PALLIATIVE SEDATION THERAPY MONITORING RECORD

Main diagnosis ______________________

Other relevant conditions ______________________

Indication to administer palliative sedation ______________________

Date sedation initiated Year ________ Month ________ Day ________ Time ________

Patient Name *(last)* ______________________

(first) ______________________

DOB *(dd / mm / yyyy)* ______________________

PHN ____________ MRC ____________

Account / Visit # ______________________

Date (Day)	Time	**Level of Sedation** RASS-PAL (+4 to -5)	**Level of Pain** PAIN-AD Score (0-10)	**Level of Respiratory Distress** RDOS Score (0-16)	Other observations	**Administration of medication** Opioids, sedatives (lorazepam or midazolam; haloperidol or methotrimeprazine; phenobarbital),	**Continuous (pump) or intermittent infusion**				
							Additional bolus (mg)	Cumulative dose (mg)	Flow (mg / h)	Check pump	Initials

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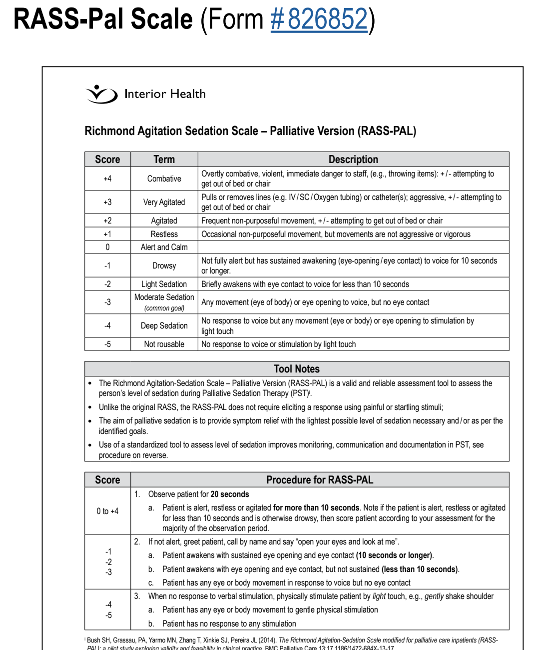
DOB *(dd/mm/yyyy)* ______________________________

PHN ______________ MRC ______________

Account/Visit # ______________________________

Palliative Sedation Assessment and Monitoring Tools should include:

RASS-Pal Scale (Form #826852)



Interior Health

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

Tool Notes

- The Richmond Agitation-Sedation Scale – Palliative Version (RASS-PAL) is a valid and reliable assessment tool to assess the person's level of sedation during Palliative Sedation Therapy (PST)[i].
- Unlike the original RASS, the RASS-PAL does not require eliciting a response using painful or startling stimuli;
- The aim of palliative sedation is to provide symptom relief with the lightest possible level of sedation necessary and/or as per the identified goals.
- Use of a standardized tool to assess level of sedation improves monitoring, communication and documentation in PST, see procedure on reverse.

Score	Procedure for RASS-PAL
0 to +4	1. Observe patient for **20 seconds** a. Patient is alert, restless or agitated **for more than 10 seconds**. Note if the 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.
-1 -2 -3	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
-4 -5	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

[i] Bush SH, Grassau, PA, Yarmo MN, Zhang T, Xinkie SJ, Pereira JL (2014). *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,13:17 1186/1472-684X-13-17.

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PAINAD (Form #810310)

Interior Health

Pain Assessment in Advanced Dementia (PAINAD) 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*

Warden, V., Hurley, A. & Volicer. L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. JAMDA, 4(1), 9 -15.
Horgas, A., & Miller, L. (2008). Pain assessment in people with dementia. American Journal of Nursing, 108(7), 62-70.

810310 Feb 13-19

Respiratory Distress Observation Scale (Form #826853)

Interior Health

Respiratory Distress Observation Scale (RDOS)

Purpose

This tool is to be used for assessing the intensity and distress of patients unable to report dyspnea during monitoring for Palliative Sedation Therapy[1,2,3].

Variable	0 Points	1 Point	2 Points	Sub-Total
Heart rate per min (beats/min = bpm)	< 90 bpm	90–109 bpm	≥110 bpm	
Respiratory rate per minute (auscultated) (breaths/min)	< 19 breaths	9–30 breaths	> 30 breaths	
Restlessness: non-purposeful movements	No	Yes - Occasional, slight movements	Yes - Frequent movements	
Paradoxical breathing pattern: abdomen moves in on inspiration	No		Yes	
Accessory muscle use: rise in clavicle during inspiration	No	Yes - Slight rise	Yes - Pronounced rise	
Grunting at end-expiration: guttural sounds	No		Yes	
Nasal flaring: involuntary movement of nares	No		Yes	
Look of fear: ☐ Eyes wide open ☐ Facial muscles tense ☐ Brow furrowed ☐ Mouth open ☐ Teeth together	No		Yes	
			Total	

Instructions for Use

- Count respiratory and heart rates for one full minute;
- Grunting may be audible with or without auscultation;
- An RDOS score of < 3 indicates respiratory comfort[2];
- An RDOS ≥ 3 signifies respiratory distress and need for palliation[2,3];
- Higher RDOS scores signify a worsening condition[2,3].

References:
1. Campbell, M. L. (2008b). Psychometric testing of a respiratory distress observation scale. J Palliative Care Medicine, 11(1), 48.
2. Campbell, ML and Templin TN. (2015). Intensity cut-points for the Respiratory Distress Observation Scale. Palliat Med. 29(5): 436–442
3. Zhang et al. (2019). Validity, Reliability, and Diagnostic Accuracy of the Respiratory Distress Observation Scale for Assessment of Dyspnea in Adult Palliative Care Patients. J Pain Symptom Manage;57(2):304-310.

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Provincial Palliative Care Consultation Line (physicians and NPs only): **1-877-711-5757**

Nurses, please contact the **Regional Clinical Nurse Specialists** for PEOLC for Palliative Sedation consults: **1-250-354-2883 or 1-250-212-7807**