SEDATION HOLIDAYS:
WHY THEY SHOULD BE IMPLEMENTED

By
ALISSA NOEL RALSTON, RN, BSN, MSN candidate
Washington State University, Spokane/Pullman Washington

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The members of the Committee appointed to examine the non-thesis research project for ALISSA NOEL RALSTON find it satisfactory and recommend that it be accepted.

Sara Schmoe
Chair

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>iv</td>
</tr>
<tr>
<td>JOURNAL IDENTIFICATION</td>
<td>v</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>vi</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>viii</td>
</tr>
<tr>
<td>SUMMARY OF KEY POINTS</td>
<td>ix</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>OVERVIEW OF THE PROBLEM</td>
<td>1</td>
</tr>
<tr>
<td>LITERATURE REVIEW</td>
<td>2</td>
</tr>
<tr>
<td>CONCLUSION</td>
<td>9</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>11</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table A: Procedure for Scoring MSAT ................................................................. 13
Table B: AACN Sedation Assessment Scale ...................................................... 14
Table C: Ramsay Motor Activity Assessment Scale .......................................... 15
Table D: Sedation Holiday Documentation sample form .................................. 16
Table E: Copyright Permissions ...................................................................... 17
JOURNAL IDENTIFICATION

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Send Manuscript to:
Grif Alspach, RN, MSN, EdD
Editor, Critical Care Nurse
P.O. Box 6680
Annapolis, MD 21401-0680

Author contact information:
Alissa Ralston, RN, BSN, MSN candidate
1669 Gerking Rd
Waitsburg, WA 99361
anrsmile@yahoo.com
509-337-6399

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**Purpose:** To discuss both the importance of implementing sedation holidays for ventilated patients receiving continuous sedation and evidence supporting the practice. To explore tools that assist the monitoring of sedation levels of those receiving sedation holidays.

**Data sources:** A review of the current literature utilizing search engines from CINHL, Proquest, and professional nursing journal websites referencing sedation holidays (also known as sedation stops, daily interruptions and sedation holds). Literature, both supporting and controversial to, sedation holidays, along with common complications of patients on ventilators is explored. Tools for assessing patients’ level of sedation during continuous infusion of sedation agents are also evaluated.

**Conclusions:** Some studies have shown preference for bolus medications, instead of continuous drip medication to prevent over-sedation. A sedation holiday is the practice of turning off continuous sedation once every 24-hour period (or once a day). This allows for a more accurate nursing assessment of the patient’s neurological and respiratory status. The development of assessment tools for levels of sedation and implementation of sedation holidays, patients are shown to have decreased length-of-stay on the ventilator, (Kress et al., 2000).
**Implications for practice:** Nurses who work in critical care units must be able to accurately assess the neurological and respiratory status of patients. A precise evaluation cannot be made if patients are overly sedated. The best way to facilitate valid assessments is to implement sedation holidays and use assessment tools to ascertain the patient’s state. These holidays have been shown to decrease the length-of-days on the ventilator compared to continuously sedated patients without sedation holidays. Sedation holidays allow for assessment of kidney and liver function (Kolleff, *et al.*, 1998).

**Terms**

*Sedation holiday* is defined as the practice of turning off continuous intravenous (IV) sedation, such as Diprovan (Propofol) or Midazolam (Versed), once daily (usually in the morning). The length-of-time the sedation is turned off is unique to each patient and is affected by the type of sedative in use. The range of time the medication is off may be anywhere from minutes to hours or indefinitely. During this “holiday” an evaluation of the patient’s neurological and respiratory status is performed with the help of an assessment tool. Sedation is reinitiated after the assessment or sooner should the patient become agitated or uncomfortable (Kress, Pohlman, O’Connor, and Hall, 2000). Sedation is restarted at a rate providing the lowest optimal dose necessary to attain both synchrony with the ventilator and allow patient comfort (Sessler, 2004).

*Sedation* is defined as providing a medication such as Propofol or Versed intravenously, “to control pain, facilitate patient tolerance of mechanical ventilation, or to control agitated behavior” (Sessler, 2004).
SUMMARY OF KEY POINTS

1. Continuous intravenous sedation must be monitored closely in order to prevent over-sedation of patients receiving mechanical ventilation.

2. Sedation holidays allow for daily interruption of the continuous IV sedation in order to assess the patients’ neurological function and respiratory status. The medication used for sedation is turned off until the patient is able to follow commands or enters a state of agitation or becomes uncomfortable (Schweickert, et al., 2004).

3. Best nursing practice dictates using the same assessment tool to measure sedation levels to allow for continuity of care between providers.

4. Continuous sedation allows for an optimal level of sedation to be attained for patients receiving mechanical ventilation.
Introduction

In critical care many patients are on ventilators, receiving sedating medications either by continuous intravenous infusion or intravenous boluses. This decreases a patient’s respiratory workload, which facilitates healing, allows greater comfort and a more tolerable stay on the ventilator. Ventilator patients on continuous sedation risk a build-up of sedating medications that may go undetected due to the difficulty of accurately assessing the state of a sedated patient. One way to better assess neurological and respiratory function is by implementing regular sedation holidays, also known as “sedation stops,” “daily interruptions,” and “sedation holds.” This practice allows for the assessment of the patient sedation, and the ability to titrate the sedation to the lowest level needed in order to keep the patient comfortable, and synchronous with the ventilator settings (Kress, et al., 2000).

The need for sedation holidays is not well understood by providers for unknown reasons. The actual methodology is not universal, and is not familiar to nurses who have not implemented sedation holidays in the past. Evidence-based practice supporting instituting sedation holidays has not been well defined by the medical and nursing professions.

Overview of the problem

Patients on ventilators are at risk for many complications, including: accidental extubation, aspiration, barotrauma, fluid overload, hypotension, infection, stress ulcer of the GI tract, tension pneumothorax, ventilator dependency or inability to wean, and psychological frustrations (Newmarch, 2006). These patients often receive continuous sedation and are now in danger of being over-sedated. Many of these sedating
medications have a relatively long half-life coupled with the patients' bodies' inability to clear the medication especially in organ failure (kidney/liver) or dysfunction (Kollef, Levy, Ahrens, Schaiff, Prentice & Sherman, 1998). Over-sedation is dangerous and, may prolong the length-of-stay on the ventilator (Egerod 2002). The benefits of daily sedation holidays include the ability to identify any organ dysfunction (such as delay in kidney filtration or the inability of the liver to conjugate the medications) and allow the nurse to better assess the patients' neurological and respiratory function, while not under sedative effects. The consistent recording of sedation holiday observations could enhance continuity of care between care providers.

**Literature Review**

Ventilator patients receive sedating medications in different manners. A surveillance study of 242 ICU mechanically ventilated patients found that continuous IV sedation (n=93) put the patients at increased risk for a longer ventilator stay compared to those receiving bolus or no medications (n=149) at all (Kolleff et al., 1998). “Duration of mechanical ventilation” was the primary metric of the research. Secondary outcome measures included: length-of-stay in the ICU department, overall hospital length-of-stay, hospital mortality, and acquired organ system derangements. In the CIS group, length-of-stay on the ventilator was 185 hours ±190 hours compared to the other group which had a stay of 55.6 ± 75.6. Length of ICU stay for those receiving CIS 13.5 ± 33.7 days, and those with boluses or no medication spent 4.8 ± 4.1 days. The total length-of-time in the hospital was again higher for the CIS group with 21.0 ± 25.1 days compared to 12.8 ± 14.1. The researchers concluded “Prospective randomized clinical trials, using well-designed sedation guidelines and protocols, are required to determine whether patient-
specific outcomes (e.g., duration of mechanical ventilation, patient comfort) can be improved compared with conventional sedation practices” (Kolleff, et al., 1998, p.541).

Luer (2002) in Protocols for Practice from the AACN reports that instead of continuous sedation, some literature supports intermittent intravenous administration of sedatives, such as Diprovan (Propofol) or Lorazepam (Ativan). The use of intermittent boluses allowing clearance of the medication prior to another bolus allows for an accurate assessment of the neurological function.

