OPTIMISING SEDATION

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Aims

- Discuss drug choices, contraindications and side effects
- Highlight the risks of agitation
- Discuss the use of chemical restraint
- Discuss the law and ethics of sedation
- Discuss the ethics of sedation in end of life care
- Highlight the psychosocial aspects of restraint

Risks of Agitation

- Further agitation
- Increased confusion
- Increased incontinence resulting in skin damage
- Constipation
- Dehydration and lower dietary intake
- Restricted circulation from positioning
- Harm to other patients and staff

PURPOSE OF RESTRAINT

Control of behaviours that are disruptive:

Wandering
Combativeness
Agitation

Control

Management of behaviours that interfere with treatment

Management

Prevent patient harm

Prevent harm to other patients

Prevent harm to staff

Why?

Chemical Restraint

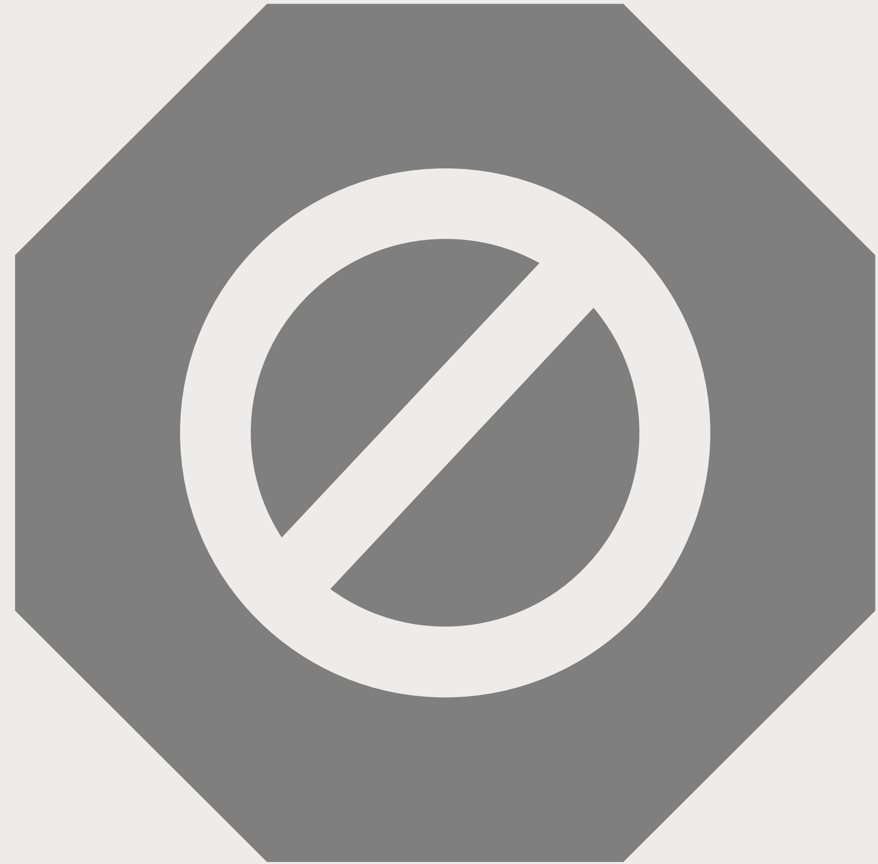
- Aim is to safely and swiftly sedate the patient
- Medication is considered a restraint when being used to restrict/manage the patients behaviour or restrict movement and is not a treatment for the current condition
- Seek alternatives first

Considerations

- Patient condition and PMH
- Medication history (? Drug abuse)
- Height and weight
- Level of agitation
- Route of administration

When is chemical restraint not suitable?

- Verbal or physical aggressive behaviour where no psychiatric ill ness or medical illness is impairing the patients cognition
- Security +/- police involvement
- Consider safety of staff and other patients



PSYCHOSOCIAL ASPECTS OF USING RESTRAINT

Patient

- Shame/humiliation
- Loss of dignity
- Anxiety
- Depression
- Feelings of isolation

Relatives

- Denial
- “makes it real”
- Disillusionment

Healthcare Professional

- Ritual/fixed rather than patient centred
- Inner conflict
- Frustration
- Guilt

Law and Ethics

- Principle of double effect – intent of the healthcare provider must be good, the good effect and not the bad effect must be intended therefore the bad effect can be tolerated and permitted
- The good effect must be sufficiently desirable to compensate for allowing the bad effect
- In the UK excessive sedation/sleep is not considered a desirable outcome, a state of calm is preferred
- Must show proof other strategies have failed
- Interventions should be a proportionate response to the risks

Ethics of sedation in end of life care

- Highly debated and raises genuine legal and ethical issues
- Used for intractable distress
- Acceptable in end of life care to continue sedation that renders the patient less conscious, if it is deemed that the patients situation is intolerable for them when more awake
- However continued deep sedation curtails the patients freedom, they are unable to experience the world around them, their life is purely biological (often termed a “social death”)
- Unable to make autonomous decisions

DRUGS

Remifentanil

Clonidine

Acts within 10 minutes of administration

Half life of 12-16 hours increasing up to 41 hours with impaired renal function

Initial dose 1 mcg/kg/hr maximum of 4 mcg/kg/hr

Abrupt cessation can cause withdrawal syndrome – should be reduced gradually

Dexmedetomidine

Usual dose 0.2-1.4 mcg/kg/hr

Provides a unique quality of conscious sedation which resembles sleep

Does not cause respiratory depression

Aiming for a RASS of 0 to -3

Depresses gag reflex and improves tracheal tolerance so useful for patients aiming to extubate

Less incidence of delirium when compared to midazolam

Prolonged infusion can cause rebound agitation when discontinued