DEATH WITH DIGNITY ACT/INITIATIVE 1000 - HOSPITAL AND ITS PROVIDERS WILL NOT PARTICIPATE

Policy:

A. 1. Washington law recognizes certain rights and responsibilities of qualified patients and health care providers under the Death with Dignity Act ("Act"). Under Washington law, a health care provider, including Okanogan County Public Hospital District dba Mid-Valley Hospital is not required to assist a qualified patient in ending that patient’s life.

2. Mid-Valley Hospital has chosen to not participate under the Death with Dignity Act. This means that in the performance of their duties, Mid-Valley Hospital physicians, employees, independent contractors and volunteers shall not assist a patient in ending the patient’s life under the Act. In addition, no provider may participate on the premises of the hospital or in property owned by the hospital.

3. No patient will be denied other medical care or treatment because of the patient’s participation under the Act. The patient will be treated in the same manner as all other Mid-Valley Hospital patients. The appropriate standard of care will be followed.

4. Any patient wishing to receive life-ending medication while a patient at this hospital will be assisted in transfer to another facility of the patient’s choice. The transfer will assure continuity of care.

5. All providers at Mid-Valley Hospital are expected to respond to any patient’s query about life-ending medication with openness and compassion. Mid-Valley Hospital believes our providers have an obligation to openly discuss the patient’s concerns, unmet needs, feelings, and desires about the dying process. Providers should seek to learn the meaning behind the patient’s questions and help the patient understand the range of available options, including but not limited to comfort care, hospice care, and pain control. Ultimately, Mid-Valley Hospital’s goal is to help patients make informed decisions about end-of-life care.

Scope:

Medical Staff
Responsibilities:

Health care providers educate patients on end-of-life options; advice patients that MVH does not participate in the Act; and transfer care as requested. Administration shall advise public and update educational material as necessary.

Procedure:

A. 1. Educational materials about end-of-life options will be provided to patients if requested. An informational brochure on the Act will be made available in patient waiting areas. These materials will include a statement that Mid-Valley Hospital does not participate in the Act.

2. If, as a result of learning of Mid-Valley Hospital’s decision not to participate in the Act, the patient wishes to have care transferred to another hospital of the patient’s choice, Mid-Valley Hospital staff will assist in making arrangements for the transfer. If the patient wishes to remain at Mid-Valley Hospital, staff will discuss what end of life care will be provided consistent with hospital policy.

3. If a patient requests a referral to a physician who will fully participate under the Act or expresses the desire to take medication that will result in the patient’s death, the provider may choose to provide the patient with a referral, or may instruct the patient that he or she must find a participating provider on his or her own. The relevant medical records will be transferred to the physician taking over the patient’s care. The patient’s primary clinical care giver (nurse or social worker) will be responsible for:

   a. Informing the patient’s attending physician as soon as possible, and no longer than one working day, that the patient wishes to take life-ending medications.

   b. Ensuring that the medical record is complete and all required documentation is included. A copy of the Resuscitation Status (DNR) order, copies of advance directives, and POLST form are to be included.

   c. Communicating with other clinicians involved with the patient to ensure continuity of care.

   d. Documenting all communication in the patient’s medical record.

B. Nothing in this policy prevents a physician or provider from making an initial determination that the patient has a terminal disease and informing the patient of the medical prognosis.

C. Nothing in this policy prevents a physician or provider from providing information about the “Washington State Death with Dignity Act” to a patient when the patient requests information.

D. Nothing in this policy prohibits a physician who is employed by or who is an independent contractor of Mid-Valley Hospital from participating under the Act when not functioning within the scope of his or her capacity as an employee or independent contractor of Mid-Valley Hospital.

SANCTIONS

If a provider participates in the Act beyond what is allowed in the policy, Mid-Valley Hospital may impose sanctions on that provider. Mid-Valley Hospital shall follow due process procedures provided for in the medical staff bylaws. Sanctions may include:

- Loss of medical staff privileges;
- Loss of membership;
- Restriction from provider panel;
- Termination of lease or other property contract; and/or
- Termination of contracts;
PUBLIC NOTICE

Mid-Valley Hospital will provide public notice of this policy in the following ways: posting the policy or information about the hospital’s stance on the Death with Dignity Act on the hospital’s web page; informing local media; including information in hospital materials regarding advance directives; and including information in patient’s rights handbooks.

RESOURCES

Any patient, employee, independent contractor, volunteer or physician may contact Social Services for assistance.

*Laws/Regulations:* Initiative 1000/Washington Death with Dignity Act
Washington State Department of Health Regulations Chapter 246-978 (Currently at CR-102 stage)

*Reference Materials:* The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals

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<td>Rebecca Christoph: Director of Patient Care Services</td>
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<td>Randy Coffell: HR Director/Safety/Education</td>
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Foregoing Life-Sustaining Treatment

POLICY:
Compliance with the Natural Death Act of Washington.

SCOPE:
Patient Care Services

RESPONSIBILITIES:
Physicians: Comply with the Law. RNs: Remain familiar and provide for patient advocacy.

CONTROL:
Doctors, Administrator, Board

PROCEDURE:
A. Foregoing life-sustaining treatment in the presence of medically defined death:
   Life support measures should be discontinued when a patient is medically dead, unless provisions have
   been made, utilizing proper informed consent, for organ harvesting or medical research; provided, special
   consideration may be given to continue life support in the case of a pregnant patient.

B. Mid-Valley Hospital complies with the Natural Death Act of Washington.
   1. The State of Washington shall recognize the right of an adult person to make a written directive
      instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a
      terminal condition or permanent unconscious condition. The legislature also recognizes that a
      person's right to control his or her health care may be exercised by an authorized representative who
      validly holds the person's durable power of attorney for health care.

   2. Any physician, health care provider acting under the direction of a physician, or health facility and its
      personnel who participate in good faith in the withholding or withdrawal of life-sustaining treatment
      from a qualified patient in accordance with the requirements of the Washington chapter, shall be
      immune from legal liability, including civil, criminal or professional conduct sanctions, unless
      otherwise negligent.
C. Definitions Surrounding Withholding or Withdrawing Treatment

1. "Life-sustaining treatment" means any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration to sustain, restore or replace a vital function and which would serve only to prolong the process of dying. "Life-sustaining treatment" shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.

2. "Permanent Unconscious Condition" incurable and irreversible condition caused by injury, disease or illness, that, within reasonable medical judgement, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

D. Guidelines to Withholding or Withdrawal of Life-Sustaining Treatment

1. In a terminal condition:
   The patient must be diagnosed in writing to have a terminal condition by the patient's attending physician who has personally examined the patient.

2. In a permanent unconscious condition:
   The patient must be diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient.

3. Before life-sustaining treatment can be withdrawn, the patient's immediate family must concur. If the patient has a Durable Power of Attorney for Health Care, the person designated in this document should speak for the patient. In a situation of family conflict, the physician is advised to consult Patient Care Administration and the Risk Manager.

4. A copy of the patient's written Advance Directive should be made a part of the patient's medical record and referenced on the patient's chart. All orders to forego treatment that are usually automatically initiated, e.g., CPR, etc., or to forego life sustaining treatment should be written and signed by the attending physician(s) or his/her designee, i.e., partner, in the patient's medical records. Orders may be taken by phone if given to a Registered Nurse. When possible, a second staff nurse should witness the order. Phone orders should be signed by the attending physician at the earliest possible moment. Progress notes should document the circumstances surrounding the decision to forego life sustaining or disproportionate care. This documentation should include a summary of the medical situation (including mental status, diagnosis and prognosis), outcome of discussion with the patient, family and medical consultations and the basis upon which a person or persons have been identified as surrogate decision makers. Additionally, a conference should convene (not necessarily formal) for the purpose of informing those directly involved in the patient's care.

   The existing written Advance Directive will be honored until such time as the attending physician determines that the Advance Directive is either invalid or otherwise notes in the patient's file that the Directive has been revoked by the competent patient.

E. Competent Patients:

Competent adults may decline both lifesaving and life-sustaining treatment, even if refusal may lead to death. If a competent patient and attending/consulting physicians agree that the treatment is disproportionate and the person wishes to discontinue treatment, disproportionate care may be foregone and proportionate measures only may be provided. When the attending/consulting physicians disagree with the competent patient's decision to refuse treatment, the options include: consultation, transfer of
care to another physician, allowing the competent patient to remove himself/herself from the hospital, if possible, or referral to hospital legal counsel to determine whether judicial resolution should be sought. Where the attending/consulting physicians have questions about the patient's competency, psychiatric or other appropriate consultation should be sought and the procedure followed for competent or incompetent patients depending on the judgement reached.

F. Incompetent Patients:
In the case of a decisionally incapacitated the following principles should be observed to insure that the patient's best interests are being served.

1. The accurate determination of prognosis is pivotal to the determination of proportionally of care.

2. Disproportionate care may be discontinued when it is apparent that the patient would have refused the treatment if he or she were able to choose. Information bearing on the patient's intent, such as oral directives to friends, family members, or health care providers; evidence of what the patient said in reaction to medical treatment given to others; deduction from the patient's religious beliefs and deduction from the patient's consistent pattern of conduct regarding prior decisions about his or her own medical care should be considered. In order to insure that only disproportionate care is being terminated, the patient's surrogate decision-maker must receive the same medical information as one would expect a competent patient to have before consenting to or rejecting treatment.

3. If no sufficient evidence exists that the patient would have wanted disproportionate care foregone, family members may assert the patient's right to termination of same provided the attending physician(s) is in agreement that the termination of that care would serve the patient's best interest that there is no reasonable chance of recovery as a result of therapy. If a disagreement exists between the above parties, a court appointed legal guardian may be required.

4. When no family, friends or guardian have been located, after reasonably diligent search, within a reasonable period of time, in accordance with Washington State Law, a court appointed legal guardian will be requested prior to discontinuing care.

G. Proportionate/Disproportionate Care
The moral distinction between proportionate and disproportionate care is foundational for decisions regarding the foregoing of life-sustaining treatment for both competent and decisionally incapacitated persons.

1. A person's moral obligation to preserve his or her life or the obligation of those who represent a decisionally incapacitated person to preserve that person's life, is not unlimited. The distinction between proportionate and disproportionate care is a guidelines for determining the moral limits of an individual's obligation to preserve his or her own life. This distinction also should guide those who make decisions on behalf of the decisionally incapacitated.

2. Disproportionate care is care (surgery, medication, {other comfort medication}, treatment, therapy, etc.) which is so excessive from the patient's perspective in terms of pain, effort or other relative to the anticipated benefit, that this care is not morally obligatory for the patient or their representative to pursue.

3. Proportionate care is care by which anticipated benefit is great enough relative to all burdens that it is morally obligatory to provide.

H. Care for Dying Persons:
The primary goal of care for the dying person should be relief of suffering and the promotion of comfort through the use of patient care measures and appropriate medication. This goal includes support for significant others in the dying and grieving process.
I. Treatment of Body after Death
   The body, even after death, deserves respect, and all procedures affecting it must be conducted with
dignity and appropriate consent. The decision to forego artificially provided hydration and nutrition at this
point should prompt a careful review of medical prognosis and the patient's comfort.

J. Organ Donation:
   See Protocol for Organ Donation and Procurement.

All revision dates: 08/2000
Attachments: No Attachments

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Pain Management

**Policy:**
Mid-Valley Hospital will assist the patient in maintaining an optimal level of pain relief by providing regular assessments for pain as a "vital sign" and developing a plan for its management based on these assessments.

