A STUDY TO EVALUATE COMPLIANCE OF PROCEDURAL SEDATION PROTOCOLS FOR DIAGNOSTICS PROCEDURES

BY- DR.KOPAL BANSAL

MBA-HOSPITAL AND HEALTH MANAGEMENT, JAIPUR.

ABOUT THE ORGANIZATION

- Global Health Limited (Medanta), largest multi- specialty tertiary care provider in the North and East regions of India with bed capacity (2,467 installed beds) founded by Dr. Naresh Trehan.
- Medanta delivers advanced, affordable end-to-end healthcare in Delhi, Gurugram, Indore, Ranchi, Patna and Lucknow through a network of five hospitals, six Mediclinic, diagnostic laboratories, home-care and telemedicine services.
- Has received different national and international accreditations, such as from the Joint Commission International (JCI) and the National Accreditation Board for Hospitals and Healthcare Providers (NABH).
- Their **mission** is to deliver world class healthcare by creating institutes of excellence in integrated medical care, teaching and research.
- It aspire to create an ethical and safe environment to treat patients with care, compassion and commitment.

PROCEDURAL SEDATION

- Procedural sedation is a technique used to manage pain and discomfort during medical procedures and diagnostic tests and purposes that requires patient cooperation.
- A procedural sedation form is a legal document which captures all the details about the patient condition right from their medical history to the overall patient health.
- It records details such as type of sedation, monitoring of the vitals, documentation of post-procedure complications, episode of any adverse events and documentation of discharge criteria met or not.
- Procedural sedation is done in various areas such as in endoscopy, bronchoscopy, interventional radiology, emergency department and in dental practices.

IMPORTANCE OF PROCEDURAL SEDATION DOCUMENTATION

- Acts like a legal document of consent which ensures patient is aware about procedure that with the full knowledge of the complications and risks that it possess.
- Compliance ensures safe and effective sedative procedures, ensures that patients fully understand the sedation process and the potential risks involved.
- Incompetency in documentation of the procedure, possesses potential risks like adverse reaction to the sedative drug being injected to the patient or any post sedation complication.

- The study was conducted in Medanta Hospital, Gurugram.
- The study took place for a period of 3 months from Feb’23 to May’23 in the quality department.

AIM AND OBJECTIVES OF THE STUDY

THE AIM:-

- Aim of the study is to improve the patient outcome by encouraging the effective and proper adherence to the sedation protocols and documentation of the findings in the form.

OBJECTIVES:-

- To check the compliance to ASA grading documentation.
- To evaluate the adherence to post sedation monitoring.
- To check compliance to discharge criteria of endoscopy unit.
- To find out the Compliance to post anaesthesia complication reporting and its documentation.

METHODOLOGY

Study Design

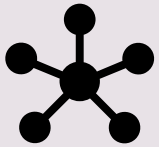
Retrospective in phase I (September 2022) and prospective study in phase II (April 23)

Sampling Technique

- Purposive sampling

Sample Size

132 samples from 200 population size.



Study Population

The in-patients admitted from 19-70 years of age group who have undergone sedation other than OT procedures and are not in ICU.

- INCLUSION CRITERIA

a) Patients who are admitted in the hospital.

b) Those who underwent procedural sedation for GI endoscopy, bronchoscopy.

c) patients within the age group of 19-70.

- EXCLUSION CRITERIA

a) ICU patients.

b) Infants.

c) Non-sedative procedures.

d) OT procedures.

e) OPD patients.

DATA COLLECTION PROCEDURE:

- Collected through patient files where sedation forms were attached from the Medical Records Department (MRD) for phase 1, and live patient files and forms for phase 2 study.
- A dedicated checklist was followed as a tool to check compliance of the documentation of the sedation forms.
- The data was collected in the form of YES/NO and results were generated.

THE CHECKLIST HAD SEVERAL PARAMETERS LIKE:	ASA grading documentation	Type of sedation
Fasting status	Prediction of difficulty of airway management	Name of the procedure
Monitoring during sedation	Documentation of any complications during sedation	Discharge of the patients with no adverse events documentation.

