

ADMINISTRATION OF PALLIATIVE SEDATION TO THE DYING PATIENT

PURPOSE

To specify the circumstances under which the administration of Palliative Sedation is clinically and ethically appropriate for a dying patient.

SCOPE

This Hospital System Policy applies to the Ronald Reagan UCLA Medical Center and the Santa Monica UCLA Medical Center and Orthopaedic Hospital.

This policy does not apply to the Resnick Neuropsychiatric Hospital at UCLA.

DEFINITION

Palliative Sedation is the controlled administration of medications whose primary or secondary effect is to bring about a reduction in patient consciousness, in order to alleviate or at least render tolerable symptoms that have been refractory to standard comprehensive interventions.

CLINICAL CONTEXT

Palliative Sedation is employed to the dying patient only when all previous efforts to manage symptoms have not been successful in achieving patient comfort. Palliative Sedation may be administered intermittently or continuously, and its intensity may vary from mild to deep (see Policy HS 1327, *Policy for the Use of Sedation and Analgesia During Procedures*). In general, a patient's consciousness will be reduced to the minimum extent necessary, with deep and continuous Palliative Sedation reserved only for the most intractable cases. The goal of Palliative Sedation is to relieve distress, not to hasten death. It is therefore important to perform rigorous patient assessment and properly titrate Palliative Sedation to the patient's symptoms. Multidisciplinary consultation should be involved.

POLICY

I. Principles

- A. Patients have a right to have their pain and other symptoms adequately managed, to the extent that this is possible.
- B. Health care professionals have a corresponding ethical obligation to provide their patients with adequate symptom relief, insofar as symptoms may be alleviated or reduced to tolerable levels. This is particularly important in circumstances in which no other proper goal of medicine can be achieved.
- C. It is important that the patient's symptoms are regularly assessed. If able to communicate, the patient should be asked to communicate verbally or

non-verbally about his or her symptom burden, including the desired degree of symptomatic relief. In general, the patient's own evaluation should be the basis for assessing the adequacy of symptom management efforts. If a patient is not able to communicate, his or her symptoms and other distress should be assessed and managed based on clinical indications, with a presumption in favor of ensuring maximal comfort.

- D. Palliative care or comfort-oriented care is always appropriate. Refusal by a Legal Decision Maker to permit symptom assessment and management is unacceptable, except in the extraordinary circumstance that the patient made it unequivocally clear that palliation should not be provided in the clinical situation.
- E. In some circumstances, it may be appropriate to sedate a patient to achieve adequate symptom relief. Because Palliative Sedation either reduces or entirely eliminates consciousness, and in rare circumstances may even risk hastening the patient's death, it must always be considered an intervention of last resort. Its use can only be justified if the patient is suffering from severe, intolerable pain or other clinical symptoms which despite maximal vigorous efforts cannot otherwise be relieved without recourse to sedating medication.
- F. Palliative Sedation shall not be used with the intent to cause or hasten the patient's death. Sedation sufficient to eliminate pain and discomfort may be used even if there is a remote possibility that it may hasten the moment of death, as long as the health care professional's intention is to treat the patient's symptoms and the sedation administered is proportionate to achieving that goal. There should be a general presumption in favor of maintaining consciousness, if possible, unless this is contrary to the patient's clearly and capably expressed wishes.
- G. Palliative Sedation is only appropriate for patients who are reasonably expected to die within days-to-weeks. If a patient is not expected to die within this time frame, respite sedation may be offered.
- H. The dying process is often attended by significant emotional and spiritual suffering. This type of existential suffering is not appropriately managed using sedation, particularly deep and continuous sedation. Rather, in addition to vigorous pharmacological management, existential interventions are indicated, the goal of which is to reduce the intensity of suffering. Dying patients should be routinely assessed for existential suffering and their needs should be addressed by a multidisciplinary team of clinicians skilled in psychological, psychiatric, and spiritual care. Efforts should be made to ensure that the patient's existential suffering is not caused by a lack of human presence at the bedside. Moreover, patients should be reassured that they will not be abandoned. Should a clinician feel that an exception should be made because a patient requires

palliative sedation for refractory existential suffering, the case should be discussed with the Ethics Committee.

- I. Physicians and other healthcare professionals who object to providing Palliative Sedation for reasons of conscience should withdraw from the case so that others can assume care. In such circumstances, physicians must ensure that the patient will not be abandoned and that care will be assumed by another physician who is willing and competent to provide Palliative Sedation. When other healthcare professionals have objections of conscience, their preferences not to participate in a patient's care should be respected to the extent that care is not disrupted and the actions are consistent with their terms and conditions of employment. (Policy HS 7305 *Staff Request for Reassignment*.)

II. Implementation

- A. Establish that the patient satisfies the selection criteria.
- B. Establish guidelines for ordering and administering the sedative infusion, and for documentation.

