

**Emergency Department COVID-19 Procedural Sedation - April 8, 2020 0800**  
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**Introduction:** Evidence shows that as the prevalence of COVID-19 increases exponentially, patients presenting with seemingly non-related medical problems may expose health care providers to increased risk of contracting the disease if not properly protected. Individuals may maintain high viral loads in the upper respiratory tract with significant potential for viral shedding and transmission even if asymptomatic.<sup>68,69</sup> While primarily transmitted by droplets, airborne transmission is possible through aerosolization in the setting of high flow oxygen, bronchoscopy, open tracheal suctioning, intubation, extubation, non-invasive positive pressure ventilation, endoscopy, or transesophageal echocardiography.<sup>70</sup> We must ensure safety of providers during this time.

**Staffing**

1. Patient contact personnel to manage Procedural Sedation should be kept to a minimum to reduce staff exposure. While well intended, others should not be within 6 ft of the pt to protect themselves.
2. **In-room** personnel: FULL airborne PPE – as described below
  - a. 1 attending (Sedationist- to administer sedation meds)
  - b. 1 nurse (charting, line and meds if needed)
  - c. 1 tech or Assisting Provider(s) (assisting Proceduralists)
  - d. 1 resp therapist (respiratory monitoring/management (optional per sedation policy if using ketamine))
  - e. 1 Proceduralist (Provider performing other procedure)
3. **Optional outside room** personnel – outside of room at doorway
  - a. 1 nurse (charting)

**Protection**

1. **In room:** All personnel must wear at minimum N95 mask, gown, gloves and eye protection
2. **N95, PAPR/CAPR, or NIOSH certified Respirator for those in room:** If require intubation and started with N95, should consider switch out as soon as possible to PAPR or obtain face shield and/or alternative protection.
3. **Outside room:** Standard ED PPE

**Equipment**

1. Code carts should stay outside resuscitation bay/room. Bring defibrillator into the room for cardioversion. Other items can be passed from cart to bedside. Imperative to keep code carts clean from COVID.
  2. After sedation, all equipment that was used but not necessary for continued care during patient encounter must be cleaned carefully, including monitor leads, monitor, defibrillator, suction etc. Staff should do a 5 minute “time out” to carefully identify any and all equipment used, much like “sponge count” in operating rooms.
1. Avoid bag valve mask as much as possible, but when used, must use viral filter. PEEP valve should be used with BVM. If respiratory decompensation, consider intubation. ETT preferred over LMA.
  2. Hold compressions or other thoracic repositioning/movement for intubation or any other oral access – must decrease aerosol risk
  3. Use of ketamine- May result in decreased for need for airway manipulation and/or positive pressure ventilation with BVM. Consider widening clinical use. Pre-treatment with benzodiazepines may be helpful for adult sedations (Prophylactic midazolam 0.03 mg/kg IV). Consider glycopyrrolate administered 30 minutes prior if performing urgent (non-emergent) sedation if patient has impaired secretion clearance. In cases of a clear respiratory infection, Ketamine carries a potential increase in laryngospasm.

Note: Recommendations for management of COVID patients is rapidly changing. This information is felt to represent the best initial approach based on expert opinion and case reports.