# Sedation (Conscious/Procedural): Nursing Role – Central Coast Local Health District

<table>
<thead>
<tr>
<th>Document Number</th>
<th>PR2012_023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication Date</td>
<td>20 July 2012</td>
</tr>
<tr>
<td>Intranet location/s</td>
<td>Clinical - Medication/drugs – Injectable; Cardiovascular – cardiology; Support - Nursing &amp; Midwifery</td>
</tr>
<tr>
<td>Summary</td>
<td>This procedure outlines the minimum standards for nurses when assisting with administration and management of conscious/procedural sedation for adult patients undergoing diagnostic and/or invasive procedures in CCLHD hospitals.</td>
</tr>
<tr>
<td>Author Department</td>
<td>Division of Medicine</td>
</tr>
<tr>
<td>Contact (Details)</td>
<td>Jackie Colgan CNC Cardiac Services</td>
</tr>
<tr>
<td>Endorsed By</td>
<td>CCLHD Division of Medicine Clinical Practice Committee, CCLHD Drug and Therapeutic Sub committee, CCLHD Anaesthetic Executive</td>
</tr>
<tr>
<td>Sector/Service</td>
<td>CCLHD Sector</td>
</tr>
</tbody>
</table>
| Audience | CCLHD nurses who are involved in the care of a patient receiving conscious sedation. This procedure does not apply to the following:
- Paediatric patients
- Conscious sedation practices in CCLHD Endoscopy units are covered under the Australian and New Zealand College of Anaesthetists Guidelines – see CCH Perioperative policy & procedure manual.
- Sedation practices by Specialists or specialists-in-training in Anaesthesia and Intensive Care (Adult and Neonatal). Mental Health Sedation Practices
- Chemical restraint- see NSCAAHS Restraint minimisation policy |
| Date Created | January 2010, review July 2012 |
| Review date | July 2016 |
| Previous Reference No. | GE2010_004 |
| Related Policy/s | PD2007 079 - Correct Patient, Correct Procedure and Correct Site
PR2009 004 - Medication Administration CCH
PR2007 024 - CCLHD S4 and S8 incremental dosing CCH
PD2012 007 - User-applied labelling of Injectable Medicines, Fluids and Lines |
| Key Words | Sedation, procedures, advanced life support, resuscitation, conscious sedation, procedural sedation, AVPU |
| Status | Active |
Sedation (Conscious / Procedural): Nursing Role - CCH

1. Scope of Practice ................................................................. 2
2. Expected Outcome.................................................................. 2
3. Definitions ............................................................................ 2
4. Guideline ............................................................................. 3
4.1 Guideline Statement/Rationale ........................................... 3
4.2 Requirements ................................................................. 4
4.3 Actions .............................................................................. 5
4.4 Recovery Phase .............................................................. 7
4.5 Transfer ............................................................................ 8
4.6 Clinical Handover .......................................................... 9
4.7 Discharge ......................................................................... 10
4.8 Documentation .................................................................. 10
5. References ........................................................................ 11
Revision & Approval History .................................................. 12
Appendix: Competency ......................................................... 13

1. Scope of Practice

The Registered Nurse who is deemed independent in competency based assessment (Appendix) or demonstrates recognition of prior learning or experience in monitoring patients in a critical care environment who have undergone sedation can assist the medical officer in the sedation procedure. Assistance can be given by performing the monitor role or as an assistant to either the proceduralist or to the clinician (nursing or medical) attending the monitor role.

2. Expected Outcome

Safe, effective care, assessment, monitoring, recovery and discharge of adult patients undergoing therapeutic and/or diagnostic procedures, which require sedation / analgesia that occur in areas of Central Coast Local Health District Hospitals.

THIS PROCEDURE DOES NOT APPLY TO THE FOLLOWING:

- Paediatric patients
- Sedation practices in CCLHD Endoscopy units – these practices are covered under Australian and New Zealand College of Anaesthetists. – see CCLHD Perioperative policy & procedure manual
- Sedation practices by Specialists or specialists-in-training in Anaesthesia and Intensive Care (Adult and Neonatal).
- Mental Health Sedation Practices
- Chemical restraint- see NSCCAHS Restraint minimisation policy

<table>
<thead>
<tr>
<th>Procedure Name</th>
<th>Sedation (Conscious/Procedural): Nursing Role – CCLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document ID</td>
<td>PR2012_023</td>
</tr>
<tr>
<td>Version No.</td>
<td>1.0</td>
</tr>
<tr>
<td>Date Printed</td>
<td>20/7/12</td>
</tr>
<tr>
<td>Page No.</td>
<td>2 of 16</td>
</tr>
</tbody>
</table>
3. Definitions

Appropriately trained staff: a staff member who has the knowledge, skills and training to:
- observe the patient’s level of sedation
- perform observations (vital signs)
- maintain airway patency
- know how (and who) to call for additional help when required and commence resuscitation if required
- understand the pharmacology of the sedative agents to be used, their adverse effect profiles, and the use of appropriate antagonist agents

Moderate Sedation/Analgesia ("Conscious Sedation"): 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. \(^{(2,3)}\)

Line of sight clinical observation: from the time sedation is administered until the end of the sedation period, the patient must be in the immediate vicinity of the health care clinician (nursing or medical) who is responsible for monitoring at all times. \(^{(4)}\)

The monitoring clinician: When monitoring the patient, the monitoring clinician may not leave the patient unattended or perform other tasks that would compromise patient monitoring, including performance of the procedure itself. They are responsible for monitoring patient safety and making a written record of observations.

4. Procedure

4.1 Procedure Statement/Rationale

Any medication which is used for the purpose of inducing sedation, or any medication, which when used, results in a level of moderate sedation is subject to the standards in this procedure.

POLICY STATEMENTS

- A minimum of three appropriately trained staff must be present. \(^{(2,3)}\)
- A minimum of at least one person, preferably two, must be trained / competent and currently accredited in advanced life support. \(^{(2,3)}\)
- It is recommended that a continuous, patent intravenous (IV) access (preferably a 20g cannula) be in place throughout the procedure and until the patient is recovered.
- If a PICC or CVC line is being accessed for the procedure it should be used with the following precautions \(^{(5)}\):
- If sedation is administered via burette a large volume flush or a complete IV line change may be necessary at the end of the procedure to ensure no sedation remains in the IV line.
- If sedation is administered via IV push/bolus:
  - Strict aseptic technique must be adhered to
  - The medications should be in no smaller than a 10 ml syringe
  - Excessive force should not be used during medication administration
    normal saline flush minimum 20ml post bolus is required
- All fluid bags, burettes, syringes and lines used for the administration of medication must be labelled as per PR2012 016 Labelling of Injectable Medicines, Fluids and Lines

4.2 Requirements
The location, in which the patient is having the procedure and sedation, must be appropriately sized to allow for resuscitation if needed, and must be equipped with the following (2, 3):
- Adequate lighting and floor space
- Oxygen supply with suitable devices for means of delivering oxygen to a spontaneously and the non-spontaneously breathing patient
- Functional suction supply and suction equipment (should be tested prior to procedure)
- Pulse oximeter with audible alarms
- Non invasive Blood pressure monitor
- A means of summoning the hospital’s Rapid Response Team by phoning 77
- Emergency electricity supply
It must also have:
- Ready access to an ECG Monitor
- Ready access to a hospital standard resuscitation trolley with a defibrillator and a positive pressure breathing device
- Drugs for the reversal of benzodiazepines i.e. flumazenil and opioids, i.e. naloxone

The following should be available within the facility (2, 3):
- End tidal carbon dioxide monitoring ETCO2 (capnography)
4.3 Actions
PRIOR TO SEDATION ADMINISTRATION

