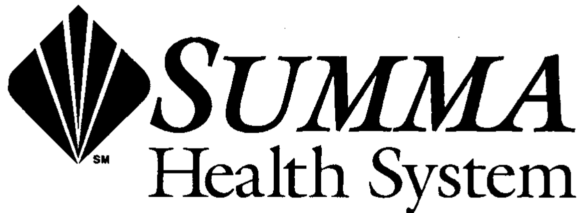

ADMINISTRATIVE POLICY

C

OBJECTIVE: To provide optimal care and comfort measures to dying patients and their significant others by assessing their physical, emotional, psycho-social and spiritual needs, and planning to meet these needs with personal sensitivity and clinical competence. To assist the patient in achieving the best possible quality of life until death occurs, and to facilitate decision-making and communication between the patient, significant other(s) and care givers. To provide an avenue for staff to resolve issues when concerns arise regarding their ability to provide certain care for dying patients. To ensure that the rights and needs of the dying patient is met with respect and dignity.

NOTE: A copy of Palliative Care Preprinted Orders is attached to this policy. The orders are intended as a means to facilitate palliative patient care. The physician can use any or all of the orders, or write orders of their choosing best suited for the individual patient's needs.

POLICY: A. **Physical Aspects of Palliative Care**

Medical management of the physical aspects of the dying patient, that of the body, continues to be a priority despite the fact that the goal has changed from cure to palliation--from extending life to promoting quality of life and a peaceful death. Although death is a normal stage of life, and many physiologic changes or patient responses serve a therapeutic or comfort enhancing purpose, many distressing symptoms can interfere with and prevent a peaceful death. At Summa Health System Hospitals we believe that through our attention to facilitating relief of symptoms, a more peaceful death can be achieved, thereby lessening the suffering for the patient and the family.

As the patient approaches death, interest in food or fluids diminishes and intake becomes minimal. This natural cessation of food or fluids has many comfort enhancing effects such as less urinary incontinence, less pulmonary secretions, less gastric secretions decreasing nausea and vomiting, less peripheral fluid accumulation, and less pain. In the days and hours before death, a patient may become increasingly weak and essentially bed bound. He or she may find routine position changing disturbing or uncomfortable. Most of all, patients may experience changes in level of consciousness, changes in the sleep/wake cycle, changes in their attention span, as well as periods of lucidity alternating with disorientation. We should prepare patients and families to expect such changes and offer/provide medication as indicated for relief/comfort.

Pain management is of vital concern. If pain management has previously been achieved through round-the-clock dosing of opiates or other analgesics, this shall continue and will be adjusted as appropriate. Patients may be disturbed by pain even when unconscious. Patients may have a physical dependence and withdrawal of pain medications may cause them discomfort. Dyspnea, another distressing and common symptom at the end of life, may be relieved by administration of opiates.

ADMINISTRATIVE POLICY

We recognize that lengthening periods of apnea or cessation of respiration is a natural response to the process of dying, not sequelae of the medication. A status of palliative care does not infer that nothing can be done for the patient, but rather mandates focusing on the goals of symptom relief, comfort and allowing a peaceful dignified death.

Patients' symptoms and drug metabolism often increase to a remarkable degree in dying patients. Analgesic and sedative administration need to be individualized according to patient needs and tolerances as well as to the drugs' pharmacological profiles. Therefore dosing of narcotics and sedatives may exceed the limits described in various policies at the discretion of the attending physician accompanied by appropriate documentation.
C These Patient Care Services policies are as follows:

- Ambulatory Infusion Pumps, section 1, page 66.
- Narcotic/Controlled Substance Administration and Regulations, section 1, page 11.
- Do Not Resuscitate (DNR), section 1, page 12.
- Granting Exception to Medications, section VI, page 38.
- Intravenous Medication Administration Guidelines, section VI, page 7.

B. Emotional Needs

The care of dying patients will be planned to minimize emotional distress. Emphasis will be given to anticipating patterns of expected changes in thinking and feeling in response to their diagnosis, prognosis and treatment. Assessment will encompass the presence of risk factors, symptoms and patterns of emotional distress and the effect on the patient and family. Patients will be supported and provided opportunity for communication and decision making as they experience the stages of grieving and associated feelings including fear, guilt, abandonment, despair and depression. Health care team interventions and treatment for emotional distress will focus on enhancing coping mechanisms and include early identification and treatment of potential sequelae of emotional distress.

