

## End of Life Care

### PHILOSOPHY

Dying patients have unique needs for respectful, responsive care. It is important to properly evaluate and treat pain and suffering, and be sensitive to emotional issues of the patient, family and friends, care givers, and other staff. Emotional support for the dying patient and his or her family is a key element of end of life care. Sensitively addressing issues such as autopsy and organ donation can assist families in making these difficult decisions.

It is the intent of Olympic Medical Center to deliver patient care that safeguards patient dignity and respects the patient's values, religion, identified cultural needs, and philosophy. The relief of pain and suffering, whether physical or emotional, is a fundamental component of the care we deliver.

### POLICY

Patients and families will be involved in decisions regarding their care. A patient care conference involving the patient and family is recommended so that the goals of care are understood by all care team members and clearly documented. The patient's spiritual, cultural, and philosophical values are an important part of the decision-making process and will be respected to the greatest degree possible.

Effective pain management is a goal for all patients. Hospital staff will work closely with physicians to facilitate achieving this goal. Interventions such as positioning, comfort measures, emotional support, and education about pain and its management may be indicated.

Should the patient be enrolled in a hospice program, hospital staff and providers will work closely with the hospice staff to ensure that the patient's stated goals are met.

### PROCEDURE

#### A. Physical Needs

1. Assess pain and comfort level frequently. Treat pain as needed and evaluate patient response. Intravenous pain medication is often indicated.
2. Assess hydration status. If patient can swallow, offer fluids as tolerated. Keeping the patient's lips and mouth well lubricated will help to avoid skin breakdown.
3. If a comatose patient's eyes are open, appropriate eye care (i.e., liquid tears) is needed to keep corneas moist.
4. Position the patient for comfort. If the patient is flat on his or her back, keep the head of the bed elevated slightly to assist in breathing and avoid aspiration. Reposition the patient at least every 2 hours, taking care to avoid pressure spots

- or linen traction on the skin, both of which may lead to skin breakdown.
5. Keep the patient's skin clean and dry. Include the patient and/or family in discussions about how to best manage this, if possible.
  6. Be aware of the patient's sensory status. Continue to talk to the patient, explaining procedures each time. Touching the patient may provide support and human warmth as vision and hearing fail.
  7. A multidisciplinary patient care conference may be convened to ensure that patient and family needs are coordinated.

**B. Emotional Needs**

1. Explain activities and care to the patient, even if he or she is unconscious--the patient may be able to hear you.
2. Answer patient/family questions as candidly as possible, being sensitive to the patient's emotional needs.
3. Encourage patients and families to express their feelings. Provide a supportive, listening environment. If there are questions or conflicts regarding care, provide patients and families with information/options for having those conflicts explored (examples: facilitating communication between families and physicians, requesting assistance from Administration, convening a patient care conference with team members, accessing members of the Ethics Committee).
4. When family members are present, include them in explanations of patient care and treatment. If appropriate, offer to teach them how to assist with patient comfort measures. Let them know their efforts are important. Work with the family, allowing them to stay with the patient as much as possible, if that is important to them.
5. Determine whether the patient or family wishes spiritual support (i.e., contacting their clergyman). Identify any particular religious or cultural needs the patient or family might have, and facilitate meeting those needs when possible. This might include administration of last rites, for example.
6. As the patient's death approaches, determine patient and family wishes regarding notification of death. If the family wishes to be present, attempt to notify them as quickly as possible so they can be with their loved one.

**APPROVED:**

*Eric Lewis*

**Eric Lewis**  
**Administrator**

*C. Bensen MD*

**Carleen Bensen, MD**  
**Chief of Staff**

## **Death with Dignity Act – OMC Position**

### **PURPOSE**

To recognize the Washington State Death with Dignity Act, (RCW 70.725/WAC 246-978), and the Board of Commissioners Resolution No. 428 regarding this Act.

These efforts are intended to guide staff in assisting patients who are seeking information on the Washington State Death with Dignity Act.

### **POLICY**

OMC recognizes and respects the right of any health care provider to counsel patients on their options and to participate, if they so choose, in activities under the Washington State Death with Dignity Act. OMC also recognizes and respects the right of any health care provider to decline to participate in activities specific to the Act.

The OMC position is that its acute care hospital and its clinics are not the appropriate setting for patients who are at the stage of taking life-ending medications.

In accordance with Resolution No. 428, the final actions ending a patient's life, under the specifications of this Death with Dignity Act, shall not occur on or within the premises of the hospital or in clinics operated by the District. Not permitted on the District's premises is the patient's self-administration of the lethal medication. Also, the medication for this purpose will not be dispensed from the hospital pharmacy.

### **PROCEDURE**

Patients who ask about the Death with Dignity Act will be given the Washington State Department of Health handout titled: Frequently Asked Questions - Death with Dignity Act.

Patients will be directed to talk with their primary care physician about various options for care at the time of terminal illness. These may include treatment options, palliative care measures, and advance directives.

In the course of diagnosis and treatment attending physicians may:

- provide information for informed consent decision-making;
- assess the patient's medical decision-making competency;
- refer the patient to a consulting physician for prognosis and competency evaluation;

- refer the patient for psychiatric consult, if deemed appropriate;
- listen to a patient's initial oral request for participation in the Death with Dignity Act process, which may include a request for lethal medication;
- advise the patient that they may rescind the request at any time;
- advise the patient that they would want someone with them;
- advise the patient to discuss this with their their next of kin.

These are all verbal components in a discussion between a physician and their patient that may occur with respect to end of life care. These discussions would be documented in the patient's medical record.

If an Olympic Medical Center employed or contracted physician chooses to work with a patient in these efforts, then the physician is required to complete all mandated forms per state regulations, as appropriate. (found at: <http://www.doh.wa.gov/dwda>)

**APPROVED BY:**



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**Eric Lewis**  
**Administrator**

*Reviewed and revised: D. Davison 6/09, 5/12*

## **OLYMPIC MEDICAL CENTER RESOLUTION NO. 428**

A RESOLUTION OF THE BOARD OF COMMISSIONERS OF OLYMPIC MEDICAL CENTER AMENDING RESOLUTION NO. 425 REGARDING PARTICIPATION IN THE WASHINGTON STATE DEATH WITH DIGNITY ACT, INITIATIVE-1000

WHEREAS, the Washington State Death with Dignity Act (“the Act”) was passed by voters, and codified to the Revised Code of Washington (RCW Chapter 70.245) and the Washington Administrative Code (WAC 246-978);

WHEREAS, while the Act provides for certain rights and responsibilities of qualified patients and willing health care providers, the Board of Commissioners does not endorse any course of action for anyone, either patient or provider, by passing this Resolution, and ;

WHEREAS, the Board previously adopted Resolution No. 425 choosing not to participate in the Death with Dignity Act;

WHEREAS, The Board has received further input from the Medical Staff and the Public in consideration of end of life issues;

WHEREAS, the Board recognizes the privacy and personal nature of the patient-physician relationship; and that much of the dialog, information, and requirements of the Act may occur in the course of comprehensive care for a patient in a physician clinic, yet believes, however, that the Hospital setting or OMC Clinics is not the appropriate location for the final step of this Act as an end of life option;

NOW, THEREFORE, BE IT RESOLVED, that Olympic Medical Center will not prohibit willing OMC physicians, employees, independent contractors, and volunteers from assisting a patient within the scope and requirements of the Act; nor will it require participation by OMC physicians, employees, independent contractors and volunteers.

BE IT FURTHER RESOLVED that the final step of self-administration of the medication will not be permitted on the premises of the Hospital or in clinics operated by OMC.

BE IT FURTHER RESOLVED except as specified in this resolution all provisions of Resolution No. 425 relating to the requirements that OMC make available of future education on end of life issues, palliative care measures, and develop internal policies in compliance with the Death with Dignity Act and this resolution remain in effect.

ADOPTED and APPROVED by the Board of Commissioners of Olympic Medical Center, at an open public meeting thereof this 3rd day of June, 2009, the following Commissioners being present and voting in favor of the Resolution.

**ATTEST:**

  
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President and Commissioner

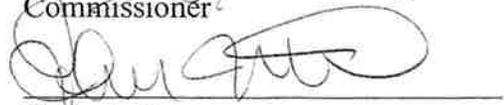
  
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## **Olympic Medical Center Advance Directives**

### **POLICY**

To provide individuals, 18 years of age and older at the time of inpatient admission or during the pre-admission process, written information regarding an individual's rights under state and federal law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.

### **ADVANCE DIRECTIVES**

Advance Directives are defined as written instructions, such as a Directive to Physicians, formerly known as a living will, Durable Power of Attorney for Health Care, or a Physicians Order for Life Sustaining Treatment ("POLST" or Code/No-Code agreement) recognized under state law (whether statutory or as recognized by the courts of the state), and relating to the provision of such care when the individual is incapacitated.

### **DIRECTIVE TO PHYSICIANS**

A Directive to Physicians indicates the type of treatment that an individual wishes to receive or forgo under specified circumstances.

### **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

A Durable Power of Attorney for Health Care designates a proxy to make treatment decisions when a person is unable to make informed health care decisions for him/herself. Notary publics will be maintained on staff for notarization purposes.

### **POLST – PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT**

A POLST is a written agreement between a physician and a patient, in which the Physician makes certain advance orders for treatment to be received in specific situations.

### **WITNESSES**

A witness to an Advance Directive shall not be an employee of the health care facility, attending physician, employee of the attending physician, or any person who has claim against any portion of the estate of the declarer upon the declarer's death at the time of the execution of the directive.

### **RESUSCITATION STATUS**

Every patient admitted to the hospital of Olympic Medical Center is automatically placed in a full resuscitating status. Exceptions to this policy are made by consultation of the physician

with the patient or the patient representative, or in accordance with the patient's Advance Directives.

## **OUTPATIENT SETTINGS**

Advance Directives brochures will be available in OMC outpatient settings. These will include resources of additional information and assistance for patients.

In the ambulatory outpatient care settings, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situation, the signed consent for treatment or services that day implies consent for resuscitation and transfer to a higher level of care.

For outpatient settings not on the hospital campus, "911" will be called for patient transport to the Hospital Emergency Department; wherein the Hospital Code Blue is called. Exceptions are:

- 1) Short Stay Unit of the Hospital- where the patient will be queried during nursing assessment about Advanced Directives and the patient's wishes will be honored in this regard.
- 2) Cancer Center, Specialty Clinics, and Primary Care Clinics- when the patient's physician is present and a copy of the Advanced Directive or POLST is immediately available and verified, then the physician will direct the type of care and/or transport necessary to comply with the patient's wishes.

## **PROCEDURE** [Note: *Appendix A, Advance Directive Flow Chart*]

- A. At the time of admission or during the pre-admission process, Advance Directive information is made available to all patients.
  1. The Admitting Nurse will obtain a 'yes' or 'no' in response to whether the patient knows their advance directive (AD). If the answer is yes, a request will be made to obtain a copy to have scanned into the EHR. Priority scanning of these documents is done when a copy is sent to Health Information Management.
  2. Case Management will see persons 18 years of age or over to answer any questions, provide educational information and Advance Directive brochure and forms, if the patient requests this.
  3. Patients admitted to the hospital are automatically placed in a full resuscitating status, *unless* directed otherwise. Exceptions are:
    - a) Patient has executed an Advance Directive and it is in the medical record.
    - b) Consultation of the M.D. with the patient regarding wishes and M.D. documents this as a Physicians order; or
    - c) Consultation of the M.D. with the patient representative regarding wishes and M.D. documents this as a Physicians order.
- B. When a patient is incapacitated at the time of admission, Case Management will:
  1. Try to determine from DPOA, guardian / family member accompanying the patient if an Advance Directive has been executed.
  2. Provide educational information to the patient's surrogate decision-maker (i.e.,

- guardian, durable power of attorney for health care, spouse, children, etc.). The Physician then does the follow up education with the patient's designee.
3. Document in patient's electronic medical record what the decision-maker stated was 'the substance' of the directive if they do not have a copy with them to provide for the medical record.
- C. Case Management will provide the following educational materials as appropriate:
1. The "*Who will decide if you can't*", pamphlet about Health Care Directives and Durable Powers of Attorney for Health Care.
  2. POLST forms
- D. If the patient revokes the Advance Directive, then document the revocation in the *Progress Notes* of the electronic medical record, stamp or write 'revoked', date and initial, and give the original back to the patient.
- E. The Patient Information Packet is provided on admission and is a primary source of AD literature.
- F. Notary service will be provided, if the patient / family requests.

**APPROVED BY:**

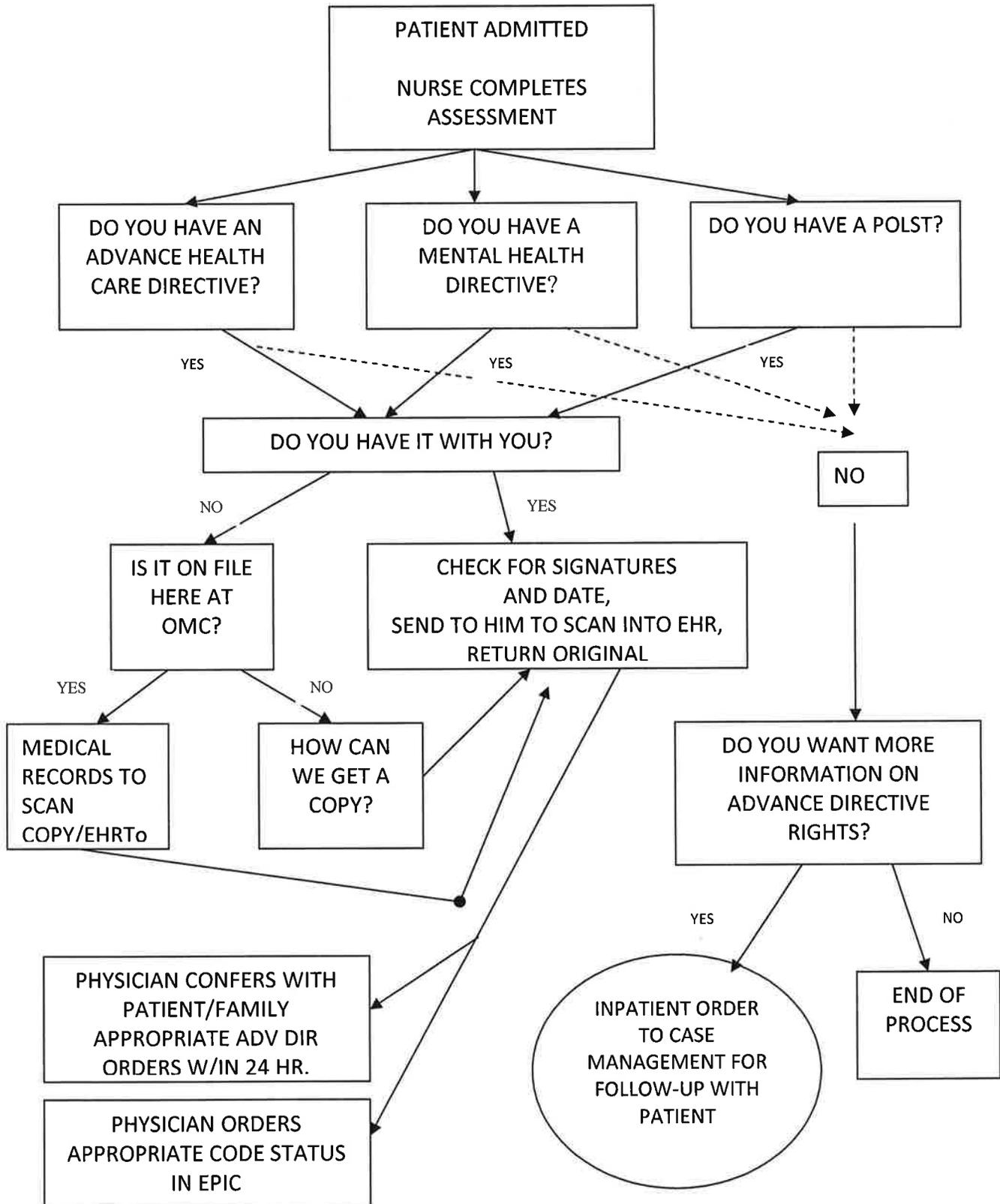


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**Eric Lewis**  
**Administrator**

<p><i>Reviewed 04/93</i> <i>Revised 03/96, 06/98, 04//9, 02/01, 04/02; by: J. Berry. 03/05, J. Des Rochers; 03/07 L. Wall 3/11 B. Tassie, 8/11D.</i> <i>Davison 3/14 D Davison, J Burkhardt, B Tassie, L. Wall</i></p>
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## ADVANCED DIRECTIVES / POLST PROCESS



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