Royal Cornwall Hospitals
NHS Trust

Procedural Sedation of Adult Patients in the Emergency Department
Clinical Guideline

V3.0

October 2025

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: resus only.
- Equipment: Resus equipment available.
- Documentation: ED sedation pro-forma completed.

Patient Assessment:

- Completion of patient assessment on ED sedation pro-forma.
- ASA Grade documented.
- Airway Assessment complete.
- **Patients who are ASA grades IV or V, or have features of a difficult airway should be discussed with a senior emergency department doctor, if procedural sedation cannot be deferred.**

WHO Checklist

During sedation

- All patients to be on continuous monitoring including ECG, NIBP, pulse oximetry, end-tidal CO2 during and after procedural sedation until return to normal conscious level:
- All patients to have 15L oxygen via non-rebreather mask.
- Documentation:
  - Observations every 5 minutes.
  - Level and depth of sedation.
  - Adverse events.

Post sedation:

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

1. Aim/Purpose of this Guideline

1.1. The purpose of this guideline is to improve patient safety and quality of care by setting standards for the safe procedural sedation of adult patients (aged 16 years and older) in the emergency department. The guideline sets training standards and requirements for emergency department clinicians delivering sedation.

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

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

Procedural sedation is routine practice in emergency departments and allows patients to tolerate otherwise painful or distressing procedures by relieving anxiety and reducing pain. Procedural sedation may avoid the need for admission and/or a general anaesthetic. The drugs used during procedural sedation have the potential to cause serious and life-threatening complications. Standards for the safe sedation of patients in the ED allow patients to benefit from procedural sedation and reduce the risk of complications.

The standards for practice in this guideline are based on the RCEM recommendations for procedural sedation in the emergency department 2022.

2.1. Definition and Depth of Sedation

Procedural sedation is defined on a continuum ranging from normal level of level of consciousness to complete unresponsiveness. The level of sedation is used in defining training and competencies for clinicians performing procedural sedation based on potential risks and consequences of deeper than expected level of sedation.

- Minimal sedation (anxiolysis) drug induced state in which patients respond normally to verbal commands. Cognitive function and co-ordination may be impaired. Ventilatory and cardiovascular functions are unaffected. In the ED this is achieved with inhaled nitrous oxide.

- Moderate sedation (conscious sedation) drug induced depression of consciousness during which 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.

- Deep sedation a drug induced depression of consciousness which 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.

- General anaesthesia patients is a drug induced loss of consciousness, patients are not rousable, even by painful stimulus. Require assistance to protect airway and maintain ventilation. Cardiovascular function may be impaired.

2.2. Dissociative Sedation

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.

2.2.1. Choice of Sedation Agents

Effective procedural sedation requires analgesia, anxiolysis and amnesia.

2.2.2. Analgesic Agents

Morphine	**Information**
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.

Morphine	Information
Antagonist	Naloxone 400 micrograms IV 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).

Fentanyl	Information
Route	IV
Initial dose	0.5mcg/kg
Repeat dose	0.5mcg/kg
Onset	2 - 3 mins (longer in the elderly)
Duration	30 – 60 mins
Adverse effects	Respiratory depression, hypotension, nausea/vomiting, pruritus.

2.2.3. **Procedural Sedation agents**

Midazolam		
Role	Sedation and 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)	
Initial onset time	1 – 2 mins (longer in the elderly)	
Peak effect time	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	Information
Role	Sedation and amnesia. Level 3 Deep sedation.
Route	IV

Propofol	Information	
Initial dose	Adult 0.5 – 1.0mg/kg (lean body mass)	Elderly 10 – 20mg given slowly
Repeat dose	Adult 0.5mg/kg every 3-5mins	Elderly 10 – 20mg given slowly
Initial onset time	30 seconds - 1 min (often longer in the elderly).	
Peak effect time	1 – 2 mins	
Adverse effects	Respiratory depression, hypotension, pain at site of injection.	
Allergens	Soya and egg lecithin in formulation.	

Ketamine	Information	
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	
Initial onset time	½ - 1 min	
Peak effect time	1 – 2 mins	

2.3. Staff and Training

Staff training requirements and competencies based on the level of sedation are defined in the RCEM procedural sedation guideline.

