OVERLAKE MEDICAL CENTER & CLINICS

Death With Dignity Act/Physician Assisted Suicide

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Policy : Death With Dignity Act/Physician Assisted Suicide

Policy Statement

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 Overlake Hospital Medical Center ("OHMC") and Overlake Medical Clinics (OMC) are not required to assist a qualified patient in ending that patient's life. Health care providers ("Providers") include any person licensed, certfied, or otherwise authorized or permitted by law to administer health care or dispense medication in ordinary course of business or practice of a profession.
2. 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 OHMC and OMC patients. The appropriate standard of care will be followed.
3. Any patient wishing to receive life-ending medication under the Act while an inpatient at OHMC's hospital will be assisted in transfer to another facility of the patient's choice, upon their request. The transfer will assure continuity of care.
4. All providers at OHMC/OMC are expected to respond to any patient's query about life-ending medication with openness and compassion. OHMC/OMC 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, OHMC/OMC's goal is to help patients make informed decisions about end-of-life-care.
5. OHMC has chosen to not participate under the Death with Dignity Act within the inpatient areas of the hospital and in most outpatient departments. This means that:
    a. Providers shall not participate under the Act in any OHMC operated in-patient facility and in all outpatient and or clinic facilties except for the Overlake Senior Care Clinic, the Overlake Oncology Clinic, the Overlake Pulmonary Clinic and the Overlake Cardiology Clinic.
    b. Except for those Providers practicing in Overlake Senior Care Clinic, the Overlake Oncology Clinic, the Overlake Pulmonary Clinic and the Overlake Cardiology Clinic, all other Providers employed by OHMC/OMC or contracting with OHMC/OMC as independent contractors shall not participate under the Act when acting within the scope of their capacity as an employee or independent contractor of OHMC.
    c. OHMC's pharmacies will not honor prescriptions for end-of-life-medications.
6. All patient contact and communications by OHMC/OMC employees and volunteers shall be consistent with this policy.
7. As used in this policy, "participate under the Act" includes performing the duties of an attending physician under RCW 70.245.040, the consulting physician function under RCW 70.245.060, or the counseling function under RCW 70.245.060.
8. Nothing in this policy:
    a. prevents a Provider from making an initial determination that the patient has a terminal disease and informing the patient of the medical prognosis,
    b. prevents a Provider from providing information about the Act to a patient when the patient requests information,
    c. prohibits a Provider who is employed by or who is an independent contractor of OHMC/OMC from participating under the Act when not functioning within the scope of this or her capacity as an employee or independent contractor of OHMC/OMC, or
    d. prohibits a Provider who is not an employee or independent contractor of OHMC/OMC from participating under the Act in the private medical office of a Provider.

Procedure

1. Patients will be provided with educational materials about end-of-life options upon request. Materials will include a statement that except as outlined above, OHMC/OMC does not participate under the Act.
2. If, as a result of learning of OHMC/OMC's decision not to participate in the Act, the patient wishes to have care transferred to another hospital of the patient's choice, OHMC/OMC staff will assist in making arrangements for the transfer. If the patient wishes to remain at OHMC, staff will discuss what end of life care will be provided consistent with hospital policy.
3. If a patient requests a transfer 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 Provider receiving the request shall inform 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. The attending physician shall be responsible for:
    a. 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.
    b. Communicating with other clinicians involved with the patient to ensure continuity of care, either by communicating that the attending physician will continue to provide care for that portion of the patient's care that does not require participation under the Act, or by cooperating with the transfer of that care to another physician.
    c. Documenting all communication in the patient's medical record.
    d. The relevant medical records will be transferred to the physician taking over the patient's care.

Sanctions

1. If a provider participates under the Act beyond what is allowed in the policy, OHMC/OMC may impose sanctions on that provider through the process provided in the OHMC Medical Staff Bylaws, including the due process right to hearing and appeal. The sanctions may include:
    a. Loss, suspension or restriction of medical staff privileges;
    b. Loss or suspension of Medical Staff membership; or
    c. Placing medical staff privileges or membership on probation
2. If a Provider who is employed or who has an independent contractor agreement with OHMC/OMC participates under the Act beyond what is allowed in the policy, OHMC/OMC may also impose sanctions on that Provider in relation to the agreement. The sanctions may include termination of any written or oral employment or independent contractor agreement, or any other remedy or sanction available under the agreement and/or OHMC/OMC policies.

