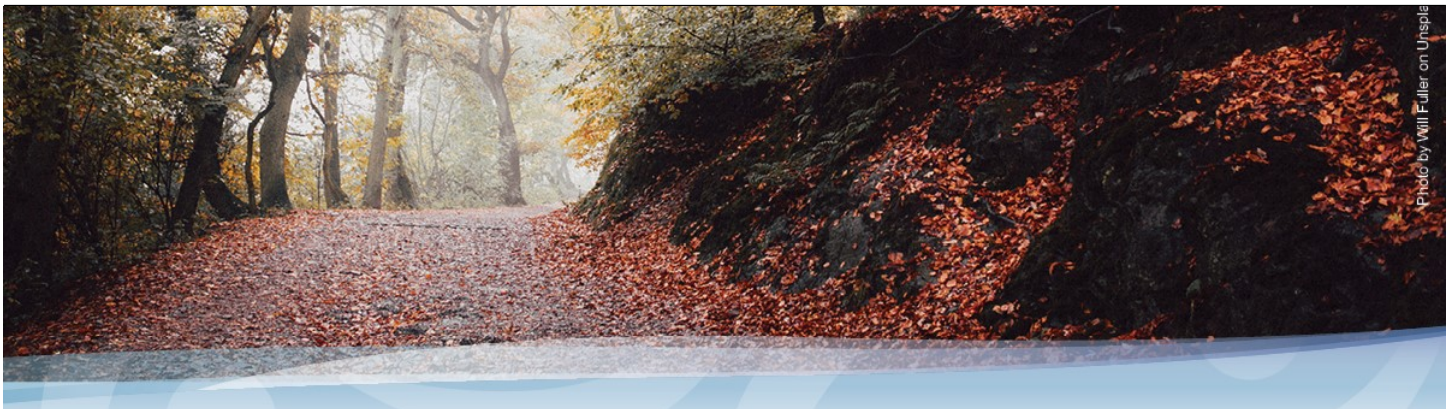

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Palliative Sedation

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When used appropriately, palliative sedation is a very useful tool in providing symptom relief in palliative care. It is also one of the more challenging therapies offered in palliative care when considering both the ethical and practical issues involved. In this article we will be focusing on palliative sedation therapy (PST) at end of life until natural death occurs.

Definitions

When discussing PST, there are a few common terms that are important to define for understanding and consistent communication.

Palliative Sedation Therapy (PST) is defined as "the monitored use of pharmacological agent(s) to intentionally reduce consciousness to treat refractory, intractable and intolerable symptoms for a patient at end of life with an advanced life-limiting, progressive illness." (BC Centre for Palliative Care, 2019)

A symptom is considered *refractory* or *intractable* if it is associated with intolerable suffering and further interventions are inaccessible or are unable to provide adequate relief in a reasonable timeframe, are associated with intolerable or unacceptable side effects, do not align with a patient's goals of care, and/or there are other reasons that make the intervention unacceptable to the patient or family.

Common symptoms that require PST include agitated delirium, dyspnea and pain. (Hasselaar, 2021)

A *difficult symptom* is a symptom that may respond to treatment in a reasonable time frame and has treatments available that will produce adequate relief without excessive side effects. Often this treatment will preserve consciousness. (Downing, 2006)

And finally, another important term to understand is *consequential sedation*, which is an unintended side effect of

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some medications used to control symptoms in patients (i.e: opioid given with the intent for pain management causing sedation as a side effect, rather than causing sedation as the intent of the medication). It is a common effect that is usually transient and can be managed with dose adjustments or medication changes. As well, tolerance to the sedating effect may develop over time leading to this effect being reduced or resolving. (Downing, 2006).

Opioids are not appropriate to induce PST. (BC Centre for Palliative Care, 2019)

Criteria

PST may be considered for physical symptoms or psychological suffering/spiritual distress. For many patients there is a combination of these symptoms that may be refractory at end of life. The incidence of PST is estimated to be 3 to 10% of palliative patients, and will vary depending on the care setting. (Pereira, 2016)

The following criteria is required to initiate PST in Northern Health:

1. Patient has an **advanced, life-limiting illness.**
2. Prognosis of death is **imminent,** within days.
3. Presence of **refractory or intolerable symptoms.**
4. **A No CPR order is in place** and MOST form is up to date.
5. The patient or Substitute Decision Maker (SDM) has provided **informed consent**, and this is documented.
6. The **care setting** is appropriate and resources are available for initiating and ongoing monitoring of treatment.

While there are validated assessment tools for physical symptoms (i.e. Edmonton Symptom Assessment System), assessment for existential or psychology suffering is more difficult. Psychological suffering and refractory suffering assessment is complex but may be identified when 1) no further psychological, social or spiritual intervention are possible, 2) intervention will take too long to be effective or 3) the patient determines that associated morbidity with further intervention is unacceptable. (Downing, 2006) When considered as a single refractory symptom at end of life, existential suffering is a difficult symptom to base PST on as it can be difficult to determine how close a patient is to end of life, and medical sedation may not be the best treatment option.

PST usually continues until natural death occurs. A decreased level of consciousness is common as a patient nears end of life as a part of the natural process of dying. When used appropriately, with the level of sedation proportional to symptom relief, PST does not hasten death. (Maltoni, 2012). It can sometimes be difficult to determine how close a patient is to end of life, but a general guideline for initiating PST is that the patient will pass in the next days to week.

It is not uncommon that, while a patient is unconscious or relatively comfortable, the family members or caregivers may request PST for the patient. It can be difficult for loved ones or caregivers to follow along with the journey of dying, especially if this will be over a period of weeks, however these requests likely reflect their own suffering, not the patient's, and is not an appropriate use of PST.

PST is only offered to manage the patient's suffering, and it should not be considered as an option to relieve the discomfort or perceptions of others. (BC Centre for Palliative Care, 2019)

PST vs MAiD

With the availability of Medical Assistance in Dying (MAiD), it is increasingly important for health care providers to understand the differences and similarities between these options and to be able to clearly communicate this to the patient and their family. The main differences between the two are intent and patient eligibility.

For patients that express a wish to hasten death, a palliative care consultation may be offered. Often a request to hasten death is due to an uncontrolled symptom or psychosocial distress and addressing and managing these concerns can greatly improve the patient's quality of life.

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Table 1. Palliative Sedation Therapy vs MAiD

Palliative Sedation Therapy (PST)	Medical Assistance in Dying (MAiD)
Suffering is unbearable for the patient.	Suffering is unbearable for the patient.
Intent is to provide symptom management and relief of suffering.	Intent is to end life to relieve suffering.
Does not hasten death.	Hastens death.
Natural death from illness is imminent.	Natural death from illness is "reasonably foreseeable".
All other palliative interventions have been considered and are not possible or acceptable.	The patient has been made aware of means that are available to potentially relieve their suffering, including palliative care.
Consent is required.	Consent is required.
Does not require that the patient be competent to provide consent. The SDM may consent on the patient's behalf.	Requires that the patient is competent to provide consent at the time of administration.

Goals of Care

A goals of care conversation must have occurred with the patient, family and/or SDM and be documented. Goals of care should include a focus on comfort and symptom management and allowing a natural death. When discussing PST, confirm goals of care and consider the following:

Medications: Consider that the patient will be unable to swallow medications when sedated therefore medications must be given via an alternate route (i.e. SC injection, buccal or sublingual). Review current medications and consider discontinuing any unnecessary or life-prolonging medications, such as diabetic medication, antibiotics or anticoagulants. Continue medications that contribute to a patient's comfort and are in alignment with a patient's goals of care, such as opioids for pain or dyspnea. Consider discontinuing any benzodiazepines or neuroleptic if these medications will be duplicate therapy with PST medication.

Nutrition/hydration: As patients near end of life, oral intake decreases as part of a natural progression. Artificial hydration or nutrition is generally not needed, especially if artificial hydration may worsen existing symptoms.

Bowel and bladder: Bowel care medication is usually stopped. Urinary catheterization is considered only if indicated for patient comfort (i.e. palpable bladder distension) and should only be initiated once patient is sedated. (BC Centre for Palliative Care, 2019)

Assessment

A thorough assessment is required to determine if a symptom is difficult or refractory and if PST is appropriate. To ensure that all symptom management and supportive measures have been considered, it is strongly recommended to consult the NH Palliative Care Consultation Team. As a part of the assessment, inquire about and explore the cultural values and beliefs of the patient, their family and their community to help understand decisions made around the dying process. Include a consultation to inter-professional specialists such as social workers, spiritual workers or counsellors if patient has existential or emotional distress.

In Northern Health, we have adopted the Decision Support Tool from the BC Inter-professional Palliative Symptom Management Guidelines, which is a useful tool for documenting that each step has been assessed and considered. It is highly recommended to print this off, review and include in the patient's documentation.

Monitoring

While sedation continues until a patient's death, it is important that ongoing monitoring, reassessment and dose titration is performed. (Pereira, 2016). As part of the documentation, indicate the level of sedation as discussed with

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the patient or SDM. All patients should be monitored for level of sedation, level of comfort or discomfort, and airway patency. Consider using the Richmond Agitation Assessment Scale-palliative version (RASS-PAL) to assist with monitoring sedation level, as well as observing the patient's facial expression and body language. Provide the same supportive care as for an unconscious/unresponsive patient by performing mouth care and positions changes. Frequency of monitoring will depend on the medication chosen for PST.

Ethics

Health care providers have a responsibility to relieve suffering and to do no harm. Consider if the risks of providing PST outweigh the harm of having someone remain in unbearable pain and suffering. Has the patient or the SDM been made aware of the treatment options, had full disclosure on the disease trajectory and is the patient making the choice themselves or, in the case of SDM, based on what the patient would want. These are not unilateral decisions and must include the patient or SDM, health care team, and inter-disciplinary care providers.

Recognize that there may be some degree of personal professional distress that occurs when witnessing suffering of the patient and family/ caregivers. There may be many factors that make the patient's case challenging, including perceived or amplified distress. If there are any uncertainties, The Northern Health Ethics Service may be consulted.

Myths

Review the following common myths around PST and consider how comfortable you are with addressing them:

1. Palliative sedation hastens death.
2. Treating symptoms at end of life and providing symptom relief causes death.
3. Palliative sedation is very common and used on most patients.
4. Providing artificial nutrition and hydration reduces suffering and prolongs life.
5. All medication and support should be stopped when palliative sedation is initiated.
6. There are no guidelines or protocols around palliative sedation.

The impact of providing palliative sedation to patients can be profound. Unrelieved symptom not only effect the suffering and distress of the patient at end of life, but can effect the family, care givers and health care providers involved in care. Ensure clear communication with all staff involved and communicate clearly with the family what palliative sedation involves. Include family in the decision making process to ensure that there is understanding and that any questions or concerns are addressed. These finals moments are what often stay with the family and health care providers long after the patient has passed.

Resources

- NH Palliative Sedation Therapy Policy 1-10-2-140
- Richmond Agitation Scale 10-513-5008
- BC Inter-Professional Palliative Symptom Management Guidelines *-Refractory Symptoms/Palliative Sedation*
  - Appendix A – Decision-Support Tool for Refractory Symptoms, Palliative Sedation Therapy
  - Appendix C – Medication Table
  - Appendix D – Recommendations for patient and family printed material

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Upcoming Palliative Care Education Sessions

The Northern Health Palliative Care Consultation Team is excited to offer a variety of upcoming palliative care education in both in person and online formats. If you are interested or have questions about our upcoming training please e-mail Palliative.Care.Consult.Team@northernhealth.ca.

In Person

Session:	Date:	Time:	Location:	Who can register:
LEAP Mini—Learning Essential Approaches to Palliative Care	September 27, 2022	08:00 to 17:30	Fort St John	Physicians, Pharmacists, Social Workers, RNs & LPNs
Serious Illness Conversation Guide Training	September 28, 2022	13:00 to 16:00	Dawson Creek	All Primary Care Providers
LEAP—Learning Essential Approaches to Palliative Care	November 2 & 3, 2022	08:00 to 16:30	Prince George	Physicians, Pharmacists, Social Workers, RNs & LPNs

Online

Session:	Date:	Time:	Who can register:
ECHO—Basic (Free)	Sessions Monthly beginning in September	12:00 to 13:00	RNs and LPNs
Integrating a Palliative Approach: Essentials for Personal Support Workers	Starting September 23, 2022	Online	Personal Support Workers, Community Health Workers, and Care Aides
Essentials in Hospice and Palliative Care: A Practical Resource for Every Nurse	Start anytime– self-paced	Online	RNs and LPNs