1. Check emergency equipment is working and ready to use
2. Attend hand hygiene
3. Ensure IV access is secure and patent (2,3)
4. Prepare medications for sedation. As multiple medications may be prepared but not administered immediately (i.e. prepared by a person who takes the medication directly to a patient for administration without a break in that continuum) the syringes must be labelled as per PR2012_016 Labelling of Injectable Medicines, Fluids and Lines (6,7).
5. Ensure appropriate sedation reversal agents are near to hand
6. Participate in and document Correct Site /Time Out (6) in the patient’s medical record

DURING THE SEDATION

7. Patient must remain in the “line of sight” of the clinician who is monitoring during the entire procedure (4)
8. Monitor patient vital signs as outlined below in fig.1.

Patients receiving sedation require continuous monitoring and assessment throughout the procedure and the recovery phase. The patient must have supplemental oxygen in place both during and post procedure (2,3). Oxygen saturations should be as close as possible to 100% throughout the procedure or to level appropriate for patient's pre morbid condition.
MINIMUM FREQUENCY OF VITAL SIGN OBSERVATIONS

<table>
<thead>
<tr>
<th>MONITORING PARAMETER</th>
<th>INTRA PROCEDURE</th>
<th>IMMEDIATELY POSTPROCEDURE</th>
<th>POST SEDATION (MINIMUM TIME PERIOD IS 60 MINS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVPU</td>
<td>Continuous</td>
<td>Continuous</td>
<td>15 minuteley</td>
</tr>
<tr>
<td>Skin colour</td>
<td>Continuous</td>
<td>5 minuteley</td>
<td>15 minuteley</td>
</tr>
<tr>
<td>Respiratory rate, depth and effort</td>
<td>Continuous</td>
<td>5 minuteley</td>
<td>15 minuteley</td>
</tr>
<tr>
<td>Oxygen saturation level</td>
<td>Continuous</td>
<td>Continuous</td>
<td>15 minuteley</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Every 3-5 minutes</td>
<td>15 minuteley</td>
<td>15 minuteley</td>
</tr>
<tr>
<td>Cardiac rate and rhythm (if utilised)</td>
<td>Continuous</td>
<td>5 minuteley</td>
<td>15 minuteley</td>
</tr>
<tr>
<td>ETC02 (if utilised)</td>
<td>Continuous</td>
<td>Continuous until AVPU returns to baseline</td>
<td>15 minuteley</td>
</tr>
<tr>
<td>Documentation</td>
<td>5 min intervals</td>
<td>As recorded- minimum 15 minuteley</td>
<td></td>
</tr>
</tbody>
</table>

NOTE
This is a minimum standard.
Frequency of vital signs must be based upon the patient’s clinical condition, and must continue as frequently and for as long as necessary to ensure the patient has fully recovered from sedation.

SPECIAL RISKS

Use of reversal agents
If the patient received reversal agents close observation may need to continue for up to 2 hours to observe for potential re-sedation when the reversal agents wear off.

The elderly
Elderly patients have an increased variability of drug response, a decreased requirement of drug dosages and require longer dosing intervals.

ROLE OF THE MONITORING CLINICIAN DURING THE SEDATION PERIOD

From the time sedation is administered until the end of the sedation period, the patient must have "line of sight" clinical observation by the monitor. During the procedure the designated monitor will also document vital signs every 5 minutes.
In addition ‘the Monitor’ will:

1. Not assist with the procedure
2. Record medications administered (route, time, site, and dose) including oxygen therapy on the medication chart (MR 71). Any person administering a drug to a patient is responsible for the management of the patient and of the IV line. Any drug given at the end of a procedure should be flushed through with normal saline or appropriate solution to ensure there is no residual drug left in the IV line.

Procedure Name: Sedation (Conscious/Procedural): Nursing Role — CCLHD
Document ID: PR2012_023
Version No.: 1.0
Date Printed: 20/7/12
Page No.: 6 of 18
3. Frequently assess the patient’s head position and patency of airway. A pulse oximeter should be attached to the patient until discharge from the unit is contemplated. Specifically:
   - Observe the rhythmic rise and fall of the chest.
   - Observe the rate and pattern of breathing.

