Palliative Sedation is the equivalent of a procedure. It is the intentional induction of controlled sedation to relieve severe, refractory symptoms at the end of life and is best performed by a multi-disciplinary palliative care team.

PRIOR TO INITIATING SEDATION

- Assure a peaceful, quiet setting, with a minimum of intrusions for the discussion. Attempt to have the discussion at the bedside, making efforts to ensure that family members and decision makers are present.
- Recognize that palliative sedation is not an emergency procedure. It is a last resort, meant for truly refractory symptoms and should be discussed thoroughly with the patient, family, and health care team until all are comfortable with the decision and process.
- Ensure thorough discussion of proposed treatment plan and expected outcomes with patient (if able), all family members and all medical staff (physicians, nurses, therapists, social workers, chaplains, etc.). Confirm any specific goals that need to be met prior to starting sedation (e.g., visit from distant relative)
- Review plans for use of artificial nutrition/hydration—ensure treatment plan has been discussed (either stopping or continuing) and documented with patient/family and medical team.
- Document informed consent discussion and DNR discussion.
- Review patient/family desire for chaplain/spiritual support.
- Review medication and treatment orders—discontinue orders not contributing to comfort (e.g. vital sign monitoring, blood glucose checks).

STARTING SEDATION

Many drugs have been used to provide effective sedation; there are no controlled trials comparing efficacy. Midazolam, other benzodiazepines, barbiturates and hypnotics all have efficacy as sedatives. Opioids should be continued, along with the sedating drug, to avoid opioid withdrawal and to treat unobserved pain. The following table lists starting doses for the use of sedating drugs including the bolus dose, and a starting continuous infusion (CI) rate; the CI rate can be increased as needed to achieve the desired level of sedation. If signs and symptoms of delirium develop benzodiazepines should be discontinued.*

- Midazolam (subcut,iv) (Versed®) 1-5 mg bolus; 1 mg/hr gtt;
- Lorazepam (subcut,iv) (Ativan®) 2-5 mg bolus; 0.5-1 mg/hr gtt;
- Thiopental (iv) (Pentotha®) 5-7 mg/kg bolus (300mg); then 20-80 mg/hr gtt;
- Pentobarbital (iv) (Nembutal®) 2-3 mg/kg bolus (50-100mg up to 300mg); 1 mg/hr gtt;
- Phenobarbital (iv,subcut) 200 mg bolus (can repeat q10-15 min); then 25 mg/hr gtt;
- Ketamine (iv) (Ketalar®) 0.1-0.2 mg/kg; 1mg/hr may increase to 10mg/hr

*First line therapy for delirium or terminal restlessness is haloperidol (Haldol®) 0.5-4 mg iv bolus every 1-4h
CONTINUED SEDATION

The depth of sedation can vary depending on the symptoms being palliated, and prior discussions with the family regarding goals of treatment are critical. Generally, the infusion is initiated and then titrated to a point where the patient appears to be comfortable. However, open-ended “titrate to comfort” orders are not allowable. See Fast Fact on How to Properly Write Titrate to Comfort Orders. Orders should be written to make further adjustments when necessary to facilitate palliative nursing care. Provide orders for a breakthrough bolus dose every 15 minutes in the amount of 50-100% of the hourly rate.

Reassess the need for a change in the basal rate no more frequently than every 2-3 hours for midazolam and every 6-8 hours for lorazepam; use the number of administered bolus doses as a rough guide when calculating a new basal rate—however, never increase the basal rate by more than 100% at any one time. When increasing the basal rate, always administer a loading dose so as to more rapidly achieve steady-state blood levels.

References: