Lincoln County Public Hospital District No. 1 d.b.a.
Odessa Memorial Healthcare Center
Department: Administration (in cooperation with Medical Staff)
Title: WA State Death with Dignity Act Policy
Reviewed/Revised: January 2019

POLICY

1. Washington law recognizes certain rights and responsibilities of qualified patients and health care providers under the Death with Dignity Act ("Act"). Under Washington law, a health care provider, including Odessa Memorial Healthcare Center is not required to assist a qualified patient in ending that patient's life.

2. Odessa Memorial Healthcare Center has chosen to not participate under the Death with Dignity Act. This means that in the performance of their duties, Odessa Memorial Healthcare Center physicians, employees, independent contractors and volunteers shall not assist a patient in ending the patient's life under the Act. In addition, no provider may participate on the premises of the hospital or in property owned by the hospital.

3. No patient will be denied other medical care or treatment because of the patient's participation under the Act. The patient will be treated in the same manner as all other Odessa Memorial Healthcare Center patients. The appropriate standard of care will be followed.

4. Any patient wishing to receive life-ending medication while a patient at this hospital will be assisted in transfer to another facility of the patient's choice. The transfer will assure continuity of care.

5. All providers at Odessa Memorial Healthcare Center are expected to respond to any patient's query about life-ending medication with openness and compassion. Odessa Memorial Healthcare Center believes our providers have an obligation to openly discuss the patient's concerns, unmet needs, feelings, and desires about the dying process. Providers should seek to learn the meaning behind the patient's questions and help the patient understand the range of available options, including but not limited to comfort care, hospice care, and pain control. Ultimately, Odessa Memorial Healthcare Center's goal is to help patients make informed decisions about end-of-life care.

PROCEDURE

1. All patients will be offered educational materials about end-of-life options. These materials will include a statement that Odessa Memorial Healthcare Center does not participate in the Act.

2. If, as a result of learning of Odessa Memorial Healthcare Center's decision not to participate in the Act, the patient wishes to have care transferred to another hospital of the patient's choice, Odessa Memorial Healthcare Center staff will assist in making arrangements for the transfer. If the patient wishes to remain at Odessa Memorial Healthcare Center, staff will discuss what end of life care will be provided consistent with hospital policy.

3. If a patient requests a referral to a physician who will fully participate under the Act or expresses the desire to take medication that will result in the patient's death, the provider may choose to provide the patient with a referral, or may instruct the patient that he or she must find a participating provider on his or her own. The relevant medical records will be transferred to the physician taking over the patient's care. The patient's primary clinical care giver (nurse or social worker) will be responsible for:

- Informing the patient's attending physician as soon as possible, and no longer than one working day, that the patient wishes to take life-ending medications.

- Ensuring that the medical record is complete and all required documentation is included. A copy of the Resuscitation Status (DNR) order, copies of advance directives, and POLST form are to be included.
- Communicating with other clinicians involved with the patient to ensure continuity of care.
- If a referral is requested, offer the patient information about the End of Life Washington website. The website contains a "support services" option. (Endoflifewa.org) or call 206.256.1636 **.**
  The state of WA also has related web information at:
  http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/FrequentlyAskedQuestions
- Documenting all communication in the patient's medical record.

4. Nothing in this policy prevents a physician or provider from making an initial determination that the patient has a terminal disease and informing the patient of the medical prognosis.

5. Nothing in this policy prevents a physician or provider from providing information about the "Washington State Death with Dignity Act" to a patient when the patient requests information.

6. Nothing in this policy prohibits a physician who is employed by or who is an independent contractor of Odessa Memorial Healthcare Center from participating under the Act when not functioning within the scope of his or her capacity as an employee or independent contractor of Odessa Memorial Healthcare Center.

SANCTIONS
If a provider participates in the Act beyond what is allowed in the policy, Odessa Memorial Healthcare Center may impose sanctions on that provider. Odessa Memorial Healthcare Center shall follow due process procedures provided for in the medical staff bylaws. Sanctions may include:

- Loss of medical staff privileges;
- Termination of Employment contracts

PUBLIC NOTICE
Odessa Memorial Healthcare Center will provide public notice of this policy in the following ways: posting this policy on the hospital's web page.

ADVANCE DIRECTIVES

STANDARD: The resident's end of life decisions will be honored when an Advance Directive is properly documented in the medical record.

POLICY:

- In accordance with federal and state laws and regulations on Residents Rights, Free Choice, Quality of Life, Dignity, Self-Determination and Participation, and the Patients Self Determination Act (PSDA), this facility will respect a resident's right to make treatment decisions and to execute Advance Directives.
- Advance Directives are a method by which residents may voluntarily provide written treatment directions regarding possible future medical care needs and/or appoint a person(s) to act as their health care decision-maker. Advance Directives are relied on by the facility when:
  - The resident is no longer able to make medical treatment decisions and
  - The treatment direction is consistent with their current treatment need and their current condition.
- If the advance directive is a Durable Power of Attorney for Health Care, the facility will look to the person appointed for health care treatment direction while the resident is incapacitated.
- Advance Directives are prepared while a resident is still competent and before there is a medical need for treatment decision to be made. The most common types of Advance Directive, in the nursing facility setting are: Health Care Directive (Living Wills), Durable Power of Attorney for Health Care (DPOHC) and Do Not Resuscitate instructions (POLST).
- The facility will not provide the resident with legal advice regarding the execution of advance directives.

