

PALLIATIVE COMFORT (SEDATION) PROTOCOL

2nd.draft 9/08/04

PURPOSE:

To provide comfort and symptom management, when standard interventions have not been successful for unrelenting physical or emotional suffering of the dying patient. The intent is to minimize discomfort until natural death occurs, not to hasten death.

SUPPORTIVE DATA:

1. There are “two roads to death.” The usual road is one of adequate pain and symptom control as the dying process occurs. The patient progresses from being sleepy and lethargic, to obtunded and semicomatose, and then to coma and death. The difficult road is one of restlessness, confusion, tremors, hallucinations, delirium, myoclonic jerking (rigors of death), and seizures, with semicoma, coma and death. The neurological changes associated with the dying process are the result of multiple non-reversible factors, which may include reduced cerebral perfusion, hypoxemia, metabolic imbalance, acidosis, toxin accumulation due to liver and renal failure, medication effects, sepsis, and disease related factors.
2. Patients at risk of experiencing severe pain or other uncontrolled symptoms such as dyspnea, delirium, and restlessness, include those who have cancer, neuropathic pain, past history of alcoholism, and preexisting psychiatric problems.
3. Additional factors that may require sedation include the withholding or withdrawing of life support, violent vomiting, massive bleeding, or seizures.
4. The following indicate the potential need for palliative sedation at the end of life:
 - Intolerable pain in the last 48 hours
 - Uncontrolled dyspnea
 - Delirium
 - Terminal restlessness/agitation
 - Status epilepticus
 - Any intractable symptoms that become unbearable for the patient
 - Uncontrollable hemorrhaging

MANAGEMENT

1. Mutual goals should be set with the patient and/or family/healthcare proxy.
2. Assess contents of existing Advance Directives if the patient is unable to communicate.
3. Confirm DNR (Do Not Resuscitate) status.
4. Intermittent or continuous sedation routes of administration for palliative sedation may be IV, subcutaneous, sublingual, or rectal.
5. Obtain baseline assessment of pain and any other symptoms the patient may have.
6. Obtain baseline vital signs [B/P, pulse and respiration] then assess as directed by the physician. Make sure this is acceptable with the patient and/or family/healthcare proxy. In an effort to not disturb the patient, if Vital Signs are ordered more than once a shift, discuss decreasing the frequency with the physician.
7. Cardiac and oxygen monitors are not necessary, the patient may be placed in a private room anywhere in the hospital or Transitional Care Unit.

8. After initiation of the medications and any time the dosage is changed:
 - a. assess the patient's comfort level, sedation level, and respiratory rate every 15-minutes times 1-hour or until the patient is comfortable, then resume vital signs as ordered.
 - b. if the patient is unable to communicate their comfort level:
 - assess for restlessness, grimacing, rigidity, increased heart rate or B/P
 - ask the family for their input as to the patient's comfort level
8. The physician will order the sedating medication, rate and route of administration.
9. Possible medications ordered alone or in combination are:
 - a. opioids such as Morphine, hydromorphone, oxycodone or fentanyl
 - b. antianxiety medications such as Valium, Versed, Ativan or Haldol
 - c. barbiturate such as Nembutal
8. Patient care:
 - a. turn every 2-hours from side-to-side
 - b. head of bed elevated at least 30 degrees
 - c. provide oral cares every 2-hours and prn
 - d. suction prn, use medications as ordered to decrease oral secretions such as Atropine, Robinul or Scopolamine patch. [Refer to PHYSICIAN ORDERS-SUPPORTIVE-Management of secretions in the last hours of living]
8. Documentation:
 - a. protocol initiated in patient progress note
 - b. medication, rate and route on patient MAR
 - c. patient response in patient progress note
 - d. patient/family teaching on plan of care.

Resources and References:

1. Rardin, Dorreen, RN, Palliative Care Consultant, Boone Hospital, Columbia, MO Palliative Care Manual, July, 2000
2. Ed. By Kuebler, Kim K., MN, RN, ANP-CS, and Peg Esper, MSN, RN, AOCN, Palliative Practices from A-Z for the Bedside Clinician, 2002, by the Oncology Nurse Society
3. McCaffery, M & Pasero, C., Pain: Clinical Manual 2nd ed. 1999, St. Louis, Mosby
4. Ed. By Emmanuel, L., Von Guten, C, Ferris, F., & Portney, R., EPEC Curriculum: Education for Physicians on End-of-Life Care 1999, The EPEC Project, Chicago, American Medical Association
5. Carolla, Robert, M.D., Medical Director Cancer Services, Hulston Cancer Center, Springfield, Missouri
6. Willoughby, Donna, RN, PCS, Palliative Care Nurse Coordinator, CoxHealth