PATIENT NAME AND UHID												
PARAMETERS												
ASA grading												
Prediction of difficulty in airway management												
Pre-procedural fasting status												
There should be documented evidence of the patient's informed consent												
Procedural sedation requires the presence of all of the below: A doctor as sedationist A second doctor as procedurist A nurse												
Level of sedation intended • Minimal • Conscious – Moderate • Deep												
Documentation of Performed time out prior to the procedure												
Which agents were used for sedation • Opioid • Benzodiazepine • Ketamine • Propofol • Narcotic • Other agent: _____												
Monitoring during procedural sedation must be documented												
Name of procedure for which sedation was required												
Documentation of any of the following complications arise • Yes • No • Not recorded												
Formal assessment of discharge suitability documented												
What was the speciality of the sedating practitioner (along with name & staff ID)												

RESULTS

GENDER	percentage of patients
MALE	92 patients
FEMALE	40 patients

PERCENTAGE OF MALE AND FEMALE

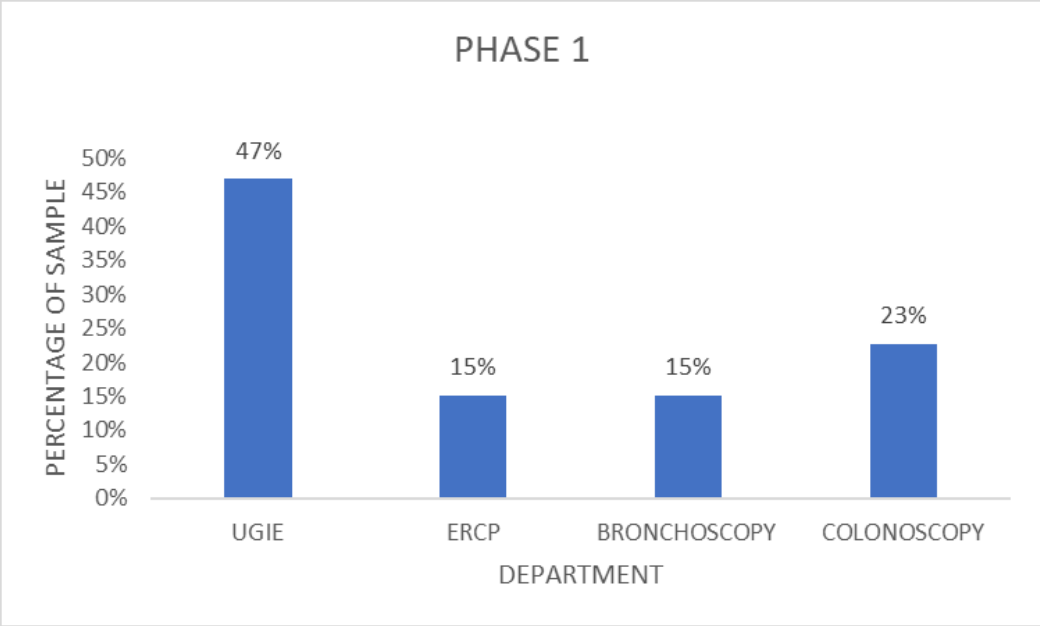
Age group	Percentage of patients
19-35	10%
36-50	25%
51-66	65%

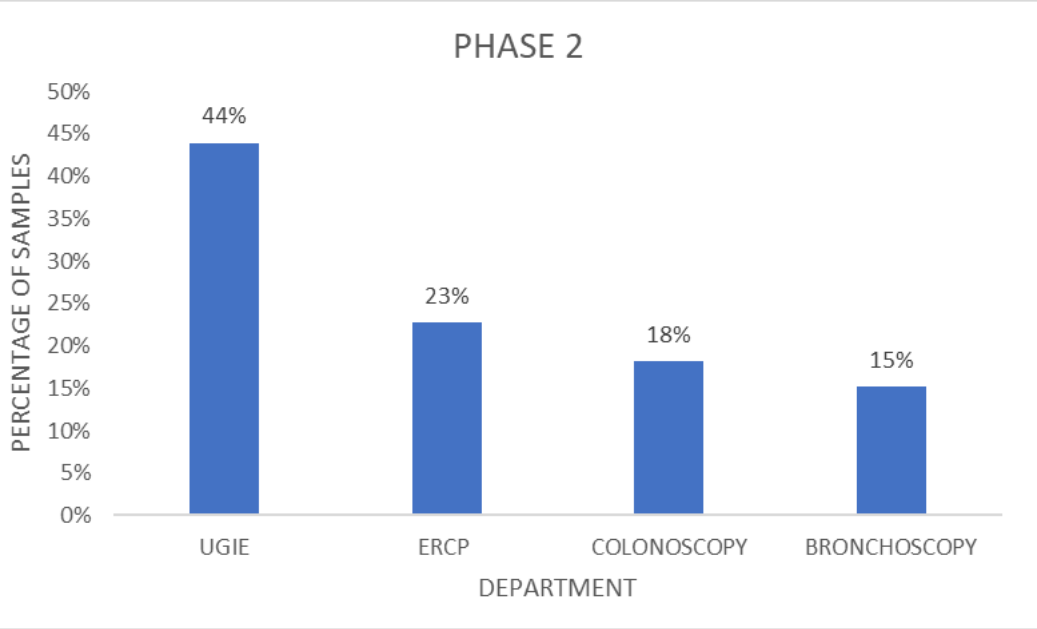
PERCENTAGE OF AGE GROUP

- The data was collected for the age group of 19- 70 years of age where 40 were females and 92 were males. Most of the age group was between the range of 40-65 years of age comprising of about 80% in total.