Public Notice

OHMC/OMC will provide public notice of this policy in the following ways: posting the policy or information about the hospital's stance on the Death with Dignity Act on the hospital's web page.

Laws/Regulations: Initiative 1000/Washington Death with Dignity Act; RCW Chapter 70.245, Washington State Department of Health Regulations Chapter

246-978 /WAC.

Reference Materials: The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals.

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OVERLAKE MEDICAL CENTER & CLINICS

Advance Care Planning

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Approvals

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Protocol : Advance Care Planning

PURPOSE

To ensure:

- The right of every adult patient or emancipated minor is to participate in and direct their own healthcare decisions, consistent with the Patient Self Determination Act.
- The right of the patient to formulate an Advance Directive.
- The right of a patient to have a Durable Power of Attorney for Healthcare that appoints a healthcare agent to make health care decisions on his/her behalf to the extent permitted by law.
- The right of the patient to have a POLST.
- Patients and their healthcare agency or other medical decision maker receive written information and verbal communication of these rights at the time of admission and when clinically indicated
- That the patient will receive care whether or not he/she has an Advance Directive, POLST, or Durable Power of Attorney for Healthcare

SCOPE

This policy applies to patients who receive care on the inpatient hospital units, in the emergency department, and at the Overlake Clinics.

- Outpatient clinic patients or healthcare agent or other medical decision makers will be asked to provide copies of any existing Advance Care Planning documents. Written educational materials are provided to any patient asking for more information related to Advance Care Planning (ACP).

- Emergency response, including 911 call, should be initiated for outpatient clinic patients experiencing a medical emergency, regardless of documented preferences. If legal documentation of CPR or intubation preferences is not readily available, these measures should be initiated.

DEFINITIONS

Adult: A person who is age 18 or older and has capacity to make healthcare decisions.

Advance Care Planning (ACP): A process of planning for future health care, focused on care to be received in the context of serious illness or incapacity. It may include conversations about future treatment, education about and completion of advance care planning documents, end of life (EOL) treatments, selection of and education of healthcare agents. Advance directive such as a Living Will and Durable Power of Attorney for Healthcare are recommended for all persons over the age of 18 with the capacity to understand these documents. For patients with serious illness, limited functional status, or self-defined poor quality of life, advance care planning can include completion of state Physician Orders for Life Sustaining Treatment (POLST) forms.

Advance Directives: A written instruction, such as a Living Will or a Durable Power of Attorney for Healthcare, recognized under state law, relating to the provision of healthcare when the individual is incapacitated. The document expresses the patient's wishes about treatment preferences or designates a health care agent if the patient is incapacitated, respectively.

Other Medical Decision Maker: According to the Washington State Hierarchy, in the absence of a guardian or a named healthcare agent in a Durable Power of Attorney for Healthcare, medical decisions for an incapacitated person can be made by other decision makers. The order of priority for the other medical decision makers are outlined below:

- The patient's spouse or state registered domestic partner
- Children of the patient who are at least eighteen years of age
- Parents of the patient
- Adult brothers and sisters of the patient
- Adult grandchildren of the patient who are familiar with the patient
- Adult nieces and nephews of the patient who are familiar with the patient
- Adult aunts and uncles of the patient who are familiar with the patient
- An adult who:
    - Has exhibited special care and concern for the patient

- Is familiar with the patient's personal values
- Is reasonably available to make health care decisions

Healthcare agent: This is the person chosen by the patient to make medical decisions if the patient cannot make them for his/herself. This person is authorized to make decision with the patient's health care providers about his/her care.

Decision Making Incapacity: An individual is incapacitated if he/she lacks the ability to make informed medical or other decisions. Incapacity is a medical determination by a physician or psychiatrist. Incapacity is not a legal determination.

Emancipation of Minors: Emancipation of minors is a legal mechanism by which a child before attaining the age of majority, is freed from control by their parents or guardians, and the parents or guardians are freed from any and all responsibility for the child.

- Consult with Risk Management, Ethics, and Social Work.

