HPC Consultation Services
Waterloo Wellington

Best Practice:
Standardized Monitoring in Palliative Sedation Therapy

Hospice Palliative Care Tip of the Month April 2018

Use of a standardized tool to assess a patient's level of sedation improves clinician monitoring, communication and documentation in Palliative Sedation Therapy (PST).

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/SQ/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 not aggressive or vigorous	
0	Alert and calm		
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (10 seconds or longer)	Verbal stimulation
-2	Light sedation	Briefly awakens with eye contact to voice (less than 10 seconds)	Verbal stimulation
-3	Moderate sedation	Any movement (eye or body) or eye opening to voice (but no eye contact)	Verbal stimulation
-4	Deep sedation	No response to voice, but any movement (eye or body) or eye opening to stimulation by light touch	Gentle Physical Stimulation
-5	Not rousable	No response to voice or stimulation by light touch	Gentle Physical Stimulation

Procedure for RASS-PAL

1. Observe patient for **20 seconds**. a. Patient is alert, restless, or agitated **for more than 10 seconds**. **Note:** If patient is alert, restless, or agitated for less than 10 seconds and is otherwise drowsy, then score patient according to your assessment for the majority of the observation period.	**Score 0 to +4**
2. If not alert, greet patient, call by name and say "open your eyes and look at me". a. Patient awakens with sustained eye opening and eye contact **(10 seconds or longer)**. b. Patient awakens with eye opening and eye contact, but not sustained **(less than 10 seconds)**. c. Patient has any eye or body movement in response to voice but no eye contact.	 **Score -1** **Score -2** **Score -3**
3. When no response to verbal stimulation, physically stimulate patient by light touch e.g. gently shake shoulder. a. Patient has any eye or body movement to gentle physical stimulation. b. Patient has no response to any stimulation.	 **Score -4** **Score -5**

- The Richmond Agitation-Sedation Scale (RASS) is a simple observational instrument which was developed and validated for the intensive care setting.
- RASS is commonly used and recommended in palliative care settings to assess sedation and distress levels in palliative care patients with lowered consciousness.
- The RASS was adapted to the palliative care context in a recent study, which confirmed the validity and feasibility of the RASS-PAL.
- Unlike the original RASS, the RASS-PAL does not require eliciting a patient's response using painful or startling stimuli, in keeping with the aim of palliative sedation therapy: to administer the lightest sedation necessary for symptom relief.

Sources:

- *Bush SH, Grassau PA, Yarmo MN, Zhang T, Zinkie SJ, Pereira JL: The Richmond Agitation-Sedation Scale modified for palliative care inpatients (RASS-PAL): a pilot study exploring validity and feasibility in clinical practice. BMC Palliative Care 2014, 13:17. 10.1186/1472-684X-13-17*
- *Sessler CN, Gosnell MS, Grap MJ, Brophy GM, O'Neal PV, Keane KA, Tesoro EP, Elswick RK: The Richmond Agitation-Sedation Scale: validity and reliability in adult intensive care unit patients. Am J Respir Crit Care Med. 2002, 166: 1338-1344. 10.1164/rccm.2107138*
- *Waterloo Wellington Interdisciplinary HPC Education Committee; PST Task Force (2015). The Waterloo Wellington Palliative Sedation Therapy Protocol. Canada: Author. Available at http://hpcconnection.ca/wp-content/uploads/2016/10/22916_palliativesedation_protocol_w.pdf*