1. Assessment
   a. Determine if the patient has a history of previous emotional instability, etc.
   b. Observe for the presence of discomforting thoughts, feelings, behaviors such as nervousness, worry, hopelessness, withdrawal, difficulty concentrating, etc., recognizing that many of these symptoms are a normal part of the dying process.
   c. Watch for patterns of distress including onset, frequency, intensity and a associated symptoms, as well as aggravating and alleviating factors.

ADMINISTRATIVE POLICY

2. Interventions
   a. Empathize with the patient regarding concerns precipitating the patient's emotional distress.
   b. Provide teaching regarding diagnosis and what to expect.
   c. Explore past coping responses to stressful events and support the use of coping skills that have been successful.
   d. Inform and support use (as desired by the patient and family) of appropriate resources for management of stress including support groups, psychotherapy and relaxation training.
   e. Provide a comfortable, supportive environment.
   f. Allow patient to ventilate feelings and fears. Listen actively and encourage the identification and use of self-help interventions.
   g. Observe for somatic symptoms and discuss such possible treatment with the health care team.
   h. Observe for more severe symptoms including anxiety, depression, and suicidal ideation, and discuss such findings with the patient's physician.
   i. Observe and report untoward effects of pharmacological management of symptoms.

C. Spiritual

Dying patients will receive palliative care consistent with their spiritual beliefs and needs. The interventions will including the following aspects:

   a. Provision of patient access to spiritual support consistent with the patient's beliefs.
   b. Provision of information to the patient regarding hospital services, pastoral care, clergy access and chapel availability.
   c. Encourage spiritual practices as the patient wishes (prayer, meditation, etc).
   d. Facilitate unlimited access/communication for the patient's clergy, as the patient desires.

1. Assessment

   Religious practices which have meaning will be identified and facilitated for individual patients, i.e., religious affiliations, religious rituals or sacraments, degree of involvement with church/synagogue/other religious institutions, etc.

2. Interventions
   a. Listen to and support the patient as she/he questions spiritual issues. Remain non-judgmental.
   b. Encourage the family to remain with patient.
   c. Refer to clergy or Hospital chaplain as requested or indicated.
   d. Plan for end of life rituals.

ADMINISTRATIVE POLICY

D. Social

Dying patients will receive palliative care in an environment that is supportive to patients, families, and friends. Patients will be assisted to interact effectively with the environment and individuals with whom they come in contact throughout their illness. Assessment will encompass the presence of behaviors and characteristics indicative of the patient's social functions, which includes interpersonal patterns and skills, support systems and coping skills. Assessment will also include a description of the family and their relationships. Health care team interventions will support "family" (as defined by the patient) cohesiveness, and integrate family strengths into the care of the patient. The patient and family will have access to educational opportunities (including how to care for the patient, as appropriate), support groups and community resources. In accordance with patient wishes, information will be shared with families and they will have opportunities to communicate their feelings regarding death and dying.

1. Assessment
   a. Identify the family support system.
   b. Collaborate with social worker to complete family assessment.
   c. Identify primary caregiver/s and learning needs.

2. Interventions
   a. Encourage communication among family members.
   b. Listen actively to family members and patient.
   c. Address fears directly and provide information to allow family to deal with fears.
   d. Respect the patient's and family's privacy.
   e. Accept the patient's and family's coping styles.
   f. Contact outside resources, as indicated or requested, to provide additional support (i.e., hospice, respite, community agency, and homemaking support, etc.)
   g. Provide instructions regarding technical skills in comfort care.
   h. Help patient redefine long-term goals and set more immediate goals such as seeing friends and completing unfinished business.

ADMINISTRATIVE POLICY

E. **Staff Considerations**

Caring for dying patients can be fulfilling, but physically and emotionally draining. Support for staff caring for these patients will be made available through Pastoral Care or other Hospital services.

Integral to the initiation of palliative care order is multidisciplinary coordination of care. This should take place as a part of the process of discussing comfort care with the patient, family and should proceed through the course of care.