PRINCIPLES;

I. NON-DISCRIMINATION

Under no circumstances will the facility require a resident to execute an advance directive or otherwise discriminate against a resident on the basis of whether or not the resident has executed and advance directive

II. COPIES OF ADVANCE DIRECTIVES

The Facility will seek copies of all advance directive documents and place copies of any documents in the resident's medical record.

III. IDENTIFYING THE DECISION-MAKER AND PRIOR DECISIONS MADE

The Facility will determine;

1. If the resident has executed an advance directive. If so the facility will identify the type(s) of directive(s) executed. Depending on the type(s) of directives executed, the facility will also identify the type of authority granted, when the authority granted takes effect and the treatment instructions provided.

2. If the resident has not executed a Health Care Directive (Living Will), POLST (Do Not resuscitate) and/or DPOAHC advance directive, the facility will determine whether the resident has capacity to execute an advance directive. The resident's capacity will be determined within the required initial assessment period and at quarterly care plans or with any significant change in condition which affects the resident's capacity.

IV. RIGHT TO EXECUTE ADVANCE DIRECTIVES

Upon admission and every 3 months (at the resident's care planning) thereafter and as the residents' condition changes, the resident will be informed both in written and orally, in a language they understand, of their right to make health care decisions. At a minimum, the facility will review these rights annually and upon significant change in the resident's medical condition.

V. FACILITY ASSISTANCE

If a resident with capacity wishes to execute an advance directive, Social Services will assist the resident in obtaining needed outside assistance, including copies of forms, witnesses, and legal advice at the resident's cost.

VI. REVIEW OF EXECUTED ADVANCE DIRECTIVES

Each completed advance directive will be reviewed with the resident:

a) Upon admission
b) At the residents request
c) When the resident experiences a change in condition
d) When the resident's condition (health) requires interdisciplinary review and/or revision to the care plan.
e) During the quarterly review of the resident's care plan. At this time the resident with capacity will be asked if there is any modification on an advance directive and/or to execute one., i.e. the POLST

VII. ACTIVATION OF ADVANCE DIRECTIVE

A Resident's advance directive(s) will be activated/effective when properly executed and as follows

a) For medical treatment decisions, a resident's Health Care Directives (Living Will) or Do Not Resuscitate (DNR) will be honored:
   * Upon loss of capacity and
   * Upon the occurrence of the medical/pyschological condition and related factors specified in the directive.

If the advance directive appointing a DPOHC is silent as to when it is to go into effect, It will become effective when the facility determines the resident lacks decisional capacity.

b) Any medical treatment direction included in the DPOHC document will not be relied on by the facility, since this facility considers any such treatment

direction to be guidance or instruction to the resident's legally appointed representative. The facility will, however, consult with the person appointed, using the informal consent process to obtain needed treatment direction.

VIII. RELIANCE ON ADVANCE DIRECTIVES

The facility will honor the advance directive of a resident, unless the facility has reason to question the legal validity of such directive. Absent a reason or basis for questioning the legal validity of an advance directive this facility will presume the directive is valid.

The facility will, however, honor the right of a capacitated resident to change their directive.

The facility will also honor the right of an incapacitated resident, who strongly and persistently objects to the facility's implementation of the directive, to either refuse or request treatment which would otherwise be provided or withheld pursuant to the resident's directive.

The Facility may question the decision of the DPOHC if the facility does not believe that the DPOHC's decision has been made in accordance with the known wishes or, if not known, in the best interest of the resident. If the facility has a reasonable basis for questioning the decision of the DPOHC, the facility will immediately notify the DPOHC and explain to such person the basis for our concern. The facility will attempt to resolve with the DPOHC any possible misunderstandings.

In the event the facility continues to have concerns regarding the DPOHC’s decision, believing that it is not made based on the known wishes or best interest of the resident, the Ombudsman will be contacted by either the facility or the DPOHC.

Pending the Obudsman's determination, the facility will provide medically appropriate treatment to the resident, with notice to the DPOHC, and consistent with the resident's strongly and persistently expressed wished, if incapacitated, or consistent with the resident's known wishes if the facility has determined that the resident has decisional capacity.

To determine whether the resident has decisional capacity, the facility will rely on the criteria, if any, specified in the DPOHC document, or if the document is silent, then in accordance with WAC 388-97-0240.

The facility reserves the right not to honor an advance directive pending advice of counsel or a judicial determination.

If a staff member objects to carrying out a resident's advance directive, then another staff member will be assigned to provide care for the resident consistent with their wishes. If a physician objects to carrying out a resident's treatment in accordance with their advance

directive, the facility will assist in finding a physician who will provide care consistent with the resident's wishes.

If a terminally ill resident wishes to die either **in** the facility or at home, in accordance with the POLST, the facility will honor those wishes. A POLST form will be completed upon admission and will be discussed at quarterly Care Conferences to ensure that all information on the POLST is current and written in accordance of the resident's wishes.

IX. FACILITY ACTION IN THE ABSENCE OF AN ADVANCE DIRECTIVE. For the residents who have not executed an advance directive or whose advance directive does not address the treatment which is currently needed, medical decisions will be made consistent with facility policies on Decisional Capacity and Informed Consent.