In the 1st phase of the study, 47% of UGIE samples, 15% each of ERCP and bronchoscopy samples and 23% of colonoscopy samples.

In phase II study, 44% of the samples of UGIE, 23% samples of ERCP procedure, 18% of colonoscopy procedure and 15% of the bronchoscopy procedure.

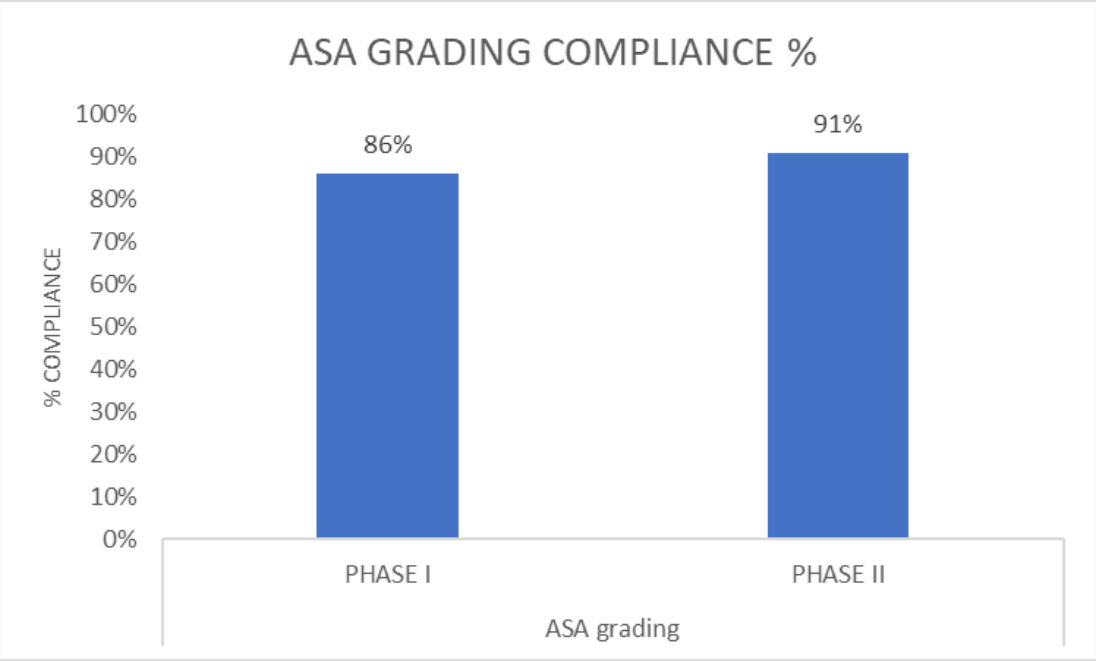




percentage of samples collected from various departments in different phases.

PARAMETERS	SAMPLE	SAMPLE COMPLIANT	SAMPLE NON-COMPLIANT	COMPLIANCE %
ASA grading	66	57	8	86%
Prediction of difficulty in airway management	66	49	17	74%
Pre-procedural fasting status	66	62	4	94%
There should be documented evidence of the patient's informed consent	66	66	0	100%
Procedural sedation requires the presence of all the below: A doctor as seditionist A second doctor as procedurist A nurse	66	60	6	91%
Documentation of Performed time out prior to the procedure	66	63	3	95%
Monitoring during procedural sedation must be documented	66	65	66	98%
Documentation of any of the following complications arise • Yes • No • Not recorded	66	58	8	88%
Formal assessment of discharge suitability documented	66	62	4	94%