The nursing manager/supervisor is to be notified immediately upon initiation of comfort care preprinted orders. The manager/supervisor will talk to the involved nursing staff to assess their need for assistance and support. Actions will be taken as indicated. The manager/supervisor can utilize hospital support services as indicated, e.g., Pastoral Care, Hospice, etc.

If a member of the health care team has personal, religious or cultural beliefs that are in conflict with the care being provided to a particular patient, they should discuss their concerns with an appropriate staff (e.g., Medical Department Chairman, Nursing Supervisor, etc.). If this discussion does not resolve the conflict, they may request to be removed from the case.

Date Ordered	Time Ordered	Diet, Treatment and Medication
		ALLERGIES: **WEIGHT:**
		1. Admit to the service of Dr.
		2. Diagnosis
		3. Hospice to follow patient (per patient's choice)
		Agency: ❑ Hospice of Summa ❑ Other:
		4. Diet ❑ Foods/fluids of choice as patient requests
		❑ NPO
		❑ No parenteral or enteral hydration/nutrition
		❑
		5. Activity ■ Out of bed, turn, reposition, etc., only as the patient requests or if the activity causes
		no symptoms of distress or discomfort
		■ No restraints
		■ Side rails can be in the down position while family present
		❑
		6. Nursing ■ Assess for pain every 2 hours while awake and PRN
		❑ Nonpharmacological pain relief methods:
		■ Mouth care every hours
		■ No routine vital signs
		❑ Discontinue all mechanical/electronic devices
		■ No weights
		■ Transfer to private room as available
		■ Unlimited visitors
		■ Foley catheter to straight drain as required for incontinence or discomfort
		■ Identified spokesperson:
		❑ DNR on chart
		■ If available, Living Will/Durable Power of Attorney on chart
		❑
		7. Respiratory ■ Suction only as the patient/family requests
		❑ O2 liters via nasal canula
		■ Pulse oximetry only as ordered
		8. Diagnostics
		■ Cancel routine labs/x-rays
		❑
		❑
		9. Medications ❑ PRN lock only for medication administration
		See back of this page for medication dosing guidelines
		❑
		❑
		Immediate release pain medication:
		❑ Morphine Sulfate mg every IVP/SQ ❑ scheduled ❑ prn
		❑ Morphine Sulfate per PCA pump (see PCA standing orders/protocol)
		❑ Morphine Sulfate 100mg/100ml (1mg/ml) at mg per hour continuous IV infusion
		❑
		❑ **Sustained release pain medication:**
		❑ MSContin mg every p.o./per rectum
		❑ OxyContin mg every p.o./per rectum
		❑ Duragesic Patch mcg/hr - apply every 72 hours
		■ Review opiate regimen and patient status with attending physician if respiratory rate
		falls below 4/min
		Physician Signature:

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IMPRINT AREA

PHYSICIAN ORDERS - PALLIATIVE CARE (Pg 1 of 2)

DOSAGE RECOMMENDATIONS FOR PALLIATIVE CARE ORDERS

INDICATION	AGENT	USUAL DOSE	COMMENTS
ANALGESIA	Morphine IV Push	2 - 10 mg every 1-2 hours	No maximum limit per SHS Medication Administration Guidelines
	Morphine SQ	2 - 10 mg every 2-3 hours	
	Morphine IV Infusion	1 - 80 mg per hour	No maximum limit per SHS Medication Administration Guidelines
	MsContin (morphine)	15 - 200 mg every 12 hours PO/PR	Every 8 hour interval may be needed to maintain adequate analgesia
	Oxycontin (oxycodone)	10 - 240 mg every 12 hours PO/PR	
	Duragesic patch (fentanyl)	25 - 100 mcg/hr every 72 hours	Every 48 hour interval may be needed to maintain adequate analgesia. Dose adjusted no more often than every 3 days. Start 25 microgram patch in opioid naive patients.
EMESIS/NAUSEA	Promethazine	12.5 - 25 mg IM/IV/PR/PO every 4 hours	IM route indicated if IV not accessible
GENERAL	Dexamethasone	1-4 mg PO/PR/IV/IM (total daily) 4-8 mg PO/PR/IV/IM (total daily) 16-32 mg (total daily)	appetite bone pain nausea or brain metastasis
AGITATION/SEDATION/ INSOMMNIA	Temazepam	7.5 - 15 mg PO before bedtime	Maximum daily dose should not exceed 30 mg
	Haloperidol	0.5 - 5 mg PO 2-3 times daily 2 - 5 mg IM/IV every 4 hours	
	Lorazepam	0.5-2 mg PO/IV/IM every 4 hours prn	
	Chlorpromazine	25 - 50 mg PO 3 times daily 25 - 50 mg IM/PR every 4 hours	
FEVER/GENERAL DISCOMFORT	Acetaminophen	650 - 1000 mg every 4 hours PO/PR	Maximum daily dose should not exceed 4 grams/day
DYSPNEA	Furosemide	20 - 80 mg PO, 20 - 40 mg IV	

