Sedation Weaning Guidelines – Ward 118

EXCLUSIONS

- Fulminant Hepatic Failure
- Unstable spinal patient
- Paralysed patient
- Head Injuries
- Difficult Airway
- High levels of oxygenation/ventilator requirements

CONSIDERATIONS
Discuss with NIC or medical team

- CVS Instability
- Planned Interventions for the day
- Agitated/Distressed/at risk
- Complicated sedation
- One way wean

SEDATION HOLD between 7am and 8am if appropriate or before 12 midday.

1. STOP Propofol and/ or Midazolam
2. Keep opiate running and ensure analgesic requirements are adequate, pain score less than or equal to 1.
3. Assess patient
4. Continue to hold sedation until patient obeys commands OR RASS -1 or greater unless patient agitated, distressed, at risk or cardiovascular instability.
5. Restart sedation at **half** the previous rate and titrate as required.

If after 1 hour patient remains RASS –5 to –2 then discuss with medical staff or NIC about stopping opiates

AIM FOR SPONTANEOUS BREATHING MODE

Reduce Mandatory rate by half, assess after 3 minutes and if patient breathes sufficiently - change to ASB

If RR and TV within patients normal limits then reduce Pressure Support by 2cm H2O an hour

If SaO2 above patient target, consider reducing FiO2
- When FiO2 <50% consider reducing PEEP(unless PEEP at 5 cm H2O)

Monitor EtCO2 and ABG

If unable to change patient onto a spontaneous mode keep patient on original settings and speak to medical staff or NIC.

All long-term weaning patients must be discussed with senior medical team, physiotherapists and NIC and personalised weaning plans made.

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Adapted from Ward 20 WGH Wake & Wean Protocol