2.3.1. Training requirements for adult procedural sedation.

Level 1 Sedation Training Requirements	Level 2 Sedation Training Requirements
ASA grading	As per level 1
Pre-procedural assessment incl. prediction of difficult airway	Drug selection with emphasis on potential alternative strategies and/or lighter sedation
Pre-procedural fasting and risk benefit assessment	Monitoring, complications (e.g. hypoxia, hypotension) and rescue strategies
Consent and documentation	Safe use of propofol

Level 1 Sedation Training Requirements	Level 2 Sedation Training Requirements
Drug selection and preparation: benzodiazepine/opioid combinations; increments and reversal	Safe use of ketamine
Monitoring, complications (e.g. hypoxia, hypotension) and rescue strategies	Governance and audit
Governance and audit	

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 Contraindications	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:** Initial dose 4 – 5mg/kg and repeat dose 2 – 2.5mg/kg every 5 – 10 mins.	

2.3.2. Requirements for adult procedural sedation

	Moderate/ "Conscious" sedation	Deep Sedation	Dissociative Sedation
Drug	Benzodiazepines	Propofol	Ketamine
Monitoring	Pulse oximetry, capnography, ECG, BP	Pulse oximetry, capnography, ECG, BP	Pulse oximetry, capnography, ECG, BP
Minimum staffing	Nurse. Sedationist. Proceduralist.	Nurse. Sedationist. Proceduralist.	Nurse. Sedationist. Proceduralist.
Competencies	• IAL/ ALS • Completed RCEM procedural sedation e-learning module. • Moderate sedation sign-off performed minimum 5 supervised moderate sedations. The number of supervised procedures required to be deemed competent will be at discretion of the supervising ED consultant but is likely to a require a minimum of 5 supervised procedures. • Completion of procedural sedation logbook (Appendix 3).	• ALS. • RCoA initial assessment of competencies. • Completed RCEM procedural sedation e-learning module. • Attendance at theatre sessions to maintain airway skills. Recommended minimum requirement 1 session per year. • Deep sedation local sign-off performed minimum 5 supervised moderate sedations. The number of supervised procedures required to be deemed competent will be at discretion of the supervising ED consultant but is likely to a require a minimum of 5 supervised procedures.	• ALS. • RCoA initial assessment of competencies. • Completed RCEM procedural sedation e-learning module. • Attendance at theatre sessions to maintain airway skills. Recommended minimum requirement 1 session per year. • Dissociative sedation local sign-off performed minimum 5 supervised moderate sedations. The number of supervised procedures required to be deemed competent will be at discretion of the supervising ED consultant but is likely to a require a minimum of 5 supervised procedures.

	Moderate/ “Conscious” sedation	Deep Sedation	Dissociative Sedation
		• Completion of procedural sedation logbook (Appendix 3).	• Completion of procedural sedation logbook (Appendix 3).
Location	Resus room	Resus room	Resus room

2.4. Procedural Sedation Patient Assessment, Consent and Fasting

2.4.1. Pre-Sedation Patient Assessment

Pre-sedation patient assessment should be completed and documented on the sedation pro-forma (appendix 4) and must include assessment of co-morbidities, drug history, allergies, previous sedation and anaesthesia, date and time last food and oral intake, recent drug and alcohol, pregnancy, ASA grade and airway assessment.

ASA Grade

ASA grade must be recorded for all patients prior to sedation. Patient who are ASA I and II and selected III patients can be sedated in the ED. **Patients who are ASA IV and V should be discussed with a senior emergency department doctor, or senior anaesthetic, if procedural sedation cannot be deferred.**

ASA I	A normal healthy patient.
ASA II	A patient with mild systemic disease.
ASA III	A patient with severe systemic disease.
ASA IV	A patient with severe systemic disease that is a constant threat to life.
ASA V	A moribund patient not expected to survive without the procedure.

Airway Assessment

Airway assessment should be completed and documented on the sedation pro-forma (appendix 3). Airway assessment must include history of features associated with difficult airway including anaesthetic/sedation complications, history of sleep apnoea or stridor, severe arthritis limiting neck mobility of laxity, history of reflux.

