Sedation in ICU & Sedation Vacation

May 1, 2018

Set Goals	
☐ Pain Free	
☐ RASS every 1 hours till controlled then every 4 hours	
☐ Bispectral Index (BIS)	40-60
☐ Notify MD when at maximum dose and target RASS / BIS score not achieved or dys-synchrony with the ventilator	
☐ Daily sedation vacation	

Rule out and correct Reversible causes

- Medication, drug/ETOH withdrawal
- Medical emergencies (such as pneumothorax)
- Malpositioning ET tube
- Ischemia/Hypoxia/Hypercarbia
- Urinary retention
- Hypoglycemia
- Sleep deprivation

Non Pharmacological Treatments
☐ Adjust positioning
☐ Eliminate irritating physical stimuli (i.e. movement of the ET tube)
☐ Adjust lighting
☐ Adjust volume levels
☐ Family support
☐ Sleep promotion
☐ Calm environment (Cold/Hot packs)
☐ Quran Therapy
☐ Music therapy

Oral Regimen

☐	Acetaminophen 325-650 mg every 4-6 hours PRN (reduce dose in mild Cirrhosis only (max 40 mg/kg/day) avoid in moderate to severe cirrhosis)
☐	Acetaminophen Codeine 300-30 mg 1-2 tabs every 4 hours PRN (use acetaminophen alone in patients with renal dysfunction)
☐	Morphine Sulfate (MS Contin)15 g every 12 hours PRN
☐	Hydromorphone 1-2 mg every 4-6 hours PRN
☐	Lorazepam 1-2 mg Po/NG q 4 to 8 hourly PRN
Intermittent IV Regimen	
☐	Fentanyl: 25 - 50 mcg every 0.5 - 1 hour PRN until pain goal is achieved (preferred in renal failure patients)
☐	Midazolam: 1 - 2 mg IV every 0.5 – 1 hour PRN until RASS goal is achieved
☐	Lorazepam: 1 - 2 mg IV every 4-6 hours PRN until RASS goal is achieved
☐	Propofol: 10 - 50 mg IV every 0.5 hr PRN x2 doses until RASS goal is achieved
Continuous IV Regimen (if goals not achieved with intermittent regimen)	
☐	Fentanyl 2500 mcg in 50 ml; infusion range 0 - 100 mcg per hr
☐	Dexmedetomidine: 0.2 - 0.1.5 mcg per kg per hr IV infusion.
☐	Propofol infusion 0 – 200 mg per hr (Obtain triglyceride level on day 4 while on infusion)
☐	Midazolam infusion range 0 -10 mg per hr (not preferred in general and especially in renal failure patients)
Sedation vacation	
☐	Do not do sedation/analgesia vacation in the following conditions: 1. Paralyzed 2. Haemodynamically unstable 3. FiO2 > 0.6 4. Minute ventilation > 15L/min 5. Non-conventional vent. mode 6. Head injury 7. Difficult airway intubation 8. Recent (≤ 3 weeks) Myocardial infarction
☐	Use retrains to avoid self extubation
☐	Stop infusion at 9:00 AM
☐	Decrease sedation to stop gradually over 1hr starting at 8 AM

☐	If RASS=3-4, restart ½ dose. Be prepared to bolus dose with same sedating agent and increase if necessary
☐	If RASS 1-2 , add Haloperidol 2.5-5 mg iv PRN q 2-4 hourly, inform physician to assess
☐	If RASS 0, alert MD to assess for weaning patient off the ventilator or applying extubation pathway
☐	If RASS remains < 0 after 1 hour of complete stop, call physician to assess