TITLE: PALLIATIVE SEDATION PROTOCOL

PURPOSE: To provide a framework for the use of palliative sedation.

POLICY

Palliative Sedation is the monitored use of medications (sedatives, barbiturates, neuroleptics, hypnotics, benzodiazepines or anesthetic medication) to relieve refractory and unendurable physical, spiritual, and/or psychosocial distress for patients with a terminal diagnosis, by inducing varied degrees of unconsciousness. The purpose of the medication(s) is to provide comfort and relieve suffering and not to hasten death.

Refractory Symptoms that justify the use of **Palliative Sedation** are symptoms that cannot be adequately controlled despite aggressive efforts by the interdisciplinary team to provide timely, tolerable therapies that do not compromise consciousness.

Ethical Issues/Justification

The justification for Palliative Sedation is based on the principles of beneficence, non-maleficence, autonomy, and fidelity. The **intent** of Palliative Sedation is the relief of suffering and not to end the patient's life. Congruent to this intent, the **outcome** is that the patient is made unaware of un-endurable suffering through sedation. According to the principle of autonomy an individual has the right to decide care for themselves according to their values, beliefs, or life plan. Informed consent is required in order to make autonomous decisions based on the risks and benefits of any intervention. When a patient no longer has capacity to make decisions for himself/herself, the principle of fidelity, which includes the promise not to abandon another, allows a designated health care proxy or patient representative who knows the patient's wishes, to make informed decisions regarding the patient's care.

Assumptions regarding appropriateness of palliative sedation.

1. Palliative Sedation is used only when there are refractory symptoms
2. Generally the patient's prognosis is hours to days. The intent of palliative sedation is control of suffering, not to hasten death
3. An interdisciplinary team is involved in completing a comprehensive assessment and determining the plan of care
4. The patient, or if lacking capacity, the patient's representative, family, physician, and the interdisciplinary team collaborate regarding the appropriate utilization of Palliative Sedation.
5. Pain management is maintained
6. Informed consent is obtained from the patient if possible or from the patient's health care proxy or designated representative
7. For existential suffering "respite" sedation can be considered for a limited amount of time. Patients requiring respite sedation may not have a prognosis of hours to days.
8. The patient has a DNR order

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9. Palliative sedation in a setting other than a hospice inpatient unit or hospital may require continuous care nursing for a minimum of the first twenty four hours of care. A competent hospice team member must document daily confirmation of effectiveness of the treatment.
10. Staff competency must be demonstrated in the provision of palliative sedation
11. Hospice providers will discuss the provision of hydration and nutrition as a separate intervention with the patient and family

PROCEDURE

1. Whenever a patient experiences refractory symptoms, palliative sedation may be considered as an intervention to control unendurable suffering.
2. A decision to initiate palliative sedation must be preceded by a comprehensive interdisciplinary assessment of the patient and a discussion of treatment expectations and options
3. Informed consent is required of the patient, or in cases where the patient lacks decision-making capacity, by their health care proxy or designated representative. A discussion of the risks and benefits of palliative sedation will be part of the informed consent process. The written consent for Palliative Sedation will be obtained
4. The patient's primary physician will be involved in the decision to initiate palliative sedation. The patient's physician and the hospice medical director must agree on the decision to implement palliative sedation.
5. Palliative sedation may be implemented in an inpatient setting or at home. For patients who remain at home a continuous care nurse may be provided <u>at least</u> twenty-four hours.
6. If conflicts or disagreements arise relative to initiation of palliative sedation a consultation with the hospice ethics committee is recommended
7. The patient's primary physician or hospice medical director will write the order for palliative sedation (see attached medication guidelines)
8. Once the patient is sedated, medications are not increased unless there is evidence of renewed distress. A lowering of the dose of the sedatives may be attempted at the discretion of the physician, or at the request of the patient's representative. "First stage anesthesia" is the goal of sedation. First stage anesthesia is defined as the onset of disorientation to loss of consciousness. The eyelash reflex is used to assess level of sedation. A soft tactile stroke over a closed eyelid should cause a reduced flicker/reflex in a first state anesthesia. A lack of flicker (reflex) indicates deep sedation and a need to cut back on the dose.
9. Decrease in sedatives will be initiated if the patient experiences, heavy snoring, and abrupt onset of apnea. **Gradual** deterioration of respiration is expected in terminal patients and should not alone constitute a reason to decrease sedation

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10. A registered nurse will assess the patient continuously during initiation of therapy and every one-hour until the dose is adjusted to a stable dose. The nurse will monitor the patient for any adverse effect.
11. Sedation will not be attempted by increasing opioid dosages, however opioids will be continued at the previous level in order to ensure pain management and to prevent opioid withdrawal.

VP of Hospice Signature:	_____ Date _____
CEO Signature:	_____ Date _____

Policy #: 9087

	Date	Initial
Effective:	3/09	
Reviewed:		
Revised:		

PALLIATIVE SEDATION FOR REFRACTORY SUFFERING CONSENT FORM

Patient name_____

Documentation of refractory suffering:_____
_____
_____
_____

Palliative measures previously attempted:_____
_____
_____
_____
_____

Outcomes of previously attempted palliative measures:_____
_____
_____

Patient _____ Health Care Proxy/Patient representative _____ (check one)

( ) Able to respond intelligibly to queries

( ) Able to take a part rationally in decision-making

( ) Able to articulate the decision

Information presented:

( ) Nature and progress of stage of terminal illness (prognosis)

( ) Nature and possible impact of proposed controlled sedation

( ) Limitation, side effects, and risks of the proposed controlled sedation.

( ) Issues related to hydration and nutrition during sedation

( ) I am aware that Dr._____ (primary physician) agrees with the plan to initiate palliative sedation.

With knowledge of the risks discussed by the physician(s), I consent to controlled sedation for refractory suffering.

Date_____ _____ _____

Patient or authorized representative signature relationship

Physician Signature_____ **Date**_____