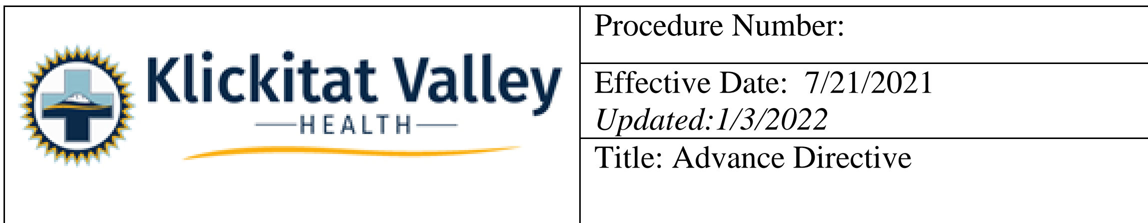


Klickitat Valley HEALTH	Procedure Number:
	Effective Date: 7/21/2021 *Updated:1/3/2022*
	Title: Advance Directive

SCOPE *(choose from: District wide, Family Medicine, Hospice, Hospital):* ***District Wide***
LEVEL *(any departments within service areas that the procedure applies to):* ***All***
POSITION(S) RESPONSIBLE: ***Providers*** ***RN's/LPN's*** ***CNA's*** ***MA's***
PURPOSE: 1. To determine a patient/representative's preferences for health care decisions and to honor those wishes 2. To inform personnel of the advance directives content so it will be honored 3. To provide a continuum of care from birth to death with respect for life and dignity at each stage of the human experience. Klickitat Valley Health respects the right of the patient to make decisions regarding the extent of resuscitation they wish to have performed.

DEFINITIONS:

Advance Directive: A document in which a person either states choices for medical treatment or designates who should make treatment choices if the person loses decisional capacity. Advance directives may include a Living Will and/or Durable Power of Attorney for Health Care, Mental/Behavioral Health Advance Directive (MHAD), POLST or other document recognized by state law. In addition, any oral statement by a competent patient of his/her desire for treatment or withholding of treatment may be considered an advance directive.

Do Not Resuscitate (DNR): A medical order to refrain from cardiopulmonary resuscitation if a patient's heart stops beating.

Surrogate Decision Maker: A person legally appointed to make decisions for someone else, as in a durable power of attorney for health care (also called an agent).
Policy – KVH recognizes that all persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. It is the policy of KVH to encourage individuals and their families to participate in

decisions regarding care and treatment. Valid advance directives such as Living Wills, Durable Powers of Attorney for Health Care, MHAD, DNR orders and POLST will be followed to the extent permitted and required by federal and state laws. In the absence of advance directives KVH will provide appropriate care and emergency procedures, according to the plan of treatment authorized by the attending physician. KVH will not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive. KVH patients will be informed of their right to use state or Medicare hotline numbers to lodge complaints concerning the implementation of the advance directive requirements.

PROCEDURE:

1. At the time of admission the admitting RN or provider will provide the patient/representative written information about advance directives and the related rights and discuss and respond to any questions the patient or family have about the materials.
2. The written materials will contain:
   - The definition of advance directive
   - KVH policies related to advance directives including any limitations caused by the agency’s conscientious objection to implementing a particular advance directive element. KVH will clarify for the patient if the state allows the agency legal authority permitting such objection and the range of medical conditions affected by the objection.
   - The patient’s rights under state law to make decisions about medical care including the right to formulate an advance directive
   - Competent adults, 18 years of age or older, have the right to refuse or accept medical care or treatment. Patients under 18 years of age shall have decisions made by their parents/legal guardians with physician input.
   - MHAD’s has expanded the law from applying to “adults” to “persons” and including within the definition of “persons” those who are at least 13 years of age but under the age of majority, provided that the person is able to demonstrate that they are capable of making informed decisions related to behavioral health care.
   - To ensure compliance with state laws KVH will inform the patient of their right to lodge complaints concerning advance directives via agency, state and/or Medicare hotlines
   - The right to access, request amendment to and receive an accounting of disclosures regarding their health information
3. KVH will not condition the provision of care or otherwise discriminate on the basis of whether or not the patient has executed an advance directive.

