Adult Weight-Based Dosing Analgesia & Sedation Protocol for the Mechanically Ventilated Patient

**Continuous Infusion**

- Analgesia (Titrate to a Pain Score of 4 or less)
  - Fentanyl: 0.01 - 0.1 mcg/kg/hr
  - Hydromorphone: 0.2 - 0.6 mg IVP q 1 hr
  - Morphine: 2 - 4 mg IVP q 1 hr
  - Ketamine: 15 - 50 mcg/kg/min

- Sedation
  - Choices: Midazolam (0.02 - 0.1 mg/kg/hr)
  - Propofol: 5 - 50 mcg/kg/min
  - Dexmedetomidine: 0.2-1.4 mcg/kg/hr

**PRN Dosing**

- Analgesia
  - Choices: Fentanyl 25 - 200 mcg IVP q 1 hr
  - Hydromorphone 0.2 - 0.6 mg IVP q 1 hr
  - Morphine 2 - 4 mg IVP q 1 hr

- Sedation
  - Choices: Midazolam 2 - 4 mg IVP q 1 hr
  - Lorazepam 1 - 2 mg IVP q 1 hr

If patient receives PRN dosing for 3 consecutive hrs

If patient is difficult to control

Patient difficult to control

MD to bedside to reassess patient

**DAILY SEDATION INTERRUPTION**

1. Hold both sedative and analgesic infusions every morning to allow for an accurate neurological assessment.
2. Provider should be immediately called to the bedside to evaluate the patient once there is a change in clinical status including but not limited to agitation, fighting the ventilator, O2 desaturation, or awake and able to follow commands.
3. If the physician or the nurse has evaluated the patient, the infusion(s) THAT ARE NECESSARY for adequate patient sedation and or analgesia is (are) re-started at ½ the previous dose(s) and then titrated up as necessary to the minimal effective dose(s).
4. A spontaneous breathing trial should be done in conjunction with the daily sedation holiday. Please refer to Spontaneous Breathing Trial Protocol for exceptions.

**CONTRAINDICATIONS TO SEDATION INTERRUPTION:**

- Undergoing active treatment for elevated ICP
- Status Epilepticus
- Receiving neuromuscular blocking agents
- Hypoxemia PEEP > 18 or FiO2 > 80% - ARDS
- Patients identified at increased risk of self-extubation should not be turned during the sedation interruption.