Physical examination to identify features of difficult airway using the LEMON mnemonic. **Patients with features of a difficult airway should not be sedated in the ED without discussion with a senior emergency department doctor or senior anaesthetist, if procedural sedation cannot be deferred.**

LEMON Airway Assessment Tool	
L	Look (short neck, beard, trauma, obesity).
E	Evaluate: 3 mouth opening, 3 chin to hyoid, 2 floor mouth to thyroid cartilage.
M	Mallampati score: patients with Mallampati score 1 or 2 can be sedated in the ED. **Patients with Mallampati scores of 3 or 4 should not be sedated in the ED without discussion with a senior emergency department doctor or anaesthetist.**  • Class I : Uvula, fauces, soft palate, pillars visible. • Class II : Uvula, Soft palate, fauces visible. • Class III : Base of uvula visible, Soft palate, . • Class IV : Only hard palate visible
O	Is there any evidence of, or potential airway obstruction? Presence of epiglottis, peritonsillar abscess, tumour, trauma, tracheostomy scar.
N	Is neck mobility limited or unstable due to injury, immobilisation or pre-existing disease (severe rheumatoid arthritis, Downs syndrome).

2.4.2. Fasting

There is no clear evidence that non-compliance with elective fasting guidance increases risk of aspiration and adverse events in procedural sedation. RCEM recommends that dynamic risk assessments are made including risk factors for aspiration (e.g. obesity, pregnancy, choice of sedation agent) and the urgency of the procedure to be performed.

2.4.3. Consent

Consent, ideally written, if time allows depending on the urgency of the procedure should be gained before sedation. Consent should include the rational, benefits and risks of procedural sedation and the procedure.

2.5. Procedure for Procedural Sedation

2.5.1. Staff

At least three dedicated members of staff are required for ketamine sedation:

- A clinician to perform procedural sedation. **Another middle grade or consultant should be available to cover the rest of the department while sedation is performed.**
- A clinician or practitioner to perform the procedure.
- A nurse to monitor and support the patient, and clinical staff.

2.5.2. Environment and Equipment

Procedural sedation should only take place in resus with access to appropriate resuscitation and airway equipment.

The following equipment must be available when procedural sedation is performed:

- Full resuscitation equipment for basic and advanced life support equipment including airway trolley.
- Difficult airway equipment/ trolley.
- 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.
- Trolley capable of being tilted head down.
- Monitoring equipment: pulse oximetry, ECG, NIBP, capnography.
- Appropriate range of intravenous cannula and intravenous fluids.
- Clock/ event timer.
- Emergency resus drugs and reversal agents (Flumazenil and Naloxone) available.

2.5.3. Documentation

The emergency department sedation pro-forma should be completed for all patients undergoing procedural sedation (appendix 4).

2.5.4. During the Procedure

- The pre-procedure WHO safety checklist should be used prior to starting sedation (appendix 5).

- Monitoring

  During and after procedural sedation until consciousness has returned to normal all patients should have continuous monitoring including 3-lead ECG, non-invasive blood pressure, pulse oximetry and end-tidal CO_2.

