

VALLEYCARE
OLIVE VIEW-UCLA MEDICAL CENTER/HEALTH CENTERS
POLICY & PROCEDURE

NUMBER: 209
VERSION: 2

SUBJECT/TITLE: CARE OF DYING PATIENT PROTOCOL

POLICY: Health care providers will do everything reasonably possible to address the special needs of the acutely dying patient. The needs of these patients should not be underestimated, unrecognized, or dismissed because of the terminal nature of their condition. The acutely dying, terminal patient has special needs that must be considered by the healthcare providers. The goals of care in this situation are specifically defined, to aim for alleviating suffering, minimize discomfort without attempts at eliminating the disease process.

PURPOSE: To alleviate, to the greatest extent possible, the physiological and psychological stress which is commonly experienced by acutely dying patients and their loved ones. Healthcare providers need to be able to address the special needs of dying patients; the fear of pain, the fear of being alone, and the concern about what is going to happen to their loved ones. The Healthcare providers will take into full account and focus on the individual's physical, emotional, cultural, and spiritual needs.

DEPARTMENTS: All

DEFINITIONS: For the purpose of this protocol, the acutely dying patient is an individual who:

- Has a irreversible, terminal disease
- Usually, but not always, has exhausted all therapeutic possibilities that would reverse the process.
- Who is not expected to live more than 1-2 weeks. This time is expected to be advisory, not limiting. Any patient who may benefit from this protocol is eligible.

PROCEDURE: The Palliative Care consultation service is available to assist with symptom management, prognosis determination, psychosocial support of the patient and/or family, care transition planning, and other issues related to end-of-life decisions.

Patients are treated with respect to their individual wishes for care and treatment with consideration of their values, religion, and individual philosophy. A request to discontinue treatment will be honored with the same support and respect as the decision to continue treatment.

Area 1 – Assessment of Needs

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- I. A multidisciplinary assessment of the patient's needs shall be undertaken, to include, but not be limited to:
 - A. Breathing
 - B. Discomfort/pain
 - C. Presence or absence of an Advance Directive and/or DNR order
 - D. Mobility
 - E. Ability to perform bodily functions
 - F. Level of assistance Needed
 - G. Nutritional Status
 - H. Spiritual Needs – Hospital Chaplain & community-based pastoral services
 - I. Special Death Procedures/Rituals
 - J. Psychosocial support for family/patient
 - K. Financial issues of concern
 - L. Burial/cremation arrangements or the need to make arrangements.

II. Area 2 – Pain Control

The primary fear for patients is dying in pain. Health care providers need to address all aspects of pain control, not just limited to pharmacological management. Guidelines for control are as follows:

- A. Every effort should be made to prevent and minimize pain.
- B. To the greatest extent possible, minimize the cause of pain, or factors that may be aggravating the pain (e.g., loss of sleep, anxiety).
- C. Every effort should be made to identify all factors that relieve pain for the individual (heat, cold, touch).
- D. When pharmacological measures are needed, patients should be treated for their pain in a stepwise pattern, with the least toxic drugs given first. All routes of administration (e.g., oral, I.V., transcutaneous, subcutaneous, and rectal) should be considered, and decisions made to optimize comfort and minimize invasiveness base on the patient's clinical status.
- E. The degree of pain control desired is best determined by the individual patient not the physician or nursing staff. If a patient wishes to be pain free at any cost, that goal should be attempted. If the patient wishes to be able to converse with his/her loved ones, even if that means that some discomfort is involved, than that wish should be respected. The patient's stated wishes are of the highest priority regardless of the views, although, important, of family members or health care providers.
- F. Pain medications should be given around the clock, respecting the patient's right refuse if desired. Additional orders for medication, as

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- needed for breakthrough pain should also be written.
- G. Needs for medication should be regularly assessed and the medications titrated to optimize pain relief. This should be done regardless of respiratory rate, heart rate or blood pressure are to be monitored.
 - H. A terminal patient should not be denied opioid pain medications just because they have a past (or present) history of drug abuse. Additionally, the health care team must recognize that these patients may require higher doses of these medications, due to tolerance. Their requests for higher doses due to uncontrolled pain and do not necessarily indicate drug seeking behavior.
 - I. A dying patient should never be denied opioids medications out of fear of making them “an addict”.
 - J. The administration of Narcan to a terminally ill patient may cause acute withdrawal and severe pain. Thus, there are few, if any, situations where it is indicated in a dying patient.

