



Snoqualmie Valley Hospital End-of-Life Care

Policy

Med-Surg

11743

Official (Rev: 0)

Scope:

All those involved caring for patients in the hours/days approaching the anticipated end of life.

Purpose:

To clarify priorities

Statement:

While maximizing a patient's comfort is a priority at all times in the course of care, when patients are rapidly approaching the end of life with death anticipated to come in the next few hours or days the overall focus is prioritized to their comfort and symptom management. This includes an expanded tolerance for medication side effects such as sedation or respiratory depression and an abandonment of goals for recovery. The patient's (or their surrogate's) declaration of value will hold the greatest influence upon which interventions are added, continued, discontinued, or avoided.

I. Definitions

- A. "Palliative Care": Symptom management for a terminal/non-curable illness, treatment for disease control may be aggressively occurring but without goal of cure. Life expectancy is measured in years.
- B. "Hospice Care": This term should be limited to referring to care provided as part of a formal Hospice program. As a Critical Access Hospital we are not eligible to participate in providing this Medicare benefit while also providing Swing bed services (both are Medicare part B services and only one can be utilized at a time). Our use of the term should only be used as a transition of care recommended upon discharge and should not be used to describe the care provided by us.
- C. "Comfort Care": this term is to be AVOIDED at SVH. Regardless of a patient's status we are always considerate of their comfort.
- D. "End of Life Care" **PREFERRED LANGUAGE** This phrase will be used to indicate we are managing the active dying process with a focus on symptom management. While maximizing a patient's comfort is a priority at all times in the course of care, when patients are rapidly approaching the end of life with death anticipated to come in the next few hours or days the overall focus is prioritized to their comfort and symptom management. This includes an expanded tolerance for medication side effects such as sedation or respiratory depression and an abandonment of goals for recovery. The patient's (or their surrogate's) declaration of value will hold the greatest influence upon which interventions are added, continued, discontinued, or avoided.

II. Hospitalist Role

- A. Discuss with patient/surrogate decision maker/family that imminent death is approaching. Explore with them their definitions of quality in these final hours/days. Do not presume what their preferences will be; many will prioritize avoiding the side effects of medications to preserve the ability to communicate with loved ones at the expense of experiencing physical symptoms. Others will direct instead for all symptoms to be maximally managed despite side effects such as sedation or respiratory suppression.
 1. The priority of decision makers is as always: patient then surrogate decision maker/DPOA for Healthcare then next of kin (if no surrogate decision maker/DPOA has been identified). The patient can declare their surrogate decision maker even if DPOA for Healthcare is not formally documented.
 2. There are instances where the requests of the family or surrogate decision maker are medically futile and are not in the patient's best interest; in this scenario it is appropriate for the physician to declare the medical futility and enact treatments that maintain patient

dignity and adhere to what is known about how the patient would speak for themselves if they were able in regard to symptom management.

3. SVH does not participate in physician assisted suicide. Should this be a request the provider is obligated to comply with current state regulations in regard to confirming patient eligibility then arrange for transfer to a facility or a home-based environment that can meet the patient's request. The local Hemlock Society is often a helpful resource for these facilities or home-services.

B. Decisions regarding medications, artificial fluid and nutrition, and other treatments will be made by the hospitalist on a case by case basis

1. Some medications on the current profile may be continued due to the likelihood of adding to the patient's burden of suffering if they are removed (e.g. rate control medications for atrial fibrillation)
2. Many medications in the current profile will likely be discontinued since they are intended for prevention (e.g. lipid lowering medications) or are a risk with the anticipated decreased intake of food and fluids in the coming hours/days (e.g. diabetes medications)
3. Guidelines for intervention will also need to be adjusted--for example, adjust sliding scale insulin to apply only with profound blood sugar elevations, when/if naloxone will be administered, etc.
4. Scheduled future radiographs and recurring lab testing should be discontinued in most circumstances
5. There is no evidence that hydration during this phase has any benefits and the insertion of intravenous catheters has an associated element of pain. If the patient/surrogate decision makers are unable to reconcile to not delivering artificial hydration can give consideration to hypodermoclysis.
6. There is clear evidence that artificial nutrition during this final phase of life is not helpful and is often harmful.
7. It is imperative to document medical decision making conversations with the family in adequate detail to position all care team members to understand how to proceed in their role

III. Nursing staff role

- A. Support the focus of symptom management consistent with and respectful of the patient/surrogate decision makers requests
- B. Assessments: full shift assessments should continue to be completed in order to identify any issues developing that need to be addressed to prevent additional symptom burden. Post intervention assessments are of great importance during end-of-life care to assure symptoms are being effectively managed (rapid escalation of symptom management medication doses and intervals are often required in this phase--communicate to hospitalist if symptom management incomplete for order adjustment)
- C. Care Plans should be adjusted to reflect new goals of care
- D. Standard safety measures such as Bar-Code Medication Administration and skin protection should continue.
- E. Vital signs frequency can and should be minimized or even discontinued. The hospitalist will place an order either discontinuing vital sign collection or specifying the reduced frequency that fits the situation. This does not apply to pain scale measurements which should continue to be recorded on a regular frequency of at least once per shift.
- F. Personal care should be guided by the patient's wishes.
- G. Blood sugar checks continuation/discontinuation/frequency will be decided by the Hospitalist on a case by case basis.
- H. Maintaining attention to bowel and bladder function important for preventing unnecessary patient discomfort.
- I. Advocate for the discontinuation of any interventions that appears to have lost its value or is contributing to patient discomfort or distress.

J. Be observant for demonstration of emotional or spiritual needs; contact Social Work should these be observed so they can assist in addressing.

References

Reference Type	Title	Notes
Signed by	<i>Kim Witkop</i>	
	Kim Witkop, Chief Medical Officer (09/07/2018 03:44PM PST)	
	<i>Tom Parker</i>	
	Tom Parker, CEO (09/07/2018 03:59PM PST)	
Effective	<i>Heide Gerber</i>	
	Heide Gerber, Med-Surg Nurse Manager (09/07/2018 04:25PM PST)	
Original Effective Date	<i>Rachel Weber</i>	
	Rachel Weber, ED/Med-Surg Nursing Director (09/07/2018 05:05PM PST)	
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	09/07/2018	
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