instructions and orders to RNs for oral self-administration of medical aid in dying:

Attending/prescribing provider name and contact information:
In case the above provider is unavailable, backup/alternative provider name and contact information:

3-7 days before the planned procedure:

1. Instruct the patient and family on planning and what to expect on the day of the procedure:
    - Constipation or loose stools must be carefully managed, using medications if needed. The goal is to have a formed, easily passed bowel movement every 3-5 days to ensure the aid-in-dying medications are easily absorbed.
    - Any nausea or vomiting also must be thoroughly controlled, ideally with non-sedating medications.
    - Before proceeding, the patient should be tolerating eating at least small amounts for 72 hours.
    - The patient should practice swallowing 2 oz of slightly thick liquids for several days before the procedure to be sure they can easily do so on the day. If it is easier, a straw can be used.
    - Continue all medications, including comfort medications, unless otherwise ordered by the attending provider.
    - On the planned aid-in-dying day, the patient must be sufficiently oriented to communicate to the bedside staff an understanding of their disease, prognosis, and their end-of-life options, including aid-in-dying.
    - The patient should stop eating after midnight the night before the procedure and consume clear liquids only after that.
    - Patients may feel more comfortable wearing an incontinence brief in case of urination but are unlikely to pass stool.
    - Staff will arrive between 10 am and noon to mix the medications and provide bedside support throughout the process.
    - Please have 8 oz of clear filtered apple juice and non-fat popsicles or sorbet on hand.
    - The patient must swallow the medications without assistance, but staff or family can help hold the cup and straw if needed.
    - The 2 oz of liquid medication is bitter and can cause a burning sensation, which can be soothed by a non-fat popsicle or a few teaspoons of non-fat sorbet just before and after swallowing the medications.
    - Sitting upright during swallowing can help prevent coughing, and it is best to remain upright until sedation begins to take effect. Then, the patient can be gently laid down, and the family can come in close for comfort.
    - Typically, the time to sleep or coma is 5-10 minutes, and the time to death is 1 day to 10 minutes.
    - Any discomfort from ingestion passes quickly as sedation begins, and the usual symptoms of the dying process are not uncomfortable for the patient in a coma. The patient's lips may become blue, their face

may become pale, and their jaw may relax. There can be slight stiffening and relaxation of the body and sudden deep breathing, which may stabilize and become shallow for several hours.
    - The staff will stay until the patient is deeply comatose for at least 30 minutes and until the family is sufficiently comfortable.
    - The patient's heart and lungs will slow and gently stop; death can be determined once there is no detectable neck pulse and no breath for over 10 minutes.
    - The triage team will call every 2-3 hours to reassure and offer guidance if needed.
    - A nurse visit can be provided whenever needed, including once the patient has died, for post-mortem care.
2. Prepare, update, and review contingency plans with patients and families in case aid in dying becomes not an option or clinically not advisable.
3. Be sure facility staff are prepared if needed.
4. Inspect the medications, confirm the Rx (DDMAPH, patient's name, and DOB), and put them in the lockbox.
5. Assess GI function: intake, output, symptoms (N/V, bowel sounds, constipation, diarrhea), medications.
6. Assess cognition: orientation, sedating medications, ability to communicate disease, prognosis, and end-of-life options, including aid-in-dying.
7. Assess patient's ability to swallow 60mL (2oz) of slightly thickened liquid.
8. Report assessment findings, the patient's plans and review medications to continue or discontinue before the procedure with the attending provider or their backup.

<u>1 day before the planned procedure:</u>

1. Be sure 8oz clear filtered apple juice and non-fat sorbet or popsicle are on hand.
2. Review what to expect on the day of the procedure. (see above).
3. Review contingency plans in case aid in dying becomes not an option or clinically not advisable.
4. Assess GI function: intake, output, symptoms (N/V, bowel sounds, constipation, diarrhea), medications.
5. Assess cognition: orientation, sedating medications, ability to communicate disease, prognosis, and end-of-life options, including aid-in-dying.
6. Assess patient's ability to swallow 60mL (2oz) of slightly thickened liquid
7. Review NPO instructions and medications to continue or discontinue
8. Report assessment findings, the patient's plans and review medications to continue or discontinue before the procedure with the attending provider or their backup.
    - Do not proceed with oral aid in dying if
        - any uncontrolled N/V
        - indications of bowel obstruction or gastroparesis
            - not tolerating PO for 72hrs, no bowel sounds + no BM in over 5 days
        - The patient cannot easily swallow 2 oz
        - The patient appears not to have capacity
            - Cannot communicate about disease, prognosis, and end-of-life options, including aid-in-dying.

<u>The day of the planned death, upon arrival</u> :

1. Assess/verbally confirm - patient's swallow, sufficiently orientation to proceed, no N/V, maintained NPO/clear liquids only after midnight.
2. Instruct the patient and family on what to expect during the procedure (see above)

3. Prepare medications: pour 2 oz clear filtered apple juice into the medication bottle. Cap, shake, and bring to the bedside along with a cup and straw if needed.

During self-administration

1. Sit the patient upright in or on the edge of the bed.
2. Shake the capped bottle vigorously for 30 seconds. Uncap and decant the liquid medications carefully into the cup.
3. Give the patient the cup (and straw if needed) and support if required.
4. Instruct the patient that they may proceed.
5. Once the patient has swallowed the medications, put the cup in a safe location, away from others.
6. Note the time of ingestion and the time of sedation.
7. Once sedation has begun, lay the patient down and encourage the family to come in close for comfort.
8. Support family and normalize Sx/Sy of the dying process.
9. Once the patient has been unconscious for at least 30 minutes and the family is comfortable, the RN may clean up and depart.
10. Carefully rinse the cup and medication bottle. Remove the label from the bottle, dispose of this and all potentially contaminated materials in a plastic bag, and bring this to the outside bin.
11. Instruct the family that triage will call every 2-3 hrs and to call hospice once the patient has died (no neck pulse and no breath over 10 minutes) or any time they need support.

Name, Date, and Signature of ordering the attending prescriber or backup alternative:

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