- Oxygen

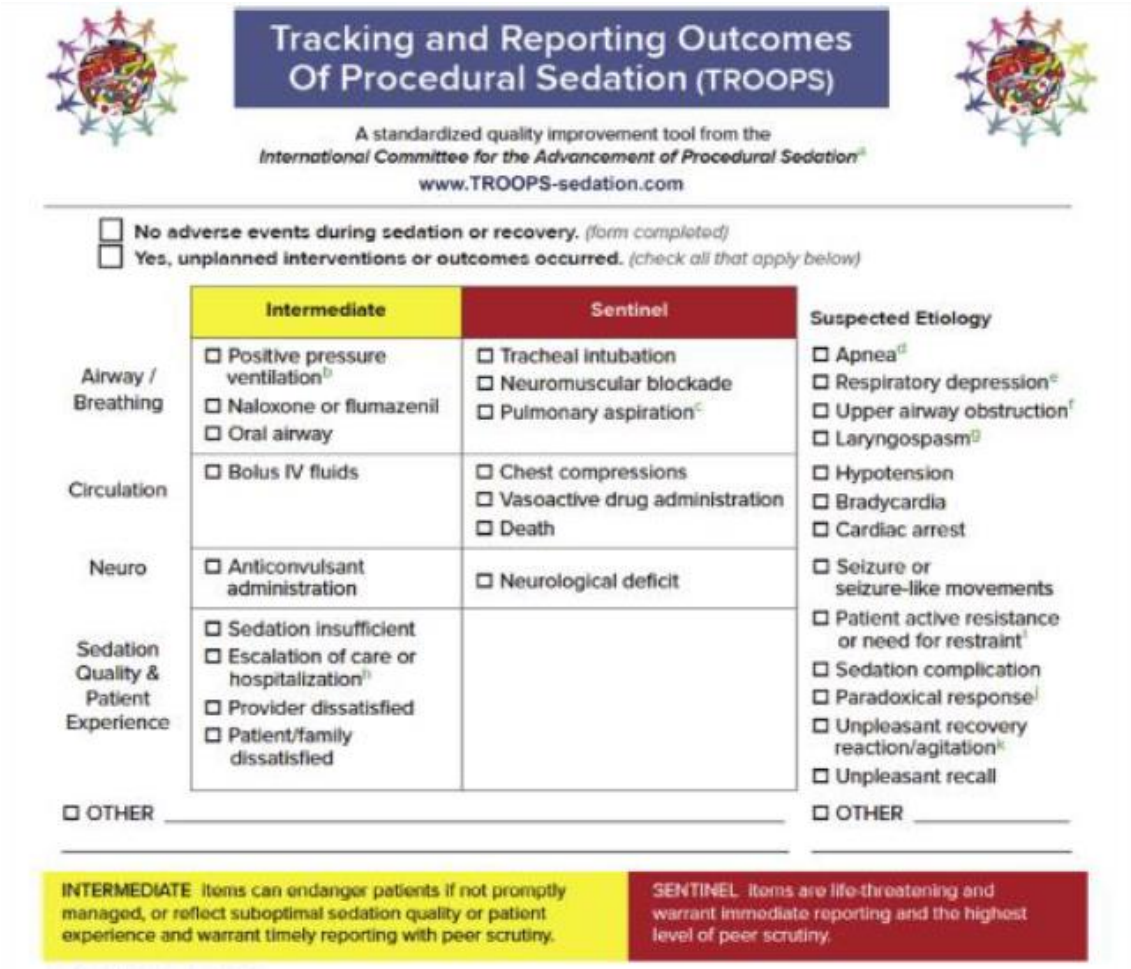
  During procedural sedation patients should have oxygen at 15 L/minute via a non-rebreather mask.

- Documentation

  Patient observations including level of sedation should be documented every 5 minutes on sedation pro-forma

2.5.5. Adverse Events

Sedation related adverse incidents are defined as “unexpected and undesirable response(s) to medication(s) and medical intervention used to facilitate procedural sedation and analgesia that threated or cause patient injury or discomfort”. The TROOPs reporting tool on the sedation pro-forma (appendix 3) should be used to report adverse events. Sentinel events which are defined as life threatening require DATIX and investigation.



Tracking and Reporting Outcomes Of Procedural Sedation (TROOPS)

A standardized quality improvement tool from the *International Committee for the Advancement of Procedural Sedation*[a]
www.TROOPS-sedation.com

☐ **No adverse events during sedation or recovery.** *(form completed)*
☐ **Yes, unplanned interventions or outcomes occurred.** *(check all that apply below)*