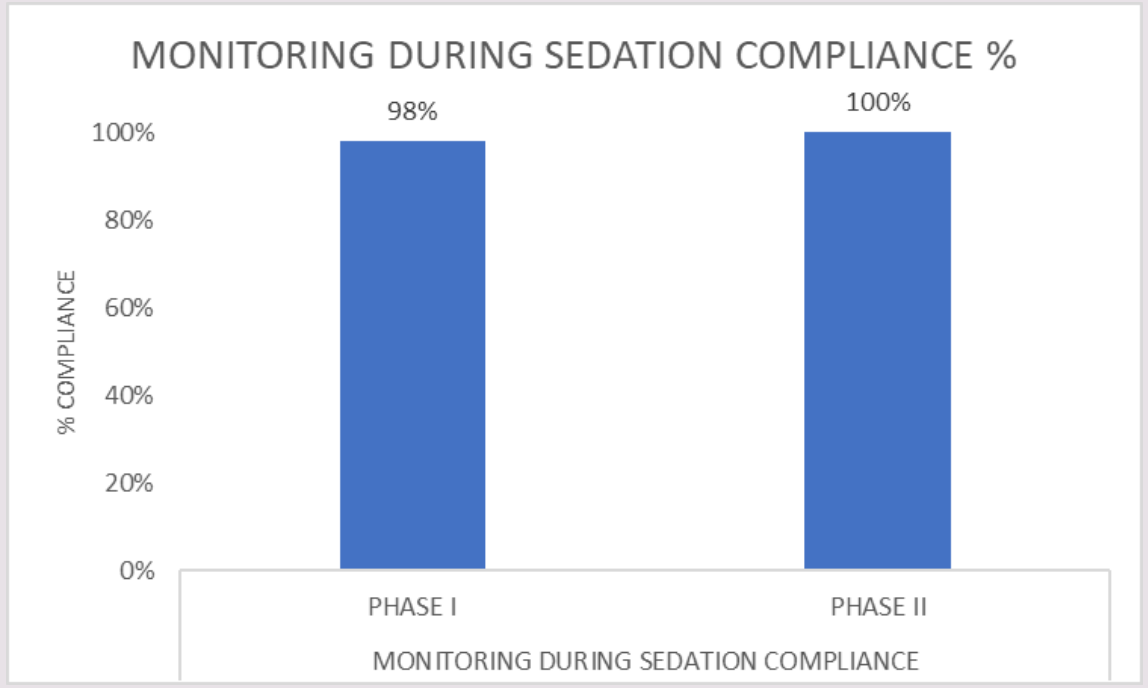
PARAMETERS	SAMPLE	SAMPLE COMPLIANT	SAMPLE NON-COMPLIANT	COMPLIANCE %
ASA grading	66	60	6	91%
Prediction of difficulty in airway management	66	59	7	89%
Pre-procedural fasting status	66	66	0	100%
There should be documented evidence of the patient's informed consent	66	66	0	100%
Procedural sedation requires the presence of all of the below: A doctor as sedationist A second doctor as procedurist A nurse	66	63	3	95%
Documentation of Performed time out prior to the procedure	66	66	0	100%
Monitoring during procedural sedation must be documented	66	66	0	100%
Documentation of any of the following complications arise • Yes • No • Not recorded	66	65	1	98%
Formal assessment of discharge suitability documented	66	66	0	100%



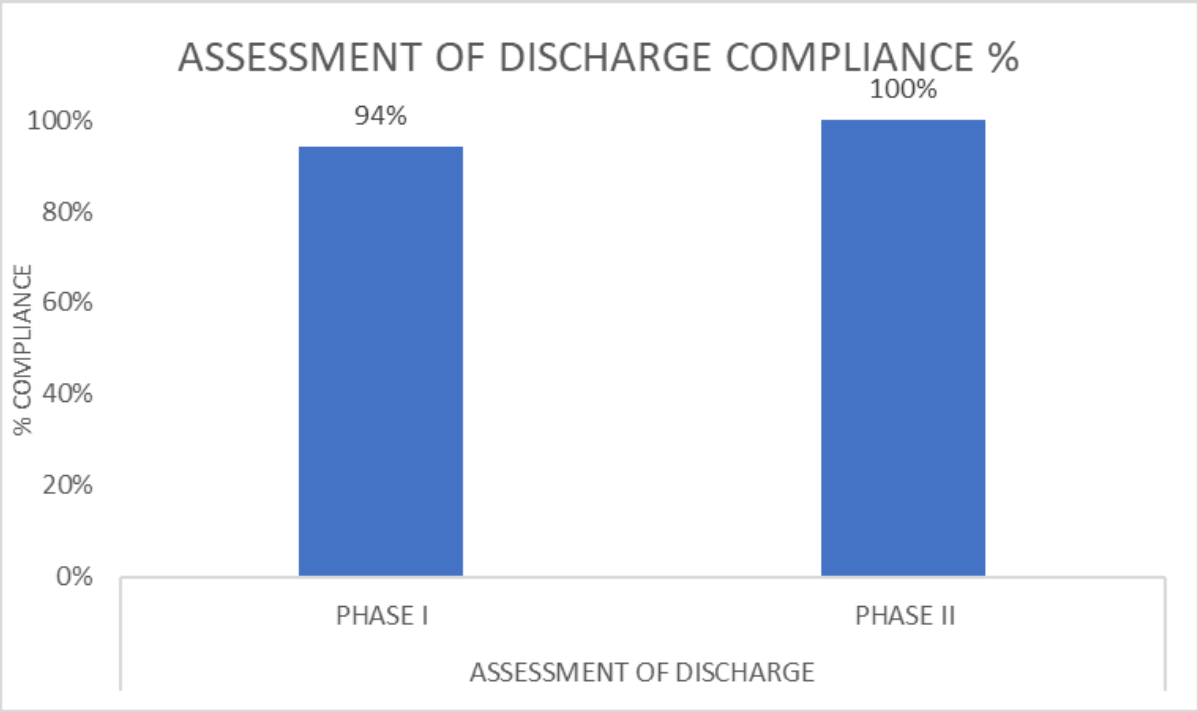
ASA grading compliance in phase I and phase II