4. Assessment of the patient’s level of consciousness - using AVPU to assess level of sedation

5. Initiate timely rescue measures - call Rapid Response Team- 77-(excluding emergency department) as required in response to changes in patient vital signs. Refer to clinical review and rapid response criteria.


7. Complete IIMS notification if required - notifying under the category of “clinical management” and ensure medication names are identified in the IIMS notification. Potential triggers for IIMS notifications\(^{(10)}\) include but are not limited to:
   a) Use of reversal agents or prolonged airway support
   b) Rapid response or cardiac arrest calls
   c) Unplanned admission to hospital (outpatient)
   d) Escalation and transfer to higher level of care (inpatient)
   e) Failed sedation / patient complaint

4.4 Recovery Phase
The standard of the recovery area should be the same as that expected of the procedure area \(^{(11)}\) (outlined in section 4.1). Recovery should take place in a well-lit area that is not too removed from the sedation site itself or patients may be recovered in the procedure room, a separate recovery area or in the ward bed.

<table>
<thead>
<tr>
<th>The recovery phase applies to the following groups of patients:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Patients who have had sedation / analgesia in a procedural</td>
</tr>
<tr>
<td>2) Patients who have had bedside procedures under sedation/</td>
</tr>
<tr>
<td>analgesia - for patients in this group the ward bed area is</td>
</tr>
<tr>
<td>considered to be the recovery area.</td>
</tr>
</tbody>
</table>

**POST SEDATION PERIOD**

**POLICY STATEMENT**
From the time sedation is administered until the end of the sedation period, the patient must be in the line of sight of the monitor at all times.
1. Place patient in an appropriate "recovery" position- for some patients this may be lying on left lateral and for others they may be better sitting up, seek advice from proceduralist if unsure.

2. Oxygenation levels and respiratory rates must be monitored until patients are considered fully recovered from the sedation, (minimum of one hour) but monitoring may need to continue for longer if reversal agents were used, the patient is elderly or the patient is slow to recover from the sedation agents.

3. Monitor and document on the observation chart all patient vital signs as outlined in section 4.3 for minimum one hour.

4. The "Sedation Period" is considered over when the patient meets the following criteria:
   - AVPU has returned to pre procedure level
   - Observations are "Between the Flag's or within the patient's altered Calling Criteria" (12, 13)

Fasting status- Unit based protocols will need to be followed for patients who have received local anaesthetic spray to their larynx and / or pharynx to facilitate their procedure. The length of post procedure recovery to discharge time will vary according to type and amount of medications administered. Observations should be recorded as outlined in section 4.6 and should continue for as long as clinically indicated.

**ESCALATION / THE DETERIORATING PATIENT.**

The staff member monitoring will need to be aware of the potential for re-sedation after the procedure as the stimulus of procedural discomfort/pain and anxiety are removed (9).

If the patient has abnormal vital signs, altered mental status, or impaired respiratory effort, they will need a longer stay in the recovery area, close observation, medical review and, if necessary, inpatient admission (patients in group 1 above) The monitoring clinician should continue to monitor for as long as necessary without duress.

If the patient has not met the above criteria, continue to reassess and monitor the patient in the "recovery" lateral position and keep the patient nil orally.

If a monitoring clinician is seriously concerned about the patient they should request a clinical review or if necessary a rapid response call should be made. (12, 13)

**4.5 Transfer**

The transfer guideline applies to the following groups of patients:

- Patients who have had sedation / analgesia in a procedural room / area
  - 1) Patient returning to a ward*
  - 2) Patient returning to Wyong Hospital via internal ambulance
  - 3) Patient being moved to a transit area prior to being discharged home

*Observations must continue on return to the ward for as long as clinically indicated
Transfer of the patient from the procedural area /recovery area should be authorised by the practitioner who administered the drugs, or another appropriately qualified practitioner (2,3,7).

