Policy Name: CARE AT THE END OF LIFE Department: Hospital-Wide	Policy No.: PC 5.0 Page No.: 1 of 3
Effective Date: 7/98	APPROVALS: Print Name & Title: Scott Puhalla, Dir. ED Signature & Date:
This Replaces: TX 6	Print Name & Title: Paul Sunderland, MD, Med.Dir., ED Signature & Date:
Review Dates/Signature: 6/01, 6/06; 4/11am	Print Name & Title: Becky Means, CNO Signature & Date:
Revised Dates/Signature: 6/06; 7/13kb	Print Name & Title: Kathleen Boswell, CQO Signature & Date:
Retired:	Print Name & Title: Alirez Bozorgmanesh, MD Signature & Date:
Related Policies:	Print Name & Title: Signature & Date:

SCOPE:
All patient-care personnel.

PURPOSE:
The goal of respectful, responsive care of the dying patient is to optimize the patient's comfort and dignity by providing appropriate treatment for primary and secondary symptoms as desired by the patient or surrogate decision maker, responding to the psychosocial, emotional and spiritual concerns of the patient and family and managing the patient's pain, if present, aggressively.

POLICY:
It is the policy of Capital Medical Center (CMC) that all patients receive the same standard of care regardless of their diagnoses. It is also recognized that some of the patient populations may require unique attention. Therefore, all staff at CMC are sensitized to the needs of the dying patient and his/her spouse, parent, children, healthcare surrogate, proxy or significant other.

Note: Within the context of this policy, the term "patient" is defined as "patient, spouse, children, parent, healthcare surrogate, proxy, or significant other who can speak on behalf of the patient's perspective.

PROCEDURE:
I) The plan of care for the dying patient includes input from the patient, depending on the patient's mental status and preferences.

II) The decision as to how aggressively to treat primary and/or secondary symptoms is made in collaboration with the physician, patient, and significant others.

III) When pain is present in the terminally ill patient, it is managed aggressively. Nursing assesses the patient's pain and response to medication/treatments according to policy and procedure. Nursing contacts the patient's physician whenever the patient's pain is not responding to ordered medications or treatments and requests new orders.

IV) A Case Management referral is made if the case manager has not yet screened the patient.

V) Discussion of Advanced Directives occurs upon admission. When a person requests further information, , Case Management, Nursing Managers or Nursing Supervisors may be contacted. Advance Directives documented according to CMC policy and procedure.

VI) Visiting hours for the spouse, parent, children, healthcare surrogate, proxy and/or significant other are expanded when possible and an attempt is made to provide accommodations so that others may remain with the patient during the night.

VII) The patient is asked about his/her religious affiliation upon admission and asked if they want clergy visitation. When a patient's condition has been assessed to be critical or terminal, clergy services should be offered to provide emotional, psychosocial, or spiritual support for the patients and others.

VIII) A direct order from the physician is required for Hospice referral. When a request is made for Hospice referral, the nurse or case manager acts as liaison and requests an order from the physician if not already obtained.

IX) When a physician order for Hospice is received, Hospice is contacted and referral made for consultation.

X) If the patient agrees to hospice care, Hospice staff will work closely with hospital staff to coordinate discharge to an alternate level of care.

XI) If hospice services are not initiated, hospital staff works closely with the patient and physician to coordinate patient's care, including ensuring accommodations for their physical, psychosocial, emotional, and spiritual needs.

ADDENDUM:

Addendum 1: Standards of Care: The Dying Patient/Family

STANDARDS OF CARE
THE DYING PATIENT/FAMILY

Nursing Dx Concern	Spiritual Distress: related to hospitalization & physical condition	Coping Ineffective: related to fear, anxiety & loss of control	Alteration in Comfort: R/T to physical & psychological pain	Knowledge Deficit: related to Dx, prognosis & treatment choices	Grieving: related to loss of family member	
Interventions	• Contact religious representative if desired. • Encourage family to bring in symbolic items. • Provide privacy & quiet. • Allow cultural/religious ceremony (pt's own belief) if not infringing on safety or rights of others. • Contact case coordinator to assess family needs for community resources.	• Assess prior coping/ problem solving abilities. • Assess emotional state associated with dying process. • Encourage verbalization of feelings. • Provide relaxed, quiet environment. • Encourage participative problem solving	• Assess location, intensity & nature of pain. • Assess prior pain management techniques. • Reposition, turn & support to improve comfort. • Utilize relaxation visual imagery, focus breathing & touch. • Apply heat & cold as effective. • Medicate as ordered.	• Explore patient/family understanding of Dx & wishes of • Assist patient/family to examine preferences: • Code status • Advance directives • Organ donation • Initiate referrals: • Pastoral care • NOPA • Financial counselor • Social services • Plan time for questions.	• Assist family with closure. • Provide time for family to be with patient after death. • Assist family with notification of others. • Assist family with funeral arrangements. • Provide medical support as needed. • Encourage use of support systems (community/religious groups)	
Outcomes	The patient/family will: • Continue spiritual practices not detrimental to health. • Express satisfaction with spiritual condition.	Patient/family will: • Verbalize feelings of fear, loss, anxiety. • Be calm, comfortable. • Make decisions and family will be accepting of patient choices.	The patient will: • Receive validation that pain exists. • Relate improvements of pain and an increase in self-care activities. • Family will verbalize feelings regarding patients comfort.	The patient/family will: • Exhibit/demonstrate less anxiety, fear related to the unknown. • Describe disease process and procedures for symptom control.	The family will verbalize feelings of loss. • After care arrangements will be in place • Family will recognize support systems.	
Initiated Initial/Date						
Resolved Initial/Date						
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