SUBJECT: **End of Life Decisions and Care**

OBJECTIVE: To establish processes for patients and their families facing life-threatening illness including caring for the dying and supporting the bereaving.

Policy: Pullman Regional Hospital will respect and participate in each individual patient's end of life decisions including palliative care and /or requests for life ending measure followed in compliance with the Washington Death with Dignity Act / Initiative 1000.

Definition:

Hospice Care: Service delivery system that provides care for patients who have six months or less to live. It supports patients through the dying process and the surviving family through the dying and bereavement processes.

Palliative Care: "Is an approach to care which improves quality of life of patients and their families facing life – threatening illness, through the prevention, assessment and treatment of pain and other physical, psychological and spiritual problems." World Health Organization Focus of palliative care is relieving suffering and enhancing quality of life as follows:

I. Providing effective pain and symptom management
II. Addressing psychosocial and spiritual needs of the patient and family
III. Incorporating cultural values and attitudes into the plan of care
IV. Supporting those who are experiencing loss, grief, and bereavement
V. Promoting ethical and legal decision-making
VI. Advocating for personal wishes and preferences
VII. Using therapeutic communication skills
VIII. Facilitating collaborative practice

Washington Death with Dignity Act / Initiative 1000:

Allows competent, terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. To receive life-ending medication a person must meet the following criteria:

I. A Washington resident
II. A competent adult (18 years or older)
III. Is diagnosed with a terminal illness
IV. Is medically predicted to die within six months; and ,
V. Is able to take the medication by him or herself, without help

Quality of Life Team (QOL):

A hospital interdisciplinary team available as a consulting body for education, review, and guidance for patient's whose care goals have shifted from cure to comfort when identified as a need by any healthcare team member, patient or family member. The team will also be involved with hospitalized patients who have decided to take life ending medication in accordance to the law.

Process for Utilization:

Hospice Care:

Hospice consults can be referred by Social Services as requested.

Palliative Care:

Palliative care can be started at any time by any physician when appropriate. It does not inhibit care but instead increases options for comfort.

Initiative 1000 Utilization: See Board of Commissioner's policy I-1 "Initiative I-1000".

Quality of Life Team (QOL) Utilization:

1. The QOL team will consist of members from Nursing, Social Services, Respiratory Therapy, Speech Therapy (swallow issues), Pharmacy and Physician Services, chaplains, Utilization Review nurse and behavior health involvement as necessary for individual cases.
2. If a healthcare team member feels a patients' comfort level is not at goal, the family could benefit with assistance from the QOL team or a pharmacy consult. A quality-of-life call can be initiated through Meditech. If more urgent concerns arise, the following persons are also available on-call:
   Katie Evermann-Druffel 509-432-3465
   Laure Larsen 208-305-7030
   Renee Heimbigner 509-432-1728 (or Pharmacist on call: ##91)
   Joan Hendrickson 509-595-5986
3. The QOL team will meet with the referring individual to hear concerns / issues and possible needs. The team will then review the chart and orders and will make decisions on next steps for each individual case using the palliative care approach and involving other team members as necessary.
4. The Ethics Committee will be convened for recommendations and consultation as needed.
5. Documentation of the consult will be made in patient notes, titled QOL consult.
6. The team will then follow-up and monitor the patient's care until discharge.

Medical Director of Intensive Care

President of Medical Staff

Chief Clinical Officer

References:

Caring Connections. www.caringinfo.org
Compassion & Choices in Dying. www.condcofwa.org
National Hospice and Palliative Care Organization. www.nhpco.org
Pullman Regional Hospital Board of Commissioners Policy & Procedures # I-1, *Initiative I-1000 Pullman Regional Hospital's role.*
Washington State Department of Health. www.doh.wa.gov/dwda
Washington State Hospice & Palliative Care Organization. www.wshpco.org/iondex.cfm
Washington State Hospital Association and The Association of Washington Public Hospital Districts. (2003). *End of life care manual: a program guide for Washington hospitals.* http://www.awphd.org/EndOfLife/manual/index.asp.
Washington State Hospital Association. www.wsha.org
Washington State Medical Association. www.wsma.org

