HOSPICE OF CENTRAL NEW YORK

Policy: Palliative Sedation

Scope: Clinical staff

Background: Palliative sedation is the active, intentional use of sedative medications for the purpose of controlling an otherwise refractory medical symptom by inducing sufficient sedation in a terminally ill patient. Defined this way it is an uncommon intervention. The interdisciplinary team caring for the patient should feel confident that all other available measures have been used prior to considering this option for symptom management. The most common symptoms this is used for include delirium and agitation, shortness of breath, and pain. The use of sedation in existential suffering is not covered in this policy.

Patients and families need to be informed and consent to this intervention. Sedation can be reversed if there is a reason to believe that the symptom status may have changed. Nutrition is a separate decision from palliative sedation. Most often sedation is performed in the last days of life and the patient has already decreased intake of fluids and food. Usually to provide artificial hydration or nutrition at this point would lead to fluid overload symptoms or other complications. Knowing this the patient and family are likely to choose to forego artificial fluids and nutrition, aware that death will inevitably ensue.

Opioids used for pain are not used for palliative sedation but would be continued for symptom control. Sedation may be a side effect of their use but the goal is pain control while maximizing pain relief. Sedation’s intent is to relieve a refractory symptom by decreasing the level of consciousness.

PROCEDURE:

1. Once a refractory symptom is identified the clinical team must perceive that further invasive and non-invasive interventions are:
    a. Incapable of providing adequate relief or
    b. Associated with excessive and intolerable acute or chronic morbidity or
    c. Unlikely to provide relief within an acceptable time frame. (Cherney 1994)

2. Before offering palliative sedation, the Hospice team reviews the case, including the availability of needed medications and nursing care. If feasible to offer home palliative sedation to the family, then the Hospice physician will contact the patient’s attending doctor to discuss. If all are in agreement, this option for care, along with all others (i.e. hospitalizations) will be discussed with the patient and family/health care proxy.

3. The benefits and burdens of the anticipated sedation process is discussed with the patient and/or immediate family/health care proxy to obtain informed consent. The use or foregoing of artificial fluids and nutrition should be addressed also. This discussion needs to include the physician prescribing the medication and the hospice nurse. The Palliative Sedation Handout for Patients should be given to the family. The following should be documented in the record:
    a. Terminal nature of the illness, i.e. generally less than about 2 weeks.
    b. Presence of refractory symptoms despite appropriate treatments, determined by the Hospice team and 2 physicians familiar with the case; typically the attending and Hospice physician.
    c. Agreement and consent from patient, family and health care team to proceed with palliative sedation as the therapeutic option to alleviate end-of-life suffering. Patient Handout given.
    d. Goal for sedation – temporary or indefinite, level of sedation chosen (see suggested order format), and drug chosen.

4. Spiritual closure and/or counseling for the patient and family are offered and encouraged prior to the medication being administered.

METHODOLGY:

1. A physician and/or Hospice or hospital RN should be present at initiation of medication and remain until the patient exhibits signs of stable sedation.
2. This policy applies when the level of sedation desired is greater or equal to 4 on the Modified Ramsay Sedation scale (see definitions.) The level of sedation desired is clarified and if not achieved within 4 hours the physician needs to be contacted.
3. The following drugs and routes are the most commonly used sedatives.
    a. Lorazepam – starting dose of 1-4 mg q 4-6 h po or dissolved buccally; infusion of 0.5-1 mg/hr IV or SQ. Usual maintenance dose is 4-40 mg/day
    b. Midazolam –starting dose of 0.5-1.5 mg/hr after bolus of 0.5 mg IV or SQ. Usual maintenance dose is 30-100 mg/day. It is short acting and must be given as an infusion.
    c. Phenobarbital – 200mg loading dose IV over 5 minutes or SQ, repeated q 10-15 minutes until patient is comfortable. Mainentance dose starts at 50mg/hr.
    d. Chlorpromazine and propofol are less commonly used.

    Dose should be increased by about 30% every hour (15 -30 minutes if midazolam is used) until sedation is achieved. Once desired sedation level achieved, maintain the same infusion level. If symptoms recur, increase dose by 30% increments until sedation again achieved.

