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

Management of behaviours that interfere with treatment

Prevent patient harm
- Prevent harm to other patients
- Prevent harm to staff
Chemical Restraint

- Aim is to safely and swiftly sedate the patient
- Medication is considered a restraint when being used to restrict/manage the patient's 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 illness 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
Dose should be calculated based on IBW not ABW

Initially 6-9 mcg/kg/hr then adjust in increments of 1.5 mcg/kg/hr every 5 minutes

Maximum rate of 12 mcg/kg/hr

Common side effects inc muscle rigidity, respiratory depression and cardiac arrhythmias

Rapid onset and half life of 3 minutes

Maximum use = 3 days

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