

University of Virginia Health System
Clinical Practice Guideline
Adult Critical Care Sedation Guideline

Principles

1. **If a reason for pain exists**, treat pain first.
2. **Once pain has been addressed**, then establish a reason for the use of sedatives. Reasons may include: amnesia, patient safety/ agitation management, substance withdrawal, sleep, anxiolysis, ventilator synchrony, or control of ICP. Remember that the combination of analgesics and sedatives are synergistic.
3. **If delirium** (confused and/or disordered thinking) is suspected, consider the use of antipsychotics.
4. **Consider non-pharmacologic interventions** to reduce symptoms of discomfort/distress.
5. **Choose a sedation target** in collaboration with the health care team using the Richmond Agitation-Sedation Scale (RASS).
6. **PRN/bolus dosing** by IV or enteral route is the preferred method for managing sedation. Sedative infusions may be used for patients meeting exclusion criteria for daily wean (see 1. below), or when PRN/bolus dosing is ineffective.
7. **Chemically paralyzed** patients should have the paralytic turned off before weaning any sedative or analgesic.

Guidelines

1. Turn off sedative infusions every morning at a time directed by the medical team, unless exclusion criteria are present. **The decision to interrupt the analgesic drip is separate and discussed on rounds.** Reasons for not attempting a daily sedation interruption or weaning may include:
 - Hemodynamic instability
 - Patient ventilator dyssynchrony with signs of intolerance
 - Open chest
 - Chemically paralyzed
 - Increasing ICP
 - Other medical issues/plans
2. All sedating infusions should be weaned to **minimum adequate** level on a daily basis.
3. RASS **desired** target level is determined daily by the health care team and documented on Critical Care Flow Sheet (CCFS) in Patient Plan Of Care Goals Update under the heading “Other individualized goals”.
4. The patient’s **assessed** RASS score is also documented on the CCFS on front using a blank column labeled “RASS”. Variances from the desired target level should be addressed by the health care team, and rationale noted on the flow sheet. Document as Assessed/Target (i.e.: -3 / -2) at least Q12 Hours, and also with change of RN staff, as patient condition warrants or with changes in sedation infusions. When actively titrating infusions document sedation level Q1 Hour until desired RASS level achieved then Q12 Hours or with change of RN staff until next titration.
5. PRN and/or scheduled doses of sedatives may be ordered to maintain sedation. To prevent symptoms of withdrawal from sedative agents consider an enteral dosing taper when patients are on prolonged periods of sedative infusions.

If Inadequate Sedation

- PRN/bolus dose 1 - 2 times before starting or increasing the infusion.
- TITRATE infusion and/or PRN/bolus dose according to the sedation scale target.

If Too Sedated

- STOP the infusion (or hold PRN doses) until target level is reached.
- If patient **then** becomes agitated use PRN/bolus dosing first, and if necessary restart infusion at 50% of preceding level.

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If RASS Score Achieved

- CONTINUE current plan, and attempt to wean the infusion by 25% every 6-12 hours (or longer time period with prolonged duration of IV sedation), or as per medical team plan.

Richmond Agitation-Sedation Scale (RASS)

<u>Score</u>	<u>Term</u>	<u>Description</u>
+4	<i>Combative</i>	Overtly combative or violent; immediate danger to staff
+3	<i>Very agitated</i>	Pulls or removes tube(s) or catheter(s) or has aggressive behavior towards staff
+2	<i>Agitated</i>	Frequent non-purposeful movement or patient-ventilator dyssynchrony
+1	<i>Restless</i>	Anxious or apprehensive but movements not aggressive or vigorous
0	<i>Alert and Calm</i>	
-1	<i>Drowsy</i>	Not fully alert, but has sustained (<u>more than 10 seconds</u>) awakening, with eye contact, <u>to voice</u>
-2	<i>Light Sedation</i>	Briefly (less than 10 seconds) awakens with eye contact <u>to voice</u>
-3	<i>Moderate Sedation</i>	Any movement (but no eye contact) <u>to voice</u>
-4	<i>Deep Sedation</i>	No response to voice, but any movement <u>to physical stimulation</u>
-5	<i>Unarousable</i>	No response <u>to voice or physical stimulation</u>

Procedure

1. Observe patient. Is patient alert and calm (score 0)?
 - Does patient have behavior that is consistent with restlessness or agitation (score +1 to +4 using the criteria listed above, under Description)?
2. If patient is not alert, in a loud speaking voice state patient's name and direct patient to open eyes and look at speaker. Repeat once if necessary. Can prompt patient to continue looking at speaker.
 - Patient has eye opening and eye contact, which is sustained for more than 10 seconds (score -1).
 - Patient has eye opening and eye contact, but this is not sustained for 10 seconds (score -2).
 - Patient has any movement in response to voice, but no eye contact (score -3).
3. If patient does not respond to voice, physically stimulate patient by shaking shoulder and then rubbing sternum if there is no response to shaking shoulder.
 - Patient has any movement to physical stimulation (score -4).
 - Patient has no response to voice or physical stimulation (score -5).

Bedside nurse responsibilities

Document the sedation scale, infusion changes, and boluses on the CCFS, along with rationales.

Long-Term Mechanical Ventilation - Outcomes manager

Assure that the sedation goals are being addressed daily per health care team plan.

Guidelines are general and cannot take into account all of the circumstances of a particular patient. Judgement regarding the propriety of using any specific procedure or guideline with a particular patient remains with that patient's physician, nurse, or other health care professional, taking into account the individual circumstances presented by the patient.

Created – 8/05, Rev. 1/07

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