D-00-07-30205

Palliative Sedation - Information Guideline

Site Applicability

North Shore and Coastal

Practice Level

INFORMATION ONLY- RN, LPN, ALLIED HEALTH

Policy Statement

Clinical Practice Guidelines are to be used in conjunction with clinical judgment to support clinician and patient decisions for best care and treatment.

Need to Know

PURPOSE

1. To establish ethically acceptable criteria and guidelines for the use of palliative sedation as a form of treatment for intractable symptoms (most common symptoms include agitated delirium, dyspnea, pain, bleeding) associated with acute or chronic morbidity in the final stages of end of life care. To support and optimize quality decision-making processes for patients, families and clinicians associated with the ethical and responsible application of palliative sedation therapy

DEFINITIONS

2. 2.1.1 Palliative sedation is: The process of inducing and maintaining deep sleep, in the final hours to days of life, for the relief of severe suffering caused by one or more intractable symptoms when all appropriate alternative interventions have failed to bring adequate symptom relief.

2.1.2Palliative Sedation is NOT, and should be distinguished from:

- Temporary use of complete sedation with the intention of reversal within a limited time.
- Use of benzodiazepines, neuroleptics, and other drugs for the management of symptoms. (e.g., delirium, dyspnea, etc.), where their use is to provide partial sedation (Chater, 1996; Fine, 2001; Walton & Weistein, 2002)

2.2 Refractory or intractable symptom:A symptom is considered refractory if it cannot be adequately controlled despite aggressive therapy that does not compromise consciousness.A refractory symptom must be distinguished from the "difficult to managesymptom" in that a "difficult symptom" could respond, within a tolerable time frame, to aggressive interventions that yield adequate relief and preserve consciousness,without excessive adverse results.

Decision points to determine a symptom as refractory - Further invasive or non-invasive interventions are either:

- Incapable of providing adequate relief
- Associated with excessive and intolerable acute or chronic morbidity, or
- Unlikely to provide relief within a tolerable time frame (Cherny and Portenoy, 1994)

3.0 RATIONALE

3.1 The use of palliative sedation has been confused with euthanasia by various members of the health care team and public, leading to a need to clarify the indications for use. This guideline does not include any support for the practice of euthanasia.

3.2 The use of palliative sedation likely **does not** hasten death (Maltoni, 2009; Cherny, 2009), but further studies are needed.

3.3 The guidelines and decision-making algorithm for palliative sedation will enable clinicians to recognize patients who may be candidates for palliative sedation.

3.4 An approved guideline outlining the practice of palliative sedation may provide the staff with organizational support and guidance to improve comfort with initiating and administering palliative sedation.

3.5 The palliative sedation guideline provides a common base of understanding for what palliative sedation is and is not. Further, it allows patients, families, clinicians and care providers to make appropriate and informed choices.

4.0 CRITERIA

The basic criteria for considering the use of palliative sedation include **all** of the following;

- A terminal disease exists
- The patient/client suffers from a refractory symptom(s)
- In all but the most unusual circumstances, death must be imminent (within days)
- A DNR /NO CPR Ordermust be in effect.
- Informed consent must be obtained from the patient or substitute decision maker (as outlined in an Advanced Directive or a relative from a ranked list. If the patient is incapable or a substitute decision maker is not available, 2 physicians documented consent will also suffice.
- Palliative Care physician consult and agreement with Palliative Sedation must be obtained

5.0 PROCESS

5.1 In considering the use of palliative sedation, the attending physician shall ensure the patient is assessed by an interdisciplinary palliative care team that includes, at minimum, a palliative care physician.

There may be circumstances where a telephone or video-consultation will be considered appropriate as an interim measure or where geographical circumstances preclude a face to face consultation. In rural areas where a face to face consultation is not immediately possible, the patient should be discussed with the Palliative Physician on-call.

5.2 The attending physician and the palliative care physician/team shall consult directly with the patient and family and, as appropriate, with the other care providers regarding the option of palliative sedation.

5.3 The physician shall ensure that the discussion by which the appropriate consent was obtained is documented on the health record. This documentation should include mention of all criteria met.

5.4 Once consent is obtained for palliative sedation, the palliative care physician/team will arrange for palliative sedation and appropriate monitoring of the patient.

5.5 Where the patient is under the primary care of a Palliative Care physician, consult shall be sought from another Palliative Care physician.