4. Prior doses of opioids and other symptom relieving medications should be continued.

Definitions:

Modified Ramsay Sedation scale:
Light 1 = anxious and agitated, or restless or both
2 = cooperative, oriented and tranquil
3 = responds to commands only
Deep 4 = brisk response to light glabellar tap or loud auditory stimulus
5 = sluggish response to light glabellar tap or loud auditory stimulus
6 = no response to light glabellar tap or loud auditory stimulus

Anxious – words or facial expressions suggest fear, anxiety or discomfort. Muscle tone may be increased, but movements are infrequent and constructive.
Restless – patient is fidgety or changes body position frequently.
Agitated – vascular lines and tubes are threatened.
Glabellar tap – tap in middle of forehead just above eyebrow with finger.

References:

Doyle, Hanks and MacDonald, editors Oxford Textbook of Palliative Medicine. Oxford University Press, 1998, pp. 945-47.

Cherney, NI and Portenoy, RK, "Sedation in the Management of Refractory Symptoms", Journal of Palliative Care, 1994; 10: 31-38.

Snyder, L and Quill, TE, Physicians Guide to End-of-Life Care, American College of Physicians, 2001, pp. 168-72.

National Hospice and Palliative Care Organization, Total Sedation: A Hospice and Palliative Care Resource Guide, 2001.

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Palliative Sedation

People who are dying of a serious medical condition for which no cure is available or for which treatments have failed have a **terminal illness**. These patients can receive comfort care, which focuses not on life-prolonging measures but on relieving pain and suffering at the end of life. **Palliative care** provides comfort care to the patient by focusing on relieving symptoms such as pain, anxiety, nausea, and difficulty breathing. Family members as well as the patient are provided with emotional, social, and spiritual support to help them with the dying process. **Hospice care** provides palliative treatment, often with a team approach, to serve a variety of patient and family needs such as home nursing care, social services, pain management, and spiritual support. The October 12, 2005, issue of *JAMA* includes an article about **palliative sedation**.

PALLIATIVE SEDATION

Terminal illnesses can cause distressing symptoms, such as severe pain, mental confusion, muscle spasms, feelings of suffocation, and agitation. Despite skilled palliative care, in some cases these symptoms may not respond to standard interventions. After all other means to provide comfort and relief to a dying patient have been tried and are unsuccessful, doctors and patients can consider palliative sedation. Palliative sedation is the use of sedative medications to relieve extreme suffering by making the patient unaware and unconscious (as in a deep sleep) while the disease takes its course, eventually leading to death. The sedative medication is gradually increased until the patient is comfortable and able to relax. Palliative sedation is not intended to cause death or shorten life.

ADVANCE DIRECTIVES

Decisions regarding the end of life are difficult. It is imperative to maintain open communication between the palliative care team, patient, and family members. If possible, patients should make their own decisions about end-of-life care. If a patient is unable to make his or her own decisions and has no **advance directive** (documents that state in advance a patient's end-of-life wishes), a **health care surrogate** (someone who is appointed by the patient in advance or who is appointed to represent the patient) may make decisions based on what the patient would want.

WHAT TO CONSIDER REGARDING PALLIATIVE CARE

Patients and their families should feel comfortable discussing their feelings and what to expect with the palliative care team. Patients should consider what they want for comfort and discuss their wishes regarding family good-byes, funeral plans, and religious rituals. It is important to know that the timing of death is difficult to predict and could be anywhere from hours to days after palliative sedation is initiated. Although many times these issues are discussed only when death is near, you should consider discussing your end-of-life wishes, including palliative care decisions, with family, friends, and your doctor before a terminal illness occurs.

FOR MORE INFORMATION

- National Hospice and Palliative Care Organization
  800/658-8898
  http://www.caringinfo.org
- Hospice Foundation of America
  800/854-3402
  http://www.hospicefoundation.org
- International Association for Hospice and Palliative Care
  http://www.hospicecare.com

INFORM YOURSELF

To find this and previous JAMA Patient Pages, go to the Patient Page link on *JAMA*'s Web site at http://www.jama.com. A previous Patient Page on palliative care was published in the March 16, 2005, issue; one on hospice care in the February 21, 2001, issue; and one on end-of-life care in the November 15, 2000, issue.

Sources: American College of Physicians—American Society of Internal Medicine End-of-Life Care Consensus Panel, National Hospice and Palliative Care Organization

TOPIC: PALLIATIVE CARE

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JAMA. 2005;294:1850.

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