	Intermediate	Sentinel	Suspected Etiology
Airway / Breathing	☐ Positive pressure ventilation[b] ☐ Naloxone or flumazenil ☐ Oral airway	☐ Tracheal intubation ☐ Neuromuscular blockade ☐ Pulmonary aspiration[c]	☐ Apnea[d] ☐ Respiratory depression[e] ☐ Upper airway obstruction[f] ☐ Laryngospasm[g]
Circulation	☐ Bolus IV fluids	☐ Chest compressions ☐ Vasoactive drug administration ☐ Death	☐ Hypotension ☐ Bradycardia ☐ Cardiac arrest
Neuro	☐ Anticonvulsant administration	☐ Neurological deficit	☐ Seizure or seizure-like movements
Sedation Quality & Patient Experience	☐ Sedation insufficient ☐ Escalation of care or hospitalization[h] ☐ Provider dissatisfied ☐ Patient/family dissatisfied		☐ Patient active resistance or need for restraint[i] ☐ Sedation complication ☐ Paradoxical response[j] ☐ Unpleasant recovery reaction/agitation[k] ☐ Unpleasant recall
☐ OTHER _____			☐ OTHER _____

INTERMEDIATE items can endanger patients if not promptly managed, or reflect suboptimal sedation quality or patient experience and warrant timely reporting with peer scrutiny.

SENTINEL items are life-threatening and warrant immediate reporting and the highest level of peer scrutiny.

2.5.6. Recovery and Discharge

Full monitoring should continue in resus until level of consciousness and vital signs have returned to pre-procedure levels.

Minimum discharge criteria:

- Vital signs returned to baseline0
- Alert and oriented.
- Able to tolerate oral fluids.
- Adequate analgesia.
- No/ minimal nausea.
- 2 hours elapsed since use of reversible agent.
- Appropriate care at home.

All patients discharged home must be in the care of a responsible adult and discharged with written advice (appendix 6).

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Adverse events during procedural sedation.
Lead	ED sedation lead Dr Bareham.
Tool	Periodic ED audit of procedural sedation. Serious adverse events reported using Datix.
Frequency	Within 6 months of guideline publication. As serious adverse events occur.
Reporting arrangements	Report to the ED sedation lead.
Acting on recommendations and Lead(s)	Required changes to practice will be identified and actioned in as rapid timeframe as possible.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned. A senior member of the ED team will be identified to take each change forward where appropriate. 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 Diversity And Inclusion 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

Information Category	Detailed Information
Document Title:	Procedural Sedation of Adult Patients in the Emergency Department (ED) Clinical Guideline V3.0
This document replaces (exact title of previous version):	Procedural Sedation of Adult Patients in the Emergency Department (ED) Clinical Guideline V2.0
Date Issued/Approved:	September 2025
Date Valid From:	October 2025
Date Valid To:	October 2028
Directorate / Department responsible (author/owner):	J Bareham, ED Consultant
Contact details:	01872 252452
Brief summary of contents:	The purpose of this guideline is to improve patient safety and quality of care by setting standards for the safe sedation of adult patients in the ED. The guideline sets training standards and requirements for ED clinicians delivering sedation.
Suggested Keywords:	Sedation, Emergency Department.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Emergency Department Governance Group. Urgent, Emergency Governance Group.
General Manager confirming approval processes:	Johanna Floyd
Name of Governance Lead confirming approval by specialty and care group management meetings:	Paul Evangelista
Links to key external standards:	None required

Information Category	Detailed Information
Related Documents:	The Royal College of Emergency Medicine Best Practice Guideline: Procedural sedation in the Emergency Department August 2022. Roback MH, Green SM, Andolfatto G et al. Tracking and reporting outcomes of procedural sedation (TROOPS) quality improvement and research tools from the international committee for the advancement of procedural sedation. Br Journal of Anaesth 2018; 120(1): 164-172.
Training Need Identified?	See section 6.2.1.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Emergency Department

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
April 2019	V1.0	Initial issue	Dr J Bareham – ED Consultant
February 2022	V2.0	Changes to the Care Group name.	Dr J Bareham – ED Consultant
June 2025	V3.0	Up-date to guidelines based on updated RCEM best practice guidelines	Dr J Bareham – ED consultant

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Procedural Sedation of Adult Patients in the Emergency Department (ED) Clinical Guideline V3.0
Directorate and service area:	Urgent, Emergency and Eldercare Medicine, Emergency Department0
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Dr J Bareham, ED Consultant
Contact details:	01872 252452

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To promote the practice of safe sedation of adults in the emergency department.
2. Policy Objectives	To identify standards required for safe procedural sedation in the emergency department.
3. Policy Intended Outcomes	To improve patient safety and quality of care by setting standards for the safe sedation of adult patients in the emergency department. To identify training standards and requirements for emergency department clinicians delivering sedation.
4. How will you measure each outcome?	Audit process. Investigation of serious adverse events.