6.0 SCOPE AND LIMITATIONS

6.1 The expertise required to assess for the suitability of palliative sedation is a specialized skill set requiring advanced education and experience in hospice palliative care medicine.

6.2 This guideline is intended to apply to patients as identified by the palliative care physician as suitable for palliative sedation.

6.3 In all but the most unusual circumstances, death must appear imminent (within days).

7.0 PALLIATIVE SEDATION ORDERING AND MONITORING REQUIREMENTS

7.1 Whenever possible, palliative sedation is to be ordered by a Palliative Care Physician**.** In situations where a telephone or video-consultation has determined that palliative sedation is appropriate, the attending physician may order palliative sedation as discussed with the Palliative Care Physician on call. Please make note of section 5.1.

7.2 The standard sedative infusion to be used is Midazolam.
A starting dose of Midazolam 1mg/hr by continuous infusion (IV or SC) is suggested. This dose may need to be titrated rapidly to effect. In most cases, doses of between 1mg/hr - 7 mg/hr are required.

Fentanyl 20 -50mcg/hour may be used instead of midazolam and opioids in the following conditions:
a. renal failure
b. hepatic failure

7.3 The patient's other medications, such as opioids, should generally be maintained during deep sedation but it may be possible to reduce their dosage.

Monitoring of patient response to palliative sedation and any required adjustments to palliative sedation delivery rate and amount (within the range detailed in the palliative physician's orders) will be by a registered nurse, optimally with experience in palliative sedation delivery. If the patient is at home,

then the family can be trained by the registered nurse to monitor and adjust the medication administration, under close supervision (both face-to-face and phone) of that registered nurse.

7.4 It is recommended that a patient response monitoring tool (eg Riker scale (see Appendix)) be used to ensure that all care providers are aware of the degree of patient sedation that was agreed on.

7.5 If the respiratory rate becomes low, such as six or less per minute, the opioids should be held and the dose of midazolam can be reduced. Patients should be evaluated to assure adequate ventilation is occurring.

8.0 GOAL OF MONITORING PALLIATIVE SEDATION (as per definition):

Inducing and maintaining deep sleep, in the final hours to days of life, for the relief of severe suffering.

8.1 Key observations and assessment indicating this goal is not being achieved is a trigger to clinical decision for adjusting palliative sedation.
8.2 RASS level -1 to -4 would be consistent with deep sleep

Evaluation Guideline

Richmond Agitation Sedation Scale (RASS)

Target	RASS Description
+ 4	Combative, violent, danger to staff
+ 3	Pulls or removes tube(s) or catheters; aggressive
+ 2	Frequent non purposeful movement, fights ventilator
+ 1	Anxious, apprehensive, but not aggressive
0	Alert and calm
- 1	awakens to voice (eye opening/contact) >10 sec
- 2	light sedation, briefly awakens to voice (eye opening/contact) <10 sec
- 3	moderate sedation, movement or eye opening. No eye contact
- 4	deep sedation, no response to voice, but movement or eye opening to physical stimulation
- 5	Un-rousable, no response to voice or physical stimulation

This guideline is adapted from the Calgary Health Region guideline with permission.

Note about the evidence used in the guideline:

This document has been developed by incorporating the existing literature on the use of palliative sedation with the experiences of multidisciplinary pain and symptom management experts to produce a consensus based guideline

Site Specific Practices

Palliative sedation can be undertaken in any location (home, hospital or care centre) provided that the above criteria can be satisfied.

Documentation

Documentation should include:

- "This is palliative sedation"
- The discussion with the patient and family by which all criteria were met, and the appropriate consent was obtained
- Name and dosage of medication administered
- Changes to dose of medication
- Patient's level of sedation (e.g. Richmond Agitation Sedation Scale (RASS))
- Nature of information and support offered to patient and/or family

References

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COMMITMENT TO CPG MANAGEMENT

Ongoing management of the clinical practice guideline includes implementation, evaluation, and revisions for the purpose of maintaining a current evidence based document to guide the delivery of palliative sedation within VCH- Coastal. The responsibility for upkeep of this document rests within the authoring clinical team and should be clearly named here within this document as the current Medical Director, Palliative Care.
Guidelines should be reviewed at a minimum of every 3 years or as new evidence or other guidelines become available.
Palliative Sedation Guideline - Developed 2011;

Developed By

Reviewed By

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(CANPAC / PCC group / CAIAC)

Endorsed By

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Approved for Posting By

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