X. RESIDENTS RIGHTS

The existence of an advance directive, directing the facility to provide or not to provide certain treatments (POLST forms) or appointing a surrogate decision maker, does not diminish the resident's right to participate, to the extent possible, in decisions affecting care, treatment and day to day life in the facility.

The family is to be involved in care, treatment and service decisions to the extent permitted by the resident or the surrogate decision maker, in accordance with law and regulations.

A family is described as: "A person(s) who plays a significant role in an individual's life. A family is a group of two or more persons united by blood, adoptive, martial, domestic partnership or other legal ties. The family may also be a person(s) not legally related to the individual (such as a significant other, friend, or caregiver) whom the individual personality considers to be family" (Joint Commission).

Residents will be encouraged to participate in all aspects of the decision-making, to the extent possible, even when the resident appears to be unable to make a particular decision.

Residents' expressed choices and preferences will be considered and accommodated whenever possible.

Residents, with or without capacity, have the right to override their advance directives, however, if the resident is incapacitated their right to override their advance directive will be honored when the resident's wishes are strongly and persistently expressed. Residents may execute a new advance directive, POLST form if the resident has the necessary capacity.

Capacitated residents have the right to refuse treatment and to refuse continued stay in the facility. The facility will notify the resident's surrogate when the facility has determined that the resident has regained capacity. The facility will explain to the surrogate the basis for its capacity finding, The facility and surrogate will attempt to resolve any

disagreements they may have regarding the capacity finding, however, the Ombudsman intervention may be necessary.

Pending the recommendation of the Ombudsman, if necessary, the facility will provide medically appropriate treatment consistent with the resident's expressed wishes when the facility has reasonably determined that the resident has capacity. The informed consent process will be followed to determine the resident's treatment wishes.

Incapacitated residents have the right to refuse treatment and to refuse continued stay in the facility when the resident's refusal is strongly and persistently expressed.

Lincoln County Public Hospital District No. 1 d.b.a.
Odessa Memorial Healthcare Center
Department: Social Services
Title: Advanced Directives Hospital
Reviewed/Revised: January 2022

ALLOW NATURAL DEATH/WITHHOLDING AND/OR WITHDRAWING L I F E - S U S T A I N I N G T R E A T M E N T / NON-BENEFICIAL CARE AND RESUSCITATION POLICY

STANDARD:
To specify the parameters within which decisions regarding the withholding and/or withdrawing of life-sustaining treatment/non beneficial care and/or no initiation of cardiopulmonary resuscitation (CPR) shall be made.

POLICY:
It is the policy of Odessa Memorial Healthcare Center to support a patient's right to self-determine life closure by respecting the free and informed judgment made by a competent adult patient concerning the withdrawal of life-sustaining procedures while administering supportive care appropriate to the patient's needs to ensure patient's comfort and dignity consistent with OMHC mission to protect human life and respect human dignity through a just system of health care. Supportive care includes emotional and spiritual support, nutrition, hydration, oxygen, hygiene, and temperature regulation as needed. Medication to maintain comfort will be continued or initiated. Other treatments may be used with the recommendation of the healthcare provider and the agreement of the patient or family/surrogate decision-maker.

It is the policy of OMHC to initiate Advanced Cardiac Life Support (ACLS) for all patients who suffer a cardiac and/or respiratory arrest unless there is a written order by the healthcare provider (as defined by the Medical Staff By-Laws) to the contrary. ACLS includes, but is not limited to, immediate recognition of sudden cardiac and/or respiratory arrest, activation of emergency response (i.e., Code Blue), early performance of high quality CPR (compressions, airway, ventilation), identification and treatment of rhythms according to ACLS algorithms and correction of reversible causes.

It is also the policy of OMHC facilities that no person is obligated to receive life-sustaining treatment when the burdens of such treatment are greater than the benefits that can reasonably be expected. Life- sustaining treatment may be withheld/withdrawn when there is a terminal condition or a state of permanent unconsciousness.

- Physician Orders for Life Sustaining Treatment
- Organ Tissue and Eye Donation Policy
- Consents –Informed
- Code Status Orders are utilized as the single source document for a patient's code status.

If a Physician Order for Life Sustaining Treatment (POLST) form is identified by the LN, notify the MD.

- Obtain appropriate code status order.
- Original POLST form will be placed in the patient/resident chart on admission. Upon discharge, it will be returned to the patient/resident.

DEFINITIONS:

Advance Directive - A Living Will or Durable Power of Attorney for Health Care written or executed in accord with the laws of the State of Washington.

Code Status - A decision whether ACLS resuscitation will be attempted or not, if a patient suffers from cardiac and/or respiratory arrest. See POLST

Durable Power Of Attorney For Health Care: A document authorizing a person to provide informed consent for health decisions on behalf of a qualified patient.

Life-Sustaining Treatment - Any medical or surgical procedure or intervention that, when administered to a qualified patient,
will serve only to prolong the process of dying or to maintain the patient in a state of permanent unconsciousness. The artificial provision of nutrition and hydration is included as life-sustaining treatment if specified by the physician.

Permanent Unconsciousness - A medical condition that has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment (includes a persistent vegetative state and irreversible coma).

