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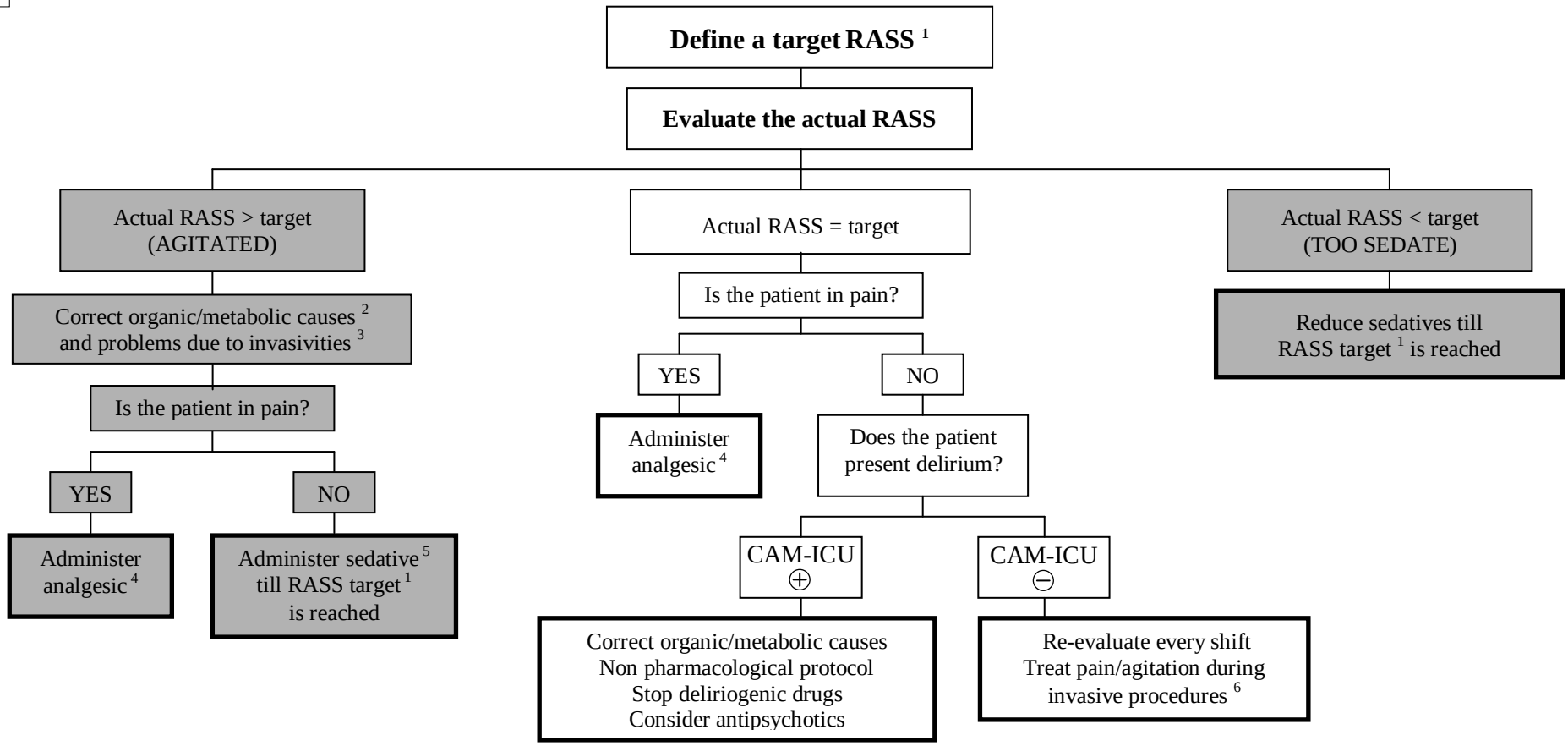
AGITATION/SEDATION MANAGEMENT IN ICU



[1] Always aim for **RASS target = 0 / -1** (patient awake and tranquil, well adapted despite invasivities and critical condition).
RASS target may be between -2 to -4 if clinical conditions require it.
Ask yourself constantly: is it possible to decrease the sedation level by reducing or stopping sedative drugs administration?

[2] Sepsis, ipoperfusion, ipo/iperglycemia, hypoxia, fever, electrolytic imbalance, drugs abstinence, hepatic encephalopaty, alkalosis/acidosis, …

[3] Mode of ventilation; bronchial aspiration; respiratory prosthesis, vascular lines, NGT, drainage tube, bladder catheter positioning; patient decubitus; restraints; …

[4] Prefer bolus administration. Evaluate pain with validated instruments (VNR o BPS).

[5] *Intravenous sedation*: Propofol (max 6 mg/kg*h) or Midazolam (max 0.2 mg/kg*h) in bolus or in continuous infusion: always administer the lowest effective dose.
Enteral sedation: Hydroxizine (max 600 mg/die) e Lorazepam (max 16 mg/die): always administer the less effective doses.
Melatonin 3 mg b.i.d. (8p.m. - midnight) from admission to discharge.

[6] Evaluate the necessity to administer analgesics or sedatives in bolus during painful or invasive procedures (tubes or catheters positioning, endoscopies, diagnostic procedures, patient mobilization, …).