Collaborative Regional Benchmarking Group

Sedation in Critical Care

Aim: To provide guidance on nursing care for the management of sedation in Critical Care patients

Scope: All adult patients in Critical Care

ASSESS FOR AGITATION
2- 4 hrly minimun

- Use the **Richmond Agitation and Sedation Scale (RASS)** to evaluate any patient in receipt of sedation.
- Use the **Critical Care Pain Observation Tool (CCPOT)** for those unable to self report pain

Treat Pain First :
Sedation is not always routinely required in Critical Care patients.

RASS

It is a method of assessing the effectiveness of a given sedative agent on an individual patient, *not* the underlying neurological status of that patient.

- **+4 = Combative**
- **+3 = Very agitated**
- **+2 = Agitated**
- **+1 = Restless**
- **0 = Alert and calm**
- **-1 = Drowsy**
- **-2 = Light sedation**

} Target Range

- **-3 = Moderate sedation**
- **-4 = Deep sedation**
- **-5 = Unrouseable**

STANDARD CARE	
1	Control pain first :analgesia is first line of sedation
2	Optimise non-drug measures
3	Use the minimum sedation necessary : agree/record daily RASS target
4	Titration of sedation to achieve target RASS of 0 to -1 and/or daily sedation hold (Spontaneous Breathing Trial) if not contraindicated (see below)
5	Do not record a GCS if your patient is receiving any sedation. Use RASS instead.

Daily Sedation Holds

- **If RASS 0 to -1 may not need sedation hold as at target**
- **Stop sedative first, wean analgesia as needed**
- **DO NOT abruptly stop Clonidine**
- **Restart sedation at HALF the original dose and titrate**

Sedation Hold Contraindications

- **Receiving neuromuscular blocking agents**
- **Traumatic Brain Injury with raised ICP**
- **FiO2 >=0.6, PEEP >=10cmH2O, prone, inverse ratio ventilation**
- **Un-cleared spine**
- **Haemodynamically unstable**
- **No airway personnel available**
- **End of life care**

Please see your units full guidelines for more information

West Yorkshire Critical Care & Major Trauma Operational Delivery Networks
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