WRHA Clinical Practice Guideline: Sedation for Palliative Purposes (SPP)

Developed by: WRHA Regional Working Group

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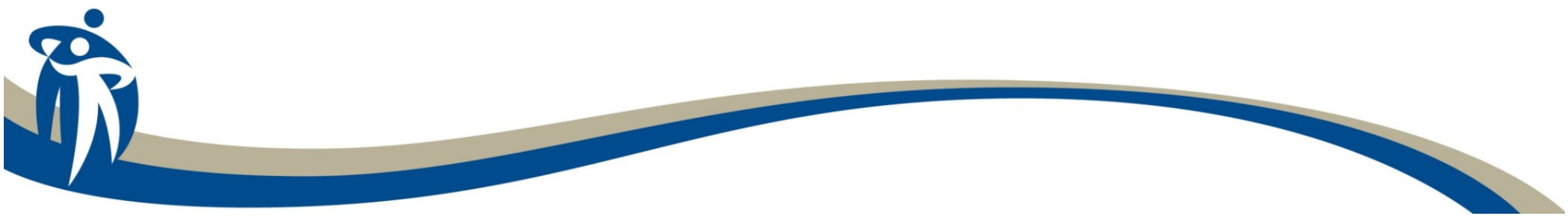
No conflicts of interest to disclose

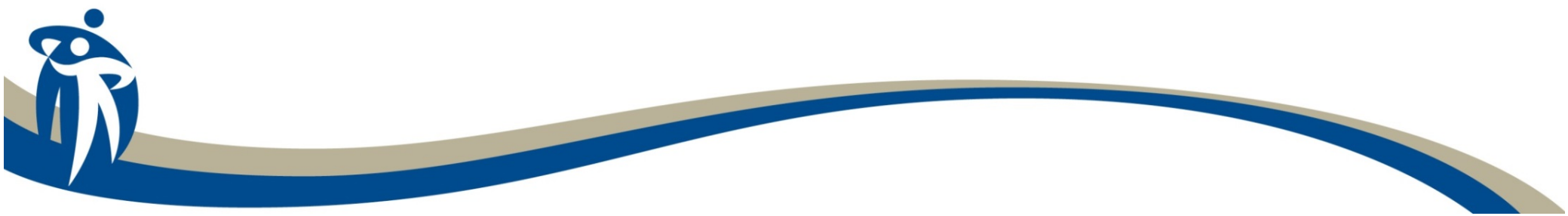


Objectives

- Background and purpose of guideline
- Definition
- Criteria/ Indications for SPP
- Decision- making
- Medications used in SPP
- Ongoing monitoring and documentation
- Other Resources

Background

- Symptom control in the dying patient has advanced considerably in the past decades but there are instances, despite the efforts of all involved, when symptoms remain uncontrolled and intolerable to the patient.
- **Sedation for Palliative Purposes*** (SPP) is a valuable therapeutic intervention that, in certain cases, can and should be initiated to facilitate a more comfortable death.
- Intentionally referred to as “sedation for palliative purposes” as this term is a more specific description of the goal of the proposed intervention.



CPG Purpose

To provide recommendations in the practice of sedation for palliative purposes (SPP) regarding:

- Indications
- Decision-making process
- Medications
- Monitoring
- Documentation

To provide clinical support for the following care settings:

- Adult clinical practice
- Pediatric clinical practice
- Designated palliative care units
- Hospice
- Community and tertiary health care facilities
- Long term care facilities
- Home

Reasons for Sedation

Symptoms	Stone et al. (1997) (n=115)	Morita et al. (1999) (n= 157)	Porta Sales (2001)	Bobb (2016)
Delirium	60%	42%	39%	54%
Dyspnea	20%	41%	38%	30%
Pain	20%	13%	22%	17%
Bleeding	-	-	9%	-
N/V	-	2%	6%	5%
Fatigue	-	-	20%	-
Psych	26%	2%	21%	19%

Palliative Sedation vs. Euthanasia (MAID)

	Palliative Sedation	Euthanasia
Goal	Decrease suffering	Decrease suffering
Intent	To sedate	To end the life of the patient
Process	Administration of sedating drug doses, titrated to effect	Administration of a lethal drug dose
Immediate Outcome	Decreased level of consciousness	Death
Cause of Death	Natural progression of underlying illness	Medications administered

Definition

Sedation for Palliative Purposes is the planned and proportionate use of sedation to reduce consciousness in an imminently dying patient, with the goal to relieve suffering that is intolerable to the patient and refractory to interventions acceptable to the patient.

