Sedation holds and goal setting

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What is a sedation hold and why do we do them?

- In a sedation hold we normally switch off all of the infusions of sedative and analgesic drugs and see how the patient responds.
- The consultant should request sedation holds, normally in the morning and in consultation with the senior nurse on the pod.
- A sedation hold may be requested at other times, particularly for patients who have been admitted already sedated who we think might be able to be woken up.
- The consultant and senior nurse will agree which patients should have sedation holds and in what order or if several can happen at the same time.
- The consultant and other staff should also agree the target sedation for the other patients (see presentation on RASS scoring). This should be recorded on the observation charts
- We do these holds because research has shown that patients are more likely to survive critical care if we use this approach. Surprisingly research also shows patients with sedation holds make a better psychological recovery because they can remember some aspects of their ICU stay.
- It is really good to see a patient awake and off the ventilator after a sedation hold, similarly it's important to diagnose unexpected neurological problems that would otherwise be hidden by sedative drugs.
- Sometimes a sedation hold might be modified, for example by leaving some analgesic drug running or continuing a low dose of Propofol.

What could happen when we turn off the sedative medication-

Often we don't know what's going to happen even if we can often make a good guess. Because we don't really know we should be ready for any of the options-

Sedation turned off

1. The patient does not wake up- This may be because they have accumulated sedative drugs, particularly midazolam. They may also have had a problem with their brain like a stroke without it being recognised due to the sedation

2. The patient wakes up but is very agitated or for some other reason (like poor ventilation) and they have to be re-sedated

3. The patient wakes up and is able to breath without problems. These patients can be extubated and managed on face mask or nasal oxygen

4. The patient wakes up and is happy without sedation but for some reason is not ready for extubation, they can continue to be managed without sedation

As we can't predict what's going to happen you should be ready for- Your patient waking, often unexpectedly in an agitated state, and potentially removing their endotracheal tube or removing other medical devices.

How should we prepare for a sedation hold?

- We should be ready for the patient become agitated and for them to remove their endotracheal tube.
- We should not remove the sedative drugs so we could restart them quickly.
- We should have equipment and staff available to manage an unexpected extubation both in terms of being able to provide face mask or nasal oxygen and that we could rapidly re-intubate the patient if required.
- The patient should be closely observed so we are ready for the unexpected
- If you are unsure of what to have ready then ask!
- Keeping the sedation holds to those prescribed by the consultants should reduce the risks of these things going wrong.
- Sometimes the Consultant may ask for several sedation holds, they may well judge that some of the patients will be very slow to wake while others should wake quite quickly. This will keep the workload manageable.
- Clearly sedation should never be interrupted in patients who are receiving muscle relaxants and we must be sure these drugs have worn off.

Other goal setting

- What level of sedation is required will be different for different patients and will also change for each patient during their critical care stay.
- It's the responsibility of the medical staff to prescribe what level of sedation we should be aiming for. Ideally this should be by prescribing a target RASS score in writing on the observation chart.
- The decision is based in part by a knowledge of the patient's disease process but also based on discussion and feedback from other members of the critical care team who may well have been able to observe the patient more closely.