Interior Health

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PALLIATIVE SEDATION THERAPY ADULT

Weight (kg)

Bulleted orders are initiated by default, unless crossed out and initialed by the physician/prescriber. Boxed orders (☐) require physician/prescriber check mark (☑) to be initiated.

1. **ALLERGIES:** See Adverse Reaction record

2. **CODE STATUS/MOST**
   - Refer to completed Medical Orders for Scope of Treatment (MOST) #829641
     Note: Patient must have MOST Status M1 documented and submitted on chart

3. **CONSULTS:** ☐ Palliative Physician ☐ Social Worker ☐ Spiritual Care ☐ Other _____

4. **DIET**
   - NPO

5. **CONSENT**
   - ☐ Refractory, intolerable symptom(s) requiring palliative sedation: _____
     (see Symptom Indications for PST, please refer to guidelines on reverse of page 2)
   - ☐ Provide individual, family and/or Substitute Decision Maker (SDM) with Palliative Sedation Patient and Family Information Sheet (#826584)
   - ☐ Arrange family conference with inter-professional health care team
     Note: Explanation and rationale for palliative sedation has been discussed with patient/SDM, and verbal consent has been obtained for continuous sedation therapy to relieve intractable distress and suffering, and documented in the patient record.

6. **MONITORING**
   - Preferred Sedation Goal:
     Richmond Agitation Sedation Scale – Palliative Version (RASS-PAL, Form #826582) Sedation Goal:
     ☐ -3 Moderate Sedation
     ☐ other *(specify)* _____
   - Discontinue Vital Sign Monitoring
   - RASS-Pal (Form #826582) Q4H and PRN to maintain preferred sedation goal
   - Pain Assessment in Advanced Dementia Scale (PAIN-AD) (Form #810310) Q4H and PRN
   - Respiratory Distress Observation Scale (RDOS) Form (#826583) Q4H and PRN

Date (dd/mm/yyyy)	Time	Prescriber's Signature	Printed Name or College ID#
/ /			

Palliative Sedation Assessment and Monitoring Tools should include:

RASS-Pal Scale (Form #826582)

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Richmond Agitation Sedation Scale – Palliative Version (RASS-PAL)

Score	Term	Description
+4	Combative	Overtly combative, violent, immediate danger to staff, (e.g., throwing items): +/- attempting to get out of bed or chair
+3	Very Agitated	Pulls or removes lines (e.g. IV/SC/Oxygen tubing) or catheter(s); aggressive, +/- attempting to get out of bed or chair
+2	Agitated	Frequent non-purposeful movement, +/- attempting to get out of bed or chair
+1	Restless	Occasional non-purposeful movement, but movements are not aggressive or vigorous
0	Alert and Calm	
-1	Drowsy	Not fully alert but has sustained awakening (eye-opening/eye contact) to voice for 10 seconds or longer.
-2	Light Sedation	Briefly awakens with eye contact to voice for less than 10 seconds
-3	Moderate Sedation *(common goal)*	Any movement (eye of body) or eye opening to voice, but no eye contact
-4	Deep Sedation	No response to voice but any movement (eye or body) or eye opening to stimulation by light touch
-5	Not rousable	No response to voice or stimulation by light touch

Tool Notes

- The Richmond Agitation-Sedation Scale – Palliative Version (RASS-PAL) is a valid and reliable assessment tool to assess the person's level of sedation during Palliative Sedation Therapy (PST)[1].
- Unlike the original RASS, the RASS-PAL does not require eliciting a response using painful or startling stimuli;
- The aim of palliative sedation is to provide symptom relief with the lightest possible level of sedation necessary and/or as per the identified goals.
- Use of a standardized tool to assess level of sedation improves monitoring, communication and documentation in PST, see procedure on reverse.

Score	Procedure for RASS-PAL
0 to +4	1. Observe patient for **20 seconds** a. Patient is alert, restless or agitated **for more than 10 seconds**. Note if the patient is alert, restless or agitated for less than 10 seconds and is otherwise drowsy, then score patient according to your assessment for the majority of the observation period.
-1 -2 -3	2. If not alert, greet patient, call by name and say "open your eyes and look at me". a. Patient awakens with sustained eye opening and eye contact **(10 seconds or longer)**. b. Patient awakens with eye opening and eye contact, but not sustained **(less than 10 seconds)**. c. Patient has any eye or body movement in response to voice but no eye contact
-4 -5	3. When no response to verbal stimulation, physically stimulate patient by *light* touch, e.g., *gently* shake shoulder a. Patient has any eye or body movement to gentle physical stimulation b. Patient has no response to any stimulation

[1] Bush SH, Grassau, PA, Yarmo MN, Zhang T, Xinkie SJ, Pereira JL (2014). *The Richmond Agitation-Sedation Scale modified for palliative care inpatients (RASS-PAL): a pilot study exploring validity and feasibility in clinical practice.* BMC Palliative Care,13:17 1186/1472-684X-13-17.