III. Area 3 – Respect for Privacy

- A. Terminally ill patients frequently lose control over very basic functions of life, including bowel and bladder habits. Patient should never be allowed to have these needs go unaddressed, regardless of the level of consciousness or awareness.
- B. Such patients may need closer levels of observation to ensure that such bodily needs are rapidly addressed.
- C. When possible, a dying patient should be given a private room (consider comfort care rooms if possible) or the bed farther from the door. This will allow the patient and family more privacy in their interactions (and post mortem grieving). The bed closer to the door may be too disruptive.
- D. The privacy of the patient should be ensured at all times, including, keeping appropriate clothing on the patient.

IV. Area 4 – Comfort Measures

- A. The patient’s comfort should be the ultimate goal of the medical care in the terminal situation. All procedures, including blood draws, should be evaluated with respect to the amount of discomfort testing will caused, and the purpose of the test(s) maybe serving. If little or no benefit will be achieved, and/or no therapeutic intervention made base on the results, then the advisability of a given procedure should be reassessed. The physician’s wish to know the status of a particular laboratory value is not an appropriate reason to order a test.
- B. Rules regarding visiting hours should also be revised. Visitation by family and friends should be permitted at all times and for any duration

as long as the patient is not distressed by it.

- C. Therapeutic measures, such as fluid restriction, should be considered in light of their potential benefit. It may be better to allow the patient free access to fluids, if that is their wish, as opposed to trying to correct electrolyte abnormalities.
- D. Family members should be encouraged to bring in the patient's favorite food if tolerated and personal items. There should be **NO** dietary restrictions, such as low calorie, low sodium, and low fat.
- E. The spiritual needs of the dying patient and his/her family should be addressed and respected. Any rites particular to a certain religion or culture should be allowed, as long as they do not interfere with the care of the patient. If such rites do interfere, then attempts should be made to move the patient to an area more conducive to this behavior.
- F. It should be recognized that the physiology of the dying patient is different from normal physiology. The needs of the patient should not be forced to eat if it is not desired and I.V. hydration is not necessary and may contribute to further discomfort.
- G. The spiritual and religious needs of the patient should be documented on admission, and hospital personnel should contact the appropriate religious figures if desired by the patient and family. The hospital chaplain is available for assistance. The need for Social Work assistance should be assessed and contact made.
- H. When a patient dies, an appropriate area should be found for the family in order for them to grieve and view the body, if desired. If possible, the body should be kept in the room until the family members arrive, provided their arrival is expected in a reasonable amount of time. It would be reasonable to four hours for family to arrive. It must be recognized that many of our patients live far away from the hospital and do not have easily accessible means of transportation.
- I. The following aftercare information will be available for the family members: Medical Records Mortuary Clerk, 818 364-4117, Monday through Friday, 8am to 4pm, (contact Nursing Administration if you are unable to reach the Mortuary Clerk). Nursing Administration (818) 364-3170, 24 hours per day.

V. Area 5 – Home Health Care Patients

- A. All patients on the home hospice program should be considered as covered under these guidelines. Unnecessary/futile treatment and/or diagnostic tests are not appropriate.

VI. PREMISES: Since patients may be adversely affected by the suffering of their loved ones, we should attempt to address the needs of significant others, as well as the patient. However, the needs of the patient should

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always take precedence over the needs of the family and staff.

References:	
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