

SEDATION

State Behavioral Score (Assessing Sedation for all patients)

Score	Description	Definition
+2	Agitated	May have difficulty breathing with ventilator Coughing spontaneously No external stimulus required to elicit response Unsafe (biting ETT, pulling at lines, cannot be left alone) Unable to console Increased movement (restless, squirming, thrashing or kicking)
+1	Restless and difficult to calm	Spontaneous effective breathing/Having difficulty breathing with ventilator Occasional spontaneous cough Responds to voice/No external stimulus required to elicit response Intermittently unsafe Does not consistently calm despite 5 minute attempt/Unable to console Increased movement (restless, squirming)
0	Awake and able to calm	Spontaneous and effective breathing Coughs when repositioned Responds to voice/No external stimulus is required to elicit response Distress with procedures Able to calm with comforting touch or voice when stimulus removed Occasional movement of extremities or shifting of position/increased movements
-1	Responsive to gentle touch or voice	Spontaneous but ineffective non-supported breaths Coughs with suctioning/repositioning Responds to voice/touch Able to pay attention but drifts after stimulation Distresses with procedures Able to calm with comforting touch or voice when stimulus removed Occasional movement of extremities or shifting of position
-2	Responsive to noxious stimuli	Spontaneous yet supported breathing Coughs with suctioning/repositioning Responds to noxious stimuli Will distress with a noxious procedure Does not move/occasional movement of extremities or shifting of position
-3	Unresponsive	No spontaneous respiratory effort No cough or coughs only when suctioning No response to noxious stimuli Does not distress with any procedure (including noxious) Does not move

GOALS for Sedation:

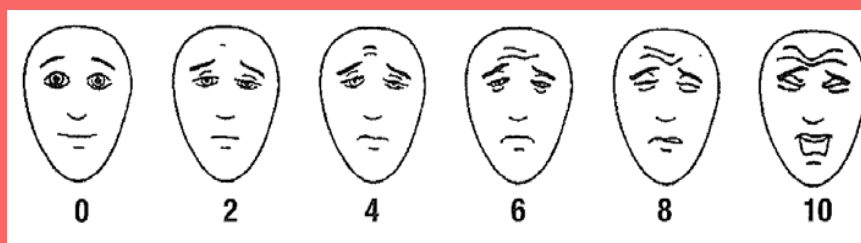
For most PICU patients the **Goal is 0 to -1**. Exceptions may be made to oversedate based on protecting the child from harm (e.g., tube dislodgement)
If muscle relaxed score as P for paralyzed

PAIN

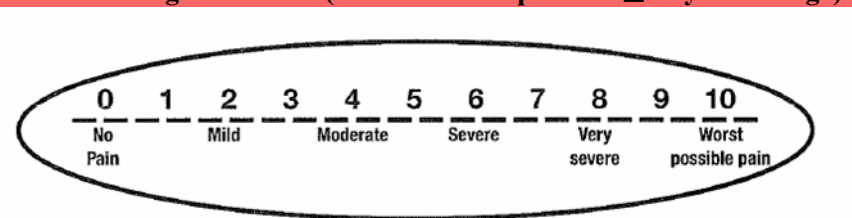
Multidimensional Assessment of Pain Scale (MAPS) for NON-VERBAL PATIENTS (score is sum of each category)

Categories	0	1	2
Vital signs (HR & BP)	Within baseline	More than 10% increase	More than 20% increase
Breathing Pattern	No change	Development or increase in respiratory distress	Increased respiratory distress with silent or weak cry
Facial Expressions	Relaxed	Grimace	Grimace associated with silent or weak cry
Body Movements	No movements or purposeful movements	Restless	Rigid and/or limited body movements
State of Arousal	Calm or asleep	Hyper-reactive	Shut down

Faces Pain Scale-Revised (for VERBAL patients ≤ 8 years of age)



Visual Analog Pain Scale (for VERBAL patients ≥ 8 years of age)



Pain Scales Scoring Range:

0-2: Comfortable 3-6: Moderate Pain 7-10: Severe Pain

GOAL: 0-2

Acute Phase Pain and Sedation Algorithm

Assess patient for Pain Using the appropriate score and Sedation using the SBS. Refer to Physicians orders for pain and sedation target goals. Document pain and sedation scores on flow sheet

