Quick Look Procedure Resource for NON-CRITICAL CARE staff

Sedation Assessment and Safety

WHEN TO PERFORM
1. All intubated and ventilated patients
2. Every 2-4 hours and as needed
3. Changes in patient ventilation, vital signs
4. When muscle relaxants (paralyzing agents) are used

HOW TO PERFORM
1. Assessing sedation level
   - Use Richmond Agitation and Sedation Scale (RASS) (or similar) to assess sedation level
   - Lower number = more sedated
   - Doctors will tell you what sedation level to aim for – this should NEVER result in an agitated patient

To assess sedation level
   - First observe for restless, agitated behaviours
   - Then speak (loudly) to patient, ask to open eyes
   - If no response, use physical stimulation - start with light touch, if no response then trapezius squeeze
   - Document findings
     - Always be aware of patient’s sedation status as can change rapidly
     - Common sedative agents include propofol (as infusion), fentanyl, benzodiazepines e.g. midazolam

KEY SAFETY CONCERNS/WHEN TO CALL FOR HELP
1. Sedation can cause hypotension, particularly if bolused. Call for help if SBP drops <90 or MAP<65 following a bolus
2. If using bolus sedation, need to assess sedation level more frequently to ensure target is maintained
3. Sedation can wear off quickly, patients can become difficult to ventilate or agitated and remove ETT/lines – Call for help
4. NEVER use a paralysing agent without sedation
5. If using continuous sedative infusion, NEVER let it run out - check infusions regularly & prepare new well in advance