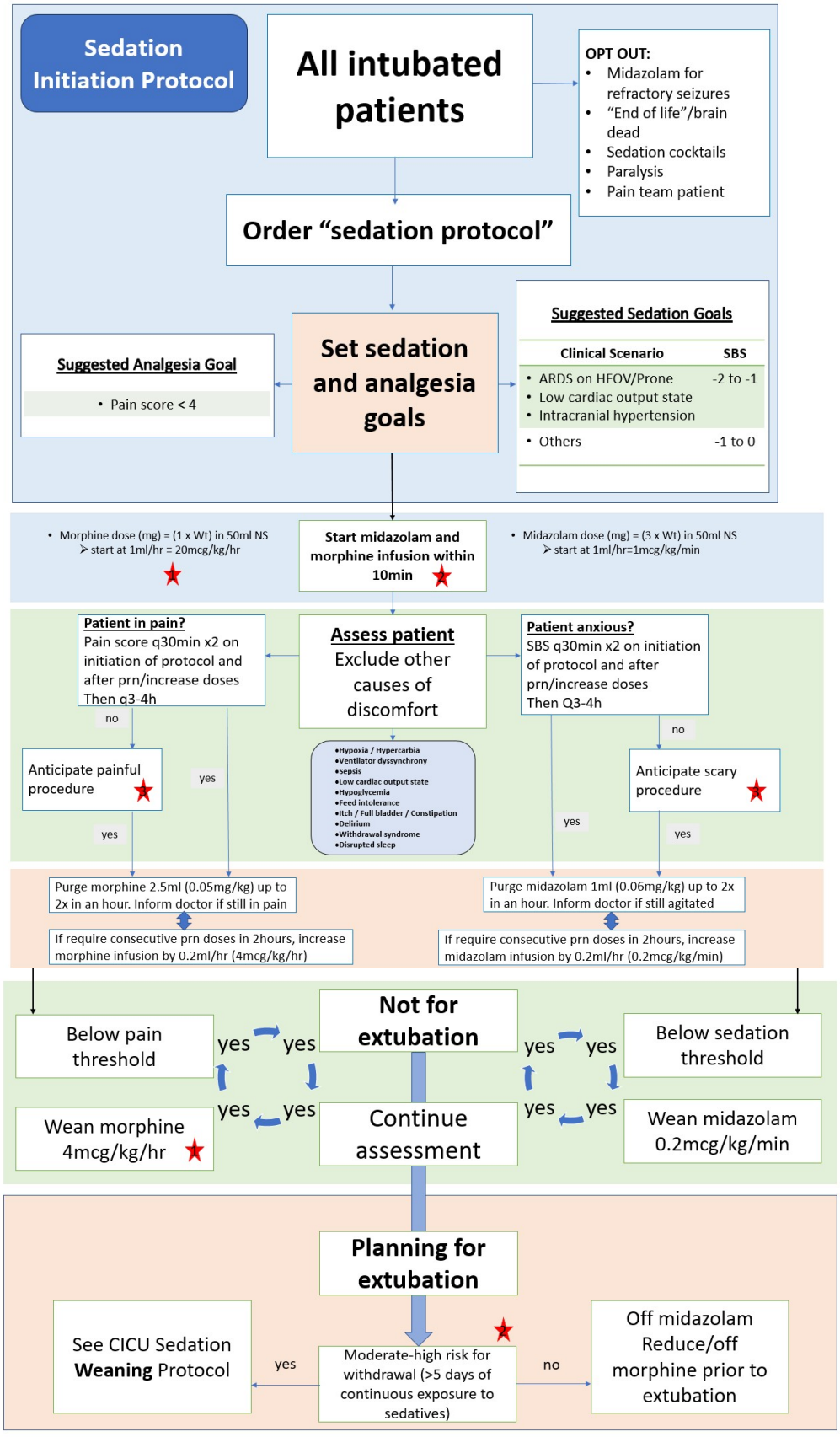

1. Patients >50kg (adult doses) should be on standard 50mg morphine in 50ml NS
2. After intubation/admission, if the child requires more analgesia or sedation and if purge doses have been exhausted, the doctor may still order additional purges/increase the basal rate
Recommended for elective change to nasal ETT for stable infants (not part of sedation protocol)
3. If procedure is anticipated to be painful and anxiety provoking, the nurse has the discretion to purge either/both midazolam/morphine.
Clinical judgement is required to gauge which drug/what dose may work well for the child. Intermittent paralysis may be considered for high-risk patients during nursing care/procedures – to be requested by nurses and doctors to be present during administration to adjust ventilation

1. Optimize the use of IV paracetamol and reduce the use of IV morphine for mild-moderate pain. Do not change paracetamol to oral when still requiring IV morphine for pain. Avoid the use of morphine for sedation.
2. High risk patients = patients who develop tolerance to opioids/ benzodiazepines
Tolerance=reduced reaction to a drug following its repeated/prolonged use resulting in increasing doses required to generate the same response
High risk criteria
- >10-14 days of IV sedation in opioid naïve patient
- > 7days of IV sedation in patients on pre-existing opioids/ sedative drugs
- Patients on > 3 sedative agents

3. Criteria for referral to the Pain team.
- Complicated withdrawal
  - At physician discretion