POLST-The POLST Form is a Physician's order regarding Life sustaining treatment, sanctioned by the Washington State Department of Health, which outlines a patient's wishes for End of Life care. The form is a physician's order signed by both the physician and the patient or the patient's surrogate decision-maker outside the hospital**.**

Qualified Patient - One who has executed a Durable Power of Attorney for Health Care and who has been determined to be in a terminal condition or in a state of permanent unconsciousness.

Surrogate Decision-Maker - The following classes of persons, in order of priority, may be surrogate decision-makers if no individual has been specified as Durable Power of Attorney for Health Care:

1. Patient's legal guardian
2. Patient's spouse
3. Patient's children (adopted children may consent but not stepchildren)
4. Adult Children
5. Patient's parent
6. Patient's adult brother or sister

Terminal Condition - An incurable and irreversible medical condition in an advanced state which will, in the opinion of the healthcare provider and a reasonable degree of medical certainty, result in death regardless of the continued application of life-sustaining treatment.

Non-Beneficial Care - An action, intervention or procedure that might be physiologically effective in a given case but cannot benefit the patient no matter how often it is repeated.

Unemancipated Minor: Any person who is less than 18 years old, not married to a person 18 years of age or older, and not otherwise emancipated as defined by a court having jurisdiction (RCW 26.28.020).

CONTENT:

PATIENTS CAPABLE OF CONSENTING TO OR REFUSING TREATMENT

1 A conscious adult patient capable of consenting may request that specific, medically recommended care and treatment, including life-sustaining treatment, be withheld and/or withdrawn, as well as having the authority to make the decision regarding resuscitation.

2. The patient's healthcare provider (Physician or Allied Health Provider credentialed by the OMHC Medical Staff), as well as other appropriate OMHC personnel should thoroughly explore the decisions with the patient, pointing out the probable consequences of the indicated choice. If, after the above disclosures, the patient remains firm in his/her decision, the healthcare provider is required to respect such instructions (see #20).

3. The healthcare provider shall document the following items in the patient's medical record:
   A. Factors supporting the patient's capacity to give informed consent or refusal,
   B. Disclosure to the patient of relevant risks and alternative treatments,
   C. Disclosure to the patient of the medical situation supporting the code status order, as appropriate,
   D. The patient's ability to comprehend the nature and content of the discussion, especially the possible and/or likely consequences of withholding and/or withdrawing life-sustaining treatment, and
   E. The patient's decision.

4. The healthcare provider shall write the orders necessary to ensure compliance with the patient's decision.

PATIENTS INCAPABLE OF CONSENTING TO OR REFUSING TREATMENT

5. Patients lacking decision-making capacity have the same rights concerning treatment, including life-sustaining treatment, as do conscious adults presently capable of consenting to or refusing treatment.

6. If an adult patient, when conscious and capable of consenting to or refusing life-sustaining treatment, clearly and verifiably expressed an informed desire regarding the provision of specific life-sustaining treatment, the patient's last conscious expression shall be controlling unless the patient's medical condition has changed significantly from that foreseen at the time the conscious patient expressed his/her desire or there is conflict with state law.
   A. Evidence of a patient's clearly and verifiably expressed desires may consist of a Durable Power of Attorney for Health Care, or written or oral expressions made to his/her healthcare provider, surrogate decision-maker (see definition), a member of the clergy or others close to the patient. Oral expressions must be substantiated by another source, and family members must agree that the evidence does represent the will of the patient.

B. If there is any question about conflict of interest, or if there is significant disagreement over the reliability of the evidence, the healthcare provider will institute the appropriate conflict resolution mechanism in accordance with #12 and #13.

7. If a qualified patient has executed a Durable Power of Attorney for Health Care, or in the case of a patient incapable of decision-making, the healthcare provider may arrange for an examination of the patient by a second provider for confirmation of the diagnosis.

8. If a patient is presently incapable of consenting to or refusing treatment and has not previously spoken for him/herself, the patient's healthcare provider shall consult with the patient's surrogate decision-maker regarding appropriate treatment (see #10 below). If the patient's surrogate decision- maker requests that specific medically recommended care and treatment, including life-sustaining treatment be withheld and/or withdrawn, the healthcare provider is to follow the procedure outlined in #1, #2 and #3, utilizing the guidelines in #12 and #13 below, should disagreement persist.

9. Decisions concerning the treatment of an unemancipated minor may be made by his/her legal guardian, the parent with legal custody, a natural parent, or an adult sister or brother, in the order described (see also Consent – Informed).

10. Decisions concerning treatment of an adult with a court-appointed guardian shall be made by his/her legal guardian.

11. Decisions concerning the treatment of an unconscious or comatose adult or of an adult determined to be presently incapable of consenting to or refusing treatment may be made by his/her legal guardian or surrogate decision-maker, in the order described. When no individual is known who can provide a legitimate surrogate, consent, or refusal for a patient lacking the capacity to make treatment decisions for him/herself, the healthcare provider shall consult with the OMHC Social Services and Administration.

CONFLICT RESOLUTION

12. In some situations the medical decision regarding appropriate care and the desires of the patient or surrogate decision-maker may not be in agreement. When that occurs should consider involving other staff resources as well as appropriate medical consultations.

