 CREDIT VALLEY <small>THE CREDIT VALLEY HOSPITAL</small>		CLINICAL PRACTICE GUIDELINE	PROFESSIONAL PRACTICE
TITLE: Sedation and Analgesia for Diagnostic or Therapeutic Procedures			
DATE OF ISSUE: 2002, 11	PAGE 1 OF 11(Appendix)	NUMBER: CPG 3-1	
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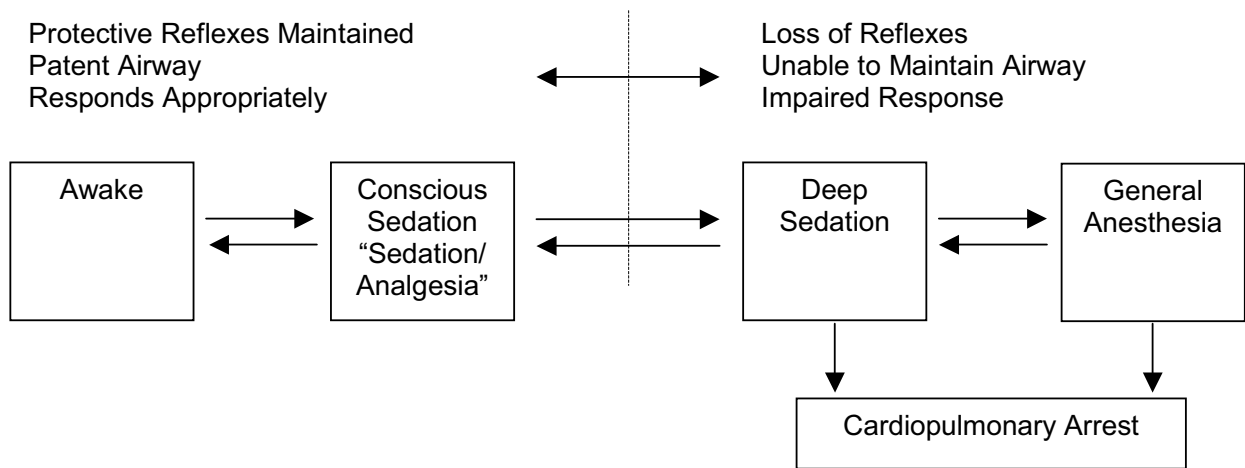
Purpose:

To provide guidelines for the administration of sedation and analgesia to patients requiring a diagnostic or therapeutic procedure.

Definitions:

The Sedation Continuum:

Sedation is a continuum, it is not always possible to predict how an individual will respond.



- **Conscious Sedation** describes a state of sedation, tranquilization and amnesia, that allows a patient to tolerate a painful diagnostic or therapeutic procedure while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal command and/or tactile stimulation.

Deep Sedation is a state of unconsciousness from which the patient is not easily aroused, which may be accompanied by impairment of airway protective reflexes and ventilatory drive.

- **General Anesthesia** refers to a state of unconsciousness plus partial or complete loss of protective reflexes including the inability to independently maintain an airway.

Selection Criteria:

Inclusion for All Sedation

- For patients undergoing a procedure where sedation and analgesia is required to relieve anxiety, discomfort or pain.
- For children or uncooperative adults where sedation and analgesia may expedite the conduct of procedures and require that the patient not move.
- Those elective patients who have been fasting as outlined in the **Fasting Protocol for Sedation and Analgesia for Elective Procedures - Appendix 1**.
In Urgent/Emergent situations where gastric emptying may be impaired due to anxiety and pain, or when the patient has not been fasting, and the physician has decided there is a greater risk to the patient if the procedure is delayed, the potential for pulmonary aspiration of gastric contents must be considered in determining the timing of the intervention and the degree of sedation/analgesia.
- **American Society of Anesthesiologists Classification (ASA)** - Class I and II patients – **Appendix 2**
- The availability of adequately trained professionals to provide intra and post procedure care.

