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**Prolonged Time to Sedation Orally – Protocol**

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

1. Indications: For a patient who has completed oral aid in dying medications but at 20-30 minutes or more has not achieved adequate sedation for comfort (as defined by patient or attending professional), or who is at risk of arrhythmias (from medications, hypoxemia or agitation).
	1. The most common causes of Prolonged Time to Sedate Orally would be lack of absorption of medications and/or high opiate/sedative tolerance.
2. Next steps:
	1. Poor upper GI absorption, patient not opiate/benzo tolerant:
		1. If rectal administration not possible, use sublingual sedation: (titrate to sedation)
			1. Lorazepam 10mg s.l. self-administered q 5 to 10 minutes, to effect, and/or
			2. Morphine 40 to 120mg s.l., self-administered Q 10 minutes to effect.
		2. Rectal sedation: Place rectal catheter. Titrate meds to sedation.
			1. Lorazepam 10mg dissolved in 30mL water, self-administered q 5 minutes, to effect, and/or
			2. Liquid Morphine 40 to 120 mg Q 10 minutes, to effect, and/or
			3. Chloral Hydrate: 10gm doses (each in about 60cc of water or juice), titrate q5-10 min as needed until sedation is adequate, to total of 30gm, and/or
			4. Rectal Phenobarbital: 400 to 1,000mg, titrate to effect.
			5. If patient is still awake/responsive due to poor UGI absorption, strongly consider rectal self-administration of Digitalis 100mg and amitriptyline 4,000 to 8,000 mg.
	2. Opiate/Benzo tolerance:
		1. Phenobarbital, oral or rectal: 400 to 1,000mg, and/or
		2. Place rectal catheter for repeat self-administration and/or sedation
			1. Chloral hydrate self-administered rectally in 10gm doses (each in about 60cc of water or juice), titrate q5-10 min as needed until sedation is adequate, to total of 30gm