Types of Advance Directives

Advance Directive/Living Will: Permits an individual with decisional capacity to specify preferences regarding the withholding or withdrawal of life-sustaining treatment if terminally ill or permanently unconscious, *see* RCW 70.122. It also allows an individual to write down health care values and any other directions for his/her medical providers. Washington State requires this Advance Directive/Living Will to be witnessed by two people or acknowledged by a notary public. The witnesses to this document must be adults with decisional capacity and NOT be related to the patient by blood or marriage, entitled to any portion of the patient's estate upon his/her death, be the patient's attending physician or an employee of the attending physician or health care facility where the patient receives care or any person who has claim against any portion of the patient's estate at the time of signature of this document.

Exception: During periods of limited visitation at the hospital (i.e. pandemic), healthcare staff, who are not part of the patient's treatment team on the day that the Health Care Directive is completed, may witness this document.

Durable Power of Attorney for Healthcare: A legal document that designates a healthcare agent to make health care decisions if the patient is no longer able to make them. *See* RCW 11.94. The healthcare agent is authorized to consent to stop or refuse most medical treatment for the individual if a physician determines the individual to be unable to make those decisions for his/her self. Washington State requires this directive to be witnessed by two people or acknowledged by a notary public. The witnesses to this document must have decisional capacity and must NOT be related to the patient or the patient's health care agent by blood, marriage, or state registered domestic partnership, the patient's home care provider or a care provider at an adult family home or long-term care facility where the patient lives or the patient's designated health care agent(s).

POLST (Physician Orders for Life Sustaining Treatment): Is a medical order, signed by both a provider and patient that is used to communicate medical care decisions to health care providers and emergency responders. It is appropriate for anyone with a serious and/or life limiting illness. It is a portable document meant to follow the patient through all care settings. It is not an advance directive, but rather is meant to compliment an advance directive. WA honors POLST from multiple other states.

Mental Health/Psychiatric Advance Directive: Allows a person to state their preferences for treatment in advance of a crisis. They can serve as a way to protect a preson's autonomy or capability to self-direct.

SUPPORTIVE INFORMATION

An Advance Directive need not comply with any particular form or formalities, as long as it is in written form, is signed and appears to be authentic.

An adult patient who has capacity to make his/her own health care decisions should be consulted about their health care wishes, even when the patient has an Advance Care Planning document.

Healthcare staff should not witness any financial documents, such as wills or Durable Power of Attorney for Financial.

The most current Advance Directive/Living Will, Durable Power of Attorney for Healthcare, and POLST forms are located on the P: drive under Advance Care Planning Resources.

For Advance Directive documents in other languages, please use Honoring Choices Pacific Northwest booklets at the following web link: https://www.honoringchoicespnw.org/advance-directive-documents/

PLEASE NOTE: These documents can be used to assist patients with understanding informaton in their primary language, but tne **English version** of the form needs to be signed and scanned into EPIC. Interpretations are also available through Interpreter

Services to assist with review of these documents and these conversations.

National POLST www.polst.org provides information about POLST

Steps

1. All hospitalized patients (including both inpatient and observation), surgical outpatients, and Hospital Based Outpatient Services patients (18 years or older), or their healthcare agent or other medical decision maker will be asked if they have Advance Care Planning (ACP) documents, including Advance Directive/Living Will, Durable Power of Attorney for Healthcare, or POLST.
    a. **Key Point - If the patient is admitted to the hospital, upon arrival on the nursing unit, the Advance Care Planning Questionnaire is completed by the nurse per information communicated by the patient, healthcare agent, or other medical decision maker.**
2. If the patient, healthcare agent, or other medical decision maker has ACP documents, they will be asked to provide a copy of the document(s)
3. The patient, healthcare agent, or other medical decision maker will also be asked if they want additional information about any of the ACP documents.
4. If the patient, healthcare agent, or other medical decision maker requests information, Admitting, nurse, or other clinical staff will offer the patient a copy of the patient education booklet "Your Guide to Advance Care Planning" and document acceptance or declination of booklet on the Advance Directive Questionnaire for inpatient units or per documentation standards in clinics, typically using the dot phrase (.acpoptions).
5. Patient, healthcare agent, or other medical decision maker will be encouraged to talk with the clinical team about any additional questions.
6. When a patient, healthcare agent, or other medical decision maker provides a copy of any of the ACP documents, it is the responsibility of the primary nurse to complete the steps outlined below:
    a. Ask patient, healthcare agent, or other medical decision maker to review the document and confirm that the document is the most recent version and that it is still correct. Ask the patient, healthcare agent, or other medical decision maker to sign and date the form as evidence of their review of the document for accuracy.
    b. Two nurses will conduct an independent double check, which includes reviewing the document for the following:
        - Two patient identifiers verified by two nurses independent of each other and then this independent verification is compared by the two nurses
        - Confirming that the Licensed Independent Provider (LIP) and the patient, healthcare agent, or other medical decision maker have signed and dated the document
        - Confirming that the patient identification information is on each page of the ACP document

