Emergency Department Procedural Sedation and Analgesia Physician Checklist

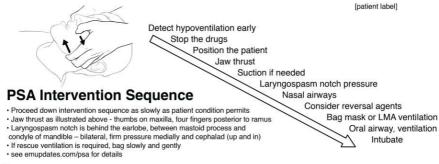
[patient label]

Thysician officerist							
Pre-Pro	cedure Assessr	ment					
□ Past medical history (note history of OSA) □ Prior problems with sedation/anesthesia □ Allergies to food or medications □							
Procedu Denture	S none / upper /			· · ·			
	Cardiorespiratory reserve no or mild impairment / moderate impairment / significant impairment						
I —	Difficult airway features none / mild concern / significant concern						
	I intake (see fasting grid	y procedure until					
. ☐ Weight	☐ Weight (kg) ☐ Benefits of proceeding with PSA exceed risks						
Difficult	Airway Features						
Difficult BV Difficult LM	Difficult Laryngoscopy: Difficult BVM Ventilation: Difficult LMA: Difficult Cricothyroidotomy: Difficul						
☐ Is this	patient a good car	ndidate for ED procedura	al sedation a	ind analgesia?			
should not re	eceive PSA in the emerger		date for ED-base	ded PSA, other options include regional or local			
Pre-pro	cedure Prepara	tion	Airway Equ	uipment			
☐ Analgesia - maximal patient comfort prior to PSA ☐ Ambu bag				connected to oxygen			
				ppy handles and blades			
				al & nasal airways			
				eal tubes & stylets			
/ 5				ubricant and syringe			
				ic capnometer			
	e for endotracheal intub		Bougie & d	ifficult airway equipment			
Agent	Dose*	Contraindications		Comments			
Ketamine	1-2 mg/kg IV over 30-60 sec or 4-5 mg/kg IM, repeat half dose pm	Absolute: age < 3 months, schizophreni Relative: major posterior oropharynx pro airway instability, tracheal surgery, or tra active pulmonary infection or disease; co disease; CNS masses, abnormalities, or	ocedures; history of cheal stenosis; ardiovascular	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 mittigated 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	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		0.		Caution			
	10.01-0.1 mg/kg IV or IM (typic	cal adult dose 0.4 mg), max 2 mg		8			
Naloxone Flumazenil		ose 0.2 mg) over 20 seconds, max 1 mg		Only use in benzodiazepine naïve patient			

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^{*}All doses should be reduced in the elderly and in patients with marginal hemodynamics



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 ₂ monitoring until patient responding to questions appropriately	
☐ If reversal agent use	d, observation two hours after answering questions appropriately	
Mental status and an	nbulation at baseline at time of discharge/disposition	

asting G					Higher-risk patient**				
Oral intake in the prior 3 hours	Emergent Procedure	Urgent Procedure	Semi-urgent procedure	Non-urgent procedure	Oral intake in the prior 3 hours	Emergent Procedure	Urgent Procedure	Semi-urgent procedure	Non-urgent procedure
Nothing	All levels of sedation	All levels of sedation	All levels of sedation	All levels of sedation	Nothing	All levels of sedation	All levels of sedation	All levels of sedation	All levels of sedation
Clear liquids only	All levels of sedation	All levels of sedation	Up to and including brief deep sedation	Up to and including extended moderate	Clear liquids only	All levels of sedation	Up to and including brief deep sedation	Up to and including extended moderate sedation	Minimal sedation
Light snack	All levels of sedation	Up to and including brief deep sedation	Up to and including dissociative sedation; non-extended moderate	sedation Minimal sedation only	Light snack	All levels of sedation	Up to and including dissociative sedation; non- extended moderate sedation	Minimal sedation only	Minimal sedation
Heavier snack or meal	All levels of sedation	Up to and including extended moderate sedation	sedation Minimal sedation only	Minimal sedation only	Heavier snack or meal	All levels of sedation	Up to and including dissociative sedation; non- extended moderate sedation	Minimal sedation only	Minimal sedation

model	ate sedation	Section of Section Contraction	Carried Section 100 Control (100 Control (10
Additional Comments			
MD Name	Sign	Date/Time	

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[&]quot;Walls RM and Murphy MF: Manual of Emergency Airway 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,
Am Emergy Moz. 2007;49:434-481.