Information Category	Detailed Information
5. Who is intended to benefit from the policy?	All patients aged 16 years and older who require procedural sedation in the emergency department at RCHT. All staff involved in procedural sedation in the emergency department will be aware of the standards expected of their practice.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Representatives in ED and Anaesthetics.
6c. What was the outcome of the consultation?	Ratified.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	Additional consideration for elderly patients when performing procedural sedation.
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Considering mental capacity act and consent issues, consider associated health conditions.
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	Additional consideration for pregnant patients when performing procedural sedation.
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Dr J Bareham, Emergency Consultant.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. RCHT ED Procedural Sedation Logbook

Name: **Grade:**

Category	Date	Signature
RCEM e-learning procedural sedation module completed:		
ALS course		
RCoA initial assessment of competencies (for sedation using propofol and ketamine)		
Attendance at theatre for airway procedures		
Read RCHT ED procedural sedation guideline		

Log-book of sedation experience: Benzodiazepine

Date	Age	ASA	Procedure	Comments (adverse events)	Supervisors Signature

Competency achieved:

Date: **Consultant Signature:**

Log-book of sedation experience: Propofol

Date	Age	ASA	Procedure	Comments (adverse events)	Supervisors Signature

Competency Achieved Date: **Consultant Signature:**

Log-book of sedation experience: Ketamine

Date	Age	ASA	Procedure	Comments (adverse events)	Supervisors Signature

Competency Achieved Date: **Consultant Signature:**

Appendix 4. CHA4188: Emergency Department Safe Sedation

Name: _____
Address: _____
_____
Date of birth: _____
CR number: _____
NHS number: _____
Affix patient label

NHS
Royal Cornwall Hospitals
NHS Trust

Emergency Department Safe Sedation

Planned procedure:			Date:
			Time:
STOP! Think! Does this patient need sedation? Is this procedure appropriate to perform in the ED?			
The Team			
Name of person performing the procedure			
Name of person performing sedation			
Name of nurse			
The Patient		Weight	
Consent for sedation	Written / Verbal / None	Time last ate	
Consent for procedure	Written / Verbal / None	Time last drank	
Previous sedation/ GA	Yes / No	Complications?	
Current medication reviewed	Yes / No	Allergies	

Co-morbidities (circle)

IHD	HTN	DM
Asthma	COPD	Obese
Schizophrenia	Polytrauma	Head Injury
Recent alcohol	Pregnancy	

ASA grade (circle) I II III IV V

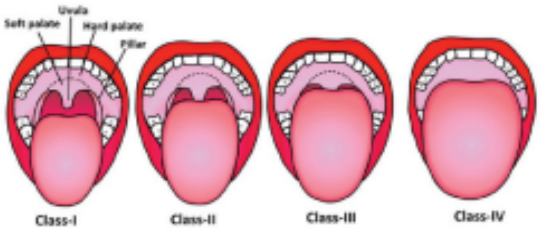
ASA I	A normal healthy patient
ASA II	A patient with mild systemic disease
ASA III	A patient with severe systemic disease
ASA IV	A patient with severe systemic disease that is a constant threat to life
ASA V	A moribund patient not expected to survive without the procedure

Airway assessment LEMON (circle)

No concern / Some concern / Definite concern

Mallampati Class (circle)

Class I / Class II / Class III / Class IV



If ASA grade 3+ or anticipated airway difficulties STOP and consider should this procedure be performed in the ED and discuss with ED senior

Pre-sedation Checklist

Airway kit identified	Yes / No	3 members of staff available	Yes / No
Trolley capable of head down tilt	Yes / No	Suction checked	Yes / No
Monitoring HR, BP, SpO2, ETCO2	Yes / No	Antidotes available	Yes / No
WHO checklist completed	Yes / No		

Urgent, Emergency and Trauma
CHA4188 V2 Printed 07/2025
Review due 2028

affix patient label

Sedation Drugs and Doses	
Planned sedation level:	Minimal / Moderate / Deep / Dissociation
Sedation level achieved:	Minimal / Moderate / Deep / Dissociation

