**Prolonged Time to Death Protocol**

NOTE: These are suggestions. Each clinician must make their own care decisions

1. Indications: For a patient who has completed aid in dying medications orally, and who at any time shows *any* signs of consciousness or response to external stimuli – eyelash reflexes, coughing, grimacing, facial or limb movements, groaning, tachypnea with signs of respiratory distress, or other signs of the patient becoming responsive, related to aid in dying medications wearing off or to poor absorption or effect of aid-in-dying medications.
2. Chart date/time, and “Failure of Medical Aid in Dying” so that self-administration rule no longer applies, and the patient is now receiving palliative care for terminal agitation.
3. Sublingual medications:
	* 1. Titrated to deep sedation but not with the intent of respiratory suppression
			1. Lorazepam 2 to 10mg s.l., q 15-30 min, and/or
			2. Morphine 40 to 120mg s.l., q 15-30 minutes
4. Rectal medications: Place rectal catheter
	* 1. Titrated to deep sedation but not with the intent of respiratory suppression
			1. Lorazepam 2 to 10mg (if tablets, dissolve in 30mls water or juice), q 15-30 min, and/or
			2. Liquid Morphine 40 to 120mg p.r., q 15-30 minutes, and/or
			3. Chloral hydrate: 5-10gm q 5 to 10 minutes (each in about 60cc of water or juice), titrated to deep sedation but not with the intent of respiratory suppression, and/or
			4. Phenobarbital 200 to 1000mg rectally, Q15-30 minutes until deep sedation achieved but not with the intent of respiratory suppression.
5. If the terminal agitation is prolonged (> 4 to 8 hours) and the patient needs continued sedation:
	* 1. Hospice patients: Contact hospice, ask for the RN and/or physician on call, and explain the clinical circumstances. If appropriate, request that they come to see the patient for “palliative sedation” and or continued treatment of terminal agitation.
		2. Non-hospice patients: Contact the aid-in-dying prescribing physician.
6. All of the above should be done with consideration of the “Double Effect,” i.e. you are administering medications with the intent of patient comfort, not to stop respiration and/or heart function.