Waterloo Wellington Palliative Sedation Therapy (PST) Protocol Frequently Asked Questions

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How does a team request an urgent palliative care specialist consultation?

Depending on the sector and organization(s) your patient* is involved with, the avenues for accessing an urgent consultation with a secondary-level palliative care expert may differ.

In any setting, team members may be working alongside colleagues with secondary level palliative care expertise. This is instance, a request could be made to the colleague for a consultation.

- Patients may have palliative care specialist involvement from tertiary care centres (i.e. Regional Cancer program) who the patient's care team may contact.
- Requests for one-time, case-based consultations to determine refractory symptoms can be requested through:
  - the LHIN Home and Community Care for patients in community: *Clinical consultation with a Palliative Care Physician or Nurse Practitioner.* **Link:** https://www.healthcareathome.ca/wp-content/uploads/2022/09/WW-031B-request-for-hospice-pallaitive-care-services.pdf
  - HPC Consultation Services: *Case-based team consultation with a Palliative Care Nurse Consultant.* **Link:** http://hpcconnection.ca/consultation/what-we-do/

How does a team involve an ethicist?

Ethical issues may be brought forward by the patient, the patient's family members and/or members of the team. Consultation with or referral to healthcare professionals in different disciplines may be needed in order to address and/or resolve those issues (i.e. psychology, spiritual care, social work, etc.).

The paths for accessing ethics support vary by sector, organization and team. Some teams will have connections to an ethics committee which may be able to provide support and resources.

The team has questions about artificial hydration and/or artificial nutrition at end of life?

A patient who meets the criteria for palliative sedation therapy is approaching their natural end of life. The patient may or may not have a reduced intake of food and/or fluids. As with any intervention at the end of life, it is important that the patient and/or their substitute decision maker(s), as well as the team have clear information regarding a person's nutritional and hydration needs during the natural dying process, as well as information regarding why therapies like artificial hydration and nutrition may be considered.

What is meant by an appropriate level of sedation?

The appropriate level of sedation required refers to the amount that achieves *continuous* sedation at the lowest dose of medication. For some patient's a deeper level of sedation will be required to *maintain* the patient's sedated state. For other patient's, even light levels of sedation will produce the continually sedated state that reduces their awareness of the refractory symptom(s).

**NOTE: The term "patient" is used to represent a person who is the recipient of care, such as a "resident" or "client" in certain healthcare settings.*

Would we ever adjust the target level of sedation?

Once PST has been initiated, the intention is for the patient to remain sedated for refractory symptom management until their natural end of life. If the initial sedation goal level is insufficient for achieving the patient's continuous sedation, the target sedation level may be adjusted.

The revised PST Protocol recommends administration methods of medication at frequencies that aim to produce a steady state of the sedative medication(s) in the patient's bloodstream. When the target sedation level is achieved and maintained, it is not necessary or recommended to have the team attempt to lighten the patient's target level of sedation at any time.

As the natural dying process proceeds, it is expected that the patient's sedation level will deepen and that the patient will die as a natural consequence of their disease process.

Is there a PST medication order set within the protocol?

The medication orders for palliative sedation therapy are highly dependent upon the individual circumstance of the patient and may be adjusted as a result of the patient's response. Certain organizations or teams may choose to utilize a medication order set to assist with standardizing documentation and communication practices.

What are the differences between consequential sedation and PST?

Despite processes and efforts to minimize or avoid consequential sedation from appropriate symptom management, it does occur in some instances. The outcomes may appear the same: a sedate patient with managed symptoms until their natural end of life. However, it is *essential* to understand how PST differs:

- SYMPTOMS: In consequential sedation, symptoms are managed appropriately by evidence-based symptom management interventions whereas PST may be applied when symptoms are *refractory* despite optimal symptom management.
- TIMING: Consequential sedation from symptom management may occur at a variety of points along a patient's trajectory toward their natural end of life, whereas PST is limited to use in the last days or weeks of life.
- INTENTION: The intention of a symptom management intervention is aimed at effective relief of the symptom which consequently results in sedation whereas PST seeks to reduce conscious awareness of refractory symptoms by inducing and maintaining sedation.

Why are patients only eligible for PST at the end of life?

Sedation eliminates conscious awareness and abilities that require consciousness. The patient who is sedated cannot perform conscious activities such as sensing and responding (i.e. self-repositioning in response to pressure). The sedated patient will independently not eat or drink and may be unable to void or defecate without intervention if they were previously able to.

Reducing a patient's consciousness through sedation impairs their ability to interact with their surroundings, including relating with their loved ones and self-advocacy. A sedated patient's loss of

capacity requires their SDM(s) to direct their on-going healthcare in a manner that respects their goals and wishes.

Is PST an "end of life choice"?

Real and anticipated suffering in advancing life-limiting illness and at the end-of-life is a reality that many patients and their families confront.

PST is refractory symptom management at end of life. Not every patient will experience refractory symptoms at the end of life, therefore PST is not indicated for every patient as they reach the natural end of their life. Only a small number of patients will experience refractory symptoms at the end of life and those patients are appropriate to be considered to receive PST.

Providing on-going assessment and palliation of symptoms and end of life care in a wholistic, team-based fashion supports patients and their families.

Can RPNs be involved in PST?

Caring for a patient during palliative sedation therapy requires a team approach. Teams are required to practice in a manner that follows their organizational policies as well as the practice requirements set out by their Colleges.

For teams that include RPNs, it is necessary to determine if a) the assignment of a patient receiving PST is within scope of the RPN, and b) which elements of PST are within the scope of practice of an RPN. Certain aspects of PST may be restricted from RPN practice due to patient instability, limited availability of an RN to provide support, organizational policy or other factors.

The College of Nurses of Ontario utilizes the Three Factor Framework to support nurses in determining which category of nurse (RN or RPN) to assign a patient to - taking into consideration a variety factors pertaining to the nurse, the client and the environment.

For more detailed guidance please see the CNO's Practice Standard, RN and RPN Practice: The Client, the Nurse & the Environment and refer to your organizational policies.

The protocol asks for more one-on-one nursing care than our setting typically provides to an individual patient. How do we accommodate the increased nursing needs for initiating, titrating of PST and monitoring of the patient receiving PST?

It is essential that health care settings and organizations consider these accommodations proactively, in order to mitigate barriers that would impede the process of PST for an eligible patient.

The revised PST protocol outlines best practices that are supported by evidence, including recommendations regarding the need for nursing assessment and monitoring during initiation and any titration of the sedation.

The need for PST is rare. The duration of PST is short, as it is applied in the last days/weeks for management of refractory symptom(s) until the patient's natural end of life. Therefore, health care settings or organizations can use the evidence-based protocol to advocate for and support short-term increases in nursing, and other healthcare provider, support while a patient is receiving PST.

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