


WORK STANDARD	 Saskatchewan Health Authority		Title: IV Ketamine – Inpatients Series – PANDEMIC PLAN ONLY Role performing Activity: Anesthesia and Nursing Role in ECT Suite	
	Location:	Saskatchewan Health Authority	Department/Unit:	Mental Health & Addiction Services
	Document Owner:	Provincial Head, Anesthesiology	Date Prepared:	March, 2020
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	Related Policies/Documentation			

Work Standard Summary: The purpose of this WS is to identify the care delivery process for IV ketamine in the ECT Suite within the Saskatchewan Health Authority (SHA). It is explicitly recognized this Work Standard may need to be adapted to specific local practice and resources.

Essential Tasks: Psychiatrists will write orders for patients to receive IV ketamine in the ECT suite at a frequency to be determined by Psychiatry, the standard dosing being 0.5 mg/kg IV to be given over 40 minutes in normal saline.	
1.	Psychiatrists to obtain consent for treatment specific to IV ketamine – education, risks and benefits are to be explained as a part of this consent process.
2.	Psychiatrists will write orders for patients to receive IV ketamine in the ECT suite at a frequency to be determined by Psychiatry, the standard dosing being 0.5 mg/kg IV to be given over 40 minutes in normal saline.
3.	Perform hand hygiene as per the 4 moments of hand hygiene. Refer to SHA-02-005 Hand Hygiene for more information.
4.	Patient to be prepped for IV ketamine in the same fashion as for ECT – COVID-19 Screening and pre-op checklist to be completed on inpatient units. <ul style="list-style-type: none"> • Refer to CV-19 A0015 Management of ECT Patients during COVID-19 for actions/precautions to take based on COVID-19 screening/testing. • If patient screens negative, Routine Precautions are to be followed. • If the patient screens positive or is known COVID-19 positive, all Healthcare Workers (HCW) in the room are to take full Droplet/Contact Plus Precautions. • NOTE: Refer to CV-19 G0006 Continuous and Extended PPE Use Guidelines - Acute Care for more information on mask use.
5.	Once patient is placed in assigned bed have the patient complete SHA 0064 PHQ-9 and GAD-7 Form prior to each treatment. Put a patient label/addressograph on this form and place in patient chart.
6.	Prepare patient for treatment – attach vital signs and cardiac monitor, start IV fluids at TKO, (preferably 20G catheter) - record baseline vital signs.
7.	Have TIVA syringe pump and tubing ready at bedside for anesthesia.
8.	Anesthesia will prepare and initiate Ketamine infusion to run over 40 mins.
9.	Nurse to monitor and record vital signs q 10 mins during infusion, using the standard post-anesthetic record sheet. The suggested nurse:patient ratio is a maximum of 1:2.
10.	Monitor vital signs and scoring q 15mins following discontinuation of ketamine infusion until standard PACU discharge/transfer criteria are met.
11.	Once step 9 is achieved, call the unit to arrange for patient to be transferred back to appropriate unit.
12.	Report off to the accepting care nurse.
13.	Primary nurse to follow post ECT standards re: continued monitoring.
14.	Continue to monitor vital signs and scoring as per Day Surgery record sheet.