Adapted for clinical use in Interior Health with written permission of Dr. Shirley Bush, original author, February 2020.

826582 Mar 3-20 page 1 of 1

Respiratory Distress Observation Scale (Form #826583)

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Respiratory Distress Observation Scale (RDOS)

Purpose

This tool is to be used for assessing the intensity and distress of patients unable to report dyspnea during monitoring for Palliative Sedation Therapy[1,2,3].

Variable	0 Points	1 Point	2 Points	Sub-Total
Heart rate per min (beats/min = bpm)	less than 90 bpm	90 – 109 bpm	greater than or equal to 110 bpm	
Respiratory rate per minute (auscultated) (breaths/min)	less than 19 breaths	19 – 30 breaths	greater than 30 breaths	
Restlessness: non-purposeful movements	No	Yes - Occasional, slight movements	Yes - Frequent movements	
Paradoxical breathing pattern: abdomen moves in on inspiration	No		Yes	
Accessory muscle use: rise in clavicle during inspiration	No	Yes - Slight rise	Yes - Pronounced rise	
Grunting at end-expiration: guttural sounds	No		Yes	
Nasal flaring: involuntary movement of nares	No		Yes	
Look of fear: ☐ Eyes wide open ☐ Facial muscles tense ☐ Brow furrowed ☐ Mouth open ☐ Teeth together	No		Yes	
			Total	

Instructions for Use

- Count respiratory and heart rates for one full minute;
- Grunting may be audible with or without auscultation;
- An RDOS score of less than 3 indicates respiratory comfort[2];
- An RDOS score greater than or equal to 3 signifies respiratory distress and need for palliation[2,3];
- Higher RDOS scores signify a worsening condition[2,3].

References:
1. Campbell, M. L. (2008b). Psychometric testing of a respiratory distress observation scale. J Palliative Care Medicine, 11(1), 48.
2. Campbell, ML and Templin TN. (2015). Intensity cut-points for the Respiratory Distress Observation Scale. Palliat Med. 29(5): 436–442
3. Zhang et al. (2019). Validity, Reliability, and Diagnostic Accuracy of the Respiratory Distress Observation Scale for Assessment of Dyspnea in Adult Palliative Care Patients. J Pain Symptom Manage;57(2):304-310.

826583 May 4-20 ***Not a permanent part of the health record*** Page 1 of 1

PAINAD (Form #810310)

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Pain Assessment in Advanced Dementia (PAINAD) Scale

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial Expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched, knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
			TOTAL	

Scoring:
- 1 – 3 Mild pain — *Provide comfort measures (i.e., non-pharmacologic approaches such as repositioning or distraction or a mild analgesic such as acetaminophen)*
- 4 – 6 Moderate pain
- 7 – 10 Moderate to Severe pain — *Pain that warrants stronger analgesia, such as an opioid, as well as comfort measures*

Warden, V., Hurley, A. & Volicer, L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. JAMDA, 4(1), 9 -15.

Horgas, A., & Miller, L. (2008). Pain assessment in people with dementia. American Journal of Nursing, 108(7), 62-70.

810310 Feb 13-19

Provincial Palliative Care Consultation Line (physicians and NPs only): **1-877-711-5757**

Nurses, please contact the **Regional Clinical Nurse Specialists** for PEOLC for PS consults: **1-250-354-2883 or 1-250-212-7807**

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7. MEDICATIONS

- Stop all oral medications
- Continue parenteral analgesia[1]

☐ **glycopyrrolate 0.4 mg SUBCUT Q4H PRN** for respiratory congestion
OR

☐ **atropine 0.6 mg SUBCUT Q4H PRN** for respiratory congestion

- Choose one of the following:

