

SEDATION/ANALGESIA PERFORMANCE IMPROVEMENT/OUTCOMES SURVEY TOOL

1. Patient's initials and last 4 of SSN	2. Date of procedure	3. Date of chart review	4. Doctor	5. Procedure <input type="checkbox"/> Colon <input type="checkbox"/> EGD <input type="checkbox"/> FS <input type="checkbox"/> Oral surgery
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6. Biopsies? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Medication given			
7. Polypectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Demerol _____ mg <input type="checkbox"/> Versed _____ mg <input type="checkbox"/> Fentanyl _____ mg <input type="checkbox"/> Other: _____			

9. Nurses

a. Admitting:	b. Procedure:	c. PACU:	d. Recovery:
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10. Indicator checklist		Y	N	Comments
a. Indication for procedure on chart.				
b. Updated H&P on chart (within 30 days of procedure), ASA classification, list of patient's current medications; airway and mental status.				
c. Procedure nurse evaluation of patient prior to procedure.				
d. Provider's, patient's and witness's signatures present on consent and discharge instructions.				
e. Charting of medications administered and vital signs (to include pain) documented per protocol.				
f. Equipment available per protocol: SAO2/EKG/BP monitor, suction, ambu bag, etc.				
g. Complete description of procedure with post-procedure impressions included.				
h. Completion of post-anesthesia flow sheet. <small>(1) Meets discharge criteria. (2) Admission note. (3) Discharge note.</small>				
i. Absence of drug reversal agent use (for example, Narcan and Romazicon) or other medications (Atropine, etc.).				
j. Use of mechanical ventilation or manual airway support.				
k. Decrease of O2 saturation below 90% for 5 minutes or longer; or below 80% any time during the procedure.				
l. 30% change in the admission baseline in HR/BP and or the occurrence of atrial or ventricular arrhythmia.				
m. Development of CNS complications, loss of consciousness, peripheral neurological deficit, MI, cardiac arrest or death.				
n. Unplanned transfer via stretcher, admission to hospital, or increase in the level of care required.				
o. Equipment problems encountered during the procedure.				
p. Discharge criteria met or MD notified of problem.				
q. Follow up phone call initiated and documented.				