THIS IS LOOKING GOOD!
WE MIGHT WANT TO CONSIDER SOME ILLUSTRATIONS OF SOME STEPS (PHOTOS) AS I ASSUME THIS WILL BE A TRAINING DOCUMENT TO SOME DEGREE. (I INDICATED THOSE AREAS PERHAPS)

**Sedation Protocol** — PROTOCOL FOR ORAL, NASAL, SUBMUCOSAL SEDATION IN DENTISTRY
**KH 9.28.16**
**Steve 9.27.16**
**Dr C 9.28.16**
**Deb Weatherby 10.5.16**

PROBABLY NEEDS GOALS AND EXPECTED OUTCOMES STATED IN EFFECTIVENESS AND SAFETY (LOOK @ NEWEST AAP/AAPD GUIDELINES)

**Comment [HK1]:** Here are my comments. Kim, this might be formatted as a two column per page and use the right column for illustrations, lists, etc.

**Indications:**

Healthy, ASA 1-2, age >24 months, >10kg
Fearful children with 1-2 quadrants of treatment to do
Combative child with minimal work that doesn't justify GA ← AGREE THIS IS NOT GOOD. JUST SCHEDULE THOSE KIDS WHEN I AM NOT COVERING :)!
Strip crowns with open contacts
Emergency extractions
Any dental procedure that can be accomplished reasonably, is necessary, and wouldn't by extent or risk justify GA or ambulatory care
WHAT ELSE???

safety ?

**Comment [HK2]:** (Steve S says- 2 teeth if multiple quads)

**Comment [CP3]:** Let's try to talk this out. These kids don't do well. The clinician is better off taking the meds! – Dr C, this came from Dr Amini – the case that basically we know it's going to a rodeo but we only have 1 tooth to extract, etc and better to be drugged and maybe forgetful than not?

**Scheduling:**

Resident or faculty referring to Sedation **must explain** what Sedation is – sample script "When we don't think your child will do well with just nitrous oxide, we can use a medicine, or combination of medicines, that your child will either drink, or we can squirt up their nose, to make him/her a little woozy so the procedure is easier on him/her. The medicine will not make your child go all the way to sleep." ← DO WE HAVE A BETTER WORD?

Resident or faculty referring to Sedation **must explain**: parent out of room, possible papoose use, possibility it is not effective, child still cries or fights, won't go back to school or activity the rest of that day, etc.

CAN WE BE MORE MEDICAL ? :)

THIS COULD BE A CHECKLIST RATHER THAN PARAGRAPH

Paperwork to do: Referral in EPIC. Need current weight, height, and medications entered into EPIC. [DO WE HAVE A HARD STOP IN THE REFERRAL TO BE SURE ABOVE HAS BEEN DONE?]
Give a Helping Hands?

**Comment [HK4]:** Deb W says when it is an ER pt that gets referred to sedation, usually no referral is done in EPIC – helps with checks and balances to go through the questionnaire because some kids sent to Sedation are not good candidates due to med hx and this wastes time/discussion. So we need to do better at this...

Dawn/Sedation scheduler calls parent to schedule.
Script includes:

1. Date and time and why.
2. NPO with examples of "no-no"s and potential death if not NPO
3. What to expect
4. Need two adults
5. No other children to be brought along, not a good idea to have another kid scheduled for CC, come as ER – attention needs to be on Sedation patient.
6. Booster seat
7. Mode of transport – do they need a cab?
8. EXPECTED DURATION OF PROCEDURE
9. WHAT WOULD CANCEL SEDATION?
10. CALL DAWN IF... FEVER, VOMITING, RUNNY NOSE....

**Comment [HK5]:** Deb W also says we need 2 working numbers, a lot of times Dawn can't reach to schedule bc numbers in EPIC are not correct...how do we fix this? Do we print the EPIC referral and write 2 numbers on it by asking the parent? (Like we do with PAQ form for DSC?)

**Comment [HK6]:** Deb W says she has these in her room and gives them out, but others don't...

**Comment [HK7]:** Deb W says there is a script that Bobby wrote but that "it is not followed"...

8. Will need attendance in PM for recovery
9. Potential side effects
10. Any recent illness, esp URI

Sometimes Dawn will place a sheet indicating a last-minute Sedation cancellation – please see her before approaching a patient about scheduling into one of these blocks.

NOT CLEAR WHAT THIS MEANS ?