Agent and Route	Initial Dose	Titration
☐ **midazolam SUBCUT** ☐ **midazolam IV**	_____ **mg SUBCUT/IV bolus** (recommended range: 1 to 5 mg) **then** _____ **mg/hr continuous infusion SUBCUT/IV** (recommended starting range: 0.2 to 1 mg/hr[2])	Increase or decrease infusion rate by 0.5 mg/hr Q30 min until goal achieved *Usual maintenance dose 1 to 4 mg/hr continuous SUBCUT/IV infusion*
☐ **methotrimeprazine SUBCUT** ☐ **methotrimeprazine IV**	_____ **mg SUBCUT/IV** (recommended range: 5 to 25 mg)	_____ **mg SUBCUT/IV** (recommended range: 5 to 25 mg) **Q8H and Q2H PRN** until goal achieved *Usual maintenance dose 30 to 75 mg/24hr*
☐ **PHENobarbital SUBCUT** ☐ **PHENobarbital IV**	_____ **mg SUBCUT/IV** (recommended range: 30 to 120 mg)	_____ **mg SUBCUT/IV Q8H** (recommended range: 30 to 120 mg) ***AND*** _____ **mg Q4H SUBCUT/IV PRN** (recommended: ½ of Q8H dose) until goal achieved *Usual maintenance dose 600 to 1,600 mg/24hr*
☐ **LORazepam SUBCUT** ☐ **LORazepam IV** ☐ **LORazepam buccal/SL**	_____ **mg SUBCUT/IV** (recommended range: 0.5 to 1 mg) ***OR*** _____ **mg buccal/SL** (recommended range: 1 to 4 mg)	_____ **mg SUBCUT/IV Q2H PRN** (recommended range: 0.5–2 mg) until goal achieved *Usual maintenance dose 4 to 40 mg/24hr* ***OR*** _____ **mg buccal/SL Q2H PRN** *Usual maintenance dose 1 to 8 mg/dose*

[1] CAUTION: Previously prescribed oral analgesia should be replaced by adequate parenteral equivalent. The use of opiates alone for sedation is not recommended due to high risk of opioid neurotoxicity and narcotization (overdose). Palliative Sedation should be managed with sedatives as per above.

[2] NOTE: Usual Baxter IV pumps and midazolam concentrations in acute care settings provide a minimum infusion rate of 0.5mg/hr. Other settings and pumps may provide lower rates.

Date (dd/mm/yyyy)	Time	Prescriber's Signature	Printed Name or College ID#
/ /			

Symptom Indications, Medication Principles, Cautions and Reminders for Palliative Sedation Therapy:

Symptom Indications for PST (Quebec Guidelines for PST, 2016):

- Hyperactive delirium with uncontrollable psychomotor agitation
- Major and recurrent respiratory distress
- Progressive and intractable dyspnea
- Refractory seizures
- Intolerable and untreatable pain
- Copious and refractory bronchial secretions
- Hemorrhagic distress
- Intractable nausea and vomiting
- Refractory psychological or existential distress that severely compromises comfort
- Other refractory condition

Medication Principles:

- Subcutaneous infusion is preferred due to the higher risk of apnea with bolus doses delivered intravenously.
- midazolam is first line for most patients due to short half-life, easy titration, high potential for sedation, low risk of respiratory depression, and wide margin of safety.
- methotrimeprazine can be used in settings not capable of running continuous infusions, in patients with delirium, or in rare patients (less than 2%) with paradoxical agitation on benzodiazepines.
- PHENobarbital is generally reserved for patients with refractory seizure in settings incapable of running continuous infusions.
- LORazepam buccal or SL may be the simplest option in the home setting.
- Utilize the lowest possible dose of medication and lightest level of sedation that achieves comfort. In some cases, comfort may be achieved with light to moderate sedation, while others will require deeper levels of sedation.
- Doses required to achieve the desired level of sedation may vary considerably between individuals.
- Over many hours to days, doses may need to be increased due to the development of tolerance.
- Regular pain assessment using PAINAD and analgesia should continue, however sedation should not be achieved through opiate use.
- The realities of different care settings (e.g. acute or hospice unit versus person's home) will influence the medication and protocol used.

Medication Cautions:

- Phenobarbital has an extended half life (53-118 hours) and may take several days and repeated doses to achieve full effect.
- Buccal absorption of lorazepam may be inconsistent and should only be used if other routes of administration are not available.

Medication Reminders:

- Nurses should use the established monitoring tools (RASS-PAL, PAINAD and Respiratory Distress Observation Scale (RDOS)) when titrating medications for palliative sedation;
- See the Palliative Sedation Toolkit on the insideNET for all resources.