13. THE FOLLOWING DISAGREEMENTS SHOULD BE REFERRED TO THE ATTENDING PHYSICIAN, THE PRIMARY CARE PHYSICIAN, AND ADMINISTRATION. APPROPRIATE ADMINISTRATIVE OR LEGAL CONSULTATION SHOULD BE SOUGHT AS NECESSARY.

A. A disagreement that seriously compromises the healthcare provider's sense of ethical responsibility in treating the patient

B. A request from the surrogate decision-maker to withhold and/or withdraw specific treatment when that course will result in the withholding or withdrawing life-sustaining treatment from a patient incapable of deciding for him/herself AND it is the provider's judgment that administering or continuing such treatment is appropriate.

SPECIFIC PROVIDER AND NURSE RESPONSIBILITIES

14. It is important that the patient's family and/or surrogate decision-maker be kept informed of the patient's condition, prognosis, and treatment plans. It is the responsibility of both the providers and the nurses to communicate fully with each other as well as with the surrogate decision-maker when decisions about life-sustaining treatment become necessary. Support and counseling should also be arranged for the patient and family/surrogate decision maker, as appropriate.

15. When it becomes apparent that specific life-sustaining treatment should not be initiated, or should be terminated, the patient and the family/surrogate decision-maker should be counseled and provided emotional and spiritual support. Reassurance should be given that care and treatment appropriate to the patient's condition will continue to be administered.

16. Once agreement is reached to withhold and/or withdraw life-sustaining treatment, appropriate orders and documentation must be documented in the patient's medical record. **RESUSCITATIVE MEASURES WILL BE AUTOMATICALLY INITIATED UNLESS THERE ARE DOCUMENTED ORDERS BY THE PROVIDER TO THE CONTRARY.**

17. When the healthcare provider determines that a patient's condition is such that resuscitation should not be initiated if cardiac and/or respiratory arrest occurs, the healthcare provider shall discuss the situation with the patient or family/surrogate decision-maker. This discussion and subsequent decision shall be documented in the medical record.

18. In exceptional circumstances, the healthcare provider may verbally or via telephone order the code status, other than a full code, stating that he/she has discussed the situation with the patient or family/surrogate decision-maker. Two licensed nurses must hear and verify the order and document code order. The healthcare provider must sign the order within twenty-four (24) hours. The exceptional circumstances, the decision, and the subsequent decisions shall be documented in provider's progress notes.

19. If a code status, other than a full code, is agreed upon, the medical and nursing staff shall continue to provide appropriate supportive care. The POLST form must be signed by the healthcare provider.

20. IDENTIFICATION CODE STATUS: Once the code status order is documented, the LN is responsible to incorporate the status into the patient's plan of care.

21. The healthcare provider's documentation in the patient's medical record must support the medical advisability of withholding or withdrawing life-sustaining treatment and be consistent with the criteria set forth in #33 (organ donation).

22. An order to withhold or withdraw life-sustaining treatment is NOT to be construed as an order to diminish other medical and nursing care appropriate to the patient. Both the healthcare provider and the nurses are responsible for assuring that appropriate patient care measures flow from the decision.

23. When an order to withhold or withdraw life-sustaining treatment is written by a provider it must be accompanied by a progress note documenting the healthcare provider's knowledge of and agreement with the decision. In the absence of the healthcare provider, the covering physician should be notified.

24. The healthcare provider shall review decisions to withhold life-sustaining treatment on a regular basis (at least every 48 hours) while the patient is hospitalized to determine the continuing appropriateness of such treatment.

25. When a patient or family/surrogate decision-maker wishes to modify a code status, the order is automatically canceled at the time of the request and the healthcare provider is immediately notified. The healthcare provider shall document the revocation and all pertinent discussions in the provider progress notes and order sheet. A registered nurse will also document pertinent discussions with the patient, family/surrogate decision-maker in the nursing progress notes.

26. The medical care of the patient is directed by the healthcare provider, who is not obligated to provide care that he/she feels may be of greater harm or risk to the patient than the possible benefits to be expected. If, after discussion and consultation, an healthcare provider cannot in good conscience comply with the wishes of the patient or surrogate decision-maker, the provider shall make every reasonable effort to transfer the care of the patient to another designated provider.

27. Staff members possessing ethical or religious beliefs conflicting with the withholding and/or withdrawing of life-sustaining treatment shall not be obligated to care for the patient after first assuring that care is transferred to another provider.

28. The ORIGINAL ORDERS ARE BINDING UNLESS the patient, family/surrogate decision-maker and healthcare provider agree to alter them for the duration of any interventional surgical, medical or radiological procedures.

29. Providers should inform their patients, family/surrogate decision-maker that anesthesia itself can induce significant temporary cardiopulmonary compromise. For that reason code status may be desirable for certain surgical procedures. The anesthesiologist and surgeon shall discuss the specific anesthesia risks with the patient, family/surrogate decision-maker preoperatively to ascertain whether the procedure can reasonably be undertaken with existing code status order or whether modification of the order is necessary.

30. If the patient or family/surrogate decision-maker and providers agree to change existing orders, ALL CHANGES MUST BE PRECISELY STATED IN THE PATIENT'S MEDICAL RECORD, including the onset and period for which the new orders are to be effective. An explanatory note shall be written in provider progress notes at the time of the order.