Exclusion

- **American Society of Anesthesiologists Classification (ASA)** - Class III and IV require specialized care in the OR, ICU, ER or Special Procedures Room. Anesthetist/Internist should be consulted. - **Appendix 2**
- Situations where there are not adequately trained professionals to provide intra and post procedure care.

Responsibilities:

Scope of Practice for use of Sedation and Analgesia:

Physicians and other regulated Health Professionals who will be administering and or monitoring patients receiving sedation and analgesia are responsible for familiarizing themselves with the agents administered and the role of pharmacologic antagonists for opioids and benzodiazepines and are responsible for recognizing and responding appropriately to the associated complications.

A physician competent in advanced life support and airway management will be available during the procedure and recovery period.

Patient Evaluation:

Prior to the administration of sedation and analgesia a history and physical examination will be performed to assess:

- abnormalities of the major organ systems
- previous adverse experience with sedation/analgesia as well as regional and general anesthesia
- medication and drug allergies
- time and nature of last oral intake
- history of tobacco, alcohol, or substance use or abuse

- physical examination including auscultation of the heart and lungs and evaluation of the airway

Pre Procedure Preparation:

- Obtain informed consent according to the Consent policy #PP3.1.
- Physician orders for:
 - Intravenous access
 - Medication administration
- Ensure equipment and personnel are available
- Initiate Sedation/Analgesia Flowsheet or Endoscopy Suite G.I. Procedure Record

Monitoring and Treatment:

- Initiate medication administration according to the **Guideline for Medication Administration Appendix A**
- Monitoring according to the attached **Standards for Monitored Care**.
- The physician will order the discharge of the patient according to the attached **Sedation and Analgesia Discharge Criteria**.

Guideline for Medication Administration

See Appendix A: Guideline for Drug Administration to obtain the following:

- Recommended dosages
- Onset, peak affect and duration
- Precautions, contraindications and adverse affects

This is only a brief overview. For additional information the following sources are available:

- Computer access: Manuals/Manual: MOX Library: Medication/Parenteral Manual
 - Compendium of Pharmaceutical and Specialties (CPS)
 - Pharmacist
1. Intravenous sedative/analgesic drugs should be given in small, incremental doses that are titrated to the desired endpoints of analgesia and sedation with sufficient time allowed between dosing to permit assessment of the effect before additional drug is given.
 2. The propensity for combinations of sedative and analgesic agents to potentate respiratory depression emphasizes the need to appropriately reduce the dose of each component.
 3. It is often difficult to achieve true conscious sedation without the potential for the patient to become deeply sedated, either because of delayed drug absorption or because the stimulus of the procedure is no longer present. Adherence to monitoring guidelines is critical.
 4. Reversal agents will be readily available whenever opioid analgesics or benzodiazepine sedatives are administered.
 5. In the majority of instances, intravenous drug administration will be the route utilized, although, in children, oral/rectal or IM administration of sedation and analgesia are acceptable. In these

cases intravenous access is not considered essential, however intravenous administration sets, fluids and a selection of intravenous catheters need to be readily available.

6. Oxygen administration may increase oxygen saturation in the face of hypoventilation and undetected CO₂ retention may occur.
7. Drugs administered, dosage and time of administration will be recorded in the patients record. Response to sedation and analgesia will be assessed using the sedation score and pain scale. Adverse drug reactions or complications will be documented in the progress notes.

Standards for Monitored Care:

A. Administration of Oral/Rectal or Intramuscular Agents (Excluding IM Ketamine)

Intra Procedure:

1. Required equipment: The following equipment will be at the bedside and functioning prior to administration of "sedation and analgesia":
 - Oxygen setup
 - Suction setup
2. Readily available equipment:
 - Emergency Measures Code Blue Cart
3. Pulse oximeter attached to each patient to monitor oxygen saturation.
4. There will be a record of vital signs (heart/respiratory rate/blood pressure, oxygen saturation and sedation score) pre procedure and q 15 minutes during the sedation period. The patient will be observed for signs of deep sedation. Based on clinical judgement, the frequency of BP monitoring may be adjusted so that the patient is not disturbed during crucial periods of the test or procedure.