**ALERT**

**IF THE PATIENT DOES NOT MEET THE DISCHARGE CRITERIA THEY WILL REMAIN UNDER THE CARE OF THE PROCEDURAL TEAM (2,3)**

**TRANSFER OF A PATIENT**

It is preferable to transfer patients after the effects of sedation have abated however there may be occasions when this is not possible or desirable. Transfer of patients must be attended by a health care clinician who must have experience in monitoring sedated patients and resuscitation skills to detect and manage any complications during the transfer. (2,3,4). Supplemental oxygen must be used during the transfer.

The following must be attended for transferring patients following sedation (2):

- Communicate with receiving ward/ unit using the ISBAR format
- Place patient in a suitable "recovery" position
- Administer continuous oxygen with saturation monitoring during transfer
- Ensure an appropriate sized bag and mask and working suction unit are available at all times during transportation
- Ensure emergency drugs are available during transfer (including syringes, drawing up needles and saline flushes)
- The patient will require cardiac monitoring during transfer if cardiac rhythm change has been noted intra / post procedure(9)

**4.6 Clinical Handover**

A handover to the clinician (nursing and / or medical) taking over the care of the patient must take place, which should include (14):

- Patient name (check against patient ID band) as per CCLHD Patient Identification Procedure (16)
- Type of procedure and name of proceduralist
- Significant medical history e.g. allergies
- Types of medications administered (dosage, route and time) - including any unexpected responses to medications
- Vital sign observations - Intra and post procedure - any significant deviations
- Neurological/ conscious level status e.g. AVPU (1)
- Dressing or drain sites (if applicable)
- Fluid- intake and output - fasting status
Complications

*Observations must continue on return to the ward for as long as clinically indicated.

4.7 Discharge

This section applies to the following groups of patients:

Patients who have had sedation / analgesia in a procedural room / area:

1) Patient returning to ward and being discharged home
2) Patient being returned to a transit area prior to being discharged home
3) Patient being discharged home directly from the procedure room

Discharge of the patient should be authorised by the practitioner who administered the drugs or another appropriately qualified practitioner with appropriate discharge documentation and medical follow up information as required. The patient being discharged should be discharged into the care of a responsible adult. Both verbal and written instructions should be given, including advice about eating and drinking, pain relief, and resumption of normal activities, as well as about making legally-binding decisions, driving, or operating machinery. (2, 3)

4.8 Documentation

The clinical record should include the names of staff performing sedation and/or analgesia, with documentation of the history, examination and investigation findings. A written record of the dosages of drugs and the timing of their administration must be kept as a part of the patient’s records on the national medication chart (2, 3, 4), including the inspired concentrations of inhalation sedation agents and oxygen and the duration of administration shall be documented. Such entries should be made as near to the time of administration of the drugs as possible. This record should also note the regular readings (time based record) from the monitored variables, including those in the recovery phase. (2, 3, 4)
5. References


Disclaimer: This document is solely for use within Northern Sydney Central Coast Health and unauthorised dissemination or modification should not take place.
### 6. Revision & Approval History

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1</td>
<td>Jackie Colgan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>References updated, reformatted. Changed to comply with Between the Flags terminology standards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reviewed by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dept of Anaesthetics- D.Keavy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perioperative CNC Lilian Blair</td>
</tr>
<tr>
<td></td>
<td></td>
<td>L.Moran Surgical CNE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S.Hatley ICU A/CNE</td>
</tr>
<tr>
<td>August 2009</td>
<td>New</td>
<td>Developed with input from the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Lilian Blair, Perioperative CNC,CCH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Dr Mark Bufkozor,CCH Anaesthetics Dept head</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Dr Martin Pallas, CCH ED Staff Specialist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Nicole Woodward, CNC CCH ED</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email distribution to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr.B Gunalingham, Director NSCCAHS Cardiovascular Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr M Williams, Cardiologist CCH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr A Hill, Cardiologist CCH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr de Toit, CCH Director of Medical Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gail Leonard, Gosford Radiology NUM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jan Tweedie, DON Wyong</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elizabeth Mitchell, DON Gosford</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sue Evans, ONM CCH Division of Medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Louise Waymouth, ONM CCH Division of Surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr Philip Hoyle, NSCCAHS Clinical Governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCH Clinical Practices Committee Members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bronwyn Mumford SWAHS Sedation Safety Project Officer</td>
</tr>
</tbody>
</table>
## Appendix: Competency

