Kings County Hospital Center
Patient Care Policies
Sedation/Analgesia, Pain Management, & Restraint Usage

KCHC MISSION:
Our mission is to provide quality health care services to a culturally and linguistically diverse population, regardless of their ability to pay. We recognize that every patient and every employee has great value. Therefore, our highest organizational priority must be respect for our patients, our visitors, and one another.

SEDATION & ANALGESIA

- Patients receiving sedation must be continuously evaluated and assessed to decrease the risk associated with the administration of agents that produce conscious sedation.

SEDATION:

- A continuum which ranges from minimal sedation to general anesthesia;
  - Minimal (anxiolysis), moderate (conscious), deep or general Anesthesia
- All departments utilizing sedation are responsible for monitoring and evaluating the administration of sedation by its staff members to assure compliance with the policy.

PRIVILEGING:

- Is recommended by the individual professional department.
- Is maintained within the Department, the medical board, or other appropriate areas where conscious sedation may occur.
- Must include documentation of attendance in a formal educational session developed by, or approved by the Department of Anesthesiology.
- Must be reviewed every two years.
- Educational session must include pediatric considerations in cases where sedation is to be administered to children.

SKILLS OF COMPETENT PRIVILEGED PHYSICIANS:

- Ability to administer pharmacological agents in appropriate doses to achieve the predictable and desired level of sedation.
- Monitoring patients in order to maintain them at the desired level of sedation, and recognize changes in the level of sedation.
- Capable of managing patients at whatever level of sedation is achieved, whether it is intentional or unintentional.
- Must be trained in techniques and methods required to rescue patients who unavoidably and unintentionally slip into a deeper-than-desired level of sedation or analgesia.
- Should have training in advanced resuscitation techniques (e.g. ACLS).
- Capable of adequately assessing patients prior to performing moderate or deep sedation, to include assigning of an American Society of Anesthesiologist (ASA) score.
• Capable of using Mallampati Classification to predict the ease of intubation;
  o Class I – Full visibility of tonsils, uvula and soft palate
  o Class II – Visibility of hard and soft palate, upper portion of the uvula & tonsils
  o Class III – Soft and hard palate and base of the uvula are visible
  o Class IV – Only hard palate visible

**Personnel & Qualifications:**
• A minimum of two appropriately privileged professional staff must be present at all procedures performed under conscious/moderate sedation;
  o The “Operator” – Physician/Dentist
  o The “Monitor”- Physician /dentist, Physician assistant, Nurse, Midwife, Nurse anesthetist or Nurse practitioner.

**Role of the Operator or designee:**
- Must have a consult and a written note on the medical record indicating the use of intravenous procedural sedation for the proposed procedure.
- Must inform the patient/guardian about the risks of and alternatives to sedation as a component of the planned procedure.
- Must obtain an informed consent *(B2)* for anesthesia and/or sedation analgesia prior to the administration of sedation/analgesia.
- Must obtain/ensure that a medical history, physical examination, laboratory results are recorded in the patient’s chart prior to the procedure.
- Obtain a pre-procedure assessment *(H&P, lab results)* of the patients’ ability to undergo the procedure under IV sedation including auscultation of heart and lungs which must be documented in the medical record.
- Establish an IV access.
- Must write/enter the order for IV sedation/analgesia before the nurse dispenses the medication to the physician who is to administer.
- Ensure an empty stomach.
- Ensure patient be kept NPO for solid foods and non-clear liquids at least 6-8hours prior to the procedure unless so specified.
- Ensure clear liquids may be taken 3 hours prior to the procedure.
- Ensure that appropriate monitoring is in place prior to commencing procedure.
- Ensure that resuscitation equipment is present.
- Ensure that vital signs, cardiac rhythm, oxygen saturation and level of consciousness are monitored accordingly.
- Observe patient for signs/symptoms of drug toxicity/allergic reaction.
- Conduct a **“time out”** immediately before starting the procedure.
- Documentation must reflect evidence of the procedure, continuous assessment, diagnosis, implementation and evaluation of patient care.
- Must give discharge order/instructions.
- Note that the effects of medication have worn off and the patient no longer needs monitoring.
- Specific patient actions in event of potential sensory/motor disturbances from analgesics/ pharmaceuticals used.
**PAIN MANAGEMENT**