31. The orders must be reviewed at the end of the stated period to determine whether revision to previous orders or new orders are necessary. Again, all changes shall be documented as new orders and all decision-making shall include the patient or family/surrogate decision-maker.

RELATED ISSUES

32. DETERMINATION OF BRAIN DEATH: When a determination of brain death is made, the patient shall be pronounced dead. Life-sustaining treatment will be removed at that time after appropriate support and counseling for the family/surrogate decision-maker has been arranged.

33. ORGAN DONATION: In the event of organ donation, life-sustaining treatment will continue and be subsequently discontinued according to the policy on "Organ Donation". Every effort will be made to assist the family/surrogate decision-maker through the grieving process and to distinguish brain death from permanent unconsciousness.

PREGNANCY: Life-sustaining treatment will be provided to pregnant women except when it will not permit the continuing development and live birth of the child, will be physically harmful to the mother, or would cause pain to the mother that could not be alleviated by medication. A pregnancy test is required only if the provider has reason to believe the woman is pregnant.

MENTAL HEALTH ADVANCE DIRECTIVES

HOSPITAL POLICY

I Policy:

Persons with mental illness may fluctuate between periods of capacity and incapacity. Mental health advance directives provide a method of expressing instructions and preferences for treatment in advance of a period of incapacity and providing advance consent to or refusal of treatment.

It is the policy of Odessa Memorial Healthcare Center to honor mental health advance directives that meet state law requirements, medical and ethical practice standards, and the policies and procedures of this hospital. The hospital and medical staff shall presume a properly executed mental health advance directive is valid and will honor it, even if one or more provisions of the directive are deemed to be invalid. However, in those circumstances where it is not appropriate or permissible to honor mental health advance directives, the patient and/or their designated agent will be advised and appropriate documentation made in the patient's medical record.

II. Purpose:

The purpose of this policy is to describe how the hospital, hospital staff, and medical staff will comply with their legal, ethical, and other obligations concerning mental health advance directives. The policy does not address all aspects of the law governing mental health advance directives, but attempts to focus on those most relevant to this organization.

III. Definitions:

The following are key terms referred to in the law governing mental health advance directives, and are used in the procedures discussed below:

agent: an agent has legal authority to make decisions for a patient within the limits the patient has set on the agent's decision-making power

capacity: an adult that has not been found to be incapacitated under the mental health advance directives procedures set out in this policy, or under the Washington state guardianship statute RCW 11.88.010(1)(e) has capacity

health care provider: osteopathic physician or osteopathic physician's assistant, a physician or physician's assistant, or an advanced registered nurse practitioner

incapacitated: an adult who (a) is unable to understand the nature, character, and anticipated results of proposed treatment or alternatives; understand the recognized serious possible risks, complications, and anticipated benefits in treatments and alternatives, including non-treatment; or communicate his or her understanding or treatment decisions; or (b) that has been found to be incompetent under the Washington state guardianship statute RCW 11.88.010(1)(e)

professional person: a mental health professional or a physician, or registered

nurse **principal:** an adult who has made a mental health advance directive

mental health advance directive: a written document in which a patient makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the patient regarding the patient's mental health treatment, or both, and that *is* consistent with the provisions of Washington's mental health advance directive statute

mental health professional: a psychiatrist, psychologist, psychiatric nurse, or social orker

IV. Procedure:

1. Each patient shall be asked whether he or she has made a mental health advance directive and provided with a copy of the brochure, "What Patients Need to Know About Mental Health Advance Directives."

2. On receipt of a Mental Health Advanced Directive, a copy of the directive shall be placed in the patient's chart.

3. On receipt of a directive, a medical staff member shall determine the validity of the directive. It must:

   A. Be in writing;

   B. Include language that shows an intent to create a mental health advance directive;

   C. Be dated and signed by the patient or be dated and signed in the patient's presence at his or her direction;

   D. State whether the directive may or may not be revoked during a period of incapacity; and,

   E. Contain the signatures of two witnesses following a declaration that the witnesses personally know the patient, were present when the patient dated and signed the directive, and that the patient did not appear to be incapacitated or acting under fraud, undue influence, or duress.

4. The following areas of the directive shall also be reviewed for validity:

   A. Appointment of agent: If the directive includes appointment of an agent it must contain the words "This power of attorney shall not be affected by the incapacity of the principal," or "This power of attorney shall become effective upon the incapacity of the principal" or similar words.

   B. Effective date: A directive may be effective immediately after it is executed or it may become effective at a later time. Mental health advance directives validly executed before the effective date of ESSB 5223, the law relating to mental health advance

directives, are effective until they are revoked, superseded, or expire.

C. Directives created outside Washington state: A directive validly executed in another political jurisdiction is valid to the extent it is permitted under Washington state law.

D. Witnesses: Hospital staff and employees, medical staff members or any other person involved in the patient's care are not permitted to witness a mental health advance directive.

5. The patient shall be asked whether he or she is subject to any court orders that would affect the implementation of his or her directive. If so, a copy of the court order must be obtained and placed in the patient's chart.

6. On admission the admitting medical staff member shall, in accordance with the requirements of section VI of this policy, ascertain whether compliance with the directive or portions of it is possible.

