

Pre-sedation Nursing Assessment

By Allan J. Schwartz, C.R.N.A., D.D.S.

Our nurses' training teaches us that proper patient assessment is an essential part of the foundation for the professional nursing care of patients. Therefore, a thorough knowledge of a patient's entire medical condition is necessary prior to performing sedation for the patient. Comprehensive nursing assessment is safe patient care. It provides an additional pair of eyes on the patient for the treating physician.

A good pre-sedation nursing assessment uses a systems approach to the patient: a way of looking at the whole patient breaking the human body down into specific categories or systems. The systems to be assessed are the respiratory, cardiovascular, hepatic, gastrointestinal, neurological, musculoskeletal, renal, and endocrine. A miscellaneous category covers the remaining entirety of the patient.

Figure 1 is a nursing assessment form which allows the nurse to interview the patient, ask questions, and record data. This nursing assessment form prompts the nurse to focus on specific conditions and can prompt the nurse to ask further questions of the patient's health history. Any conditions found might affect the patient's tolerance for sedation, and tolerance for the procedure(s) to be performed. If questions arise, the treating physician can be alerted to any specific problems and concerns allowing the patient to be seen for further evaluation and tests. With practice, this form can be efficiently and can be promptly completed. The form is available at:

http://www.aana.com/crna/pdfs/preeval_form.jpg.pdf

The nursing assessment form should be completed beforehand during a dedicated pre-screening appointment. Early nursing assessment reduces potential complications from the sedation and the procedure, allows time to obtain and complete any further necessary testing, and gives time to teach the patient necessary pre-sedation and pre-procedure instructions. If there has been a long span of time between when the patient was first assessed and the day of the sedation and procedure, one can use a, "day-of" form (Figure 2) to supplement the nurses assessment form. This allows the nurse to gain a, "snapshot" of the patients health status the, "day-of" the procedure and to quickly screen for any new potential problems and concerns.

In conclusion, a pre-sedation nursing assessment form is provided which uses a systems approach to thoroughly evaluate the patient, prompts the nurse to ask further questions, and record data. If a span of time has passed since the original pre-sedation nursing assessment, a brief, "day-of" form may be used to update the health status of the patient the, "day-of" the sedation and the procedure.