- As healthcare providers we must ensure optimal comfort through a proactive pain control plan which is mutually established with the patient, family members and members of the healthcare team.
- Pain must be assessed and documented on admission.
- The patient’s verbal/non-verbal communication of pain is considered to be the most reliable indicator of pain. The documentation must include the following:
  - Pain intensity/Duration/Intervals, characteristic of pain (location, type, level), evaluation of signs and symptoms, physical and psychosocial assessments, or behaviors which are potentially indicative of pain e.g. facial expressions, physical movements, vocalizations.
- Use of a pain rating scale for the measurement of pain e.g.
  - Numeric pain rating scale 0-10 or Wong Baker Faces scale.
- Education of patient during initial assessment regarding the use of the pain scales.
- Comprehensive pain assessment for a pain score of 1 or greater.

**Reassessment:**
- Patients will be reassessed as follows:
  - Every 4 hours and as needed in patients with a history of pain.
  - Every 24 hours if no history of pain and no pain within the last 24 hours.
- After pharmacological intervention:
  - 30 minutes after administration of intravenous/intramuscular analgesic.
  - 1 hour after administration of oral analgesic.

**Follow-up/Interventions:**
- Patients requiring additional treatment can be referred to the Pain Management team 24hrs/day, 7days/week.
- Request is done through the page operator for pain management.
- The anesthesia resident carrying pager will contact Pain Management attending.
- Patients requiring Patient Controlled Analgesia (PCA) must be referred to the Pain Management Service.
- PCA is available for any patient on a 24hour basis.
- Patients with chronic pain syndromes may be referred to the outpatient Pain Clinic for extended treatment and follow-up.

**RESTRAINTS**

- Restraints are used in Behavioral Health Care for healthcare needs and in General Care for protection of therapeutic modalities.

**Indications:**
- When less restrictive interventions have been determined ineffective.
- To protect the patient, staff members or others from harm.

**Not to be used for:**
- Coercion, discipline or punishment, convenience of staff, retaliation by staff, substitute for treatment programs, or on a PRN basis.
Initiation of restraints:
- Written order of a Licensed Independent Practitioner (LIP) or privileged house staff which must include:
  - Date, duration, type/placement of restraint and clinical justification for use
- The order should be followed by consultation with the patient’s treating physician, as soon as possible, if the restraint is not ordered by the patient’s treating physician.

In an emergency situation the RN may initiate restraints and notify the LIP or house staff
- In behavioral health a written order must be obtained **within 30 min**
- In general care **within 1 hour**

Discontinuation of restraint:
- Should be discontinued at the earliest possible time.

Voluntary restraint:
- When a patient requests restraint for therapeutic reasons, implementation will be according to policy & procedure.

Location of patients on restraint:
- Patient has a right to privacy, confidentiality and respect for human dignity. Restrained patients must be placed in a protected environment free from potentially violent or provocative patients or visitors.

Responsibilities of LIP & privileged house staff:
- Review of patient’s chart with special attention to the treatment plan.
- Review of medication prior to every restraint order.
- Documentation to include medication problems for possible contraindications to restraints or complications involved in using restraints.
- Evaluation of patient’s mental and physical status.

Time limits:
- General care – Order should not exceed **24 hours**
- Behavioral health need requires face to face assessment 30 minutes after initiation of restraint and order should not exceed;
  - **2 hours** for adults 18yrs and older
  - **1 hour** for child/adolescents 9-17yrs
  - ½ hour for children <9yrs of age

Behavioral Health needs:
Debriefing with staff members, patient and family when appropriate;
- Must be completed within 24hrs after each restraint episode & must include.
  - Identification of causes of behavior and course of actions
  - Patient’s physical well-being, psychological comfort and right to privacy.
  - Counseling and treatment of patient for any trauma resulting from the incident
  - Modification of patient’s treatment plan as indicated.

Death reporting requirements:
- Death that occurs while a patient is in restraints.
- Death that occurs within 24hrs. after the patient has been removed from restraint.
- When hospital personnel become aware of a death within one week after restraint, where it is reasonable to assume that the use of restraint contributed directly or indirectly to a patient’s death.