End of Life Care Pathway Guidelines

1. The End of Life Pathway is to guide continuing care interdisciplinary teams in the initiation and provision of individualized, holistic end of life care to residents/patients and their families.

2. Initiation of the End of Life Care Pathway may be suggested by any member of the interdisciplinary team when it is determined the resident/patient is nearing end of life based on CHESS Score and/or other symptoms (Step One).

3. The interdisciplinary team completes the Initial Assessment and determines the End of life Goals of Care (Step Two).

4. When the End of Life Care Pathway has been implemented, all interdisciplinary team members providing end of life care will utilize the End of Life Care Pathway for ongoing assessment, care planning, and documentation and communication (Step Three).

5. The interdisciplinary team will complete a regular reassessment of the resident’s/patient’s care needs including a reassessment of the End of Life Care Pathway use every two to five days.

6. The interdisciplinary team will document all care provided after death on the End of Life Care Pathway (Step Four).

7. Any variance(s) from the established End of Life goals or other events that require additional documentation shall be documented in accordance with organizational policy in the interdisciplinary progress notes.

8. Termination of the End of Life Care Pathway is at the discretion of the interdisciplinary team based on improvement of the resident’s/patient’s health status or upon death of the resident/patient.

9. Resource Guides are provided to assist the interdisciplinary team in the provision of appropriate symptom management at end of life and reflect current evidence-based practice.