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Owner:	<i>Katy Hillenmeyer: CMO Ministry PSJH</i>
Area:	<i>Administrative</i>
References:	
Applicability:	<i>CA - Santa Rosa Memorial Hospital</i>

Protocol For End of Life Care, E 12.0

I. VALUES CONTEXT:

Our value of Dignity calls on us to respect the inherent worth of every individual and to provide quality end-of-life care to all patients and their families.

II. PURPOSE\EXPECTED OUTCOME:

The purpose of this policy is to affirm that dying is a natural process, and to ensure appropriate care of the dying persons and their family.

"A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community." Ethical and Religious Directives for Catholic Health Care Services Sixth, Issues of Care for the Dying (ERD) # 56.

III. POLICY:

- A. When a physician makes a diagnosis that a patient has a terminal illness, the physician shall, upon the patient's request, provide the patient or surrogate decision-maker with information and counseling regarding legal end-of-life care options. In keeping with the health system's values, patients who are dying are always treated with dignity and respect. Comfort care of the dying patient is directed toward provision of the following:
1. Treatment of symptoms to improve a patient's level of comfort. (See End of Life Symptom Management, Comfort Care or Hospice in the hospital order sets.)
 2. Information and education regarding the dying process and community resources may be provided. Hospital resources whose members may support dying patients and their families include Spiritual Care, Social Work, the Palliative Care Team, and the Hospice Liaison Nurse.
 3. Support for the family and patient in their grief process with respect for their spiritual and cultural beliefs and traditions.
 4. *"In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (eg. the "persistent vegetative state.") who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and*

hydration becomes morally optional when they cannot reasonable be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the means employed." For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort." ERD # Directive 58.

5. *"Patients should be kept as free of pain as possible so that they may die comfortably with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering." ERD # 61.*

IV. PROCEDURE

- A. Advance Health Care Directive (AHCD), Physician Order for Life Sustaining Treatment (POLST) form, other DNR forms.

The patient's right to make decisions about his/her care is protected. The patient's AHCD or POLST or other DNR form (if available) is respected.

1. See Advance Health Care Directive Policy (B 1-62)
2. If the medical plan of care is in conflict with the patient's AHCD, POLST or other DNR form, the staff should discuss this with the attending physician. If the conflict is not resolved, refer to the Conflict of Opinion Policy (B1-12) and/or seek assistance from the Medical Ethics Coordinating Council (MECC) by contacting a Care Manager or the unit manager.

- B. End of Life Information and Counseling

Upon request of the patient, the healthcare provider should provide the patient with information and counseling regarding legal end-of-life care options. The comprehensive information must include, but is not limited to:

1. Hospice care at home or in a health care setting.
2. A prognosis with and without the continuation of disease-targeted treatment.
3. The patient's right to refuse or withdraw life-sustaining treatments.
4. The patient's right to continue to pursue reasonable disease-targeted treatment, with or without concurrent palliative care, providing that the interventions are physiologically appropriate.
5. The patient's right to pain and symptom management at the end-of-life.
6. The patient's right to give individual health care instruction so a patient may provide written health care instruction, such as an advance health care directive or POLST, and the patient's right to appoint a legally recognized health care decision maker.
7. Patient, families and significant others are encouraged to discuss care and treatment options for terminal illness with staff. As part of these discussions, request for medical aid in dying may occur. Any member of a patient care team may respond to questions from a patient or family, however request for medical aid in dying must be referred to an attending physician as defined in California's

End of Life Option Act.

SRM physicians, employees, contractors and volunteers may not knowingly participate in medical aid in dying and may not provide, deliver, administer or assist with the administration of any medical aid in dying medication or be present when a patient ingests medication with the intent of completing medical aid in dying.

C. Symptom Management

1. A variety of symptoms may be present in the dying patient and should be addressed through medication or education and support of family and patient.
2. Such symptoms may include, but are not limited to:
 - a. Pain
 - b. Shortness of breath
 - c. Anxiety and depression
 - d. Restlessness and delirium
 - e. Nausea and vomiting
 - f. Fatigue
3. Patient's response to intervention should be evaluated and treatment adjusted accordingly.

D. Nutrition/Hydration

When a person is approaching death, provisions of artificial hydration and nutrition often provide little or no benefit and could in fact cause harm. The benefits and burdens of these interventions must be discussed with the patient, family and significant others in the context of medical prognosis and goals of care.

E. Emotional and Spiritual Distress

1. Staff should encourage the expression of feelings and fears so that the patient, significant others and family members may be supported regarding the natural dying process.
2. Spiritual Care may be contacted to assist with the patient's spiritual needs. Assistance may include providing information about funeral arrangements, sacramental/ritual needs, and grief support for significant others and family members.
3. Acknowledge and respect different cultural and spiritual beliefs and traditions of the patient/family.
4. Arrangements may be made to accommodate significant others and family members so they may be present at the time of death.

