The number of supervised procedures required to be deemed competent will be discretion of the supervising consultant but is likely to require a minimum of 5 supervised procedures.
- Completion of sedation logbook for evidence of practice

2.5. Patient selection, pre-assessment and preparation

2.5.1. Where patients lack the capacity to understand the implications of the intervention a Best Interest meeting may need to be carried out. When the patient does not have a next of kin available or unpaid carer, the input of an IMCA may be required. In an emergency two senior clinicians can make a decision to treat in the patient's Best Interest.

2.5.2. For elective procedures pre procedure investigations e.g. baseline ECG, chest X-ray, full blood count, urea & electrolytes, liver function tests or clotting should be performed in advance.

2.6. Patient Selection

Contra-indications to procedural sedation:

- Patient refusal of consent
- Allergy to required agent
- SpO2 < 92%/ PaO2 < 8Kpa air-(exception respiratory service)
- GCS < 14
- Active unstable cardiovascular, respiratory or central nervous system disease
- Any ischaemic event (cardiovascular, neurological or peripheral vascular) within 6 weeks- (exception Cardiac service)
- History of difficult airway or potential complicating airway surgery
- Abnormal facial anatomy likely to make airway maintenance problematic
- Procedures involving posterior pharynx, severe obstructive sleep apnoea
- Head injury with loss of consciousness, reduced level of consciousness or vomiting
- Central nervous system disease including masses, abnormalities, hydrocephalus
- Psychosis, porphyria,untreated thyroid disorder
- Pregnancy: needs discussion with obstetric team +/- anaesthetists
- Intoxicated with drugs or alcohol
- BMI > 35

2.7. Pre-Procedure Patient Assessment

All patients must have a pre-procedure assessment performed and documented prior to procedural sedation. The pre-procedure assessment must include:

- Weight, BMI
- Full medical history including present medical history, indication for procedure, past medical history, drug history, allergies, social history, recreational drugs and alcohol

- Anaesthetic history including previous general anaesthetics and sedations, complications during previous procedures, known airway problems, dentition
- History of acid reflux
- Date and time of last food and oral fluid intake
- Physical examination including vital signs and airway assessment
- ASA grade

ASA GRADES	
ASA I	Normal healthy patient
ASA II	Mild systemic disease (well controlled asthma, COPD, diabetes, hypertension (single agent treatment), angina (occasional GTN))
ASA III	Moderate systemic disease examples poorly controlled asthma, COPD, diabetes, hypertension (multiple agents), angina (regular use of GTN)
ASA IV	Severe systemic disease
ASA V	Moribund

2.8. Airway Assessment

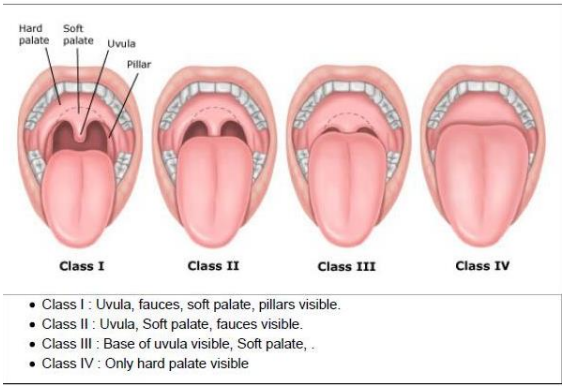
All patients must have an airway assessment to identify features associated with difficulty in airway management.

History of features associated with difficult airways should be documented:

- Previous problems with anaesthetics or sedation
- History of sleep apnoea or stridor
- Severe arthritis limiting neck mobility or laxity (Downs syndrome),
- Frank acid reflux, unless this is the indication for sedation

Patients with features of a difficult airway should not be sedated without discussion with a senior anaesthetist or airway specialist.

