Trios Health							Index No.: KGH003825 Intradoc Folder: District Page 1 of 4
TITLE: Access to End-of-Life Care							**Implementation Date:** 3/2014 **Revised Date:**
APPROVED: **(Signed)** **Signature on File** **(Typed)** Diane Sanders, CNO **Date:** 3/2014	**Reviewed by:**						
	Date:						

I. PURPOSE STATEMENT

A. To define the integration of end-of-life care as a key component of family-centered, compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families.

B. Patients have the right to accept or refuse medical treatment, including forgoing or withdrawing life-sustaining treatment or withholding resuscitative services.

C. Patients are involved in decisions about care, treatment, and services provided.

II. POLICY STATEMENT

A. Access to end-of-life care

1. End-of-life care is not bounded by a specific prognosis; rather, it involves the recognition of the irreversibility of a life-limiting medical condition(s) that will likely result in death.
2. All clinical staff at Trios Health is responsible for end-of-life care.
3. Meeting patient and family needs is the central focus of care when cure or maintaining the continuum of health is no longer possible.
    a. Patients and families have the opportunity to discuss and plan for end-of-life care including:
        i. Scenarios and treatment preferences with the physician and health care proxy
4. Assurance that physical and mental suffering will be carefully attended to and comfort measures intently secured.
5. Assurance that preferences for withholding or withdrawing life-sustaining intervention will be honored.
    a. Patients are treated with respect to their individual wishes for care and treatment with consideration of their values, religion and philosophy.
    b. A request to discontinue treatment will be honored with the same support and respect as the decision to continue treatment.

6. Assurance that dignity will be a priority at the end-of-life.
7. Patients will be provided medical resources and community support so the burden of illness will be minimized and need not overwhelm caring relationships.
8. Attention will be made to the personal goals of the dying person whether it is to communicate with family and friends, to attend to spiritual needs, or to die at home or at another place of personal meaning.
9. Hospice services are recognized as an integral part of the continuum of care.
    a. Patients who have an expected prognosis of six months or less, assuming the disease follows its usual course, should be offered hospice services.
10. Bereavement support and chaplaincy services are available to patients and their family members. Nursing, social services and the chaplaincy program are available to provide resources to families.
11. In the event of questions or differences of opinion among the patient, family or health care team members about the treatment goals, consultation is available from the hospital ethics committee.

B. Care of the imminently dying patient

1. Imminently dying (aka actively dying) specifies the period of a patient's illness when death can be reasonably expected to occur within 14 days.
2. Care will include:
    a. Communication with the patient, family and surrogate decision makers that death is imminent
    b. Preparing patient and family for what to expect during the normal dying process
    c. Managing pain and other physical/psychological symptoms effectively
    d. Educating/counseling patients and families concerning the appropriate use of pain and symptom treatments
    e. Providing options for out-of-hospital care, including home or residential hospice services
    f. Responding to the psychological, social, emotional, spiritual and cultural concerns of the patient and family, including children and

teens affected by the death

g. Treating the body post death with respect according to the cultural and religious practices of the family and in accordance with local law

h. Addressing issues of body or organ donation, autopsy and funeral planning with sensitivity

i. Providing bereavement resources through the hospital and community

C. Advanced directives

1. Trios Health assures adult patients are informed of their right to make advance directives as per policy KGH000077.
2. In the absence of an advance directive, medical decisions for an incompetent person are made by a surrogate decision-maker.
3. Factors that should be considered when determining that medical treatment is in the patient's best interest include but are not limited to:
    a. The patient's present level of physical, sensory, emotional, and cognitive functioning;
    b. The various treatment options and the risks, side effects, and benefits of each of the options;
    c. The life expectancy and prognosis for recovery with and without treatment;
    d. The degree of physical pain resulting from the medical condition, treatment, or termination of treatment; and
    e. The degree of dependency and loss of dignity resulting from the medical condition and treatment.
4. Assure that the presence or absence of any directives will not impact the patient's quality of care.
5. The adult patient may revoke an advance directive at any time, for any reason.

D. Death with Dignity Act

1. Trios Health allows its providers to participate in the Washington State Death with Dignity Act if they so choose per policies KGH003307 and KGH003308.

III. IMPLEMENTATION AND TRAINING PLAN

A. New and revised policies will be sent via email to all employees with an email address. Each department manager will ensure that those employees without a district email address are notified of new and revised policies that are pertinent to their position.

B. Employees will be shown how to access policies on the Trios Health policy site during the orientation process.

IV. REFERENCE SECTION

A. References:

1. American Medical Association, 2014. AMA Statement on End-of-Life Care.
2. Washington State Hospital Association, 2014. End-of-Life Care Manual
3. Center to Advance Palliative Care, 2014. A Crosswalk of National Quality Forum Preferred Practices

B. Distribution: House wide

C. Supersedes: New

D. Prepared/Updated by: Nicole Hammond, RN, OCN

E. Reviewed by: Policy and Procedure Committee

F. Approved by: Diane Sanders, CNO

G. Joint Commission or Other Regulatory Body: WA Department of Health WAC 246-320-141.