Time	PRE	5	10	15	20	25	30
DRUG 1							
DRUG 2							
IV FLUIDS							
Sedation level (min / mod / deep / dissociation)							
Respiratory rate							
Sp02 %							
Oxygen flow (L/min)							
Blood pressure: Systolic / diastolic 240							
230							
220							
210							
200							
190							
180							
170							
160							
150							
140							
130							
Heart Rate (bpm) 120							
110							
100							
90							
80							
70							
60							
50							
40							
30							

Adverse Event Reporting

☐ No adverse events during sedation

☐ Yes, unplanned intervention or outcomes occurred. Complete boxes below. **Complete a DATIX for any sentinel event**

Intermediate	Sentinel
☐ Positive pressure ventilation ☐ Naloxone or flumazenil ☐ Oral airway	☐ Tracheal intubation ☐ Neuromuscular blockade ☐ Pulmonary aspiration
☐ Bolus IV fluids	☐ Chest compressions ☐ Vasoactive drug administration ☐ Death
☐ Anticonvulsant administration	☐ Neurological deficit
☐ Sedation insufficient ☐ Escalation of care or hospitalization ☐ Provider dissatisfied ☐ Patient/family dissatisfied	

Suspected Etiology

☐ Apnea[a]
☐ Respiratory depression
☐ Upper airway obstruction
☐ Laryngospasm
☐ Hypertension
☐ Bradycardia
☐ Cardiac arrest
☐ Seizure or seizure-like movements
☐ Patient active resistance or need for restraint
☐ Sedation complication
☐ Paradoxical response[a]
☐ Unpleasant recovery reaction/agitation[a]
☐ Unpleasant recall
☐ OTHER

Minimum Discharge criteria			
Return to baseline level of consciousness	Yes / No	Vital signs normal for patient	Yes / No
No significant nausea or vomiting	Yes / No	Adequate analgesia	Yes / No
Able to tolerate oral fluids	Yes / No	Adequate analgesia	Yes / No
2 hours since use of reversal agent	Yes / No	Written advice leaflet given	Yes / No

To be completed by healthcare professional responsible for assessing and completing discharge	
Name:	Date:
Signature:	Time:

CHA4188 V2

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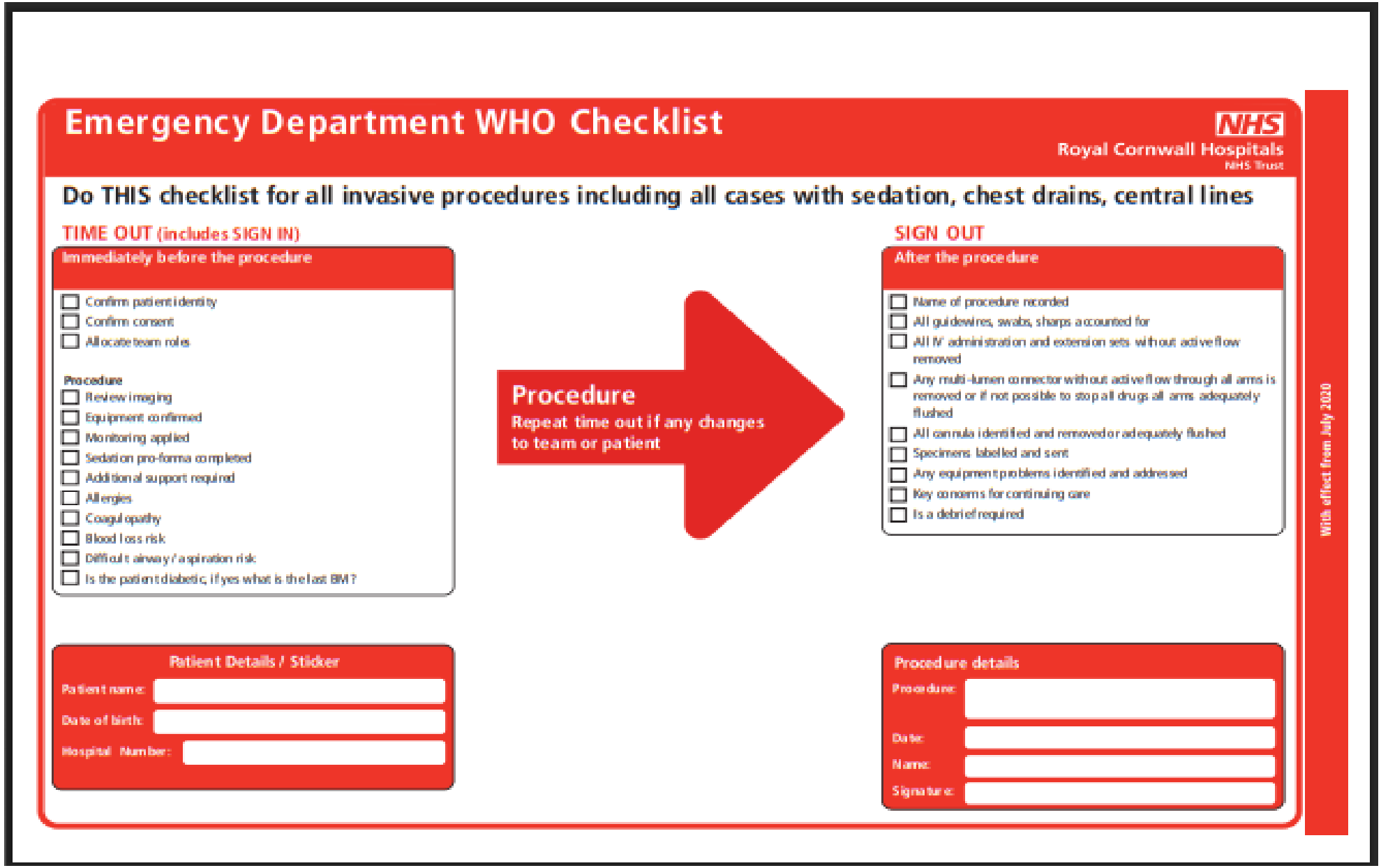
Emergency Department WHO Checklist
NHS
Royal Cornwall Hospitals
NHS Trust
Do THIS checklist for all invasive procedures including all cases with sedation, chest drains, central lines
TIME OUT (includes SIGN IN)
Immediately before the procedure
Confirm patient identity
Confirm consent
Allocate team roles
Procedure
Review imaging
Equipment confirmed
Monitoring applied
Sedation pro-forma completed
Additional support required
Allergies
Coagulopathy
Blood loss risk
Difficult airway / aspiration risk
Is the patient diabetic, if yes what is the last BM?
Procedure
Repeat time out if any changes to team or patient
SIGN OUT
After the procedure
Name of procedure recorded
All guidewires, swabs, sharps accounted for
All IV administration and extension sets without active flow removed
Any multi-lumen connector without active flow through all arms is removed or if not possible to stop all drugs all arms adequately flushed
All cannula identified and removed or adequately flushed
Specimens labeled and sent
Any equipment problems identified and addressed
Key concerns for continuing care
Is a debrief required
Patient Details / Sticker
Patient name:
Date of birth:
Hospital Number:
Procedure details
Procedure:
Date:
Name:
Signature:
With effect from July 2020

Appendix 5. Patient Information Leaflet - General anaesthetic or sedation - following (RCHT 36)

One + all | we care

NHS
Royal Cornwall Hospitals
NHS Trust

Following your general anaesthetic or sedation

The drugs we use may continue to affect you for up to 24 hours. They can cause drowsiness, reduce concentration and reaction times, although you may not be aware of it.

Therefore please:

- have a responsible adult who is capable of caring for you with you for 24 hours after you go home from hospital
- don't drive or ride a bicycle or motorbike
- don't use machinery or appliances such as cookers
- don't drink alcohol
- don't lock the bathroom or lavatory door in case you need help
- drink plenty of fluids and eat a light diet
- don't make important decisions, sign a cheque or other documents.

If you have any problems after you go home, please contact your GP.

If you would like this leaflet in large print, braille, audio version or in another language, please contact the General Office on 01872 252690