DOCUMENTATION

- A. Document inclusion of the patient and family in treatment planning, support processes and the family/surrogate contact information in the patient medical record.
- B. Document the death per protocol. (B1-26 Expiration)
- C. Funeral Arrangements are to be documented in the report of death form. (#15329)

Author/Department: Medical Ethics Coordinating Council

References: Ethical and Religious Directives for Catholic Health Care Services 6th edition 2018.

Conflict of Opinion Policy (B1-12); Advance Health Care Directive Policy (B 1-62)
 Assembly Bill (AB) 2747 (Berg/Levine, Chapter 683, Statutes of 2008); California Health and Safety
 Code Sections §442-442.7 2014 California Hospital Association Consent Manual 2018

Reviewed/Revised by: Medical Ethics Coordinating Council, pending 8/12/2020 (last reviewed 3/11/2020)

Approvals:
 Policy and Procedure Routing Committee 09/21/17
 Clinical Practice Council 9/28/17
 Medical Executive Committee 10/10/17
 Board of Trustees 2/08 12/14, 10/24/17

Distribution: All Patient Care Departments

Attachment 1) Santa Rosa Memorial Hospital Ethics Ready Reference Grid

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	David Southerland: Interim Chief Operating Officer -SONMA	12/2020
Policy and Procedure Routing Committee	Dalila Formato: Project Coordinator - NE	12/2020
	Katy Hillenmeyer: Chief Mission Officer (Ministry) - PSJH	11/2020

Applicability

CA - Santa Rosa Memorial Hospital



Implementation:	05/2016
Effective:	04/2020
Last Approved:	04/2020
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Next Review:	04/2023
Owner:	Anita Ho: Regional Ethics Dir
Area:	Administrative
References:	Ethics
Applicability:	CA - Santa Rosa Memorial Hospital

End of Life Care Options Act

VALUES CONTEXT

Santa Rosa Memorial Hospital (SRMH) provides end-of-life care that focuses on the physical, emotional social and spiritual needs of patients and their families. The end of life care SRMH provides is grounded in the core values of respecting the sacredness of life, providing compassionate care to the dying and vulnerable while respecting the integrity of health care providers. SRMH is committed to providing appropriate support for dying persons and their families by honoring patients expressed end-of-life wishes and offering palliative and hospice care to provide effective pain and symptom management as well as social, spiritual and pastoral care services.

PURPOSE/EXPECTED OUTCOMES

To describe the position of SRMHH under the California End of Life Options Act (the ACT) and provide guidance in caring for patients who express interest in ending their life under the act.

SCOPE

This policy is limited to the End of Life Care Options act regarding self-administered life ending medication. This policy applies to all SRMH ministries, employees and volunteers, including all employed and contracted physicians and other professional health care providers while carrying out work-related duties for SRMH within its facilities.

POLICY

- A. Patients and families are encouraged to discuss care and treatment options for terminal illness with staff. As part of these discussions request for self-administered life-ending medication may occur. Any member of a patient care team may respond to questions from a patient or family. All requests for self administered life-ending medication must be referred to an attending physician as defined in the ACT. We recommend a Palliative Care consult for further discussion of care treatment options.
- B. SRMH physicians, employees, contractors and volunteers may not knowingly provide, deliver, administer or assist with the administration of any medication used as part of the ACT . They may not be present when a patient ingests these medication .

PROCEDURE

In keeping with the hospital's values, patients who are dying are treated with dignity and respect. The care of the dying patient is directed toward providing the following:

1. Treatments for primary and secondary symptoms that would compromise a patient's level of comfort; (see D 12 policy for end of life care or Palliative sedation policy . The End of Life Care Orders provide care management recommendation.
2. Information and education regarding the dying process, and community resources. Resources that may be contacted include Spiritual Care, Social Workers, Palliative Care, and Hospice.
3. Supporting the family and patients in their grief process, with respect for their spiritual needs, and cultural beliefs and traditions.

Listening to the patient and family is the first and foremost approach in identifying and providing support for them. Encourage expression of feelings, dialogue of treasured memories, expression of fears so that family/ support members can be educated as to what medical care entails, and can better understand what is happening to their loved one. For patient who lack family support consider contacting Spiritual Care for No One Dies alone support.

DOCUMENTATION:

- A. Evaluate patient's response to interventions for pain management/symptom control in nurses notes.
- B. Document inclusion of patient and family in nurse's notes and care plan.
- C. Document if referrals made to Spiritual Care, Social Worker, Palliative Care and Hospice. Document use of other supportive staff.
- D. Document request for Aid in Dying and follow up with attending physician.

Chapter/Department: Ethics Coordinating Council Andrew Wagner, Katy Hillenmeyer

References: Ethical and Religious Directives for Catholic Health Care Services 5th Edition
SB-128 End of life Care Option Act 2016

Reviewed/Revised by: 2/13/19

Approvals:	(Date)	Distribution: All Patient Care Departments
Policy and Procedure Routing Committee	6/24/19	
Ethics Coordination Council	2/13/19	
Clinical Practice Committee	6/27/19	
Medical Executive Committee	7/09/19	
Board of Trustees	7/23/19	

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	Katy Hillenmeyer: Chief Mission Officer (Ministry) - PSJH	04/2020

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