**Scope:**
All patient care areas

**Responsibilities:**
- Nursing and Ancillary Personnel remain skilled in pain prevention
- Physicians maintain knowledge of pharmacological interventions
- Pharmacist consults as needed for effective pain management

**Control:**
Director of Patient Care Services, Administrator, Board of Commissioners

**Definitions:**
- Pain is an unpleasant sensory and emotional experience arising from actual or potential tissue damage; sensation of discomfort, distress, or agony unique for that individual who is the real authority on their pain.
- **Procedural related pain** is pain of short duration and generally related to invasive treatments or diagnostic tests, such as venipunctures and lumbar punctures.
- **Nociceptive pain** is a pain related to disease, surgery, or side effects of treatment (i.e. mucositis) arising from bone, joint, muscle, skin or connective tissue; usually described as aching or throbbing.
- **Neuropathic pain** is pain emanating from nerve damage or inflammation; often described as burning or piercing in nature following the path of an injured nerve such as surgical interruption of nerves (i.e. amputations, post-limb sparing procedures), chemotherapy induced (i.e. viecristine), radiation (rare).

**Procedure:**

A. 1. Effective management of pain (acute pain, chronic malignant pain, chronic non-malignant pain) can directly impact the patient and his significant others by:
   a. i. Improving quality of life.
      ii. Limiting physical and emotional effects of unrelieved pain.
      iii. Improving patient satisfaction.
      iv. Decreasing length of stay.

It is the duty and responsibility of all healthcare providers to recognize pain and to provide for comfort measures as applicable within their scope of practice. The patient will experience an optimal level of pain relief and can expect his report of pain to be accepted, analyzed and appropriate intervention to occur.

A. 1. All patients of developmental states are to be assessed for pain at the time of admission in conjunction with initial vital signs (pain is the 5th vital sign).
a. Utilize an assessment tool understandable by patient. Ask the patient if he/she is having pain. If the patient is unable to self-report, use the FLACC method. The nurse performs this assessment at the time of each visit, or admission and every four hours while the patient is awake.
   i. Numeric scale (0-10) is proved to be effective when assessing ages 13 – adult.
      a. 0 is no pain
      b. 10 is worst pain imaginable
   b. Wong-Baker Faces Scale tool is used if patient is between the ages of 5 and 13 years.
   c. CHEOPS Scale may be used if patient is a toddler between ages 1 and 3 years.
      (see Attachment: Guideline for Pain Management Flow Sheet)
   d. Modified Attia Scale is to be used if patient is less than one year old.
      (see attachment)
   e. Verbal descriptor scale may work better with elderly in particular.
      i. no pain (0)
      ii. mild (1)
      iii. discomforting (2)
      iv. distressing (3)
      v. horrible (4)
      vi. excruciating (5)
   f. FLACC (infants) : Face, Legs, Activity, Cry, Consolability
      
      | Categories   | 0 | 1 | 2 |
      |--------------|---|---|---|
      | Face         | smiling or relaxed | Occasional grimace | clenched jaw/quivering chin |
      | Legs         | relaxed | Restless / tense | kicking |
      | Activity     | lying quietly | Squirming / tense | arched /rigid /j jerking |
      | Cry          | no cry (awake or asleep) | Moans / whimpers | crying steadily/screams/sobs |
      | Consolability| content / relaxed | Distractible / consolable | difficult to console or comfort |

   Each of the five categories (F) face; (L) legs; (A) activity; (C) cry; (C) consolability; is scored from 0-2, resulting in a total score range of 0 to 10.
   g. Other means of assessing pain, usually seen only briefly after the onset or exacerbation of pain and often returns quickly to normal are considered physiological or behavioral.
      i. Physiologic signs include increased heart rate, blood pressure, and respiratory rate, sweating and pallor.
      ii. Behavioral signs may include body positioning such as guarding, cradling limb, muscle rigidity, restlessness, clenching of hands, as well as facial expressions such as grimacing, tightening of jaw, sweating, pallor, dilated pupils, moaning, crying and screaming.
         ▪ Behaviors often seen when pain continues are anxiety, irritability, depressed affect, fatigue, depression, and altered level of activity.
      NOTE: the absence of these symptoms does not necessarily mean the patient has no pain.