        Key Point - The patient label should not be placed on the ACP document until after this review process is completed.
    c. Nurse or charge nurse will scan all pages of the document into the electronic medical record, per the scanning process posted on nursing unit, and give the original back to the patient, healthcare agent, or other medical decision maker.

        Key Point → When the ACP documents are scanned, the ACP documents appear in the ACP Navigator section and the Media Tab of the EMR.
    d. The nurse or charge nurse then completes the Healthcare agent section in the Admission Navigator with the appropriate information based on the type of ACP document(s) received.
    e. The nurse documents in the progress notes using the appropriate Smart Text in EPIC
    f. The Health Information Management (HIM) staff will complete a quality assurance process on any POLST forms scanned in the last 24 hours to verify accuracy. If any discrepancies are identified, HIM will contact the Nurse Manager on the unit where the POLST originated. If the Nurse Manager is not available, HIM will contact the charge nurse.

        Key Point - If the POLST does not match current code status order, the attending physician will be asked to review the POLST scanned into EPIC and update the order as indicated.
7. If the patient is critically ill and unable to verbalize, or does not have a healthcare agent, or other medical decision maker that is aware of ACP documents, health care providers will provide care as if there is no ACP document executed.

    Key Point →ACP Questionnaire will be completed and signed by the nurse to reflect the above situation.

8. If a patient is unable to give information or answer question regarding the existence of an ACP document, the nurse will notify the healthcare agent, or other medical decision maker to provide the document, if one exists. Follow-up documentation will be added to the Navigator to ensure that it is obtained.

9. Important information about the POLST Form:
    a. **Key Point → the original green POLST form is not used as an order form. The LIP must write the patient's wishes as an order in EPIC. The LIP will confirm with a patient, who has decisional capacity, that the POLST reflects current wishes, or with a** healthcare agent, or other medical decision maker **when available.**
    b. **Key point → Within 24 hours of admission, the LIP needs to write code status in EPIC for this hospital admission to reflect the known wishes of patient.**
    c. **Key Point → If a patient is admitted with documentation of their wishes not to be resuscitated in a Advance Directive/Living Will or POLST form, and no physician order has been written at the time of arrest, a Code Blue will be initiated.**
    d. **Key Point → It is the responsibility of the Registered Nurse caring for the patient to inform the responding Physician at the time of arrival of the existence of the documented no code wishes.**

10. Referrals for assistance with health care decisions or completing the ACP documents during hospitalization may be directed to Social Work, Chaplain, and Palliative Care Consultation Services.

    Key Point → Patients with complex medical or psychosocial histories may benefit from Palliative Care Consultation services. Palliative Care consults can only be placed by an MD.

11. Advance Care Planning Reporting:
    a. Nursing Assessment indicates that patient has an Advance Care Planning document
    b. Document scanned into EPIC
    c. Appropriate Smart Text documented in EPIC

12. If a patient decides to revoke an ACP document, document this in EPIC and notify the Physician.

13. Refer to "Mental Health/Psychiatric Advance Directive" policy for information related to individuals with mental illness or psychiatric conditions.

DOCUMENTATION

1. ACP Questionnaire is completed by the nurse on admission per communication from the patient, healthcare agent, or other medical decision maker.
2. When guardianship or Durable Power of Attorney for Healthcare document are received, the nurse will complete the Healthcare agent section in the Admission Navigator.
3. When the other medical decision makers are identified, this information is documented in the "Contact Section" of the Nursing Admission Navigator.
4. Completion or follow up needs of this process is documented on the care plan within 24 hours of admission.

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Other Documents: (WHICH REFERENCE THIS DOCUMENT)	Critical Care Unit Standards of Care Advanced Care Panning Process Intermediate Care (IMC) Standards of Care		

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