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PULLMAN REGIONAL HOSPITAL

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Owner	Anna Engle: Palliative Care Coordinator
Area	Palliative Care Policies
Applicability	Pullman Regional Hospital

End-of-Life 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, utilizing the Comfort Care Team.

Comfort Care Team:

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 health care 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. The team may be reached by emailing ComfortCare@pullmanregional.org

Quality of Life Team (QOL) Utilization:

1. The Comfort Care team may consist of members from Nursing, Social Services, Respiratory Therapy, Pharmacy and Physician Services, chaplains, and other interdisciplinary staff as necessary for individual cases.
2. If a health care team member feels a patient's comfort level is not at goal, the family could benefit with assistance from the Comfort Care team or a pharmacy consult.
3. The Comfort Care 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.

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 Comfort Care Consult.
6. The team will then follow-up and monitor the patient's care until discharge.

Process for Utilization:

1. Prior to initiating Comfort Care (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. Comfort Care (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.
4. The Comfort Care Team members may check in with the primary nurse, provider, patient, and family to see if any additional support is needed.
5. If it becomes apparent that a patient may pass here in the hospital, an end-of-life care bag with literature, a blanket, and a comfort menu 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 not meeting outlined goals and the primary physician cannot be reached, please call the Comfort Care Team or the Pharmacist on call as appropriate to the situation for assistance in finding an appropriate treatment for comfort.

Reference:

ELNEC Core Curriculum. (October, 2015).
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*.

Approval Signatures

Step Description	Approver	Date
Approver	Elizabeth Lerandeau: Director of Social Work	12/2024
Owner	Anna Engle: Palliative Care Coordinator	11/2024

Applicability

Pullman Regional Hospital