Physical examination to identify features of difficult airway using the LEMON mnemonic:

LEMON Airway Assessment Tool	
L	Look externally for features associated with difficult airways including obesity, beards, facial trauma, large incisors, large tongue, micrognathia
E	Evaluate the 3-3-2 rule • Mouth opening 3 finger breadths • Hyoid-chin distance 3 finger breadths • Thyroid cartilage to mouth floor distance 2 finger breadth
M	Mallampati score: patients with Mallampati score 1 or 2 may be sedated. **Patients with Mallampati scores of 3 or 4 should not be sedated without discussion with a senior anaesthetist.** 
O	Is there any evidence of, or potential airway obstruction? Presence of epiglottis, peritonsillar abscess, tumour, trauma, tracheostomy scar Ask the patient if they can bite their top lip with their lower teeth (a jaw thrust)
N	Is neck mobility limited or unstable due to injury, immobilisation or pre-existing disease (severe rheumatoid arthritis, Downs syndrome)

2.9. Fasting

2.9.1. The RCEM current recommendation is that procedural sedation in the ED should not be delayed in adults based on fasting time as there is no demonstrated reduction in risk of vomiting or aspiration. The risk of aspiration should be discussed with patients when possible. Deep sedation should only be performed in non-fasted patients for emergency procedures. Clinicians who are required to administer sedation in an emergency must choose the safest method appropriate for that particular patient bearing in mind their co-morbidity, injury and starvation status.

2.9.2. For elective procedures the fasting guideline used for general anaesthesia (2 hours for clear fluids and six hours for solids) should be used.

The patient's usual medications should be taken with water on the day of the procedure Patients should be advised to NOT chew gum on the day of the procedure

Time before	Substance
2 hours	Non fizzy see through fluids (water, black tea/ coffee, diluted squash)
6 hours	Food and milky drinks

2.10. Premedication

1 hour pre-procedure, except glycopyrolate or hyoscine hydrobromide which can be given iv 5 mins before

Anxiolytic: Oral	Temazepam	0.2-0.4 mg/ kg (max 40 mg) PO
	Diazepam	0.05-0.1 mg/ kg (max 10 mg) PO
Topical anaesthesia	Amethocaine gel (Ametop)	
Anti-sylogogue	Glycopyrolate	5 mcg/ kg (max 300 mcg) IV
	Hyoscine hydrobromide	5 mcg/ kg (max 400 mcg) IM/ IV

Drug	Dose, total dose and route	Notes
Lignocaine	10% topical metered spray, topical 4% or SC 1- 2% 4 mg/ kg Lignocaine gel 1%	Metered throat spray is 10 mg/ spray 4% is 40 mg/ml

2.11. Drug Selection for sedation

2.11.1. When it is anticipated that a procedure will be painful it is appropriate to administer analgesia in addition to anxiolysis.

2.11.2. Wherever possible the opiate used should be administered first with time to reach effect before the administration of the anxiolytic to reduce frequency of synergistic side effects. If reversal drugs i.e. naloxone or flumazenil are used they should also be titrated to effect to avoid unnecessary physiological and psychological problems associated with rapid uncontrolled reversal. Reversal of the benzodiazepine should be performed before reversing analgesic drugs. Fentanyl is a derivative of pethidine and therefore patients who report sensitivity (but not anaphylaxis) to morphine may safely tolerate fentanyl.

2.11.3. Initial doses of opiates should be reduced to 50% and given in reduced incremental doses in patients who are > 70 years or who are acutely unwell.(10)

Drug	Dose, total dose and route	Notes
Midazolam	0.5 mg/kg to maximum of 20 mg PO or buccally Iv prep (1mg/ ml) Buccal prep (10 mg/ml)	It is possible to give the iv preparation orally mixed with equal volumes of undiluted squash. Midazloam tastes bitter.
Temazepam	1 mg/ kg maximum of 30 mg PO	Available as elixir or tablets from pharmacy. Elixir tastes very bitter.
Nitrous oxide/ oxygen mix	Entonox 50:50, Relative analgesia via quantiflex machine 30:70 – 70:30 Inhaled route via mouth or nose	See RCHT entonox guidelines