4. No agency employee is permitted to give either medical or legal advice regarding an advance directive.
5. The agency will document whether the patient has executed an advance directive in the patient's clinical record. When a patient is transferred to another agency or facility pertinent information concerning the advance directives or a copy will be forwarded to the receiving agency/facility.
6. KVH will inform involved personnel of the patient's advance directives content, including DNR orders, so it will be followed and patient wishes honored.
7. If a patient is incapacitated at the time of admission or start of care, advance directive information may be given to the family or surrogate. Follow-up procedures must be in place to provide advance directive information to the individual once he/she is no longer incapacitated.
8. If a patient is determined to be incompetent to make decisions then a legal surrogate will be identified. KVH will inform the surrogate of the plan of care and include the surrogate in decisions related to the patient's care.
9. A separate signed DNR or no-code (POLST) order will be obtained for patients who do not want CPR.
10. Each patient is encouraged to participate in all aspects of decision-making regarding care and treatment. Statements by a competent patient of his/her desire to accept or refuse treatment will be documented in the patient's record
11. Withdrawal or forgoing of life sustaining measures shall be considered on an individual basis with the patient, representative, and Provider as applicable. All discussions will be documented in the patient's medical record with final decisions and the signing of an informed consent by the patient or designated representative.
12. An advance directive may be revoked at any time by a patient either orally or in writing. The attending physician shall be notified immediately of any revocation. Documentation will be placed in the patient's clinical record following a revocation.

REFERENCES:
CMS 42 CFR 418.52(a)(2)
ACHC HSP2-6A
CHAP H11.1a1k

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: *See page 2 for complete instructions.*

MEDICAL CONDITIONS/INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A

CHECK ONE

Use of Cardiopulmonary Resuscitation (CPR): When the individual has NO pulse and is not breathing.

- ☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*
- ☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B

CHECK ONE

Level of Medical Interventions: When the individual has a pulse and/or is breathing.

Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

- ☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.
- ☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.
- ☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort.
Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): ______________________

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with: ☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
	PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**	PHONE
X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST**.

REV 04/2021

Page 1

Mental Health Advance Directive of (client name)
With Appointment of (agent name) as
Agent for Mental Health Decisions

PART I.
STATEMENT OF INTENT TO CREATE A
MENTAL HEALTH ADVANCE DIRECTIVE

I, (Client name), being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care.

PART II.
MY CARE NEEDS – WHAT WORKS FOR ME

In order to assist in carrying out my directive I would like my providers and my agent to know the following information:

I have been diagnosed with (client illnesses both mental health and physical diagnoses) for which I take (list medications).

I am also on the following other medications: (list any other medications for other conditions).

The best treatment method for my illness is (give general overview of what works best for client).

I have/do not have a history of substance abuse. My preferences and treatment options around medication management related to substance abuse are:

.

PART III.
WHEN THIS DIRECTIVE IS EFFECTIVE

(You must complete this part for your directive to be valid.)

I intend that this directive become effective (YOU MUST CHOOSE ONLY ONE):

_____Immediately upon my signing of this directive.
_____ If I become incapacitated.
_____ When the following circumstances, symptoms, or behaviors occur:

PART IV.
DURATION OF THIS DIRECTIVE

(You must complete this part for your directive to be valid.)

I want this directive to (YOU MUST CHOOSE ONLY ONE):

_____ Remain valid and in effect for an indefinite period of time.
_____ Automatically expire _____ years from the date it was created.

PART V.

WHEN I MAY REVOKE THIS DIRECTIVE

(You must complete this part for this directive to be valid.)
I intend that I be able to revoke this directive (YOU MUST CHOOSE ONLY ONE):
_____ Only when I have capacity.
I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.
_____ Even if I am incapacitated.
I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

PART VI.
PREFERENCES AND INSTRUCTIONS ABOUT TREATMENT, FACILITIES, AND PHYSICIANS, PHYSICIAN ASSISTANTS, OR ADVANCED REGISTERED NURSE PRACTITIONERS

A. Preferences and Instructions About Physician(s), Physician Assistant(s), or Advanced Registered Nurse Practitioner(s) to be Involved in My Treatment

I would like the physician(s), physician assistant(s), or advanced registered nurse practitioner(s) named below to be involved in my treatment decisions:

____
____

I do not wish to be treated by:

____
____

B. Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

____
____

C. Preferences and Instructions About Medications for Psychiatric Treatment (check all that apply)

_____ I consent, and authorize my agent (if appointed) to consent, to the following medications:

____
____

____
____

_____ I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:

____

____

_____ I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include:

____

____

and these side effects can be eliminated by dosage adjustment or other means

_____ I am willing to try any other medication the hospital doctor, physician assistant, or advanced registered nurse practitioner recommends.