2. Document Assessments
   a. patients perception of pain (self reported)
   b. location/nature of pain
   c. time of onset
   d. duration of pain (continuous, intermittent)
   e. intensity/severity of pain (using one of above methods / scales if possible)
   f. quality of pain (sharp, dull, stabbing, aching, burning, throbbing, etc. )
   g. alleviating/ aggravating factors (what makes it better or worse)
   h. parent perception of their child re: pain
   i. record assessment method used to provide consistent reproducible results and allow for regular reassessment and follow-up.
j. sedation level using sedation scale on pain management flow sheet

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<thead>
<tr>
<th>Sedation Scale</th>
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<tbody>
<tr>
<td>0= None</td>
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<tr>
<td>1= Mild Occurrence, Drowsy, Easy to Arouse</td>
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<tr>
<td>2= Moderate Frequency, Drowsy, Easy to Arouse</td>
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<td>3= Severe, Somnolent, Difficult to Arouse</td>
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<td>S= Asleep, Arousable</td>
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B. Immediately initiate non-pharmacological therapies as appropriate

1. Positioning
2. Splinting and/or Immobilization
3. Cold Treatment – Do not apply without a physician’s order.
   a. Do not apply to infants/preemies where thermoregulation is a concern
   b. Do not apply on fragile skin/skin that has had frostbite.
   c. Do not apply on those with decreased or impaired sensation.
   d. 10 minute application with ice bag
   e. Observe skin for signs of tissue damage; redness, discoloration, blanching or mottling.
      (Stop if these signs occur.)
   f. Document treatment (time applied, to what area, action, and response)
   g. For acute invasive procedure: ice applied to opposite of invasive procedure can be effective.
      (e.g. for bone marrow planned for right iliac crest, place ice on left iliac crest)
4. Heat (for muscle spasm or back pain) – Do not apply without a physician’s order.
   a. K-pad
   b. Hot water or warm packs from warmest water in faucet; DO NOT MICROWAVE
   c. Do not apply on fragile skin.
   d. Do not apply on those with decreased or impaired sensation.
   e. Apply for no longer than 10 minutes.
   f. Document treatment (time applied, to what area, action, and response)
   g. Check for warmth and reapply if necessary.
5. Oxygen
6. Complimentary Interventions
   a. relaxation
   b. distraction
   c. diversion
   d. guided imagery
   e. Massage (not on legs or calves)
   f. humor

C. Administer pharmaceutical therapies as soon as possible

1. Must have physician’s order
2. May establish pain management protocols
3. Ascertain medication allergies prior to administration
4. Those with history of chemical dependency/ abuse or use of pain medications for reasons other than pain relief may require Pharmacist consult to establish equianalgesic dosing and to develop pain management plan of care with the physician.

D. Re-assess pain frequently (at least every 30 minutes until controlled)

1. 5-10 minutes after SL medication
2. Within 30 minutes after IV medication
3. 30-60 minutes after IM or PO medication
4. Monitor closely for signs of sedation, respiratory compromise, side effects, adverse reactions
5. Non-Pharmacologic
6. Epidurals (see protocol in OB)

E. Re-medicate as needed
   1. Follow established dosing guidelines
   2. Initiate patient controlled analgesia (PCA) management as appropriate
      a. Educate significant others about PCA use.
   3. Consult pharmacist for intractable pain or other management problems as needed

F. Assess the need to establish bowel regime (stool softeners, laxatives, fiber products) for patients receiving opiates/narcotics

G. Enter "pain" to care plan/interdisciplinary plan of care and address as discharge planning criteria.

H. Educate the patient and/or significant others:
   1. use of pain scales; explain pain assessment
   2. causes of pain
   3. medication schedule and dose, time to relief
   4. when and what to report to healthcare team
      a. non-relief/ relief not as expected
      b. side effects/adverse reactions
   5. side effects and treatments
   6. include preprinted medication information sheets as appropriate
   7. document education on pain management flow sheet

I. Management issues
   1. WHO 3-step analgesic ladder
      WHO 3-step analgesic ladder
   2. If adequate relief is not obtained after maximizing doses of medications ordered, notify physician and/or utilize pharmacist's expertise to formulate a pain management plan to present to the physician. If physician refuses to order additional medication, utilize chain of command in attempt to resolve issue.
      a. Nursing Supervisor
      b. Nurse Manager
      c. Chief of Service
      d. Chief or Staff
      e. Administrator
   3. Before switching to another drug, consider increasing dosage and/or reducing interval between doses and/or changing route of administration to prescribed maximum. If side effects outweigh benefits, select a new drug. Consult Pharmacist to assure equianalgesic effects.
      a. There is no known maximum dose of morphine sulfate, hydromorphone (Dilaudid), or oxycodone, and patients with chronic/continuous pain may need greater doses than opiate naive patients.
      b. It may be necessary to separate components of combination products to reduce potential for toxic dosing.
         i. Acetaminophen dose should not exceed 4-grams/ day.
      c. Meperidine produces a metabolite Normeperidine, which is a CNS excitotoxin that produces anxiety, tremors, myoclonus, and seizures. Do not use for periods over 48 hours, at doses > 600 mg/24 hrs./or for chronic pain. Do not use at all in-patients taking MAO inhibitors (can cause hyperpyrexic syndrome with delirium, which can be fatal).
   4. Assess for and treat side effects concurrently and aggressively while you treat pain.
      a. Initiate bowel program to prevent constipation/urinary retention, notify the physician
      b. Give an antiemetic for nausea
      c. Give a stimulant for excess sedation
d. Give an antihistamine for itching

e. Give Naloxone (Narcan) in the smallest effective dose for respiratory depression

**Developmental Approaches**

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<td>Imagery</td>
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<tr>
<td>Patients should be informed that effective pain relief is an important part of their treatment, communication of unrelieved pain is essential.</td>
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<td>It is important to be aware of other influences in the patient's life (i.e. employment status, marital status, emotional stability, etc.). These factors can influence pain management.</td>
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<td>GERIATRICS</td>
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<tr>
<td>Elderly people often suffer multiple illnesses and take multiple medications. They are at a greater risk for drug/drug and drug/disease interactions.</td>
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<tr>
<td>Pain assessment in the elderly may be difficult sue to physiologic, psychologic and cultural changes associated with aging.</td>
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<tr>
<td>Aging need not alter pain thresholds or tolerance. The similarities of pain experience between elderly and younger patients are far more common than they are different.</td>
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<tr>
<td>Cognitive impairment, delirium, and dementia are serious barriers to assessing pain in the elderly. Sensory problems such as visual and hearing changes may also make it more difficult.</td>
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Older people tend to be more sensitive to the analgesic effects of opioids. The peak opioid effect is higher and the duration of pain relief is longer.

Reassessment of pain management and appropriate changes should be made whenever the elderly patient moves (i.e., from ICU to ACU; hospital to extended care facility, etc.)

PATIENTS WITH A TERMINAL CONDITION

Pain management never stands alone, exclusive of the patient’s experience. This is even truer regarding pain at the end of life. The experience of the patient involves his/her illness experience, support system, sense of satisfaction with a life lived, ability to feel in control, degree of physical well-being and many other factors. All people at the end of life may experience suffering related to the many losses they have faced and will face. Pain will be part of this suffering. It is not the pain itself that determines suffering but the meaning the pain has for the individual.

Within the context of the above description, the principles of pain management remain constant.

- Assess patient per protocol using appropriate pain scale.
- Document specific limitations of mobility and situations that exacerbate pain.
- Individualize the pain control regimen to the patient.
- The simplest dosage schedules and least invasive pain modalities should be used first.
- Administer pain medicines on a round-the-clock basis.
- Provide for breakthrough pain medication.
- Assess and document effect of medications – degree of relief of pain and duration of relief.
- Include patients & families in the pain plan. Enable them to control their course as much as possible.

All revision dates: 08/2010, 05/2005, 08/2003

Attachments:

- Guideline for Pain Management Flow Sheet.doc
- Modified Attia Score.doc
- WHO 3-step analgesic ladder