Dangers of Driving after Moderate Sedation/Analgesia

Does your moderate sedation/analgesia policy and procedure specify protocols when a patient presents for surgery without an escort home?

A 44-year-old man was scheduled for surgery on an injured knee. Before the surgery, he was told by the surgeon that he would need to arrange for transportation home on the day of the procedure and he would need to be accompanied by an adult. On the day of surgery, the patient arrived at the ambulatory surgery unit without an escort. The patient said that the friend who was to accompany him was not available.

A nurse informed the surgeon and the anesthesiologist of the patient’s desire to proceed with surgery without an escort home. The anesthesiologist and the surgeon decided that the procedure could be performed under a local anesthetic. During the procedure, the patient became agitated and the anesthesiologist administered sedation. The patient remained alert for the remainder of the procedure. After a stay in the postanesthesia care unit, the patient was discharged.

While driving himself home, the patient drove off the road, and the accident left him a quadriplegic. In the subsequent malpractice litigation, the anesthesiologist was found negligent in allowing the patient to drive home, and the orthopedic surgeon was found not guilty.

A second case involved a 35-year-old woman who was scheduled for a minor gynecological procedure under local anesthesia. The patient presented for surgery without an escort home because the babysitter had failed to show up and the patient’s husband had stayed home to care for their children. When the patient arrived, she was upset and crying. The gynecologist ordered lorazepam as a premedication, and the preoperative nurse administered the lorazepam.

After the procedure, the postanesthesia care unit nurse, who was acquainted with the patient, offered to drive her home. The patient refused and drove herself. She was in a car accident that involved another car. The patient filed a lawsuit, and both the gynecologist and the anesthesiologist were found negligent for allowing the patient to drive home. The patient and the injured parties from the other car were compensated.

TAKEAWAY

The residual effects of moderate sedation medications can linger, and a patient may not be able to drive home safely for up to 24 hours after surgery. It is important to ensure before surgery that the patient has transport home. In addition, it is more likely that a patient with an escort home will also have a caregiver at home.

Reference

Bradycardia Resulting from Administration of Intranasal Dexmedetomidine

What discharge criteria does your facility use for patients who have been sedated via alternate routes of medication administration?

For pediatric patients, do discharge instructions include having an additional caregiver when transporting the patient home, depending on the patient’s individual needs and the medications administered?

Dexmedetomidine is an alpha-2 adrenoreceptor agonist that is predominantly used for intravenous sedation of adult patients in intensive care units. During the last several years, an intranasal dexmedetomidine has been used for pediatric procedural sedation when it is not possible to give IV medications to children. Both midazolam and fentanyl can also be administered intranasally.

An 11-year-old girl with recurrent urinary tract infections was scheduled for a voiding cystourethrogram. The procedural team administered dexmedetomidine intranasally for sedation. The procedure took 15 minutes. The patient was then monitored and recovered in the sedation area for 60 minutes, at which time her vital signs and level of consciousness returned to baseline. The physician approved the patient for discharge with a respiratory rate of 20 breaths per minute, blood pressure of 97/38 mmHg, and a heart rate of 74 beats per minute.

When the patient left the sedation area 2 hours after the administration of the intranasal dexmedetomidine, she collapsed without warning. She was not injured and was alert and oriented with a blood pressure of 78/51 mmHg, respiratory rate of 17 breaths per minute, and a blood oxygen saturation of 99%. The initial heart rate (palpated) was 36 beats per minute. Cardiac monitoring and electrocardiogram showed sinus bradycardia. Blood work showed normal potassium, sodium, and glucose levels. The patient was admitted to the hospital for observation, and her bradycardia ended in 1.5 hours, nearly 4 hours after the initial dose of dexmedetomidine. The patient was discharged the next day without complications.

Bradycardia with syncope is an uncommon adverse effect of dexmedetomidine given intravenously. It was hypothesized that when administered intranasally, some of the medication could have been swallowed and later absorbed.

Reference