_____ I am willing to try any other medications my outpatient doctor, physician assistant, or advanced registered nurse practitioner recommends.

_____ I do not want to try any other medications.

Medication Allergies.

I have allergies to, or severe side effects from, the following:

____

____

Other Medication Preferences or Instructions

_____ I have the following other preferences or instructions about medications:

____

____

D. Preferences and Instructions About Hospitalization and Alternatives

(check all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)

_____ In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

_____ I would also like the interventions below to be tried before hospitalization is considered:

_____ Calling someone or having someone call me when needed.

Name:_____________Telephone/text:_________________Email:____________________

_____ Staying overnight with someone
Name:_____________Telephone/text:_________________Email:____________________

_____ Having a mental health service provider come to see me.
_____Going to a crisis triage center or emergency room.
_____Staying overnight at a crisis respite (temporary) bed.
_____Seeing a service provider for help with psychiatric medications.
_____Other, specify:
____

Authority to Consent to Inpatient Treatment

I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for _____days (not to exceed 14 days). (Sign one):

_____ If deemed appropriate by my agent (if appointed) and treating physician, physician assistant, or advanced registered nurse practitioner

____
(Signature)

Or

_____ Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization)

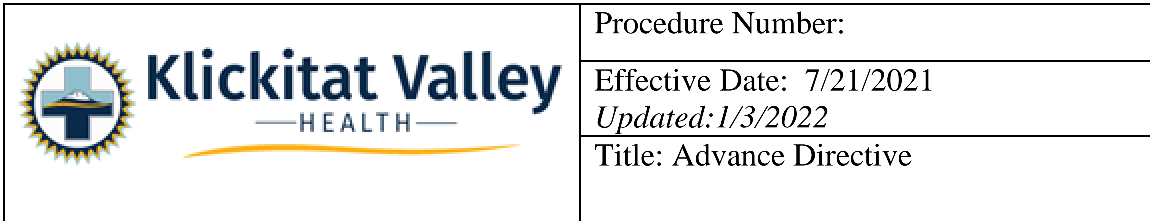
____
(Signature)

_____ I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment

____
(Signature)

Hospital Preferences and Instructions

If hospitalization is required, I prefer the following hospitals:________________________
____
____
____



I do not consent to be admitted to the following hospitals:___________________________
____
____
____

E. Preferences and Instructions About Pre-emergency
I would like the interventions below to be tried before use of seclusion or restraint is considered (check all that apply):
_____ "Talk me down" one-on-one
_____More medication
_____Time out/privacy
_____Show of authority/force
_____Shift my attention to something else
_____Set firm limits on my behavior
_____Help me to discuss/vent feelings
_____Decrease stimulation
_____Offer to have neutral person settle dispute
_____Other: ____
______

F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications
If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (choose "1" for first choice, "2" for second choice, and so on):
_____Seclusion
_____Seclusion and physical restraint (combined)
_____Medication by injection
_____Medication in pill or liquid form
In the event that my attending physician, physician assistant, or advanced registered nurse practitioner decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part VI C. of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.
G. Preferences and Instructions About Electroconvulsive Therapy
(ECT or Shock Therapy)
My wishes regarding electroconvulsive therapy are (sign one):
_____I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

____
(Signature)

_____I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

____
(Signature)

_____I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

____
(Signature)

H. Preferences and Instructions About Who is Permitted to Visit
If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:
Name: ____

Name: ____

I understand that persons not listed above may be permitted to visit me.

I. Additional Instructions About My Mental Health Care
Other instructions about my mental health care: ___________________________________
____
____
____

In case of emergency, please contact:
Name: ________________________________Address:_______________________________

Work telephone: _______________________Home telephone:_______________________

Physician, physician assistant, or advanced registered nurse practitioner:
Name: ________________________________Address:_______________________________

Telephone: ____________________________Email:_________________________________

The following may help me to avoid a hospitalization:______________________________
____
____
____

I generally react to being hospitalized as follows:__________________________________
____
____
____

Staff of the hospital or crisis unit can help me by doing the following:________________
____
____
____

J. Refusal of Treatment

_____I do not consent to any mental health treatment.

____
(Signature)

PART VII.

DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)

(Fill out this part only if you wish to appoint an agent or nominate a guardian.)
I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document and my agent does not otherwise know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.
HIPAA Release Authority. In addition to the other powers granted by this document, I grant to my Attorney-in-Fact the power and authority to serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended from time to time, and its regulations. My Attorney-in-Fact will serve as my "HIPAA personal representative" and will exercise this authority at any time that my Attorney-in-Fact is exercising authority under this document.

A. Designation of an Agent

Name: ______________________________Address:_____________________________
______

Work phone: ______________________Home/cell phone:____________________
______
Relationship: ______________________Email: ___________________________
______

B. Designation of Alternate Agent
If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:
Name: ___________________________Address:__________________________
______
Work phone: ______________________Home/cell phone:____________________
______
Relationship: ______________________Email: ___________________________
______

C. Limitations on My Agent's Authority
I do not grant my agent the authority to consent on my behalf to the following: ________
____
____
____

D. Limitations on My Ability to Revoke this Durable Power of Attorney
I choose to limit my ability to revoke this durable power of attorney as follows: _______
____
____
____

E. Preference as to Court-Appointed Guardian
In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I nominate my then-serving agent (or name someone else) as my guardian:

Name and contact information (if someone other than agent or alternate):
____
______ ____
____

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

PART VIII.
OTHER DOCUMENTS

(Initial all that apply)

I have executed the following documents that include the power to make decisions regarding health care services for myself:
_____ Health care power of attorney (chapter 11.125 RCW)
_____ "Living will" (Health care directive; chapter 70.122 RCW)
_____ I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:

PART IX.
NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS

(Fill out this part only if you wish to provide non-treatment instructions.)
I understand the preferences and instructions in this part are NOT the responsibility of my treatment provider and that no treatment provider is required to act on them.

A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible if I am admitted to a mental health facility:

Name: ________________________________Address:________________________________

Day telephone: ________________________________Evening telephone:_________________

Name: ________________________________Address:________________________________

Day telephone: ________________________________Evening telephone:_________________

Name: ________________________________Address:________________________________

Day telephone: ________________________________Evening telephone:_________________

Name: ________________________________Address:________________________________

Day telephone: ________________________________Evening telephone:_________________

B. Preferences or Instructions About Personal Affairs

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility: ______
____
____
____
____
____

C. Additional Preferences and Instructions:

____
____
____
____
____
____

PART X.
SIGNATURE

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.
In witness of this, I have signed on this _____ day of____________________, 20____.
Signature: ____
STATE OF WASHINGTON)
) ss.
COUNTY OF_____________)
I certify that I know or have satisfactory evidence that ______________________ is the person who appeared before me, and said person acknowledged that he or she signed this Durable Power of Attorney and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in this instrument.
SUBSCRIBED and SWORN to before me this _____ day of____________________, 20____.

____
SIGNATURE OF NOTARY

____
PRINT NAME OF NOTARY
NOTARY PUBLIC for the State of Washington at

____
My commission expires

____

OR have two witnesses:
This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We

declare that, at the time of the creation of this instrument, the Principal is personally known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:
(A) A person designated to make medical decisions on the principal's behalf;
(B) A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;
(C) An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;
(D) A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010;
(E) An incapacitated person;
(F) A person who would benefit financially if the principal undergoes mental health treatment; or
(G) A minor.

Witness 1 Signature: ________________________________Date:____________________________

Printed Name:______________________________________Address:_______________________

Telephone: ____

Witness 2 Signature: ________________________________Date:____________________________

Printed Name:______________________________________Address:_______________________

Telephone: ____

PART XI.
RECORD OF DIRECTIVE

I have given a copy of this directive to the following persons:

Name: _______________________________Address:_______________________________

Day telephone: ______________________________Evening telephone:____________________________

Name: _______________________________Address:_______________________________

Day telephone: ______________________________Evening telephone:____________________________

DO NOT FILL OUT PART XII UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE

PART XII.
REVOCATION OF THIS DIRECTIVE

(Initial any that apply):

_____ I am revoking the following part(s) of this directive (specify): ________________
____
____
____
____

Date: _________________________ ______

_____ I am revoking all of this directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

____ ______

(Signature)

Printed Name: ____ ____________

DO NOT SIGN THIS PART UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE