Palliative Sedation

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Host: Diana Vincze, Pallium Canada

Presenter: Kevin Wade, CD, MD, CCFP (PC)

Date: August 9, 2023

Territorial Honouring

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness and their families.

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The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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Project ECHO Palliative Care - Canada BY Pallium Canada

LEAP Core

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Taught by local experts who are experienced palliative care clinicians and educators.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) who provides care for patients with life-threatening and progressive life-limiting illnesses.
- Accredited by the CFPC and Royal College.

Pallium Canada LEAP CORE

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-core

Welcome & Reminders

- For comments, please use the chat function.
- For questions, please use the Q&A function, these questions will be addressed at the end of the session.
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session.

Disclosure

Relationship with Financial Sponsors:

Pallium Canada

- Not-for-profit
- Funded by Health Canada

Disclosure

This program has received financial support from:

- Health Canada in the form of a contribution program.
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration Fees.

Host/ Presenter:

- Diana Vincze: Nothing to disclose.
- Kevin Wade: Chief Medical Officer of Gravitii.care, a startup platform to connect home care patients directly with providers.

Disclosure

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content.

Introductions

Host

Diana Vincze
Palliative Care ECHO Project Manager, Pallium Canada

Support Team

Aliya Mamdeen
Program Delivery Officer, Pallium Canada

Presenter

Kevin Wade, CD, MD, CCFP (PC)
Palliative Care Physician, BC Cancer and Island Health, Victoria, BC
Clinical Assistant Professor, University of British Columbia
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Clinician Considerations for Palliative Sedation

Session Learning Objectives

Upon completing the session, participants will be able to:

- Identify indications for palliative sedation therapy
- Explain the difference between sedation and analgesia
- Explain pharmacotherapy for palliative sedation therapy

Indications

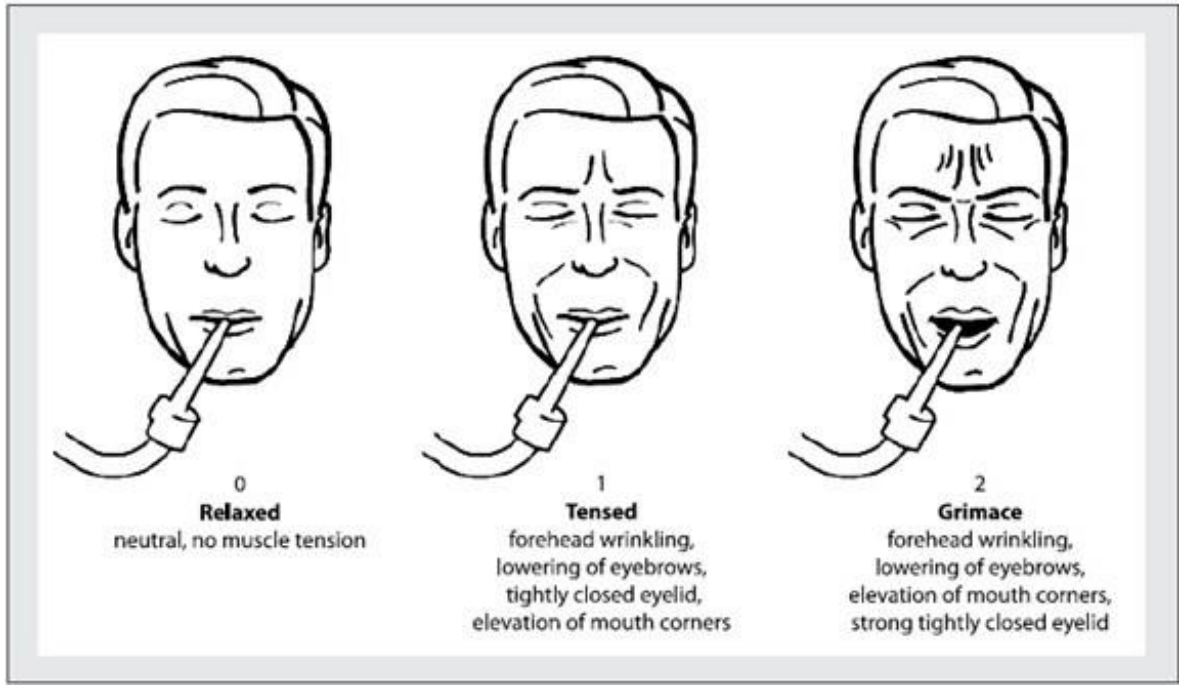
- Patient at end of life
  - Usual prognosis < 1wk, sometimes extended up to 2 wks after careful evaluation.
- Refractory Symptoms
  - Most commonly confusion/delirium.
  - Less commonly pain, dyspnea, nausea, anxiety.
  - “Refractory” after discussion of available therapies and their likelihood of efficacy, with patient or SDM. Possible trial of therapy.
- Setting Capable of handling monitoring and medication administration.
  - Usually inpatient/hospice

Indications – Determining Refractory Symptoms

- Determining whether symptoms are refractory:
  - Always requires discussion with the patient or SDM
  - May require consultation with a subject matter e.g., palliative care physician, anesthesia/pain, internal medicine
  - May require a trial of therapy e.g., typical antipsychotics, CADD pump, epidural

Sedation vs Analgesia

- Quiet does not equal comfortable.
- Consider sedation as an independent factor from other symptom measures.
  - Mostly using RASS-Pal
  - Pasero scale not appropriate
- Manage symptoms as well as possible, even in the sedated patient.



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

Pain Assessment In Advanced Dementia (PAIN-AD) 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*

Pharmacology

- **Neuroleptics**
  - Methotrimeprazine (Nozinan)
  - Haloperidol (Haldol)
- **Benzodiazepines**
  - Midazolam
  - Lorazepam
- **Less common**
  - Barbiturates (e.g., Phenobarbital)
  - Surgical anesthetics (e.g. Propofol, Dexmedetomidine)

Nursing Considerations for Palliative Sedation

Overview of the Palliative Sedation Assessment Tools for Nursing

What to Assess

- Level of Sedation
- Level of Pain (non-communicative)
- Level of Respiratory Distress/Dyspnea
- Integration of Assessment and Decision-Making

Recommended Tool

- RASS-PAL (Richmond Agitation Sedation Scale – Palliative Care)
- PAINAD – Pain Assessment in Advanced Dementia
- RDOS – Respiratory Distress Observation Scale
- Palliative Sedation Monitoring Record with the assessment tools integrated into the record

Level of Sedation

- Tool permits standardized assessment of level of sedation – as ordered goal (target) and maintenance.
- RASS-PAL:
  - Valid and reliable assessment tool for palliative sedation;
  - 10 Point scale:
  - 0 = Alert and Calm
    - +1 to +4 escalates from restless to combative
    - -1 to -5 descends from drowsy to non-rousable
  - Sedation goal is commonly ordered at -3 (Moderate Sedation)
  - No noxious stimuli
  - Procedure is standardized and part of the tool

Level of Pain

- Need a tool that permits standardized assessment of pain in non-communicative patients.
- PAINAD (Pain Assessment in Advanced Dementia) Scale:
  - Score 5 areas of described observational data in a 3 point scale (0 – 1 – 2)
    - Breathing
    - Negative Vocalization
    - Facial Expression
    - Body Language
    - Consolability
- Scoring out of 10: Mild Pain (=1-3); Moderate Pain (=4-6) and Mod-Severe Pain (7-10)

Level of Respiratory Distress/Dyspnea

- Standardized assessment tool for respiratory distress (non-communicative).
- RDOS (Respiratory Distress Observation Scale)
  - Assesses 8 variables in a 3 point scale (0-1-2);
    - Heart Rate/min and Respiratory Rate/min
    - Restlessness (non-purposeful movements
    - Paradoxical breathing
    - Accessory muscle use
    - Grunting at end-expiration
    - Nasal flaring
    - Look of fear (described)
  - RDOS < 3 = respiratory comfort; >3 = respiratory distress, need for palliation.

Clinical Decision Making & Documentation

- Quiet does not = Comfort!
- Clinical Decision Making and Problem Solving:
  - Assess PAINAD, RDOS and RASS-PAL Scores each time patient is restless/appears to be more awake.
  - Treat PAINAD and RDOS scores with opiates first *before* sedating.
  - Reassess PAINAD and RDOS 3-5 minutes later,
    - if still elevated give more opioids;
    - if within normal levels (PAINAD 3 or less; RDOS 3 or less) – give sedation bolus
- Best practice is to use a monitoring record that integrates correct tool use with clinical decision-making and guides decisions re analgesia vs sedation

Q & A

Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- Thank you for your participation!

Thank You

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