Policy Name **PALLIATIVE SEDATION**	Policy Number: **0255**
	Effective Date: March 21, 2007
Approved By: Management Committee	Date Revised: June 15, 2011
Classification: Pain and Symptom Management	Page No: Page 1 of 4

POLICY

This policy is to adapt the “Clinical Practice Guidelines for: Palliative Sedation” as outlined by the Alberta Health Services (AHS), Calgary Zone into the setting of Agapé Hospice. It will use the same definitions as those provided in this Clinical Practice Guideline document. This policy does **NOT** apply to temporary sedation or partial/light sedation.

DEFINITIONS

Palliative Sedation: 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.

Refractory or intractable symptom: A symptom is considered refractory if it cannot be adequately controlled despite aggressive therapy that does not compromise consciousness.

PROCEDURE

1. Once refractory symptoms are being entertained by physician or nursing staff, the steps outlined under “Palliative Sedation Criteria Checklist” must be undertaken. Initiation of palliative sedation will not be undertaken until adequate answers are provided to all the items on the Palliative Sedation Criteria checklist.

2. All items on the “Palliative Sedation Criteria Checklist” must be completed.

    a. Documentation of refractory suffering
    b. Palliative measures previously attempted
    c. Outcomes of previously attempted palliative measures
    d. C2 Goals of Care Designation
    e. Terminal Diagnosis
    f. Prognosis is hours to days
    g. Refractory symptoms present and validated by a Palliative Care Consultant who is experienced in pain and symptom management
    h. Prognosis is “hours to days”
    i. Informed consent obtained by patient or health advocate/family.
    j. Health advocate and/or family members informed

3. All members of the interdisciplinary team should be involved in the decision for palliative sedation. The inability to involve all interdisciplinary team members does not preclude initiation of palliative sedation for symptom control.

4. In the event that a unanimous decision is not reached between the family/health advocate and the interdisciplinary team, a referral will be made to Agapé Hospice's Ethics Committee.

ATTACHED DOCUMENTS

1. Richmond Agitation Sedation Scale (RASS)
2. Palliative Sedation Criteria Checklist
3. Alberta Health Services "Clinical Practice Guidelines For: Palliative Sedation"

REFERENCE

AHS, Calgary Zone, Seniors Health and Palliative Care and Intercare Corporation Group Inc. "Palliative Sedation Criteria Checklist for Physicians".

AHS, Calgary Zone. "Clinical Practice Guideline For: Palliative Sedation", 2009 - Page 1-5.

Palliative Sedation Criteria Checklist

Documentation of refractory suffering:

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Palliative measures previously attempted:

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Outcomes of previously attempted palliative measures

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- ☐ C2 Goals of Care Designation
- ☐ Terminal diagnosis
- ☐ Refractory symptoms present and validated by a Palliative Care physician
- ☐ Prognosis is hours to days
- ☐ Informed consent obtained by patient or substitute decision maker

<u>Physicians Orders</u>: clearly documented in chart:

- ☐ Medication(s) that are to be used, include dosages, route and frequency
- ☐ Desired level of sedation, according to an approved patient response monitoring tool (ie: RASS), must be indicated in the orders
- ☐ A clear schedule of assessment must be charted (i.e. during initiation of therapy q30min monitoring until dose is adjusted to a stable dose, then q2-4h)
- ☐ Once a patient is sedated, medications are not increased unless there is evidence of renewed distress, which should be documented in the patient's chart.
- ☐ Sedation will not be attempted by increasing opioid dosages, but opioids will be continued at the previous level in order to ensure pain management and to prevent opioid withdrawal

<u>Nursing Staff:</u>

- ☐ Clearly document in chart your assessment, medications used (dosage, route, frequency) and the effect that medication had on the patient (i.e. level of sedation)
- ☐ Once a patient is sedated, medications are not increased unless there is evidence of renewed distress, which should be documented in the patient's chart
- ☐ If physician gives a dosage range for a particular medication, clearly document in the chart why any increased dose of medication was used (i.e. renewed distress/agitation/myoclonus)
- ☐ Notify the attending physician if the desired level of sedation is not achieved (i.e. despite use of the higher end of dosage range, and/or despite use of breakthrough doses)

______________________________	______________________________
Attending Physician's Signature	Date

Richmond Agitation Sedation Scale (RASS)
(modified for palliative care – Calgary 2011)

+4	Combative	Combative, violent, immediate danger to staff
+3	Very agitated	Pulls or removes tube(s) or catheter(s);aggressive
+2	Agitated	Frequent non purposeful movement, fights ventilator
+1	Restless	Anxious, apprehensive but movements are not aggressive or vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained awakening 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 to voice (but no eye contact)
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation
-5	Unarousable	No response to voice or physical stimulation

Procedure for RASS Assessment

Observe Patient

- Patient is alert, restless, or agitated (**score 0 to +4**)

If not alert, state patient's name and *say* to open eyes and look at speaker:

- Patient awakens with sustained eye opening and eye contact. (**score -1**)
- Patient awakens with eye opening and eye contact, but not sustained. (**score -2**)
- Patient has any movement in response to voice but no eye contact. (**score -3**)

When no response to verbal stimulation, observe patient when providing physical nursing care:

- Patient has any movement to physical nursing care (**score -4**)
- Patient has no response to any physical nursing care (**score -5**)