7. During treatment, in accordance with the requirements of section VI of this policy, the attending medical staff member shall ascertain on an ongoing basis whether compliance with the directive or portions of it is possible.

8. If a patient consents in a mental health advance directive to electro-convulsive therapy, the therapy and the reason it was used shall be documented in the medical record.

9. On receipt of an agent's notice of withdrawal, the notice and the effective date shall be noted in the patient's chart. If there is no effective date, the notice is effective immediately.

10. A revocation of a mental health advance directive is effective upon receipt and shall be made part of the medical record immediately.

V. Non-compliance with Directive Instructions:

1. Ability to object on ***initial*** receipt of directive:

A. If unable or unwilling to comply with any part or parts of the directive *for* ***any reason,*** an objection can be made to that part or those parts of the directive.

B. Notify the patient of the objection, and, if applicable his or her agent and document the part or parts of the directive that are objectionable and the reason in the patient's medical chart.

2. Ability to object ***once acting under authority*** *of* ***a directive:***

A. Unless an objection to treatment in accordance with the advance directive has been noted on receiving the directive, treatment shall follow the directive.

B. When acting under the authority of a directive, the provisions of the directive shall be

followed to the fullest extent possible, ***except for the following reasons:***

1) compliance with the provision of the mental health advance directive would violate the accepted standard of care;

2) the requested treatment is not available;

3) compliance would violate the law; or,

4) the situation constitutes an emergency and compliance would endanger any person's life or health.

C. If unable to comply with any part or parts of the directive for the reasons cited above, the patient, and if applicable, his or her agent shall be notified and the reason documented in the medical record. All other parts of the directive shall be followed.

3. If a patient is involuntarily committed or detained for involuntary treatment and provisions of the mental health advance directive are inconsistent with either the purpose of the commitment or any court order relating to the commitment, those provisions may be treated as invalid during the commitment. However, the remaining provisions of the directive are advisory while the patient is committed or detained.

VI . Declaring a Patient Incapacitated:

1. When a patient with *a* mental health advance directive, or an agent for such a patient if applicA·le, seeks either ir,patient or outpatient mental health treatment for the patierit under the terms of the directive a capacity determination shall be made. Once a patient with a mental health advance directive has been determined to be incapacitated in accordance with the procedures below, his or her mental health advance directive will go into effect.

2. Capacity determinations:

A. At least one mental health professional or health care provider must personally examine the patient prior to making a capacity determination.

B. Prior to a capacity determination, a health care provider shall advise the patient that a capacity determination is being sought and that the patient may request the determination be made by *a* court.

C. If the patient chooses a court hearing:

1) the patient shall be given the opportunity to appear in court; and,

2) a mental health provider shall testify.

D. A capacity determination, for purposes of mental health advance directives, may only be made by:

1) a court, if the request is made by the patient or the patient's agent;

2) one mental health professional and one health care provider; or

3) two health care providers.

(Note: For purposes of 2 and 3 above, one of the persons making the determination must be a psychiatrist, psychologist or psychiatric advance registered nurse practitioner.)

E. ***An initial determination of capacity must be completed within 48 hours of a request.*** During the period between the request for an initial determination of the patient's capacity and its completion, the patient may not be treated unless consent is given, or treatment is otherwise authorized by state or federal law. If the patient qualifies for involuntary treatment under the state involuntary treatment laws, he or she may be treated.

F. If an incapacitated person is already being treated according to his or her directive, a request for redetermination of capacity does not prevent treatment.

3. Capacity determination time frames and obligations:

A. Inpatient Treatment

1) After 72 hours of inpatient treatment, reevaluate capacity when there has been a change in patient's condition that indicates he or she appears to have regained capacity.

2) At the request of the patient and/or his or her agent, a redetermination of the patient's capacity must be made within 72 hours.

3) Reevaluate capacity within 72 hours of admission or when there has been a change in the patient's condition that indicates that he or she appears to have regained capacity, whichever occurs first.

4) If a patient does not have an agent for mental health treatment decisions and asks for a determination or redetermination of capacity, complete the determination, or if the patient is seeking a determination from a court, make reasonable efforts to notify the person legally authorized to make decisions for the patient.

B. Outpatient treatment:

1) When a patient requests a redetermination of his or her capacity, the redetermination must be made within 5 days of the first request following a determination.

2) If *a* patient being treated does not have an agent for mental health treatment decisions, the person requesting a capacity determination shall arrange for the determination.

Note: If a capacity determination is not made within the time frames set out under "inpatient treatment" and "outpatient treatment" above, the patient shall be considered to have capacity. The patient shall be treated accordingly.

VII. Inpatient Treatment:

1. Consent to inpatient admission in a directive is effective only if there is substantial compliance with the material provisions of the directive related to inpatient treatment.

2. If the admitting physician *is* not a psychiatrist, the patient must receive a complete psychological assessment by a mental health professional within 24 hours of admission to determine the continued need for inpatient evaluation or treatment.

3. If the patient is found to have capacity, he or she may only be admitted to or remain in inpatient treatment if he or she consents or is detained under the state involuntary treatment law.

4. If an incapacitated patient continues to refuse inpatient treatment, he or she may seek injunctive relief from a court.