Morphine	
Route	IV
Initial dose	0.1mg/kg IV titrated to effect
Onset	5 – 10 mins
Peak effect	10 – 15 mins
Adverse effects	Respiratory depression, hypotension, nausea/ vomiting, pruritus
Anatagonist	Naloxone 400 micrograms IV titrated to effect In ED if no response after 1 minute give 800 micrograms, if no response give 2mg then review (this higher dose regimen should not be used in patients with opioid misuse and dependence due to risk of acute withdrawal) (BNF) Remeebr the half life of naloxone will be shorter than that of the opiate and repeat doses are likely to be necessary

Fentanyl	
Route	IV
Initial dose	0.5mcg/kg every 2 mins
Onset	1 – 2 mins (longer in the elderly)
Peak effect	3 – 5 mins
Adverse effects	Respiratory depression, hypotension, nausea/ vomiting, pruritus
Antagonist	Naloxone400 micrograms IV titrated to effect

Midazolam	
Role	Sedation/ amnesia Level 2 Moderate sedation
Route	IV (over 1 – 2 mins)
Initial dose	Adult 1 – 2mg (max. single dose 2.5mg) Elderly 0.5mg
Repeat dose	After 2 – 5 mins (reduce dose frequency in the elderly)
Onset	1 – 2 mins (longer in the elderly)

Peak effect	3 – 4 mins
Adverse effects	Respiratory depression, hypotension, poor sedative, risk of prolonged sedation (in particularly in the elderly, obese and patients with hepatic or renal disease), unpredictable action
Antagonist	Flumazenil IV 20 micrograms/kg

Propofol	
Role	Sedation/ amnesia Level 3 Deep sedation
Route	IV
Initial dose	Adult 0.5mg/kg every 3-5mins Elderly 10-20mg
Onset	½ - 1 min (often longer in the elderly)
Peak effect	1 – 2 mins
Adverse effects	Respiratory depression or apnea, hypotension, pain at site of injection
Antagonist	None available

Ketamine	
Role	Sedation/ amnesia/ analgesia Dissociative sedation
Route	IV give over 30 – 60 seconds
Initial dose	Adult 1mg/kg titrated to effect over 60 seconds Elderly 10 – 30mg
Repeat dose	0.25 – 0.5mg/kg every 5 – 10mins
Onset	½ - 1 min
Peak effect	1 – 2 mins
Adverse effects	Increased secretions, laryngospasm, vomiting, tachycardia, hypertension, increased intracranial and intraocular pressure. Emergence phenomenon – consider pre-treating adult patients with 1 – 2 mg midazolam to prevent emergence phenomenon
Specific considerations	Absolute contraindication schizophrenia Relative contraindications active respiratory disease or infection (including URTI), cardiovascular disease including angina, hypertension, heart failure, CNS masses/ abnormalities/ hydrocephalus, globe injury, glaucoma
IM Ketamine	Should only be used in adults with learning difficulties or behaviour problems. Initial dose 4 – 5mg/kg and repeat dose 2 – 2.5mg/kg every 5 – 10 mins

2.12. Environment, Equipment, Monitoring and Documentation

2.12.1. **Location**

Level 2 moderate sedation with intravenous benzodiazepines and opioids can be performed in the theatre space in the minors area of the ED, in the endoscopy suite, or in a clinical room. The availability of resuscitation equipment in this area must be checked before performing sedation.

Level 3 deep sedation with propofol and dissociative sedation with ketamine should only be performed in the resuscitation room, in the RCHT theatre complexes or ITU.