III. Patient Selection Criteria

- A. As a general rule, the patient must be suffering from a terminal disease in which a natural death is reasonably anticipated to occur within days-to-weeks.
- B. The patient must be distressed by severe clinical symptoms—e.g., pain, dyspnea, nausea/vomiting, agitation, etc.—that are refractory to standard palliative medications, such as opioids, neuroleptics and benzodiazepines. A symptom is determined to be refractory when further invasive and non-invasive interventions are either: (i) incapable of providing adequate relief, (ii) associated with excessive and intolerable acute or chronic morbidity, or (iii) unlikely to provide relief within a tolerable time frame.
- C. The patient must have a current full No CPR order (See Policy HS 1319.1 – *No CPR Orders*). In the rare circumstance that the patient's Legal Decision Maker will not provide consent to appropriate Palliative Sedation or a change in the patient's code status, the mechanisms set forth in HS Policy 1319.1 (subsection III, regarding expedited unilateral no CPR orders) or 1319 should be followed to ensure that the patient will receive adequate symptom management.

IV. Protocol For Ordering, Administering And Documenting

Physician Responsibility

- A. The rationale and goals of Palliative Sedation for the patient must be documented in the Progress Notes of the patient's medical record. A statement that the patient or Legal Decision Maker agrees with this therapy must be included. This note must be written by an attending physician fully knowledgeable about the use of Palliative Sedation.
- B. The decision to withhold or withdraw artificial nutrition and hydration (ANH) is separate from the decision to initiate Palliative Sedation. It is important that physicians discuss the potential risks and benefits of ANH with the patient or Legal Decision Maker. This discussion should be documented in the medical record.
- C. Family members must be educated about the implications of Palliative Sedation, the fact that the infusion may preclude the patient being able to communicate at the end of life, and the reasons that the infusion is indicated.
- D. A Palliative Care consult must be obtained.
- E. The medical record must contain the concurrence that Palliative Sedation is indicated by two physicians who have Medical Staff privileges. This must include the Palliative care consultant and either the attending of record or another attending knowledgeable about the use of Palliative Sedation. When possible, the outpatient primary physician (e.g., primary care physician or oncologist) should be contacted for input.
- F. The Physician's Order must begin with the statement: "Administration of Palliative Sedation to the Dying Patient." The Physician's Order must specify:
 - 1. The amount of drug, the amount of diluent, the rate of infusion.
 - 2. The time interval and amount of drug in mgs/hour for incremental dose increases.
 - 3. That incremental dose increases are to be based on pain or other symptom assessment and **not on vital sign parameters**.
 - 4. A maximum or "cap" dose is not required.
 - 5. The conditions under which the physician wishes to be notified.
- G. The order must be renewed every 72 hours.
- H. **Telephone and/or verbal orders are not acceptable when initiating the order. It is acceptable for changing the order and must be countersigned within 24 hours.**
- I. The physician must assess and document the efficacy of this therapy at a minimum, daily.

V. R.N. Responsibility

- A. Sedative medications administered as a continuous infusion must always be administered via an infusion pump. The infusion device must be clearly identified as administering a continuous infusion of sedative with the medication name clearly visible.
- B. The pharmacy is to be notified at least 30 minutes before the next bag of sedative infusion is needed to allow for drug preparation.
- C. The R.N. administering the sedative infusion will:
 - 1. Assess and titrate the medication by the amount specified in mgs/hour within the given time increments should the patient continue to experience pain or other distressing symptoms. Once the desired level of sedation has been achieved, the infusion rate should be reduced to the lowest level capable of maintaining that degree of control.
 - 2. Document the initiation and titration of the medication infusion in the Nurses' Notes. For each upward titration, document the symptoms that led to the need for the titration.
 - 3. Assess and document the efficacy of treatment on a frequent basis, using the appropriate pain and sedation rating scales, and inform the physician when pain or other distressing symptoms are not relieved.
 - 4. Not discontinue the sedative infusion in the event the order is not renewed in 72 hours, but rather notify the physician immediately so that a renewal order may be written.
 - 5. Discontinue the sedative infusion only upon the physician's order.
- D. Two nurses should co-sign any wastage of unused sedative solution on the Controlled Substance Administration Record. Any sedative solution being returned to Pharmacy must also be documented on this Record.
- E. Vital signs may be obtained to assess the patient's status in the dying process, but should not influence decisions about administering the sedative infusion in the presence of continued pain or other distressing symptoms.

FORMS

None

REFERENCES

Policy HS 1319 *Withdrawing or Withholding Medically Inappropriate Life Sustaining Treatment*

Policy HS 1319.1 *No CPR Orders*

Policy HS 1327, *Policy for the Use of Sedation and Analgesia During Procedures*

Policy, Administration of Opiates to the Terminally Ill

Policy HS 7305 *Staff Request for Reassignment*.

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