Date Ordered	Time Ordered	Diet, Treatment and Medication
		Nausea and Vomiting:
		❑ Promethazine mg every via (route) prn
		❑ Magic bullet suppository (Dexamethasone 4mg, Lorazepam 1 mg,
		Diphenhydramine 25mg, in Polybase) every 6 hours prn
		❑ Metoclopramide 10mg. p.o./IV every 6 hours prn
		❑
		GI Medications
		■ AAOC
		❑ 70% Sorbitol 30ml every day for constipation
		■ Senokot S 2-4 tablets 1 to 2 times daily for constipation (maximum 8 tablets a day)
		■ Loperamide 4 mg initially followed by 2mg per each loose stool up to
		a maximum of 16mg per day prn
		❑ Dulcolax suppository 1 to 2 per rectum daily prn
		Agitation/Sedation/Sleep aids
		❑ Temazepam 15 mg po hs prn. May repeat times 1 prn
		❑ Haloperidol mg every via (route) ❑ scheduled ❑ prn
		❑ Lorazepam mg every via (route) ❑ scheduled ❑ prn
		❑ Chlorpromazine mg every via (route) ❑ scheduled ❑ prn
		❑
		Fever Control
		■ Acetaminophen 650mg every 4 hours prn via (route)
		❑
		Dyspnea
		❑ Furosemide mg every via (route)
		■ Proventil aerosol 3ml every 4 hours prn for severe dyspnea
		❑ Transderm Scopolamine patch 1.5mg. Apply topically every 3 days
		❑ Glycopyrrolate (Robinul) 0.1-0.2mg IM/IVP every 6 hours PRN to dry secretions
		Note: consider use of narcotics or anxiolytics for dyspnea
		Discontinue the following medications:
		❑
		❑
		❑
		Other medications:
		❑
		❑
		❑
		❑
		❑
		10. Misc. ❑
		Treatments ❑
		11.Consultations ❑ Palliative Care Service
		❑ Pain Service/Anesthesia
		❑ Nutrition Services
		❑ Behavioral Health Services
		❑ Psychiatry: Dr.
		❑ Community Clergy
		❑ Hospital Chaplain (as patient/family requests)
		❑ Social Work
		❑
		Physician's Signature:

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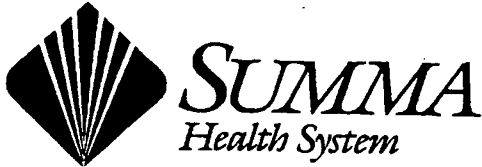

SUBJECT: END OF LIFE DECISIONS

SECTION: V

PAGE: 5.1

SUPERSEDES
POLICY DATE: 11/96

LAST REVIEW DATE: 7/00

ADMINISTRATIVE POLICY

OBJECTIVE: To ensure that the rights and needs of the dying patients are met with respect and dignity.

POLICY: The dying patient and the family will be involved in the end of life decisions.

The dying patient's wishes/consent for medical and technical procedures will be honored. Consideration in those decisions will also incorporate the advanced directive(s) and DNR wishes directives.

The dying patient's comfort needs will be met through the assessment and relief of primary and secondary symptoms, the relief of pain and in conjunction with managed/monitored care by their physician and nurse at the time.

REFERENCES: Patient Care: Advanced Directives
Admission Assessment Forms (Section IV, page 1)
Patient Care Plan: Comfort