End-of-Life Care

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Approvals

- Signature: Policy Committee signed on 10/30/2026, 8:46:42 AM
- Signature: Policy Committee signed on 11/2/2026, 11:28:09 AM
- Signature: Michael Nevins, Chief Medical Officer signed on 11/2/2026, 12:45:59 PM

Revision Insight

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Revision Note:
Updated definition of hospice care per Dr Nevin's feedback.

Policy : End-of-Life Care

Summary/Intent:

To provide guidance clinicians when decisions have been made to initiate comfort focused care only, on the Med Surg unit

Definitions:

A. Palliative Care: Symptom management for a terminal/ non-curable illness. Treatment for disease control may be aggressively being pursued, although not with the goal of cure. Life expectancy is measured in months to years.

B. Comfort Care: This is an active treatment plan that focuses solely on relieving patient's pain and discomfort rather than on cure. This is usually initiated when a shared decision has been made to initiate comfort care, including withholding or withdrawing life-sustaining treatment and initiating Comfort Care orders. This includes an expanded tolerance for medication side effects such as sedation or respiratory depression and an abandonment of goals for recovery.

C. Hospice Care: This term should be limited to referring care provided when a patient is formally enrolled in a hospice program. As a Critical Access Hospital, Snoqualmie Valley Health is not eligible to participate in this Medicare benefit while providing Swing Bed services. However, Comfort Care may be provided for acute care patients in the hospital, and transferred to a Hospice program upon discharge.

D. Surrogate Decision-Maker: Washington State Law establishes an order of priority for individuals that can serve as surrogate decision-makers if a patient is determined to lack decision-making capacity for a particular situation. Please refer to 'Snoqualmie Valley Health - Surrogates for Medical Decision-Making Policy' (DocID 11817).

E. Attending Provider: Physician or Licensed practitioner assigned to the patient who has the primary responsibility for the treatment and care of the patient.

F. Goals of Care: There are a negotiated agreement between patient/ surrogate decision maker and treatment team about the ultimate desired outcome that guides medical decision making and choice of interventions. Goals of care are specific to the individual patient, based on their preference, values and the care team's assessment of clinical likelihood of achieving the goals. Examples of goals of care include cure, restoration of health/ function, and comfort care.

Affected Departments/Services

All departments at Snoqualmie Valley Hospital

Policy: Compliance - Key Elements

While maximizing a patient's comfort is a priority at all times in the course of care, when a patient is rapidly approaching the end of life and death is anticipated, patient-specific shared decisions will be made regarding further goals of care, by active participation of attending provider, rest of the treatment team, the patient and family/ surrogate as appropriate.
When decision has been made to pursue comfort care only, the goal of care is to prioritize pain and symptom management, being respectful of socio-cultural, and emotional needs at the end of life.
There may be instances where there is lack of consensus between the patient, family and treatment team. The primary

obligation of the hospital is to base decisions on patient's expressed wishes and best interest. Resolution of such conflicts should be attempted in family meetings, multidisciplinary meetings or other actions, as applicable.

Policy: Compliance - Key Elements

Roles and Responsibilities when death is imminent:

Role of Attending Provider:
- Discuss relevant medical information, prognosis, treatment recommendation with patient/ surrogate/ family.
- Explore their values and preferences without personal biases.
- Identify appropriate decision-maker. If the patient has capacity, the priority is to honor their decisions. If patient lacks capacity, please refer to 'Snoqualmie Valley Health - Surrogates for Medical Decision-Making Policy' (DocID 11817).
- If there is a request by patient/ surrogate/ family for a treatment that is deemed to be medically inappropriate, or futile, the provider should declare so to the patient/ surrogate/ family and enact treatment that is in patient's best interest and maintains their dignity.
- Decisions regarding medications, and other treatments should be made on a case-by-case basis. Many medications intended for prevention, or long-term benefits may be discontinued. Some medications on the current regimen may be continued if there is a possibility of increased symptom burden if they are stopped (eg. Heart rate control medications, diuretics). Guidelines for interventions may need to be adjusted, such as parameters for use of sliding scale insulin, naloxone etc.
- There is no evidence to suggest that hydration has any benefit in providing comfort when death is imminent. There is clear evidence that artificial nutrition during this phase of life is not helpful, and is often harmful. These interventions are therefore discouraged.
- Scheduled future imaging and laboratory testing should be discontinued. Scheduled vital signs (except pain assessment) should be reduced in frequency or completely discontinued.
- It is imperative to document medical decision-making conversations with the family in adequate detail in a timely manner.

Role of Nursing Staff:
- Provide symptom management per provider orders. Symptom management will be focused on patient comfort.
- Complete all required assessments and documentation per documentation standards/policy, with increased focus on re-assessment post intervention to manage end of life symptoms.
- Continue to monitor bladder and bowel function to prevent unnecessary patient discomfort
- Frequency of personal care should be guided by patient/ surrogate/ family's wishes.
- Continue standard safety measures such as Bar-Code Medication Administration and skin protection to prevent harm.
- Communicate any needs or change in status to attending provider in a timely manner.
- Advocate for discontinuation of any interventions that are no longer necessary for care, are contributing to discomfort/ distress, or don't align with the goal of comfort focused care.
- Assess for emotional and spiritual needs; contact Social Work or Attending Provider for assistance in addressing.

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