## Emergency Department Procedural Sedation and Analgesia Physician Checklist

[patient label]

Difficult Airway Features  Difficult Laryngoscopy: Difficult BVM Ventilation: Difficult LMA: Difficult Cricothyroidotomy:  Look externally, Evaluate 3-3-2 rule, Mallampati score, Obstruction Beard, Obese, No teeth, Elderly, Sleep Apnea / Snoring Restricted mouth opening, Obstruction, Distorted airway, Stiff lung: Surgery, Hernatoma, Obesity, Radiation distortion or other deformit	ntil with PSA exceed risks				
Last oral intake (see fasting grid on reverse) Will delay procedure under the Weight (kg) Benefits of proceeding  Difficult Airway Features  Difficult Laryngoscopy: Look externally, Evaluate 3-3-2 rule, Mallampati score, Obstruction Beard, Obese, No teeth, Elderly, Sleep Apnea / Snoring Restricted mouth opening, Obstruction, Distorted airway, Stiff lung: Surgery, Hernatoma, Obesity, Radiation distortion or other deformit	with PSA exceed risks				
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Pre-procedure Preparation Airway Equipment					
□ Analgesia - maximal patient comfort prior to PSA       □ Ambu bag connected to or large patient consent for PSA and procedure       □ Laryngoscopy handles are unasted patient on monitor: telemetry, NIBP, SpO2, EtCO2       □ Suction, oral & nasal airw         □ Oxygenate with NC O2 and high flow face mask O2       □ Endotracheal tubes & sty         □ Select and draw up PSA agent(s)       □ LMA with lubricant and sy         □ Reversal agents and paralytic vials at bedside       □ Colorimetric capnometer         □ Prepare for endotracheal intubation       □ Bougie & difficult airway or selected to or large patients.	nd blades rays lets rringe				

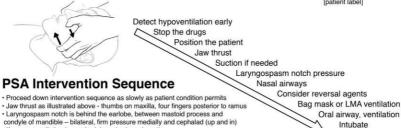
Agent	Dose*	Contraindications	Comments	
Ketamine		Absolute: age < 3 months, schizophrenia Relative: major posterior orophanyms procedures; history of airway instability, tracheal surgery, or tracheal stenoels; active pulmonary infection or disease; cardiousacular disease; CNS masses, abnormalities, or hydrocephalus	Preferred for longer procedures; avoid if hypertension/ tachycardia is a concern; have midazolam available to manage emergence distress; muscle tone is preserved or increased; post-procedure emesis may be mitigated by prophylactic ondansetron	
Etomidate	0.1-0.15 mg/kg IV, then 0.05 mg/kg q2-3 min prn		Intra-procedure myoclonus or hypertonicity, as well as post-procedure emesis, are common	
Fentanyl	1-2 mcg/kg IV, then 1 mcg/ kg q3-5 min prn		Comparatively delayed onset of action; do not re-dose too quickly	
Midazolam	.05 mg/kg IV, then .05 mg/kg q3-5 min prn	Pregnancy, allergy to benzyl alcohol	Comparatively delayed onset of action; do not re-dose too quickly	
Pentobarbital	1 mg/kg IV, then 1 mg/kg q3-5 min prn	Pregnancy, porphyria	Use for painless procedures where analgesia is not needed	
Reversal Agent	Dose		Caution	
Naloxone	0.01-0.1 mg/kg IV or IM (typic	cal adult dose 0.4 mg), max 2 mg		
Flumazenil	0.01 mg/kg IV (typical adult d	ose 0.2 mg ) over 20 seconds, max 1 mg	Only use in benzodiazepine naïve patient	

<sup>\*</sup>All doses should be reduced in the elderly and in patients with marginal hemodynamics

R. Strayer / P. Andrus emupdates.com 11.28.2013



[patient label]



· If rescue ventilation is required, bag slowly and gently

Post-procedure	Assessment	
Adverse events	none / hypoxia (< 90%) / aspiration / hypotension / agitation / other:	
☐ Interventions taken	none / bag valve mask / LMA / ETT / reversal agent / hypotension Rx / admission for PSA / other:	
Adequacy of PSA	nondistressed / mild distress / severe distress	
Procedure	successful / unsuccessful	
☐ MD or RN at bedside	e until patient responds to voice	
☐ Telemetry, EtCO₂, Sp	O <sub>2</sub> monitoring until patient responding to questions appropriately	
If reversal agent use	d, observation two hours after answering questions appropriately	
Mental status and ar	nbulation at baseline at time of discharge/disposition	

## **Fasting Grid** ndard risk patier Oral intake in the prior 3 hours Urgent Procedure prior 3 hours All levels of sedation All levels of sedatio Up to and including brief deep sedation Up to and including All levels of Clear liquids only All levels of sedation Up to and including dissociative sedation; non-Light snack brief deep sedation only sedation Brief: < 10 min Minimal sedation; brief or intermediate-length → Extended moderate → Brief deep → extended-length deep sedation rmediate: 10-20 min sedation only sedation Extended: > 20 min moderate sedation

Additional Comments			
MD Name	Sign	Date/Time	

"Walls RM and Murphy MF: Manual of Emergency Arway Management. Philadelphia, Lippincott, Williams and Wilkins, 3rd edition, 2008
"Green, Roback et al. Fasting and Emergency Department Procedural Sedation and Analgesia: A Consensus-Based Clinical Practice Advisory.
Ann Emerg Med. 2007;49:454-461.