**From 2016-2017 NCH Resident Manual:**

| Time | Task(s) Needing Attention | Critical Personnel |
|---|---|---|
| **Before Sedation** | **1 week ahead:** Review charts and make sure the patient is an appropriate candidate for sedation. Discuss with Attending, Deb, Ronda as needed. | **Resident +/- Attending, Ronda, Deb W** |
| | Check for recent ED/UC visits that could result in cancelling sedation – (i.e. respiratory infections within past month requiring hospitalization or extended care / medications) | **Resident** |
| | Review Sedation Section of Resident's Manual. | **Resident** |
| | Consider medications you may want to administer and why. | **Resident** |
| | **2 days ahead:** Complete a final review of the patient's chart in EPIC. Discuss new concerns with Attending, Deb, Ronda as needed. | **Resident +/- Attending, Ronda, Deb W** |
| | Resident discusses cases with assistant, orders additional x-rays to be taken if cooperative the morning of Sedation. | **Resident + Assistant** |
| **Day of Sedation: Pre-Op** | Place stethoscope, precordial stethoscope (with sticker on it), and Resident's Manual in treatment room. | **Resident** |
| | 1. Patient arrives | |
| | a. Note: If female aged 12+, a pregnancy test needed prior to procedure—Patient to arrive at 8:00 (for 9:30 sedation appointment), obtains prescription of | **Resident** |

MAKE CELL SO IT IS CLEAR ALL BELOW ARE 1 WEEK OUT

DITTO

DAY OF SEDATION

DO WE NEED COMMENT ABOUT LATE ARRIVAL? WHAT IS TOO LATE?

**Comment [HK8]:** Deb W goes through charts and said she found one recently who had been to Main OR – this was a big red flag for sedation that the resident did not catch – doesn't think residents are reviewing their cases ahead of time...(she says this happens frequently, this was just one example)

| | |
|---|---|
| HCG, Urine Qualitative STAT to take to Child Lab – Resident can place order in EPIC or get Rx pad from Pyxis | |
| 2. Assistant brings patient back, confirms ID via sticker, and obtains:<br>a. Height/ weight<br>b. Vitals<br>c. Confirms NPO and asks if had recent illness<br>d. Has patient taken routine meds this morning, and what time?<br>e. Asks about dental pain<br>f. Takes any necessary x-rays, if pt is cooperative<br>g. (Briefly) explains process of what Resident will do next<br>h. Gathers questions/concerns/demeanor of parent for presenting to resident | **Assistant** |
| 3. Assistant reports to resident | **Assistant + Resident** |
| 4. Resident enters room<br>a. Confirms patient ID<br>b. Who is present with child—legal guardian? How long is drive home? (Inform parent may need to stay longer if alone and/or long drive)<br>c. Reconfirms NPO<br>d. Recent illness?<br>e. Enter weight and height into EPIC<br>f. Review with parent the medical history in EPIC, including medications and allergies<br>Complete H & P in EPIC<br>g. Physically evaluate lungs and heart, AIRWAY | **Resident** |
| 5. Physically perform oral exam (ALL teeth and soft tissue) AND airway assessment | **Resident** |
| a. Order new x-rays if necessary | **Resident** |
| 6. Discussion with parent<br>a. Confirm dental procedure/tx plan<br>b. Will the patient drink meds? If meds are spit out we cannot re-dose. Otherwise explain intranasal administration.<br>c. Parents leaving room for the procedure | **Resident** |

**Comment [HK9]:** I added this here because sometimes the kid is comfortable by now with the assistant...is this appropriate?

DO WE NEED TO LIST ELEMENTS OF PHYSICAL? TO BE SURE THEY ARE DONE...

| | | | |
|---|---|---|---|
| | (unless exception approved by Attending – Examples: autism, sign language)<br>d. Use of papoose<br>e. Sedation may not be effective (60-70% success rate). May get"angry child syndrome"<br>i. If it does not work do you want us to "hold and go" or STOP?<br>ii. If we stop the options are another Sedation, GA, SDF, defer tx... | | |
| | 7. Complete paper consent: for procedure, administration of sedation medicine, use of papoose | **Parent, Resident, and Witness** | |
| | 8. Print emergency med sheet and calculate dosages for meds and local anesthetic | **Resident** | |
| | 9. Consult with Attending, present case, discuss isolation (IsoVac, rubber dam, use of water)*<br>Determine if lights to stay on, parent to stay in room, noise level/music/ stimulation, any special accommodations (Examples: lead apron, leg massage for autistic patients) during procedure | **Resident + Attending, with Assistant and Recorder present** | |
| | 10. Attending signs H&P in EPIC and orders meds in EPIC (NEEDS MORE) | **Attending** | |
| | 11. Get meds + reversal agents from Pyxis | **Resident + Assistant** | |
| | 12. Attending "Time Out" to confirm consent, NPO, med hx, dental procedure, no concerns from parent. | **Attending, Resident, Assistant** | |
| | 13. Meds administered | **Resident** | |
| | 14. Complete MAR (double MAR for intranasal) | **Attending** | |
| | 15. Allow latency for meds to work – see Handbook for guidance | | |
| | 16. Put pulse ox on patient while pt is sitting with parent, if pt is cooperative | **Assistant** | |
| | 17. Parent leaves room | | |
| **Intra-Op** | 1. Assures proper patient positioning with shoulder roll | **Resident + Assistant** | |
| | 2. Begin treatment | | |
| | 3. Use of papoose when appropriate | **Resident** | |

**Comment [HK10]:** I don't know what criteria led to this % or what this means????

I THINK RESCHEDULE IS WHAT IT MEANS...