2.12.2. **Equipment**

The following equipment must be available in the location where procedural sedation is performed:

- Full resuscitation equipment for basic and advanced life support (resus/ crash trolley)
- Difficult airway equipment/ trolley for deep sedation in resus
- Continuous high flow oxygen with appropriate devices of administration including non-rebreather masks, bag-valve-mask, Water's circuit with appropriately sized face masks
- High pressure suction with appropriate suction catheters and yankhuers
- Trolley capable of being tilted head down
- Monitoring equipment (see below)
- Appropriate range of intravenous cannula and intravenous fluids
- Reversal agent if available (Flumazenil should be available when sedating with midazolam)

2.12.3. **Monitoring**

During procedural sedation monitors should have alarms set and enabled. All patients must have direct continuous monitoring including:

- Sedation level
- ECG
- NIBP
- Pulse oximetry and respiratory rate
- End-tidal CO2 monitor, obviously for procedures involving the airway this may not be practical or possible

2.12.4. **Consent**

Informed consent must be obtained and documented prior to administering sedative drugs. Consent must include:

- Details of the procedure including type and duration of sedation
- Indications for the procedure
- Potential risks of the procedure and sedation, and the difference between sedation and anaesthesia
- Potential for failure
- Alternative procedures or sedative interventions
- Review of discharge criteria
- Consent Form 4: For patients who lack capacity to consent an IPA or IMCA should assist in the consenting process. In an emergency two clinicians must agree and sign that the procedure should be carried out in the patients Best Interest.

3. Monitoring compliance and effectiveness

Element to be monitored	Departments need to conduct an annual audit of practice targets. In addition clinical results of sedation, critical incidents, patient acceptability should also be conducted and presented at Sedation and clinical governance meetings. Flumazenil usage must be conducted in each clinical area.
Lead	Clinical leads, or staff nominated by them, from each area
Tool	Rolling audit areas and College Specific audit topics Sedation group to agree on other appropriate audit loops
Frequency	Departmental audit goals should be monitored annually A 6 monthly audit of flumazenil usage A report should be returned annually to the Safe Sedation Group.
Reporting arrangements	The completed report must be sent to the Safe Sedation Group. The reports should be reviewed openly within the group to identify successes and failures, to allow features which, with intervention, will allow practice to develop and progress within areas. This will be documented in the annual meeting minutes.
Acting on recommendations and Lead(s)	Required actions will be identified and completed in as rapid timeframe as possible. A lead member of the team will be identified to take each change forward where appropriate The Safe Sedation Group will make initial recommendations to aid improvement of practice. If there are governance issues these will need to be raised initially with the Clinical Governance Leadsfrom Appropriate area. This may require subsequent action form the RCHT Lead for Clinical Governance Investment requirements will need to be addressed with the Business managers for that area. Failure to address issue via these routes will require the attention of the Medical Director
Change in practice and lessons to be shared	Good practice will be celebrated and plans to improve other areas will be presented at the annual Safe Sedation Meeting. These presentations will be made available to Clinical Governance Leads to present as appropriate in their clinical areas, allowing lessons to be shared with all the relevant stakeholders.

	Required changes to practice will be identified and actioned when identified by audit. A lead member of the team will be identified to take each change forward in their clinical area. Lessons will be shared with all the relevant stakeholders

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. *Equality Impact Assessment*