De Wit and Epstein (2003) evaluated levels of sedation in subjects receiving a continuous dose of sedative/hypnotic or narcotic agents versus levels of those patients not receiving infusions. They compared the Sedation-Agitation Scale with the Bispectoral Index to quantify a subject’s response. The Sedation-Agitation Scale has a range of 1-7, from unarousable to dangerous agitation, while the Bispectoral Index ranges from 0-100, flat line waveform recorded before and after stimulation. A total of 19 patients were evaluated on 80 occasions. Scores from the Sedation-Agitation Scale ranged from 1-5, and correlated highly (P<.001) with the values for the Bispectoral Index. “Patients receiving continuous infusions were more deeply sedated, than patients receiving boluses or no medication. Patients receiving continuous infusions were more likely to have a score of 2 or less on the Sedation-Agitation Scale.” The strategy of giving boluses of sedatives on an “as-needed basis” would prevent the accumulation of medication, allowing for the elimination of drugs from a patient’s system between doses.

A blinded, retrospective chart review of 126 patients who either had sedative interruption or received continuous infusion sedation was conducted by Schweickert et al., (2004). These patients were randomized to daily interruption of their continuous sedation
or sedation as directed by the medical staff. They surmised the risks of intubation with
the use of continuous IV sedation can be devastating. The complications to be noted
were required to “be new and distinct from the ICU admitting diagnosis,” and included
ventilator associated pneumonia (VAP), upper gastrointestinal hemorrhage, bacteremia,
barotraumas, venous thromboembolic disease, cholestasis, and sinusitis (Schweickert
reviewed, there were 126 charts available for evaluation. “Those undergoing daily
interruption of sedative infusions experienced 13 complications (2.8%), versus 26 (6.2%)
in those subjected to conventional sedation techniques (p = .04)” (pg 1272). The data was
evaluated by investigators blinded to each patient’s assignment in the control or
experimental groups. The researchers concluded, “…complications of critical illness are
reduced, when intubated, mechanically ventilated, patients are subjected to a protocol of
daily sedative interruption. These improved outcomes are likely the result of reduced
duration of mechanical ventilation and length-of-stay in the ICU” (pg 1275).

Kress et al, (2000), also studied 128 mechanically ventilated patients needing
sedation by continuous IV infusion. Exclusion criteria included pregnancy, previously
sedated transfers from an outside facility and those being admitted status post-
resuscitation from cardiac arrest. Randomized assignment populated a test group with 68
subjects and a control group with 60. Treatment of the test group consisted of daily
interruptions of their continuous sedation, while the control sedation was altered only at
the discretion of the clinicians in the intensive care unit (ICU). These two groups were
then randomly subdivided to specify treatment with either Midazolam or Propofol.
Randomization was generated by the computer, although “the sedatives were given on an
open-label basis,” (Kress, et al., 2000, pg 1472). All four of these groups received morphine simultaneously for analgesia.

For the duration of the study, the nurses caring for these patients adjusted the dose and rate of infusion based on the Ramsay sedation scale (which is described later), to attain a Ramsay scale of 3 or 4. The investigator of the intervention group participants was not directly involved with their care and daily interrupted the infusion of sedatives (both Midazolam or Propofol, along with the Morphine simultaneously) until the patients were awake and either became uncomfortable, agitated and “were deemed to require the resumption of the sedation,” (Kress, et al., 2000, p. 1473) or were able to follow instructions. If the patients were receiving a paralytic drug, the sedative drug was not interrupted. Once the paralytic had been discontinued, these patients had daily interruptions of their sedation. The patients in the control group were monitored and their total daily dose of sedation was recorded and the care team per standard procedures handled medication changes.

Investigators found that for the intervention group mechanical ventilation was generally discontinued 2.4 days earlier, than in the control group. “The median length-of-stay in the intensive care unit in the intervention group was shorter than in the control group by 3.5 days. The length-of-stay in the hospital did not differ between the two groups,” (pg 1474). The researchers stated that, “our results suggest that daily interruption of the sedative infusion provides acceptable sedation while minimizing adverse effects,” (Kress, et al., 2000, p. 1476).