If additional sedation is given or the patient becomes deeply sedated (sedation score of 3) continuous monitoring of vital signs (heart/respiratory rate), oxygen saturation and constant observation by monitoring personnel are required until the patients sedation score is 1 or 0.

5. For intramuscular agents the sedating physician will be immediately available until the patient is assessed to be awake. For oral and rectal agents the sedating physician is not required to be immediately available.

Post Sedation Recovery:

1. There will be a record of vital signs (heart/respiratory rate/blood pressure) and sedation score post procedure and the patient will be observed every 15 minutes until awake. The discharge criteria must be met prior to discharge.

B. Administration of Intravenous Agents and IM Ketamine

Intra Procedure:

1. Required equipment: The following equipment will be at the bedside and functioning prior to administration of "sedation and analgesia":
 - Oxygen setup
 - Suction setup

- Self inflating resuscitation bag and airway
 - Intubation tray in the Emergency Department, Endoscopy Clinic and Fracture Clinic.
2. Readily available equipment:
The following equipment located on the Emergency Measures Code Blue Cart will be readily available and functioning prior to administration of "sedation and analgesia".
- A selection of appropriate sized endotracheal tubes
 - Functioning laryngoscope and blades both adult and paediatric
 - EKG monitoring
 - Cardiac defibrillator
 - Emergency drugs
 - Intravenous administration sets and fluids and a selection of intravenous catheters both adult and paediatric.
- Emergency equipment will be obtained, in the event of a respiratory or cardiac arrest, by initiating the **Emergency Measures Code Blue**.
3. Pulse oximeter attached to each patient to monitor oxygen saturation.
4. There will be continuous monitoring of vital signs (heart/respiratory rate) and oxygen saturation during the procedure. Blood pressure and sedation score will be assessed q 15 min (minimum), more frequently if indicated. Frequency of blood pressure monitoring and assessment of the sedation score will be adjusted based on clinical judgement so that the patient is not disturbed during crucial periods of the test or procedure. Monitoring parameters will be recorded every 5 - 15 minutes (minimum). Constant observation by monitoring personnel is required until the patients sedation score is 1 or 0.
5. The sedating physician will be immediately available until the patient is assessed to be awake.

Post Sedation Recovery:

1. There will be a record of vital signs (heart/respiratory rate/blood pressure) and sedation score every 15 minutes for a minimum of 1 hour and until fully recovered. The discharge criteria must be met prior to discharge.
2. Pulse oximetry monitoring will be maintained until the patient is awake, and the patient is able to maintain O₂ saturations greater than 93% while breathing room air. Patients with saturations less than 93% should receive oxygen by mask.

Sedation and Analgesia Discharge Criteria:

The nurse will assess the patient against the criteria. All criteria will be met prior to discharge. If the criteria are not met, physician assessment is required prior to discharge.

1. The patient will meet the following discharge criteria.
 - Airway patent and stable
 - Cardiovascular function stable
 - Return to baseline level of consciousness
 - Able to sit (age appropriate)
 - Able to talk (age appropriate)
 - Taking oral fluids; not vomiting
 - Accompanied by a responsible adult
2. Sufficient time (up to 2 hours) is required after the **last** administration of reversal agents to ensure that patients do not become resedated after reversal effects have abated. The duration of the sedation/analgesia and reversal agent will need to be considered when evaluating this criteria.

3. The patient will be given written adult or paediatric post sedation instructions. These instructions will be explained to both the patient and accompanying adult. The patient will be instructed to not drive a vehicle, operate hazardous machinery or consume alcohol for a minimum of 18 hours, or longer if drowsiness or dizziness persists.
4. A discharge order is required.

Appendix 1. Fasting Protocol for Sedation and Analgesia for Elective Procedures

It is important that the patient have an empty stomach to reduce the chances of vomiting and aspirating after sedation and analgesia is given.

Fasting Recommendations (1) Ingested Material	Minimum Fasting Period (2)
Clear Liquids (3)	2 hours
Breast Milk	4 hours
Infant Formula	6 hours
Non-human Milk (4)	6 hours
Light Meal (5)	6 hours

1. These recommendations apply to healthy patients who are undergoing elective procedures. They do not guarantee complete gastric emptying has occurred.
2. The fasting period noted above apply to all ages.
3. Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee.
4. Since non-human milk is similar to solids in gastric emptying time, the amount ingested must be considered when determining an appropriate fasting period.
5. A light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may prolong gastric emptying time. Both the amount and type of foods ingested must be considered when determining an appropriate fasting period.

Appendix 2. American Society of Anesthesiologists (ASA) Classification

- I. Healthy patient
- II. Mild systemic disease - no functional limitation
- III. Severe systemic disease - definite functional limitation
- IV. Severe systemic disease that is a constant threat to life
- V. Moribund patient not expected to survive without the operation

Appendix 3. Sedation Score

- 1) Awake
- 2) Mild - Arousable with verbal stimulation
- 3) Moderate - Arousable with tactile stimulation
- 4) Severe - Not arousable by tactile stimulation

Evaluation Criteria:

- Monitoring will be done through the high-risk case review process. Each department/programme will be responsible for evaluating outcome and compliance.
- An audit of Ketamine and Propofol use for procedural analgesia and sedation will be done to assess utilization and outcome.

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Approval:

Emergency Programme Steering Committee: June 18, 2002
Paediatric Programme Steering Committee: October 9, 2002
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Surgery Steering Committee: September 18, 2001
Ambulatory Care Steering Committee: September 19, 2001
Pharmacy and Therapeutics Committee: September 10, 2002
Professional Practice Committee: November 25, 2002
Clinical Quality Care Committee: October 16, 2002
Medical Advisory Committee: November 4, 2002

Appendix A
Guideline for Drug Administration

Paediatric Dosing		Adult Dosing		O D	Onset Duration	P C A	Precautions Contraindications Adverse Affects
SEDATIVES							
MIDAZOLAM	<p>IV Route: * 6 months – 5 years: Initial: 0.05 – 0.1 mg/kg Total dose: 0.6 mg/kg Total dose maximum: 6 mg * 6 – 12 years: Initial: 0.025 – 0.05 mg/kg Total dose: 0.4 mg/kg Total dose maximum: 10 mg * 12 – 16 years: Use adult doses. Total dose maximum: 10 mg</p> <p>Oral Route: * Wt < 20 kg: 0.5 – 0.75 mg/kg/dose po * Wt > 20 kg: 0.3 – 0.5 mg/kg/dose po Administer 20 – 35 minutes prior to procedure. Dose limit: 20 mg/dose</p> <p>Not applicable</p>	<p>IV Route: Initial: 1 – 2.5 mg increments slow IV push every 2 minutes titrated to patient response. Wait 2 or more minutes to evaluate effect. Maintenance: 25% of initial dose by slow titration. Decrease dose by 30% if administered concomitantly with narcotics or CNS depressant.</p> <p>Oral Route: Not applicable</p> <p>2.5 – 10 mg IV, given slowly – not to exceed 5 mg/minute – and repeated every 5 – 10 minutes titrated to patient response. Lower dose if the patient is also receiving narcotic.</p>	<p>O</p> <p>D</p>	<p>IV Route: 1 – 5 minutes, peaking within 5 minutes 20-30 minutes</p> <p>Oral Route: 20 – 30 minutes, peaking within 1 hour. May last up to 6 hours.</p>	P <p>C</p> <p>A</p>	<ul style="list-style-type: none"> renal failure elderly MAO inhibitors <ul style="list-style-type: none"> hypersensitivity <ul style="list-style-type: none"> respiratory depression hypotension paradoxical agitation amnesia <ul style="list-style-type: none"> elderly renal failure hypersensitivity egg allergy respiratory depression hypotension thrombophlebitis <ul style="list-style-type: none"> hepatic failure drug dependency <ul style="list-style-type: none"> hypersensitivity 	
DIAZEPAM	<p>Not applicable</p>	<p>2.5 – 10 mg IV, given slowly – not to exceed 5 mg/minute – and repeated every 5 – 10 minutes titrated to patient response. Lower dose if the patient is also receiving narcotic.</p>	<p>O</p> <p>D</p>	<p>30 seconds – 2 minutes with peak effect in 5 minutes. Lasts 4 hours but substantially longer in patients taking MAO inhibitors or who have renal, cardiac or hepatic disease.</p>	P <p>C</p> <p>A</p>	<ul style="list-style-type: none"> elderly renal failure hypersensitivity egg allergy respiratory depression hypotension thrombophlebitis <ul style="list-style-type: none"> hepatic failure drug dependency <ul style="list-style-type: none"> hypersensitivity 	
PENTO-BARBITAL	<p>IV Route: 2.5 mg/kg IV over 1 minute, wait 1 minute then 1.25 mg/kg IV over 30 seconds, wait 1 minute then 1.25 mg/kg IV over 30 seconds, wait 1 minute then if required give additional 1 mg/kg Total dose maximum: 4 – 5 mg/kg</p> <p>IM Route: * Wt < 15 kg: 6 mg/kg/dose IM, an additional 2 mg/kg may be given if patient still awake 1 hour after initial dose. * Wt > 15 kg: 5 mg/kg/dose IM, an additional 1.6 mg/kg may be given if patient still awake 1 hour after initial dose. Administer 30 minutes prior to procedure. Total dose maximum: 200 mg</p>	<p>IV Route: Not applicable</p> <p>IM Route: Not applicable</p>	<p>O</p> <p>D</p> <p>O</p> <p>D</p>	<p>IV Route: 0 – 1 minute 0 – 15 minutes</p> <p>IM Route: 20 – 30 minutes 3 – 4 hours</p>	P <p>C</p> <p>A</p>	<ul style="list-style-type: none"> laryngospasm chest wall spasm extravasation with IM injections 	
CHLORAL HYDRATE	<p>Oral/Rectal Route: 50 – 80 mg/kg po/pr Administer 20 – 45 minutes prior to procedure. May repeat with 20 – 40 mg/kg in 1 hour. Maximum: 2000 mg po/pr.</p>	<p>Not applicable</p>	<p>O</p> <p>D</p>	<p>Oral/Rectal Route: 10 – 20 minutes Peak effect within 30 – 60 minutes 4 – 8 hours.</p>	P <p>C</p> <p>A</p>	<ul style="list-style-type: none"> renal failure hepatic failure severe congestive heart failure hypersensitivity age less than 2 months <ul style="list-style-type: none"> respiratory depression 	

Appendix A
Guideline for Drug Administration

	Paediatric Dosing	Adult Dosing	O D	Onset Duration	P C A	Precautions Contraindications Adverse Affects
OPIOIDS						
FENTANYL	0.5 – 3 mcg/kg slow IV push over 3 – 5 minutes	25 mcg increments or 0.5 mcg/kg increments to maximum 2 mcg/kg slow IV push over 1 – 2 minutes	O D	1 – 3 minutes with peak effect in 2 – 5 minutes 30 – 60 minutes	P C	<ul style="list-style-type: none"> elderly bradyarrhythmia hypersensitivity
MORPHINE	0.05 – 0.1 mg/kg slow IV push; may repeat X 1 prn in 15 minutes	1 – 5 mg increments IV over 5 minutes titrated to patient response	O D	1 – 3 minutes, with peak effect in 20 minutes 4 hours	P C	<ul style="list-style-type: none"> hypotension respiratory depression chest wall rigidity bradycardia
MEPERIDINE	Not applicable	0.5 – 2 mg/kg with increments as high as 10 – 25 mg IV push	O D	1 minute, with peak effect in 5 – 20 minutes 2 – 4 hours	P C	<ul style="list-style-type: none"> elderly MAO inhibitors hypersensitivity
REVERSAL AGENTS						
NALOXONE	Emergency Use: 0.1 mg/kg/dose IV or 0.01 mg/kg increments titrated to effect. Partial Reversal: 0.01 mg/kg/dose IV	0.1 – 0.2 mg IV push, titrated as needed.	O D	2 – 3 minutes 20 – 30 minutes	P C	<ul style="list-style-type: none"> opioid dependency watch for resedation hypersensitivity
FLUMAZENIL	10 mcg/kg IV over 15 seconds, wait 1 – 3 minutes, if required dose may be repeated up to total 4 x q 1 – 3 minutes to total dose of 50 mcg/kg . If resedation occurs, doses may be repeated q 20 minutes or the effective dose may be given as an hourly infusion. Dose limit: 200 mcg/dose Total dose limit: 1000 mcg	0.2 mg IV push over 15 seconds, wait 1 minute. May repeat 0.2 mg every 1 minute to a maximum 1 mg	O D	1 – 2 minutes, with a maximum effect in 6 – 10 minutes 30 – 60 minutes	P C	<ul style="list-style-type: none"> severe pain due to loss of narcotic effect benzodiazepine dependency watch for resedation hypersensitivity
			A		A	<ul style="list-style-type: none"> seizures