5. Discharge after 14 days** of **treatment: At the end of the period of time that the patient or his or her agent consented to voluntary inpatient treatment, but not longer than 14 days after admission, if the patient has not regained capacity or has regained capacity but refuses to consent to remain for additional treatment, release the patient during reasonable daylight hours unless detained under the state involuntary treatment law.

6. Discharge for patients with mental health advance directives voluntarily admitted to inpatient treatment: If a patient takes action demonstrating a desire to be discharged, and makes statements requesting to be discharged, the patient shall be allowed to be discharged and may not be restrained in any way in order to prevent his or her discharge. (Note, however, that if a patient presents *a* likelihood of serious harm or is gravely disabled, the patient may be held for sufficient time to notify a community designated mental health professional in order to allow for evaluation and possible detention under state involuntary treatment laws.)

7. Inpatient treatment for patients with a ***directive consenting to admission*** but ***currently refusing admission:***

A. The following admission procedure shall be followed for a patient who:

1) Chose not to be able to revoke his or her directive during any period of incapacity;

2) in his or her mental health advance directive consented to voluntary admission to inpatient mental health treatment or authorized an agent to consent on the patient's behalf; and,

3) At the time of admission to inpatient treatment, refuses to be admitted.

B. In such cases, in order for the hospital to admit the patient pursuant to the mental health advance directive, a physician member of the hospital medical staff shall:

1) Evaluate the patient's mental condition and determine in conjunction with another health care provider or mental health professional, that the patient is incapacitated;

2) Obtain the informed consent of the agent, if any, designated in the directive;

3) Document that the patient needs an inpatient evaluation or is in need of inpatient treatment and that the evaluation or treatment cannot be accomplished in a less restrictive setting; and,

4) Document in the medical record a summary of findings and recommendations for treatment or evaluation.

C. The hospital may not use or threaten unreasonable confinement if the patient refuses to stay in the hospital.

VIII. Agent Authority:

1. Unless the directive has been revoked, the decisions of an appointed agent must be consistent with the instructions and preferences expressed in the directive or if not expressed, otherwise known to the agent. If the patient's instructions or preferences are not known, the agent must make a decision he or she determines is in the best interests of the patient.

2. Except as may be limited by state or federal law, the agent has the same right as the patient to receive, review, and authorize the use and disclosure of the patient's health care information when the agent is acting on behalf of the patient and to the extent required for the agent to carry out his or her duties.

3. A directive may give the agent authority to act while the patient has capacity. Even if the directive gives such authority to the agent, the decisions of the patient supersede those of the agent at any time the patient has capacity.

4. On receipt of an agent's notice of withdrawal, the notice, and effective date if one is provided, shall be noted in the patient's chart. If no effective date is specified, the notice is effective immediately.

IX. Revocation/Expiration of a Directive:

1. A patient with capacity may revoke a directive in whole or in part by a written statement. An incapacitated patient may revoke his or her directive only if he or she elected at the time of executing the directive to be able to revoke when incapacitated.

2. The revocation is effective immediately upon receipt and shall be made part of the medical record.

3. If a patient makes a subsequent directive, it revokes in whole or in part (either by its language or to the extent of any inconsistency) the previous directive.

4. A directive remains effective to the extent it does not conflict with a court order and no other proper basis for refusing to honor the directive or portions of it exists.

5. If a mental health advance directive is scheduled to expire, but the patient is incapacitated, the directive remains in effect unless the directive specifies that the patient is able to revoke while incapacitated and has revoked the directive.

X . Conflicting Directives or Agency Appointments:

1. Discrepancies in directives or in agent appointments shall be reported to the supervisor or nurse manager.

2. If an incapacitated patient has more than one valid directive and has not revoked any of his or her directives then the most recently created directive controls any inconsistent provisions unless one of the directives states otherwise.

3. If an incapacitated patient has appointed more than one agent via a durable power of attorney with the authority to make mental health treatment decisions, the most recently appointed agent shall be treated as the patient's agent for mental health treatment decisions unless otherwise provided in the appointment.

4. Any time a patient with capacity consents to or refuses treatment that differs from the provisions of his or her directive, the consent or refusal constitutes a waiver of any provision of the directive that conflicts with the consent or refusal. However, it does not constitute a revocation of that provision unless the patient also revokes that provision or the directive in its entirety.

XI. Responsibilities:

1. Admitting staff: question patients about the existence of a mental health advance directive,

obtain copy and place in patient record. Distribute patient brochure to all patients requesting the information.

2. Admitting physician or clinician: determine validity of mental health advance directive and provide care in accordance with directive as possible; be familiar with mental health advance directive legislation-competency determinations, patient responsibilities under the law and necessary record keeping.

3. Nursing staff: be familiar with mental health advance directive legislation-competency determinations, patient responsibilities under the law and necessary record keeping.

References:

· Engrossed Substitute Senate Bill 5223 (Washington state's mental health advance directive statute), chapter 11.94 RCW, chapter 7.70 RCW, 42 CFR Part 417 et. seq.
· Washington State Hospital Association Red Head Bulletin and attached materials including mental health advance directives power point presentation for providers, clinician check list, and patient informational brochure (http://www.wsha.org/Mentalhealth.htm)
· Srebnik, D.S., Brodoff, J.D., (2003). Implementing psychiatric advance directives: Service Provider Issues and Psychiatric Services 30(3), 257-272.