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Procedural Sedation of Adult Patients Clinical Guideline V2.0		
Date Issued/Approved:	November 2019		
Date Valid From:	December 2019		
Date Valid To:	December 2022		
Directorate / Department responsible (author/owner):	Dr Rebecca Mawer, Consultant Anaesthetist and RCHT lead for sedation		
Contact details:	01872 258195		
Brief summary of contents	Provision of Safe Sedation for Adult patients by non- specialist anaesthetists/ other clinicians , outside of the theatre environment at RCHT		
Suggested Keywords:	Sedation, Conscious sedation, Sedation training		
Target Audience	RCHT	CFT	KCCG
	✓		
Executive Director responsible for Policy:	Medical Director		
Date revised:	November 2019		
This document replaces (exact title of previous version):	Clinical Guideline for RCHT Safe Sedation Practice: Adult Patients V1.0		
Approval route (names of committees)/consultation:	Safe Sedation Group		
Care Group General Manager confirming approval processes	Ms Roberta Fuller		
Name and Post Title of additional signatories	These guidelines have been written and revised by members of the Safe Sedation Group including: i. Mr Andrew Birnie, Consultant in Oral surgery ii. Dr, K Woolson, Consultant in Acute Medicine iii. Dr Adam Forbes, Consultant in Haematology and Oncology iv. Mr K McCune, Consultant in Vascular Surgery v. Dr John Hancock, Consultant in Interventional Radiology vi. Dr Rebecca Mawer (Chair), Consultant in Anaesthesia and Critical		

	Care vii. Dr Paul Fortun, Consultant in Gastroenterology viii. Dr Jonathan Myers, Consultant in Respiratory Medicine ix. Dr Alastair Slade, Consultant in Cardiology x. Drs Jo Bareham, Anna Shekhdar, Consultant Emergency Medicine xi. Mr Adam Widdison, Consultant in Gastrointestinal Surgery			
Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings	{Original Copy Signed}			
	Name: Matthew Body			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Clinical / Corporate Clinical			
Links to key external standards	None Required			
Related Documents:	None			
Training Need Identified?	Yes. Learning and Development department have been informed.			

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
October 2017	V1.0	Initial version - Document created	Dr Rebecca Mawer, Consultant Anaesthetist
November 2019	V2.0	Reformat into new Trust clinical guideline format.	Author name

Appendix 2. Initial Equality Impact Assessment Form

Name of the strategy / policy /proposal / service function to be assessed **Procedural Sedation of Adult Patients Clinical Guideline V2.0**					
Directorate and service area: Theatres and Anaesthesia			**New or existing document:** Existing		
Name of individual completing assessment: Dr Rebecca Mawer			**Telephone:** 01872 258195		
1. *Policy* Aim* *Who is the strategy / policy / proposal / service function aimed at?*	To promote the practice of Safe Sedation in Adult patients at RCHT All staff with a responsibility to patients who require procedural sedation at RCHT				
2. *Policy* Objectives*	To identify the standards required to be met to allow Safe Sedation practice				
3. *Policy* – intended Outcomes*	To promote thought processes, back ground information and standards for training which will encourage Safe Sedation Practice To develop training opportunities for employees				
4. *How will you measure the outcome?	To use the embedded audit standards to re-audit the current sedation practice at RCHT. To re-audit the uptake of training.				
5. Who is intended to benefit from the *policy*?	All patients older than 16 years who require procedural sedation at RCHT. All staff who are involved with sedating patients will be aware of the standards expected of their practice.				
6a Who did you consult with	Workforce	Patients	Local groups	External organisations	Other
	x				
b). Please identify the groups who have been consulted about this procedure.	Consultation with Safe Sedation Group (a multidisciplinary group of Consultants representing all the specialties who practice sedation at RCHT)				
What was the outcome of the consultation?	**Acceptance**				

7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:				
Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence

Age		**X**		Consideration of older patients when administering sedation
Sex (male, female, trans-gender / gender reassignment)		**X**		
Race / Ethnic communities /groups		**X**		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		**X**		Considering MCA and consent issues
Religion / other beliefs		**X**		
Marriage and Civil partnership		**X**		
Pregnancy and maternity		**X**		Patients who are pregnant should not be sedated unless the procedure if life or limb saving. An anaesthetist and midwife should be actively involved depending on the stage of pregnancy.
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		**X**		

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	**X**

9. If you are **not** recommending a Full Impact assessment please explain why.

Has positive impact for safety and quality of care for all patient groups

Date of completion and submission	November 2019	Members approving screening assessment	Policy Review Group (PRG) **'APPROVED'**

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust's web site.