Effective: 3/03 LML
Reviewed: 5/14 JE:bmc
Revised: 5/15 RLH:bmc

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Appendix A:

Instructions and Guidelines for End-of-Life Order:

1. Prior to initiating End-of-Life orders, the following should be completed:
   - DNR orders
   - Family conference: Document rationale for End-of-Life and discussion with patient and / or family / surrogate decision maker. Family member / surrogate decision maker must be named and relationship noted within progress note. If a patient does not have family or a designated decision maker, note that situation in progress note.

2. **GOAL of treatment**:
   End-of-Life orders are intended for use in end of life care when decisions have been made to withhold or withdraw life-sustaining treatment and not to resuscitate. End-of-Life continues to be an active treatment plan with an obligation to provide medical care designed to relieve pain or discomfort. It is not implemented to hasten death. The goals of End-of-Life are to optimize comfort and dignity by providing care that is respectful, involves the patient and family, has appropriate treatment for primary and secondary symptoms as desired by the patient or surrogate decision to maker, manages pain aggressively, responds to psychological, social, emotional, and spiritual concerns of the patient and family, sensitively addressed end of life issues such as autopsy and organ donation, and is culturally relevant.

   Prior to implementation, each intervention should be assessed in the following areas:
   - What is the goal of the intervention?
   - Does the intervention agree with the patient and/or families wishes?
   - Does the intervention enhance the patient's quality of life and provide comfort?
   - Has the patient and/or family been informed as to the risks and benefits of the interventions?

3. Palliative Prognostic Score: http://palliative.info/teaching_material/Prognosis.pdf

4. End-of-Life orders can be entered into the computer as soon as appropriate as the patient's situation changes and decisions are made by the patient and family.

5. If it becomes apparent that a patient may pass here in the hospital, an end-of-life care bag with literature and a blanket should be offered to the patient and their family when appropriate.

6. Food trays may be offered to the family when appropriate.

7. It may be necessary to have more than one conference as the patient's clinical situation changes, to ensure the patient and family goals are being met.

8. Clinical conversations should be had directly with the power-of-attorney and patient when at all possible.

9. If a patient's comfort level is ever "uncontrolled" and the primary physician cannot be reached or the goals have not been met, please call the Quality of Life Team or the Pharmacist on call as appropriate to the situation for assistance in finding an appropriate treatment for comfort.

Reference:
ELNEC SuperCore Curriculum. (October, 2008).
Mercadante, S., Intravaia, I., Villari, P., Ferrera, P., David, F., & Casuccio, A. (2009, May). Controlled sedation for refractory symptoms in dying patients. *J Pain Symptom Manage, 37*(5).
University of Washington Harborview Medical Center. *Withdrawal of life sustaining measure the ICU/ acute care comfort orders.*

Patient Care # E-5
Revised: 1/15 RLH:bmc

Ventilator Withdrawal Guidelines

Preparation:

1. **Family Meeting:** Review decision to withdraw life-sustaining treatment
   - If the patient is conscious, what are his or her desires about the procedure?
   - Does the family want to be present for the withdrawal?
   - Do they want to see the patient after death?
   - Consider special readings, rituals, prayers, or music before, during or after withdrawal of the vent.
   - Advise the family on the possibility of prolonged survival after withdrawal of vent.
   - Consider discussing in advance decisions that will be faced after death, such as tissue, organ, or body donation, autopsy, and funeral arrangements.
   - Establish a time for withdrawal with the family and appropriate staff can be present.
2. **Clinical Team Meeting**: include physician, primary nurse, quality of life member, respiratory therapist, chaplain, social services, pharmacy, clinical coordinator.
   - Review current life sustaining treatments and which should be withdrawn – discontinue all previous orders including routine vitals, medications, enteral feeding, IV drips, radiographs, lab tests, whatever is causing the patient discomfort (i.e., turning); remove devices from patient and the room.
3. **Symptom Management** – enter orders for management of distressing symptoms and signs, such as agitation, air hunger, and noisy secretions (see End-of-Life and withdrawing life sustaining treatment order sets)

Withdrawal Procedure:

1. **Create Peaceful Surroundings**
   - Remove unnecessary equipment, creating bedside space for the family.
   - Provide tissues and comfortable chairs.
   - Remove mitts and poseys, lower bedrails, and set bed height to facilitate family-patient touching or handholding.
   - Discontinue monitors and alarms in the room, including but not limited to: oximeters, vital sign monitor, ECG recording, unneeded pumps, and respirator alarms.
   - Discontinue inappropriate television or radio distractions.
2. **Gather Family**
   - If they stay in the room, review the process of what they might see
   - Allow time for any rituals and for saying a final goodbye
   - Address particular needs of young children
   - Social worker, nurse, or chaplain may stay with the family by the bedside or in the waiting room
   - Check family perception of the level of patient comfort, and address appropriately to incorporate their wishes about sedation and analgesia.
3. **Determine if premedication is necessary:**
   - if the patient is capable of experiencing distress or if distress is likely during the withdrawal procedure, continue current analgesia and sedation regimen, and ***premedicate with opioids and benzodiazepine*** via bolus or infusion.
   - Even if the patient appears comfortable when undisturbed, ***anticipatory dosing*** is appropriate if he or she has shown signs of distress during nursing or respiratory care interventions. For example, a comfortable appearing patient may have experienced grimacing or distress with prior suctions, repositioning, or reduction in ventilator support, and would be expected to experience

distress with withdrawal of ventilatory support.

4. During the withdrawal process, use suctioning as needed, monitor the patient's comfort frequently, and **titrate medications for any signs of distress**, such as tachypnea, labored breathing, accessory muscle use, nasal flaring, tachycardia, hypertension, diaphoresis, grimacing, restlessness, and excess or noisy secretions. The **combination** of an opioid plus benzodiazepine is indicated because narcotics provide relief of dyspnea and pain, while suppressing cough, whereas benzodiazepines provide sedation, and anxiolysis. Benzodiazepines also offer anticonvulsant effects that may protect from hypoxemia-related seizures. Fentanyl is often preferred due to staff familiarity with the drug, while morphine is more likely to lead to toxicity (typically myoclonus) at high doses, especially with renal failure.

Ventilator Withdrawal:

1. Assure discontinuance of neuromuscular blockade (which would mask distress).
2. Is pre-sedation necessary? Target SAS < 2 (deep sedation).
3. Different methods of discontinuation: may be chosen on the basis of patient's clinic condition and family's preference:
   - **Rapid Reduction** – dialing down the ventilator settings stepwise for Fi02, PEEP, respiratory rate and volume or pressure every few minutes, watching for distress or
   - **Immediate Cessation of ventilator support** – immediate discontinuation of mechanical ventilation
   - **Endotracheal tube** – immediate or eventual extubation. Removal of the ET tube can be associated with severe coughing and messy secretions, but the tube can be a source of distress in conscious patients and prevent talking, while the ventilator may hinder family from gathering around the bed and touching the patient. Maintaining the airway protects against stridor and difficulty with copious secretions, especially when the patient lacks adequate gag or cough reflex.
   - If the patient experiences discomfort during any of the following reductions in ventilation, resume higher settings and adjust the medication for comfort prior to further ventilator changes.
   - Reduce alarm settings to minimal settings or, if possible, turn them off
   - Over 0-5 minutes, reduce FiO2 to room air and PEEP to zero.
   - You may want to wait a while at this point, expecting the patient to expire, or you can proceed over 0-15 minutes to reduce the respiratory rate and tidal volume or target pressure on the ventilator to zero.
   - Concerning the airway:
     - Extubate patient to room air, wrapping the ET tube (which may be messy) in a towel, or
     - Remove connection to the ventilator, keeping the ETT or tracheostomy in place.
   - If tracheal secretions are bothersome, an in-line suction catheter can be attached to the ETT without supplemental O2 or humidity.
   - Note the time of death, when it occurs.

After the Death

- Allow family and staff to be with patient
- Allow family to help with postmortem care, if they choose so.
- Assess family member's state of grief and ability to travel.
- Notify involved staff and allow time for health care team to debrief.

Notes on Discussing Withdrawal with Patient and / or Family

1. Describe the process. Use simple language and allow for questions
2. Pause periodically and leave time to listen to family members' concerns and / or reminiscences

3. Assure them that achieving comfort is the goal and can be managed
4. Determine in advance a reasonable level of sedation desired by the patient and family (conscious but calm, light sleep, heavily sedated).
5. Explain that breathing changes will occur, but that breathlessness can be alleviated. If the patient is capable of feeling discomfort, medications will be given to avoid the sensations of breathlessness, pain and / or anxiety
6. If a well-sedated or comatose patient shows gasping, twitching or other involuntary movements, reassure the family that such actions do not reflect conscious suffering
7. Encourage the family to engage in cultural or spiritual practices befitting of the patient's life and traditions.
8. Caution the family that, while death is expected, the timing of it is uncertain.
   "After life support machines are withdrawn, we will watch and wait as we continue to focus on comfort while letting nature take its course."

Reference:
http://www.aacn.org/WD/Palliative/Docs/mgh8.pdfeference: 6/14/11 "Ventilator Withdrawal Guideline." Pg 1-6.

Patient Care # E-5
Revised: 5/15 RLH:bmc

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial

Date of Birth ___ ___ ___ Last 4 #SSN ___ ___ ___ ___ Gender M F

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST form is always voluntary. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A Check One — Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

☐ CPR/Attempt Resuscitation ☐ DNAR/Do Not Attempt Resuscitation (Allow Natural Death)

Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.

B Check One — Medical Interventions: Person has pulse and/or is breathing.

☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS contact medical control to determine if transport indicated to provide adequate comfort.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*

Additional Orders: (e.g. dialysis, etc.) _____

C Signatures: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Guardian with Health Care Authority ☐ Spouse/Other as authorized by RCW 7.70.065 ☐ Health Care Agent (DPOAHC)	PRINT — Physician/ARNP/PA-C Name	Phone Number
	✗ Physician/ARNP/PA-C Signature ***(mandatory)***	Date ***(mandatory)***
PRINT — Patient or Legal Surrogate Name		Phone Number
✗ Patient or Legal Surrogate Signature ***(mandatory)***		Date ***(mandatory)***

Person has: ☐ Health Care Directive (living will) ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 4/2014

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

Washington State Medical Association WSMA Physician Driven Patient Focused

Washington State Department of Health

See back of form for non-emergency preferences ▶

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Other Contact Information (Optional)

Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number	
Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

D NON-EMERGENCY MEDICAL TREATMENT PREFERENCES

ANTIBIOTICS:

☐ No antibiotics. Use other measures to relieve symptoms. ☐ Use antibiotics if life can be prolonged.
☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal.

MEDICALLY ASSISTED NUTRITION:

Always offer food and liquids by mouth if feasible.

☐ No medically assisted nutrition by tube.
☐ Trial period of medically assisted nutrition by tube. (Goal: _____)
☐ Long-term medically assisted nutrition by tube.

ADDITIONAL ORDERS: (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

X Physician/ARNP/PA-C Signature	Date
X Patient or Legal Surrogate Signature	Date

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

Completing POLST

- The POLST is usually for persons with serious illness or frailty.
- Completing a POLST form is always voluntary.
- The POLST must be completed by a health care provider based on the patient's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTION A:
- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."

SECTION B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."

SECTION D:
- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:
(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

A competent adult, or the surrogate of a person who is not competent, can void the form and request alternative treatment.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

OVER ▶