While a patient is on a ventilator and receiving continuous sedation his or her level of consciousness must be assessed in order to prevent medication accumulation and
over-sedation. There are tools that assist with an accurate assessment of the patients’ level of neurological function and their respiratory status. These evaluation aids can be used during the sedation holiday. One study completed by Weinert and McFarland (2004) tested the Minnesota Sedation Assessment Tool (MSAT) (table A) "...combines the efficacy of a single-item response format, while permitting the separate reliable measurement of distinct observable characteristics of intubated patients," (pg 1883). The study took place in a medical/surgical ICU at a university-based hospital. Their design used “paired raters assessment for reliability testing and observational design for validation testing” (pg 1883). Weinert and McFarland also used the tool to assess the patients’ level of sedation. Researchers recognized the limitations of some sedation scales that utilize only a single number to describe behaviors of the patients. They argue one descriptor does not allow for adequate reflection of the sedation level of the patient. The MSAT method, however, helped the nurse to assess sedation accurately.

The American Association of Critical-Care Nurses’ (AACN) have a tool that could be used to assess sedation holidays: AACN Sedation Assessment Scale (table B). This tool consists of “five domains: consciousness, agitation, anxiety, sleep, and patient-ventilator synchrony,” (De Jong et al., 2005). In order to develop these five domains “healthcare providers with clinical practice expertise in medical, surgical, cardiovascular, neurosurgical, pediatric, and adult critical care nursing were invited to participate in the consensus conference” (pg 532). Throughout the conference these experts were questioned to assist with creating a new sedation assessment tool. The information gathered was summarized. A second phase of this project included the development of the AACN Sedation Assessment Scale. This scale is being utilized to assess critically ill
patients receiving intermittent or continuous IV sedation. Having both the original
conference members furthered face and content validity and five additional critical care
experts review the tool. These reviewers were asked to employ the tools in clinical
practice. Third phase of the trial is ongoing to test reliability and validity of the tool
developed (De Jong et al., 2005).

The Ramsay Motor Activity Assessment Scale (MAAS) (table C) is an additional
sedation assessment tool. Ranging from 0-6 with 0 being “does not move with noxious
stimuli” to 6 being “no external stimulus is required to elicit movement and patient is
pulling at tubes or lines, or thrashing side to side, or striking at staff or trying to climb out
of bed and doesn’t calm down when asked” (Whitcomb JJ, Huddleston MC, and
McAndrews KL, 2003, p. 60). The scale was found to be valid and reliable by Devlin et
al. (1999). The researchers completed a prospective, psychometric evaluation of 25
random, non-neurosurgical adults who were mechanically ventilated, admitted to the
surgical intensive care unit ≥12 hours post surgery and not receiving neuromuscular
blockers. The study took place at a University affiliated teaching hospital in a 16-bed
surgical intensive care unit (SICU). They gathered four hundred evaluations (eight per
patient). The assessments “…were completed consecutively, but independently, in pairs,
at standardized times (both day and night) by two nurses who were pre-selected for each
assessment from a pool of 32 pre-trained SICU nurses.” “To estimate validity, paired
assessments (four/patient) compared the MAAS result with the subjective assessment,
using a 10-cm visual analog sedation scale, the percent change in blood pressure and
heart rate from the previous 4-hour baselines, and the number of recent agitation-related
sequelae,” (Devlin et al., 1999, pg 1271). The MAAS validity was supported by a linear
trend between MAAS and the visual analog scale, blood pressure, agitation related effects and heart rate all having p < .001. The MAAS kappa = 0.83 with a 95% confidence interval (0.72 to 0.94) was more reliable than the subjective assessment using the visual analog scale – interclass correlation coefficient = 0.32 with a 95% confidence interval (0.05 to 0.55) (Delvin et al, 1999).

Many other assessment tools exist. However, there is no consensus on the accuracy of each tool at assessing the intubated (on a ventilator) patient (De Wit and Epstein, 2003). There is no superior tool, it is important that the same tool be utilized by all staff in the same institution, in order to maintain consistency in evaluating the patients’ level of consciousness, to manage patient recovery.

Communication amongst staff is another aspect of sedation holidays. Communication encompasses how the patient is tolerating the process, thus allowing the evaluation of the procedure itself. Henneman and associates (2001) found that the use of weaning boards/flowsheets supported a decreasing ICU length-of-stay. Their study was a pre and post quasi-experimental design evaluating 201 patients in a medical intensive care unit (MICU). The control group had 67 patients, and the experimental group 90. They studied the length-of-stay on the ventilator, length and cost-of-stay in the MICU along with the incidence of complications such as the need for reintubation, readmission and mortality rate. They researched patient outcomes for one year, before implementing their collective weaning plan flow sheet and erase board, a further year of evaluation followed the process change. The researchers utilized a white erase-board mounted in the patient’s room, allowing those caring for the patient to record the daily plans and results of tests/procedures. On these boards they documented the weaning plan along with the
assessment of the patient. Lab values such as ABG’s, pH, PaO2, PaCO2, HCO3, oxygen saturation, Potassium, Magnesium, Phosphorous, Hemoglobin, and Pre-albumin were written for all to see, along with the date and time. They also recorded why a weaning trial was stopped; respiratory rate greater than a specified value, tidal volume, oxygen saturations and end-tidal CO2 less than a particular number. This practice correlated with a decreased length-of-stay in the MICU by 3.6 days and a decrease in ventilator use by 2.7 days. There was no significant difference between the two groups in terms of cost or incidence of complications. Flow sheets and dry erase boards were found to be helpful to the staff participating in patient care.

A sample form to record information regarding sedation holidays is shown in table D. This form was created for the purpose of better understanding of the type of information that may be recorded by nurses for the sedation holiday. This form should be easily accessible to the staff caring for the particular patient receiving sedation holidays.

Conclusion

The implementation of sedation holidays on a daily basis in order to assess the ventilated patients’ neurological status may decrease the length-of-stay on the ventilator and in the ICU. Sedation holidays must be closely monitored by the nurse carrying out the procedure. The patient must be observed for signs of agitation, acute changes in their vital signs, and stress making them too vulnerable for a sedation holiday. In order to make an accurate neurological assessment, the nurses must consistently use the same assessment tool when evaluating the patient. Clear communication between the patients’ caregivers, regarding the patient’s tolerance of sedation holidays, is also important. A
single, easily accessible record of findings/results is helpful for care givers comparing and identifying a patient’s change of state.
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   *Crit Care Med 27(7).* Pgs 1271-1275.


Table A: Procedure for Scoring MSAT

Procedure for Scoring the MSAT

1. Record the highest level of unstimulated spontaneous motor activity observed in the last 10 minutes.
2. Walk to the right shoulder and observe eye opening and/or tracking.
3. If no eye opening, call first name “open your eyes!”
4. If no eye opening yet, shake right shoulder firmly, call first name and “open your eyes!”
5. Choose the arousal scale category appropriate for the patient’s response to procedures 2 to 4.
6. Judge the current quality of the sedation therapy as “adequate,” “over-sedated,” or “under-sedated.” Use clinical information available to you in addition to the scale levels.

Motor Activity Scale

1. No spontaneous movement.
2. Movement of distal limbs or head and neck muscles.
3. Movement of proximal limbs (hip or shoulder).
4. Movement of central muscle group (back or abdominal muscles).

Note: Disregard respiratory efforts, cough, swallowing, eye movement, or isolated tiny muscle contractions.

Arousal Scale

1. Eyes stay closed and no patient movement is observed in response to stimulation.
2. Eyes stay closed, but other patient movement observed in response to stimulation.
3. Eyes closed but open to shoulder shake plus sound of voice.
4. Eyes closed but open to sound of voice.
5. Eyes open spontaneously but not tracking.
6. Eyes open spontaneously with tracking.

