[redacted]

Policy Title:	**SEDATION, CONTINUOUS INTRAVENOUS**	Effective Date:	09/11
Department:	Nursing, Intensive Care Units (Adult), Emergency Departments	Reviewed/Revised:	03/17, 03/18, 03/20, 03/21
Owner Title:	President GMC Silvis, Nursing Services Administrator	Review Cycle:	Annual
Owner Signature: [redacted]		Page 1 of 4	

I. POLICY:

Continuous sedation for mechanically ventilated patients is provided consistent with National Standards.

II. APPLICABLE BUSINESS UNITS:

☐ All GHS Business Units:

☐ Crescent Laundry
☐ Crosstown Square
☐ Genesis Accountable Care Organization
☐ Genesis Convenient Care
☐ Genesis EAP
☐ Genesis FirstMed Pharmacy
☐ Genesis Family Medical Center
☐ Genesis Health Group
☐ Genesis Health Group, Aledo Rural Health
☐ Genesis Health Group, Erie Rural Health
☐ Genesis Health Services Foundation
☐ Genesis Home Medical Equipment
☐ Genesis Hospice
☐ Genesis Medical Center, Aledo
☒ Genesis Medical Center, Davenport
☐ Genesis Medical Center, DeWitt
☒ Genesis Medical Center, Silvis
☐ Genesis Occupational Health
☐ Genesis Philanthropy
☐ Genesis Psychology Associates
☐ Genesis VNA
☐ Genesis Workers Comp Plan & Trust

III. APPLICABLE ORGANIZATION ROLES:

ICU RN's & ED RN's

IV. EQUIPMENT NEEDS:

N/A

V. PURPOSE:

To ensure safe care of a patient receiving continuous IV sedation and prevent over-sedation.

VI. DEFINITIONS:

Practitioner: Physician, Advance Practice Professional/Allied Health Professional

VII. GENERAL CONSIDERATIONS:

A. Patients receiving intravenous (IV) sedation will have continuous cardiac monitoring and pulse oximetry.

VIII. PRACTICE/PROCEDURE:

ACTIVITIES	KEY POINTS
A. Evaluate patients within the critical care units receiving continuous sedative infusions using the Richmond Agitation Sedation Scale (RASS) (See Attachment A).	• The RASS score assists in establishing the amount of sedation required.
B. Baseline RASS score is documented.	
C. Goal score is ordered by practitioner.	
D. Initiate the infusion and titrate to the goal RASS score.	• Titration of the medication/RASS evaluation establishes minimum dose of sedative required (prevents over-sedation).
E. Document RASS score every 4 hours, PRN, and when titrating sedative infusions.	
F. Decrease the sedative medication to a point where a neurological assessment can be completed every 24 hours (unless otherwise ordered by the practitioner).	• Sedative medication is decreased or discontinued to both assess neurological status and confirm need for continued sedation.
1. Establish frequency of assessment for patients admitted with neurological disease (i.e., head trauma, CVA, craniotomy, etc.).	• Patients diagnosed with neurological disorders require more frequent assessment of level of consciousness as it is the first sign of deterioration in condition.
2. Notify the practitioner if decreasing the sedative medication is detrimental to the patient's physiological condition (difficult ventilation, increased ICP, decreased SpO2, etc	• Potential risk to patient outweighs the benefit. • A practitioner order must be obtained to discontinue or resume sedation decreases for neurologic assessment.
3. Complete the daily assessment in the following manner:	
a. If a paralytic agent is being used, discontinue the paralytic agent.	
b. Wean continuous sedation by decreasing the medication by no	• Allow sufficient time for the paralytic

ACTIVITIES	KEY POINTS
more than 50%. If patient does not arouse, continue to decrease the medication in increments until neurological assessment can be completed.	medication to clear. • Medication should be weaned in a manner that avoids abrupt arousal of patient to prevent fear, agitation, confusion, and combativeness.
c. After completion of the neurological assessment, increase sedative medication by no more than 50% of previous dose until the ordered RASS score is once again reached.	• Sedative medication should be infused at the dosage required to attain the desired effect. Dosage required may vary from day to day.

IX. REFERENCE:

Kress, J., Pohlman, A., O'Connor, M., & Hall, J. (2000). Daily interruption of sedative infusions in critically ill patients undergoing mechanical ventilation. The New England Journal of Medicine, 342(20), 1471-1477.

Vagionas, D., Vasileiadis, I., Rovina N., Alevrakis, E., et al. (2019). Daily sedation interruption and mechanical ventilation weaning: a literature review. Anaesthesiology Intensive Therapy. 51, 5: 320-389.

X. SUPERCEDES:

Genesis Medical Center Davenport Campus, Clinical Guideline, Sedation, Continuous Intravenous dated 12/01/2000

XI. CROSS REFERENCE:

Genesis Medical Center Davenport Campus, Departmental Clinical Guideline: Neuromuscular Junction Blocking Agents, Care of Patient Receiving

XII. ENDORSEMENTS:

Genesis Health System Nursing Standards Committee 01/2018, 01/2020, 01/2021
Genesis Health System Nursing Partnership Council 02/2018, 02/2020, 03/2021
Genesis Medical Center Davenport, Medical Executive Committee 03/2018, 03/2020, 03/2021
Genesis Medical Center Silvis, Medical Executive Committee 03/2018, 03/2020, 03/2021

Attachment A

Richmond Agitation-Sedation Scale (RASS)

Score	Term	Description	
+4	**Combative**	Overtly combative, violent, immediate danger to staff	
+3	**Very agitated**	Pulls or removes tube(s) or catheter(s); aggressive	
+2	**Agitated**	Frequent non-purposeful movement, fights ventilator	
+1	**Restless**	Anxious but movements not aggressive vigorous	
0	**Alert and calm**		
-1	**Drowsy**	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (>10 seconds)	Verbal stimulation
-2	**Light sedation**	Briefly awakens with eye contact to voice (<10 seconds)	Verbal stimulation
-3	**Moderate sedation**	Movement or eye opening to voice (but no eye contact)	Verbal stimulation
-4	**Deep sedation**	No response to voice, but movement or eye opening to physical stimulation	Physical stimulation
-5	**Unarousable**	No response to voice or physical stimulation	Physical stimulation

Procedure for RASS Assessment

1. Observe patient
    a. Patient is alert, restless, or agitated. (score 0 to +4)
2. If not alert, state patient's name and say to open eyes and look at speaker.
    b. Patient awakens with sustained eye opening and eye contact. (score –1)
    c. Patient awakens with eye opening and eye contact, but not sustained. (score –2)
    d. Patient has any movement in response to voice but no eye contact. (score –3)
3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.
    e. Patient has any movement to physical stimulation. (score –4)
    a. f. Patient has no response to any stimulation. (score –5)

* Sessler CN, Gosnell M, Grap MJ, Brophy GT, O'Neal PV, Keane KA et al. The Richmond Agitation-Sedation Scale: validity and reliability in adult intensive care patients. Am J Respir Crit Care Med 2002;166:1338-1344.
* Ely EW, Truman B, Shintani A, Thomason JWW, Wheeler AP, Gordon S et al. Monitoring sedation statusover time in ICU patients: the reliability and validity of the Richmond Agitation Sedation Scale (RASS).JAMA 2003; 289:2983-2991.