Appendix A
Guideline for Drug Administration

	Paediatric Dosing	Adult Dosing	O D	Onset Duration	P C A	Precautions Contraindications Adverse Affects
ANESTHETIC AGENTS						
KETAMINE	IV Route: Induction: 0.5 – 1 mg/kg IV over 2-3 minutes Maintenance: 0.01 – 0.015 mg/kg/min	IV Route: Induction: 0.2 – 1 mg/kg IV over 2-3 minutes Maintenance: 0.005 – 0.02 mg/kg/min	O D	IV Route: 40 seconds 5 – 10 minutes	P	<ul style="list-style-type: none"> glaucoma porphyria thyroid disorder hepatic failure
	IM Route: Induction: 2 – 10 mg/kg (4 mg/kg is considered optimal in ER procedures) Maintenance: 0.005 – 0.02 mg/kg/min		O D	IM Route: 3 – 8 minutes 12 – 25 minutes	C	<ul style="list-style-type: none"> age less than 1 year, except anesthesiologist * hypersensitivity head, pharynx or pulmonary disorder full meal 3 hours before procedure active pulmonary infection CVS disease history of airway instability seizure disorder
	Atropine should be co-administered, to decrease salivation, in a dose of 0.01 mg/kg (minimum 0.1 mg , maximum 0.5 mg) RECOMMENDED for procedures that are short and painful or likely to produce excessive emotional upset. Examples: <ul style="list-style-type: none"> Complex Laceration Fracture/Dislocation reduction Incision and drainage or foreign body removal 				A	<ul style="list-style-type: none"> emergence responses ie. <ul style="list-style-type: none"> -dreams, hallucinations, confusion, excitement or irrational behavior, psychic abnormalities respiratory depression CVS depression Increased salivation
RESTRICTED for use in ICU, ER and Special Procedures Room By: <ul style="list-style-type: none"> ANESTHETIST * INTENSIVIST and DESIGNATED INTERNISTS DESIGNATED ER PHYSICIANS DESIGNATED PAEDIATRICIANS 						
PROPOFOL	CONTRAINDICATED	Deep Sedation: 0.5 – 1.5 mg/kg IV over 3 – 5 minutes Mini dose titration recommended: 20 mg q 60 seconds titrated to effect In elderly, debilitated, hypovolemic and/or ASA III or IV patients (see exclusion criteria), the dosage and rate of administration may need to be reduced by approximately 20 – 30 percent	O D	0.5 – 1 minute 3 – 10 minutes	P	<ul style="list-style-type: none"> elderly debilitated hypovolemic severe cardiac or respiratory disease seizure disorder hypersensitivity egg or soy allergy
	RECOMMENDED for direct current cardioversion, procedural sedation and (rapid sequence intubation) RESTRICTED for use in ICU, ER and Special Procedures Room By: <ul style="list-style-type: none"> ANESTHETIST INTENSIVIST and DESIGNATED INTERNISTS DESIGNATED ER PHYSICIANS 				C	<ul style="list-style-type: none"> respiratory depression hypotension bradycardia local pain on injection