Palliative Sedation
(Sedation for Palliative Purposes)

Sedation for Palliative Purposes is the **planned** and proportionate use of sedation to reduce consciousness in an imminently dying patient, with the goal to relieve suffering that is intolerable to the patient and refractory to interventions acceptable to the patient.

The intention of the intervention is to sedate, rather than sedation being the undesired yet predictable side effect of medications such as opioids or anti-nauseants.

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Medications are titrated to the lowest effective dose. Respiratory rate and pattern are watched to prevent medication-related resp. depression

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Expected natural death within 1-2 weeks from the underlying life-limiting condition, to avoid hastening the death through dehydration caused by prolonged sedation.

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The person experiencing the suffering is in the best position to judge “intolerable”

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Sedation for Palliative Purposes is the planned and proportionate use of sedation to reduce consciousness in an imminently dying patient, with the goal to relieve suffering that is intolerable to the patient and refractory to interventions **acceptable to the patient.**

Proposed interventions may seem minor or trivial to the health care team, but unduly burdensome to the patient.

Criteria

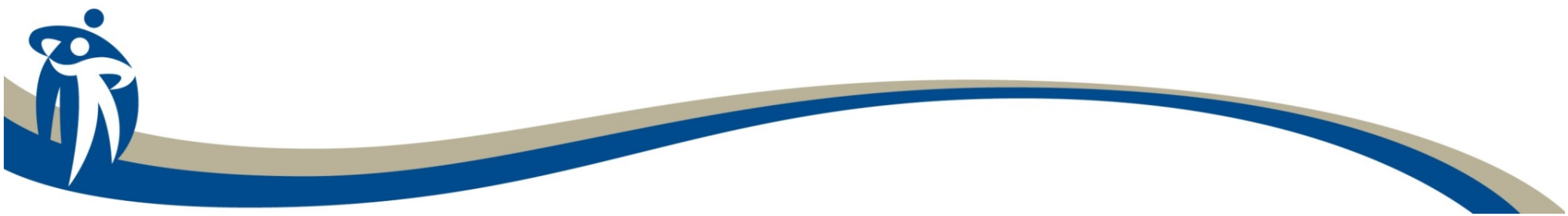
- estimated prognosis less than 2 wks
- intolerable suffering refractory to accepted interventions
- goals of care should be consistent with WRHA ACP 'C'
- health care team should have the needed expertise to undertake SPP in a manner consistent with the approach described in this document, including assessment, medication selection and use, monitoring, and family and staff support
- if the healthcare team involved lacks expertise in SPP, they must consult the WRHA Palliative Care program

Why 2 weeks?

- SPP causes abrupt cessation of fluid intake
- impact is similar to massive CVA or feeding tube withdrawal, where survival is generally 1-2 wks
- *in the best judgment of the involved clinicians* – if the natural course of the underlying illness is expected to result in death within 1-2 wks, palliative sedation is not likely to cause the patient's death
- an expected natural death within 1-2 weeks from an underlying life-limiting condition is a common criterion in palliative sedation guidelines (Schildmann & Schildmann, 2014).

What SPP is not……

- Temporary sedation of a patient to manage symptoms
- Respite sedation
- An unintended adverse effect of treatment (e.g.. opioid-related sedation)
- Sedation with the temporary use of antipsychotics to treat delirium
- Procedure-related sedation
- Sedation intended to hasten or cause death
- The sedation of patients whose life expectancy is more than 2 weeks.



Decision Making

- should involve: the **patient/SDM**; **family**; **healthcare team**.
- Documentation is key and should include:
  - intolerable and refractory nature of the suffering;
  - prognosis;
  - goals of care;
  - target level of sedation (i.e. RASS- PAL- Appendix B and C); and
  - Details of the discussions with the patient, SDM and/or family and the healthcare team
- Should be re-evaluated on an ongoing basis (not a one way intervention)

Other Components of Care

Hydration and Nutrition

•Often an area of concern – should be addressed preemptively with all involved – *including health care team*

•Should consider each as distinct issues

•In general, medically administered hydration/nutrition is not consistent with an approach that allows an expected death to unfold naturally, and does not address comfort issues