<table>
<thead>
<tr>
<th>Name of person being assessed</th>
<th>Ind</th>
<th>Sup</th>
<th>Ass</th>
<th>Marg</th>
<th>Dep</th>
<th>N or N/A</th>
<th>Assessor Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency Standard and Assessment Tool</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1st 2nd 3rd</td>
</tr>
<tr>
<td>Management of patient having conscious/procedural sedation - <em>(clinical monitoring role)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discuss the indications for conscious / procedural sedation**

**Expected Response**
- Reduce anxiety related to the procedure
- To minimise pain of invasive procedures
- Reduce memory of procedure

**Preparation**

**Expected Observation**
- Ensures that consent for procedure and/or sedation is complete.
- Ensure correct procedure /correct site/ time out attended (unless emergent procedure)
- Demonstrates correct set-up of monitoring equipment
- Identifies 'special risk' patients or situations
- Knows location of the emergency equipment and how to summon emergency assistance.
- Prepares and labels medication as per IV labeling guideline......

**Nursing Management during procedure**

**Expected Observation**
- Administers medications as per Central Coast Health policy and procedure
- Monitor the patient's level of consciousness (AVPU) and cardio respiratory status.
- Assesses total patient care requirements during sedation and recovery.
- Anticipates and recognizes potential complications and intervenes appropriately in relation to the type of medication being administered.
- Demonstrates how to document patient’s response to sedation/ analgesia.

Nursing Management post procedure

<table>
<thead>
<tr>
<th>Ind</th>
<th>Sup</th>
<th>Ass</th>
<th>Marg</th>
<th>Dep</th>
<th>N or N/A</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
</table>

Expected Response

Monitors patient as per Sedation guideline

- Anticipates and recognizes potential complications and intervenes appropriately
- Notifies medical officer immediately if changes in vital signs

Transfer / Discharge management (if applicable)

10. Discusses discharge/ transfer criteria.
11. Transfer of patient as per Sedation guideline
12. Clinical handover using ISBAR
13. Demonstrates knowledge to assess patient and documents appropriately

Identify potential complications

Expected Response

- Allergic reaction
- Deeper sedation requiring ventilatory support and administration of reversal agents
- Cardiac complications- hypotension, bradycardia
- Paradoxical medication
- Reactions – aggression, agitation, restlessness
- Falls or fractures

Troubleshooting

Expected Response

- Can state doses of reversal agents/ administration requirements for each type of drug administered
- Demonstrates ventilation with bag /mask
- Criteria for rapid response call

Client Management/ Interaction /Education

Expected Response

The Registered Nurse displays awareness of:
- Legal issues
- Infection Control
- Occupational Health and Safety
- Confidentiality and patient dignity
- Promoting safe outcomes

<table>
<thead>
<tr>
<th></th>
<th>Ind</th>
<th>Sup</th>
<th>Ass</th>
<th>Merg</th>
<th>Dep</th>
<th>N or N/A</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
</table>

References
CCH Guideline Sedation (Conscious/Procedural): Nursing Role (2009)

Comments

Competency developed by: Jackie Colgan (reviewed CWAerea) Date developed: Sept 2009, review 2012 Date for Review Sept 2015
**Reflection Activity:**

What happened?

How did you feel about the care you delivered?

What did you do well?

What did you find challenging?

What else could you have done?

How might you change your delivery of similar care?

<table>
<thead>
<tr>
<th>Identified learning needs</th>
<th>Resources</th>
<th>Evidence of learning</th>
<th>Time frame</th>
</tr>
</thead>
</table>