Key Elements of Palliative Sedation Protocols and Guidelines

Nelson P *J Hosp Pall Nursing* Volume 19 (5) Oct 2017

A. Patient condition meets criteria for palliative sedation
a. Interdisciplinary assessment of the patient includes primary nursing, medical, social work, and chaplaincy providers
b. The patient must be imminently dying
i. Life expectancy is hours to days
ii. A DNAR order is in place
c. Severe intolerable symptoms refractory to treatment
i. Aggressive palliative care short of sedation fails to provide relief
ii. Additional invasive/noninvasive treatment unable to provide relief
iii. Additional therapies are associated with excessive/unacceptable morbidity or are unlikely to provide relief with a reasonable time frame
iv. All palliative treatments must be exhausted, including treatment for depression, delirium, anxiety, and any other contributing psychiatric illnesses
v. Expert consultations from other specialties (ie, psychiatry for delirium, pain service for pain syndromes, pulmonology for respiratory issues offer no further alternatives)
vi. Completion of a psychological assessment by a skilled clinician
vii. Completion of a spiritual assessment by a skilled clinician or clergy
B. Clinician/team member competence, involvement and care
a. Consultation and collaboration
i. Primary team should consult a palliative care expert (physician or APRN)
ii. Attending of record (MD, DO, or NP) should consult appropriate specialists to discuss all invasive and noninvasive options available to manage target symptom(s)
iii. As appropriate to address additional patient needs/distress, there is further assessment by the palliative care IDT of the family and the patient to offer support
iv. Collaboration between primary care team, hospice (as appropriate), and palliative care team members with patient and family and direct care providers such as registered nurses and nursing assistants
b. Team education and support
i. All healthcare clinicians involved in the patient's care should be educated regarding process and ethics of palliative sedation
ii. Team discussion to review the process and policy for enactment
iii. Allowance for conscientious objection and process for transferring care to another provider if staff member finds practice against his moral framework
iv. Process for ongoing care and support of healthcare team and opportunity for debriefing and sharing after the death and/or palliative sedation experience
C. Informed consent and decision making with the patient and family
a. Education, information, and discussion regarding the elements of palliative sedation, including outcomes, the procedure risks, and potential benefit including clear understanding of the death to occur likely in hours to days

b. Encouragement of family in decision making
c. Discussion of impending death is included and planning for death experience includes cultural, religious, and personal wishes
d. Cessation of artificial nutrition and hydration is discussed and typically done except for cases when respite sedation is provided
e. Informed consent should be obtained from the patient or surrogate decision maker (written or verbal based on hospital policy)
f. Detailed documentation of the content of the consent discussion within medical record
D. Care of the family
a. Assess the distress of the family and provide ongoing support
b. Assurance of nonabandonment
c. Active listening
d. Conveyance of concern and caring for patient and family
e. Ongoing truthful compassionate communication regarding patient status and meanings behind medical information
E. Selection of medication for palliative sedation
a. Analgesics are not a primary sedative drug. They are continued as a symptom treatment if already in place and delivered alongside other sedatives for sedation to unconsciousness
b. Consideration for the use of respite sedation especially in patients with existential or spiritual distress as a primary cause of suffering
c. Medications used to sedate patient are based on
• the symptom to be treated
• current medications in use or successfully used in the past
• medication efficacy, potential for adverse effect
• medication access (IV, PO, PR, SQ)
d. Suggested sedatives and initial dosing
• Usual medications include barbiturates and anesthetics
• Proprofol (Diprivan): Initial bolus 10-20 mg and drip of 5-10 mg/h with titrations of increments of 10-20 mg/h every 10 min as needed until control of symptoms is achieved
• Thiopental: Initial bolus 5-7 mg/kg per hour IV bolus and the 20-80 mg/h as a drip. Titrate to control of symptoms
• Pentobarbital: 1-3 mg/kg IV bolus and drip at 1 mg/kg per hour and titrate until control of symptoms
• Midazolam: 2-5 mg IV bolus (can be SC) with a drip at 1 mg/h and titrate to control symptoms
• Precedex (Dexmedetomidine): Drip is initiated with initial bolus and typical dosing is within the range of 0.2-0.7 mcg/kg per hour
F. Care of the patient
a. Maintain hygiene, dignity, skin care, and elimination
b. Attention to the patients culture and religion and rituals
c. Creation of comfortable environment that supports the patient's family
d. Creating special memories by helping families at the bedside take pictures, make hand casts, or use other methods that will help in the transition
e. Bereavement care during the dying process and post death