**Comment [HK11]:** Is this true? Would we try another Sedation?

**Comment [HK12]:** Do we do paper papoose consent?

SOMEWHERE ENTRY INTO EPIC SHOULD BE A STEP... OFTEN RESIDENT FORGETS TO DO IT AND HAS TO GO BACK TO DO IT...

THIS COULD BE FLESHED OUT A LITTLE MORE ON DOSES/DRUG CHOICES

**Comment [HK13]:** This can be any assistant technically, right? Usually Deb/Ronda but I wanted to make it broad in case one was not here...

ANYTHING ON ORAL PROCEDURE?

DO WE LIST "READINESS CRITERIA" LIKE FLOPPY, EYES CLOSED, QUIET, etc ?..

**Comment [CP14]:** We will also need to come to some decision on capnography – likely will need its own protocol

SOME ILLUSTRATIONS?

1. POSITION OF PULSE OX
2. " " PRECORDIAL STETH
3. LOCATION DIAGRAM OF EQUIPMENT / PAPOOSE
4. LOCATION OF PEOPLE

MIGHT BE GOOD TO HAVE AN ACCOMPANYING EMERGENCY PROTOCOL — WHO DOES WHAT AND WHEN ??

| | | |
|---|---|---|
| | 4. Baseline vitals and then record vitals every 5 mins. | **Recorder** |
| * | 5. Get Attending if necessary | **Recorder** |
| **Post-Op** | 1. Take dirty instruments out of room | **Recorder** |
| | 2. Parent brought back to room when Resident or Faculty deems appropriate | |
| | 3. Parent, patient, and assistant stay in room | |
| | a. Vitals recorded, equipment removal at discretion of Resident or Attending | |
| | b. **** (any more info from the AAP 2016 guidelines???? – link below) | |
| | 3. Discharge (d/c) Instructions | |
| | a. Go over procedure d/c and all items on AVS (post-sedation instructions). Make sure to point out name of medication(s) on AVS in case patient has a complication. | **Resident or Assistant** |
| | b. Would you like a wagon, wheelchair, do you need help getting to car? | **Assistant to get ready or to call Transport**** |
| | c. Does pt meet discharge criteria? Attending needs to clear for d/c. WHAT ARE our specific D/C criteria?<br>-- return to within X% of baseline vitals<br>-- can answer questions<br>-- can grab a sticker | **Attending** |
| | d. Watch the pt's head position in the car on the way home and make sure the head is up or to the side and not down as it could interfere with normal breathing. 2nd adult to sit in back seat. | CHILD IN CAR SEAT? |
| | e. Escort patient to hallway if 2 adults. Escort to circle or to car if only 1 adult. | **Assistant or Recorder** |
| **Post-Sedation** | 1. Complete EPIC Chart | **Resident** |
| | 2. Call to check on patient | **Assistant/ Dawn?** |
| | a. Brings to attention of faculty and/or resident anything of note or that may indicate follow-up is needed. | |

DISCHARGE CRITERIA ?

**Comment [HK15]:** Or who else would be assigned to get the attending?

**Comment [HK16]:** We need a consensus on this.

*Use of water should be minimized. The risk of laryngospasm or aspiration for a sedated patient is dependent upon level of sedation and swallowing reflex of patient. In cases where a

tooth cannot be isolated with rubber dam or Isovac, combination of high speed suction, cotton rolls, and/or 2x2 gauze held next to tooth/teeth can be used to minimize water on soft-tissues. Cutting dry???

**Comment [HK17]:** (Steve asks: what is our water rule if no RDI is used? Can you rinse with small amount and HVAC to remove cement? Etc)

**Comment [CP18]:** Discuss throat pack with gauze pad wad

**Patient Transport policy:
When sedations are completed we can call patient transport by dialing the hospital operator "0" and asking for patient transport, preferably 10 minutes before patient is discharged. We may also have one of our staff members escort family to either the outpatient care loop and wait with patient while parents get vehicle. We may also escort them to their car if in our parking garage, however we are not to go off site with family. DDS will document in patient chart whether patient was discharged with patient transport or by our staff. If patient family wants to stay on site after appointment, we stop as escorts in the downstairs lobby and do not have liability after this point.

**WHAT other issues do we need to have included in this protocol?**

- SEE NOTES
- WE SHOULD HAVE PROCESS INDICATORS (SUCCESS/SAFETY) IN EPIC

**Attending HANDOFF Procedure? (In case Attending has to leave)**

- MAKE THIS COMPATIBLE TO IN-HOUSE CARE HANDOFF
- MIGHT NEED EPIC STEPS — ASK DR. KUMAR FOR HIS THOUGHTS

http://pediatrics.aappublications.org/content/early/2016/06/24/peds.2016-1212 -- Dr Kim is currently reading this to glean any info from it that we are missing or that we need evidence behind for our protocol. Feel free to read also! Thanks to Dr Amini for the link.