- ASA grading documentation compliance, 86% in phase I
- 91% compliance in phase II
- Overall improvement of 5%.

- 2nd objective- 100% compliance in phase II from 98% in phase I
- Overall improvement of 2%.



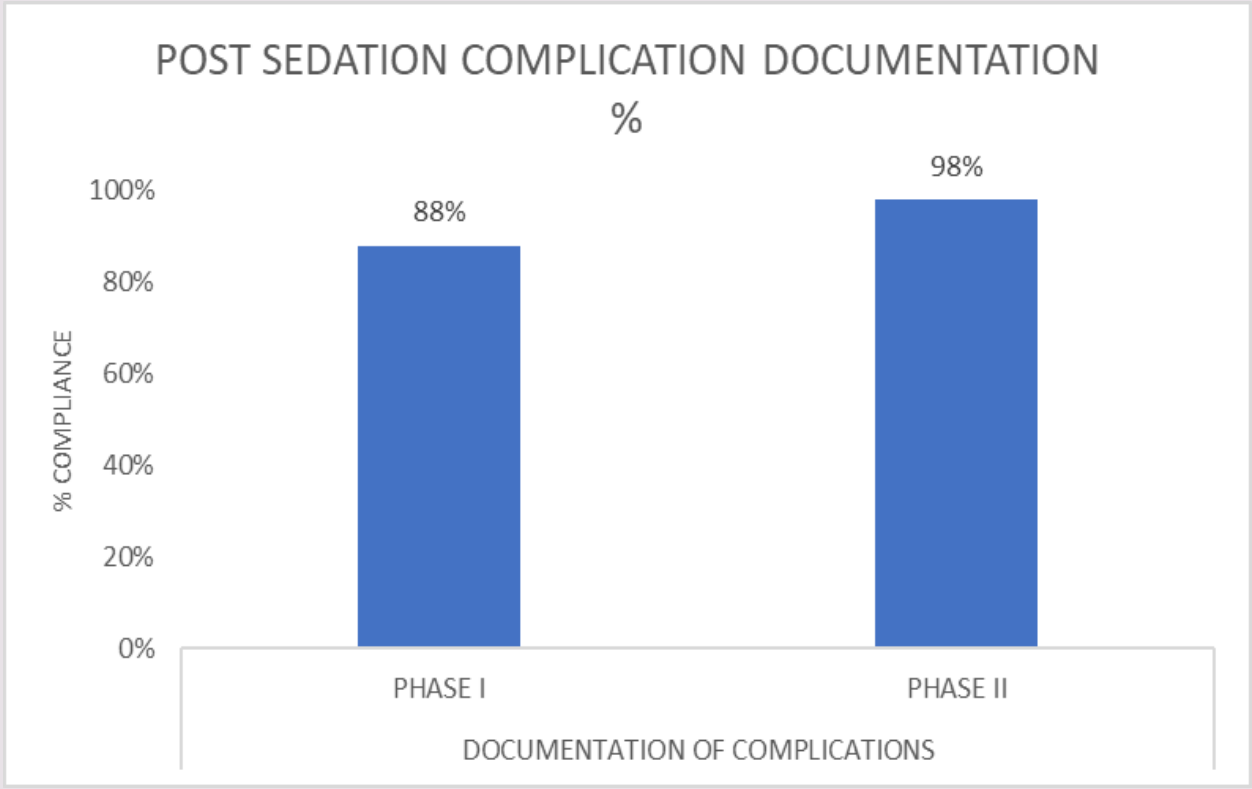
monitoring during sedation compliance in phase I and phase II



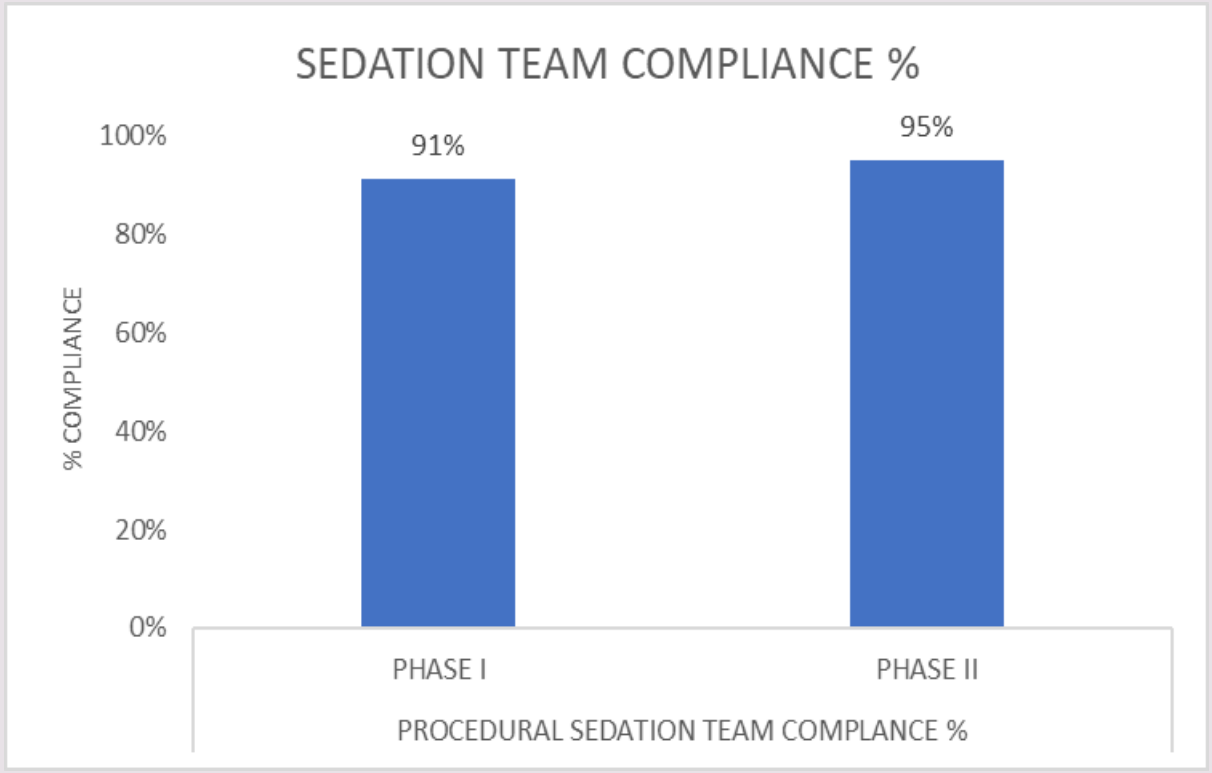
documentation of discharge compliance in phase I and phase II

- In phase 1, 94% compliance.
- In phase II, 100% compliance.
- Overall, 6% of improvement seen.

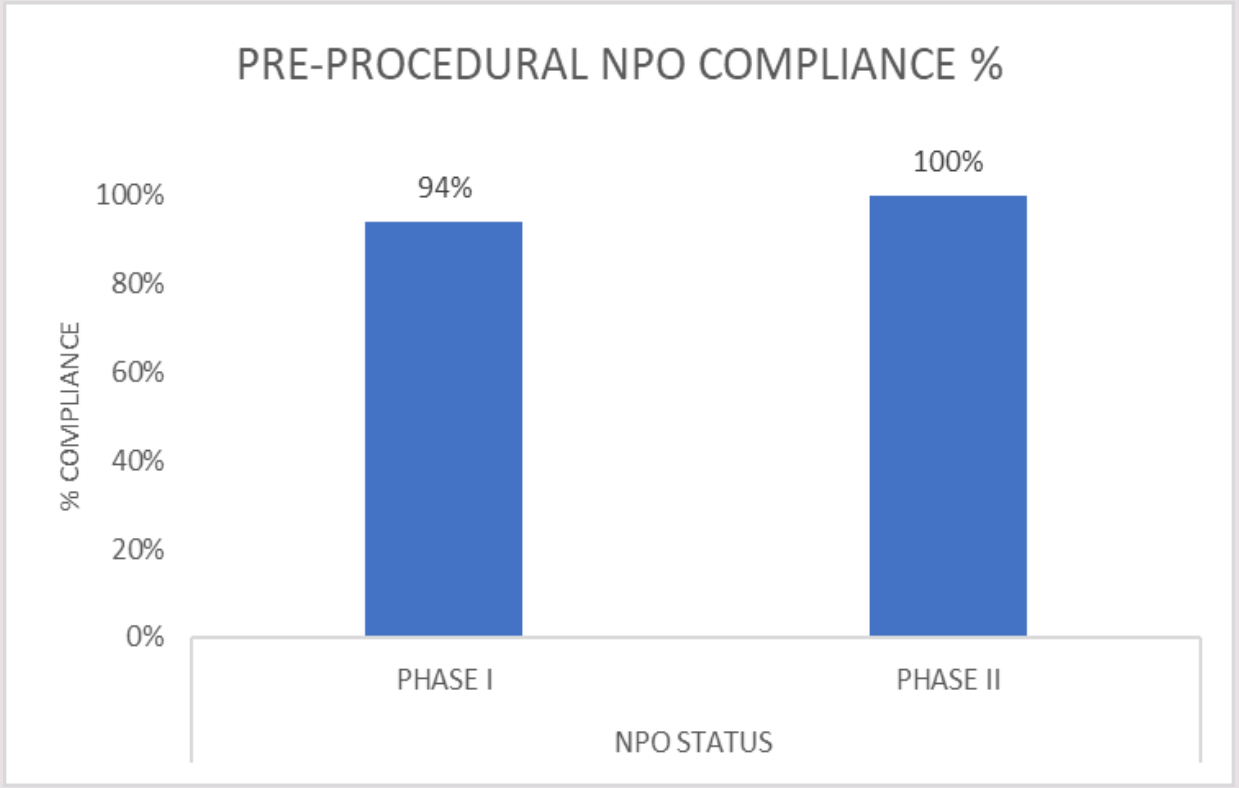
- In phase I, 88% compliance.
- In phase II, 98% compliance.
- Overall, 10% of improvement.



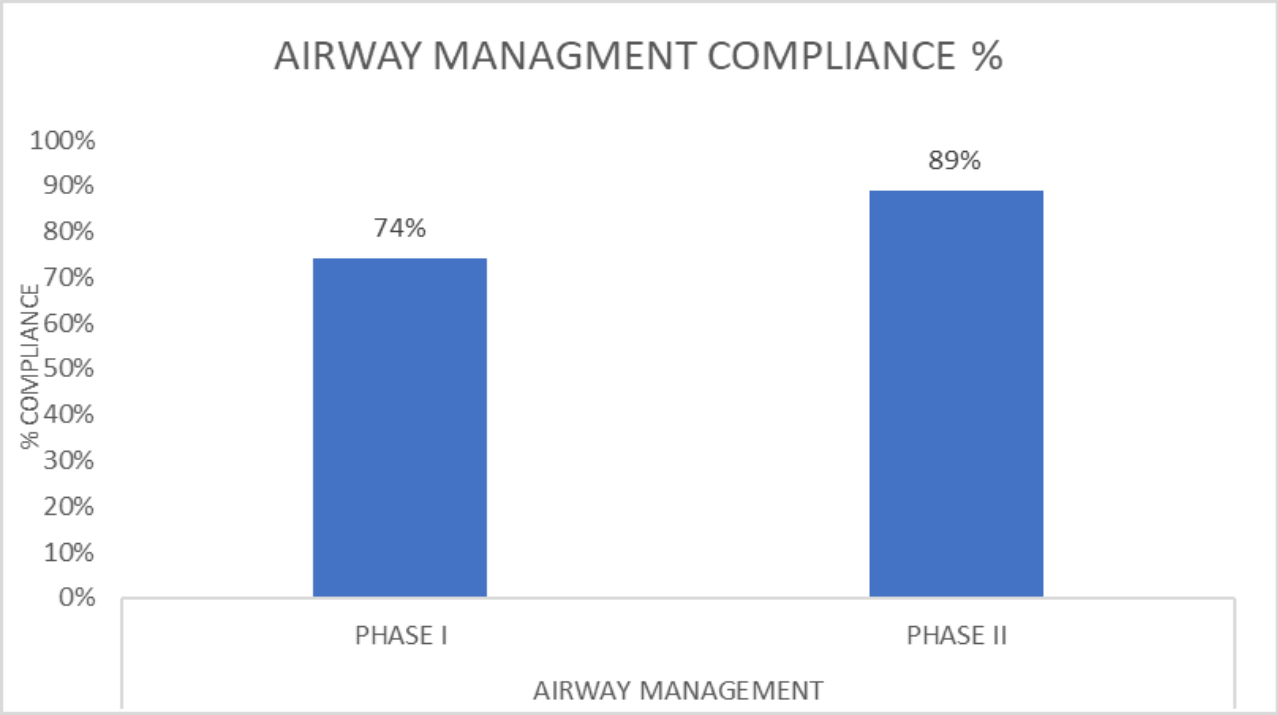
post- sedation complication documentation compliance in phase I and phase II



- In phase I, 91% compliance.
- In phase II, 95% compliance.
- Overall, 5% improvement seen.

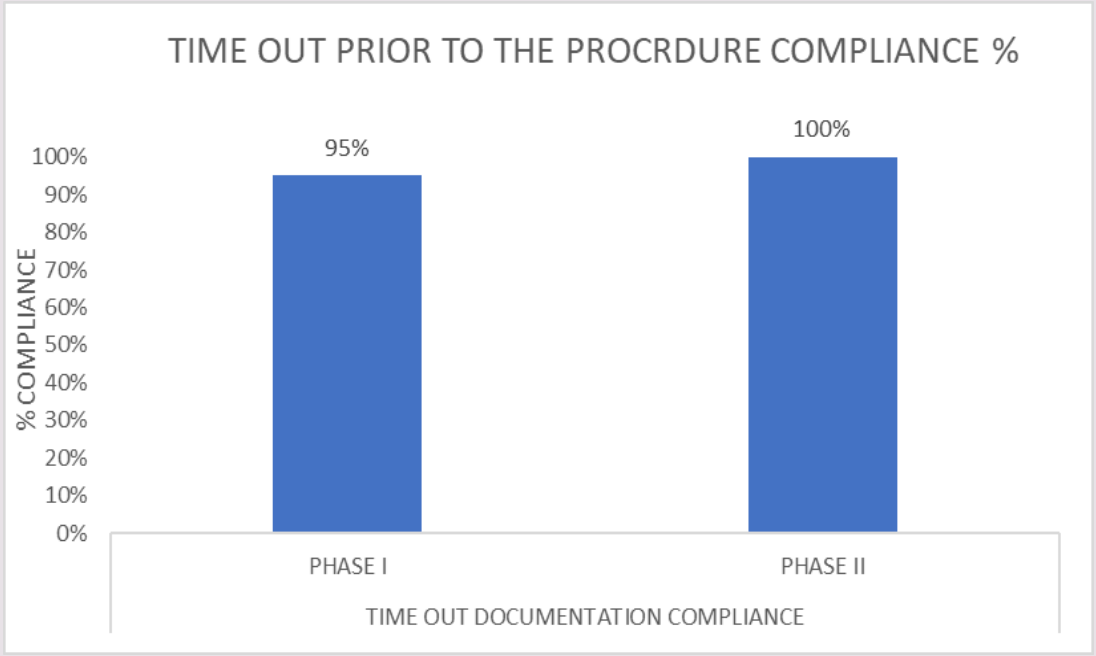


- In phase I, 94% compliance seen.
- In phase II, 100% compliance.
- Overall, 6% improvement seen.



- In phase I, 74% compliance.
- In phase II, 89% compliance.
- Overall, 15% improvement seen.

- In phase I, 95% compliance.
- In phase II, 100% compliance.
- Overall, 5% improvement.



CONCLUSION

- Maintaining a checklist to audit the documentation is important in keeping track of the performance in maintaining the standard guidelines and protocols.
- After sensitization, an overall improvement in the documentation of the sedation forms in the department where the research was conducted was seen.
- Although not all the departments were covered in the study due to confidentiality matters, but proper training and skill development can improve the overall documentation not just for one department but for all departments.
- The audit gave us an insight about how the documentation needs to be done, what were the shortcomings which lead to the problem and lead to the solutions to fulfil the objectives of the study.

RECOMMENDATIONS

1. Increase sincerity towards documentation, attitude, and incitement of healthcare workers in medical documentation practice.
2. Systematic efforts in conducting inclusive service trainings on systematic medical documentation.
3. Documentation should be made more digitalized and technology oriented.
4. Maintaining a balance in the workload of the healthcare provider for both the nurses and the doctors should be encouraged.

THANK YOU