Review of Concurrent Medications

•Review and streamline medications

•This includes the use of supplemental oxygen

Medications used for SPP

- Little evidence guiding medication choices
- Some common themes in published approaches
- ***Care setting impacts options***

- Opioids
  - Not primary sedatives, rather are analgesics with sedating side effects
  - Not sole agent
  - Pre-existing opioid needs will continue
- Benzodiazepines
  - Rarely sole agent
  - Paradoxical effect possible
- Antipsychotics
  - generally select those with higher sedating characteristics, e.g. methotrimeprazine

Ongoing assessment

Monitoring

- Baseline assessment of full clinical presentation and plan
- Prior to subsequent doses
- If a changes in clinical presentation or plan of care
- Minimum of q4h

Documentation

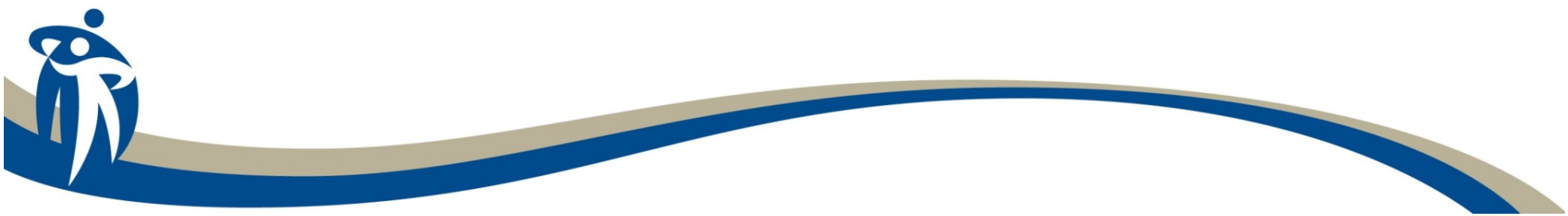
- Appearance of comfort
- Depth of sedation
- Respiratory rate and pattern
- A tool to measure the patient's level of sedation should be used.
  - The Richmond Agitation Sedation Scale- Palliative (RASS- PAL)

Why Document Respiratory Rate And Pattern?

- the manner of dying from acute sedative overdose is typically through respiratory depression, either with apnea or (more commonly) progressive slowing of regular respiratory rate
- in contrast, the typical end-of-life respiratory pattern in progressive illness includes fast shallow breathing, progressing to apneic episodes interspersed with clusters of rapid breaths
- it is possible that individual circumstances of SPP will be scrutinized:
  - staff feeling complicit in “covert euthanasia”
  - family members may express concern that SPP caused death
  - death may be reviewed by the Medical Examiner's Office in compliance with the Fatality Enquiries Act (e.g. Long Term Care setting, reportable underlying condition), and comprehensive documentation is important in supporting such reviews

- in the absence of documentation of respiratory rate and pattern, there is limited information to indicate that the sedating medications did not cause or contribute to the patient's death

- support for the health care team's practice is even further challenged when there is no documentation for the indications and effects of prn doses



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

+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/SQ/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 not aggressive or vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (10 seconds or longer)
-2	Light sedation	Briefly awakens with eye contact to voice (less than 10 seconds)
-3	Moderate sedation	Any movement (eye or 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

Adapted with permission from Bush, S.H. et al. (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,* 17-25.

Other Resources Available

If there are differences in opinion between the patient/SDM/ family and/or members of the healthcare team, consider the following additional resources for assistance:

- Second opinions;
- Available pain or symptom management specialists;
- Ethics committees and/ or services;
  - WRHA Ethics Decision Making Framework (http://www.wrha.mb.ca/about/ethics/framework.php)
- Available psychosocial support advisors
  - Available religious or spiritual care advisors;
  - Available cultural advisors;
  - Social work
- Patient advocates; and/or
- Other facility or regional resources for support.

Other Resources Available

The WRHA Palliative Care Service is available 24/7 to provide support when:

- The healthcare team does not possess expertise/ experience in assessing the need for or administering SPP
- SPP is being considered in a care settings which may have limited exposure to this intervention
- Consensus cannot be reached regarding the use of SPP
- Uncertainty exists about the patient's decision-making capacity
- There are questions or concerns regarding prognostication in the context of assessing an individual for SPP

Questions