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| Movement | Caretaker movement | Caretaker interaction | Caretaker with the child | Interaction with environment | Interaction with object or task | Eye contact | Crying | Sucking or feeding | Movement of head | Focusing on object or task | Focusing on caretaker | Making eye contact | Movement of hands and body | Suckling or feeding | Posture | Focusing on object or task | Focusing on caretaker | Making eye contact | Eye movement | Eye focus | Face and eye direction | Animal and other nongenital contact | Skin contact | Vocalisation | Smiling | Convulsions |
|----------|------------------|---------------------|--------------------------|-----------------------------|-------------------------------|----------|------|-----------------|----------------|--------------------------|------------------|-------------------|----------------------|---------------|--------------------------|-----------------|-----------------|-----------------|----------------|----------------|------------------|------------------|
| Movement | Caretaker movement | Caretaker interaction | Caretaker with the child | Interaction with environment | Interaction with object or task | Eye contact | Crying | Sucking or feeding | Movement of head | Focusing on object or task | Focusing on caretaker | Making eye contact | Movement of hands and body | Suckling or feeding | Posture | Focusing on object or task | Focusing on caretaker | Making eye contact | Eye movement | Eye focus | Face and eye direction | Animal and other nongenital contact | Skin contact | Vocalisation | Smiling | Convulsions |

**American Association of Critical-Care Nurses Sedation Assessment Scale**

**Table B: ACCN Sedation Assessment Scale**
Table C: Ramsay Motor Activity Assessment Scale

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Definition</th>
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<tr>
<td>0</td>
<td>Unresponsive</td>
<td>Does not move with noxious stimulus.</td>
</tr>
<tr>
<td>1</td>
<td>Responsive only to noxious stimuli</td>
<td>Opens eyes OR raises eyebrows OR turns head toward stimulus OR moves limbs with noxious stimulus.</td>
</tr>
<tr>
<td>2</td>
<td>Responsive to touch or name</td>
<td>Opens eyes OR raises eyebrows OR turns head toward stimulus OR moves limbs when touched or name is loudly spoken.</td>
</tr>
<tr>
<td>3</td>
<td>Calm and Cooperative</td>
<td>No external stimulus is required to elicit movement AND patient is adjusting sheets or clothes purposefully and follows commands.</td>
</tr>
<tr>
<td>4</td>
<td>Restless and Cooperative</td>
<td>No external stimulus is required to elicit movement and patient is picking at sheets or tubes OR uncovering self and follows commands.</td>
</tr>
<tr>
<td>5</td>
<td>Agitated</td>
<td>No external stimulus is required to elicit movement AND attempting to sit up OR moves limbs out of bed AND does not consistently follow commands (e.g. will lie down when asked, but soon reverts back to attempts to sit up or move limbs out of bed.</td>
</tr>
<tr>
<td>6</td>
<td>Dangerously Agitated, Uncooperative</td>
<td>No external stimulus is required to elicit movement AND patient is pulling at tubes or catheters OR thrashing side to side OR striking at staff OR trying to climb out of bed AND does not calm down when asked</td>
</tr>
</tbody>
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Table D: Sedation Holiday Documentation sample form

<table>
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<tr>
<td><strong>DATE</strong> / /  /</td>
</tr>
<tr>
<td>Current type of sedation</td>
</tr>
<tr>
<td>Current rate of sedation</td>
</tr>
<tr>
<td>Time sedation turned off</td>
</tr>
<tr>
<td>Complete AACN Assessment Tool</td>
</tr>
<tr>
<td>Record scores here</td>
</tr>
<tr>
<td>Best</td>
</tr>
<tr>
<td>Consciousness</td>
</tr>
<tr>
<td>Agitation</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Sleep</td>
</tr>
<tr>
<td>Patient/</td>
</tr>
<tr>
<td>Ventilator</td>
</tr>
<tr>
<td>Synchrony</td>
</tr>
<tr>
<td>Time sedation restarted</td>
</tr>
<tr>
<td>Rate restarted at</td>
</tr>
<tr>
<td>Reason why sedation was restarted:</td>
</tr>
<tr>
<td>How do you feel this patient tolerated the sedation holiday?</td>
</tr>
<tr>
<td>Great  Good  Fair  Poorly  Not at all</td>
</tr>
<tr>
<td>Completed by:</td>
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Place patient sticker here
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