

The COVID Clinical Response Committee (CCRC) has been asked to provide guidance on personal protective equipment requirements for routine procedural sedation in the emergency department.

1. **In the absence of assisted ventilation or airway manipulation, procedural sedation and analgesia in the emergency department is not an aerosol-generating medical procedure (AGMP).**
2. **Bag-mask ventilation is only indicated during procedural sedation if, despite a jaw thrust, there is desaturation below 90%. Apnea is not an indication for bag-mask assisted ventilation.**
3. **End-tidal CO₂ monitoring should be considered in all patients undergoing sedation, particularly those who are expected to get to deep sedation (probably most patients).**
4. **Patients with COVID (or high suspicion of COVID) and respiratory involvement should be considered high risk for procedural sedation and at high risk for desaturation. Expert consultation is advised.**
5. **We recommend a point-of-care risk assessment, including risk factors for apnea and desaturation (see below).**
 - a. **If the patient is a PUI or COVID positive and procedural sedation is indicated and it is safe to proceed, the procedure should be done with minimal people in the room and as a potential AGMP.**
 - b. **If the patient is not a PUI or COVID positive, proceed using contact-droplet precautions only.**

This decision will be revisited as requested.

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Rationale

1. The risk of adverse event (desaturation below 90%, the requirement for a jaw thrust, requirement for assisted ventilation, apnea, hypotension) during procedural sedation and analgesia in the emergency department is very low.
2. The risk of requiring bag-mask assisted ventilation is reduced by
 - a. adequate preoxygenation (5 minutes of passive ventilation using a non-rebreather or 8 tidal-volume breaths).
 - b. Avoidance of narcotic administration during sedation
 - c. Selection of ketamine at sub-dissociative doses (0.3 mg/kg 3 minutes prior to the procedure initiation) over narcotic administration.
3. Patients who are at higher risk for apnea include:
 - a. Patients on chronic opiate therapy
 - b. Patients who receive concomitant narcotic therapy at the time of sedation
 - c. Age over 65
 - d. Pre-existing lung disease
 - e. Obstructive sleep apnea
4. We acknowledge that recent literature suggests end-tidal CO₂ monitoring may result in increased intervention without necessary benefit. However, it does allow earlier detection of apnea and prediction of risk for desaturation and this may be of benefit when attempting to avoid bag-mask ventilation.