Status Active PolicyStat ID 11424131

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Owner	Cynthia Sidley: Executive Director Nursing
Policy Area	Patient Care Services
Applicability	WA - Providence Centralia Hospital

Post Mortem Care & Release of Body

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POLICY NUMBER: 86100-PCS-085

PURPOSE:

To describe post mortem care and requirements for release of body.

APPLIES TO:

Provider**, Registered Nurse** (RN), Administrative Supervisor, Security Staff, Spiritual Care

POLICY STATEMENT:

Adherence to proper post mortem procedures assures that the decedent is given the same care and respect that the patient was given in life.

1. Pronouncement of Death
    A. A RN may determine and pronounce a patient dead, but shall not certify death unless the RN is a licensed ARNP, if the following three conditions are met:
        1. The decedent was under the care of a health care practitioner qualified to certify cause of death,
        2. The decedent was a patient of the organization with which the nurse is associated, and
        3. There is a do not resuscitate order in the patient's record when the

decedent was assisted by mechanical life support systems at the time of the determination and pronouncement of death.

B. A RN who assumes responsibility for the determination and pronouncement of death shall:
    1. Perform a physical assessment of the patient's condition, assessing for pulselessness and cessation of respirations.
    2. Ensure that family, physician, and other caregivers are informed of death.
    3. Document the findings of the assessment in the electronic medical record (EMR). Under the postmortem tab in the EMR document the expiration and notification details.

C. The primary provider is responsible for certifying death

D. Recording and Reporting
    1. Complete report of death form. Document
        a. Time of death,
        b. Resuscitation efforts, if applicable and
        c. Who pronounced the death of the patient.

2. Notifications
    A. The RN assigned to the patient will assure that the patient's Provider is notified of patient death.
        1. Family/signifcant others: The RN will confirm with the Provider who will notify the family/significant others.
            a. If death is expected and occurs during the night, notification of the Provider may be delayed until morning per Provider preference.
        2. Administrative Supervisor. Include the following information:
            a. Patient's name
            b. Date and time of death
            c. If death was expected
            d. Primary diagnosis including infectious disease
            e. Donor status
            f. Mortuary selected
            g. Family contact
            h. If patient had been restrained any time within 24 hours of the time of death
            i. In ED, notification of coroner and status (within jurisdiction or declined)
            j. Patient weight if > 250lbs/113.64 K

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3. Spiritual Care staff, if the family requests a chaplain to be present.
4. Hospital operator to re-route all patient calls to nurses station.
5. Donor Referral Line **within an hour of the patient death. Refer to policy "Organ and Tissue Donation" for required notifications and procedure for additional direction.**

B. Coroner

1. Death in the Emergency Department (ED)
    a. All deaths occurring in the ED as well as patients who are dead on arrival to the ED must be reported to the Coroner.
    b. The ED RN will notify the coroner of the death and inform the Administrative Supervisor that the coroner was called and the status.
    c. The Coroner or Coroner's Deputies can be contacted 24 hours/ day 7 days/week by contacting Lewis County Central Dispatch at 911.
    d. The following information will be provided to the coroner:
        1. Name and age (if known) of the deceased
        2. Attending provider
        3. Date and time of admission
        4. Time of death
        5. Diagnosis
        6. Place, date, time and manner of accident or violence if any
        7. Name of nearest relative (if known)
        8. Any other relevant information
        9. Document on the report of death form that the Coroner was notified (date, time, name of Coroner or Deputy Coroner) and disposition of case
        10. If an autopsy is deemed necessary by the Coroner to certify the cause of death, the Coroner's office will take charge of the body.
2. Reportable deaths occurring outside the Emergency Department
    a. Operating Room (OR) Deaths
        1. All deaths that occur in the OR will be reported to the Coroner by a RN providing care.
        2. In general, the Coroner will assume jurisdiction and investigate any surgical death that occurs under the following conditions:

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a. Where the procedure performed is considered by others in the profession to be relatively low-risk, and the patient dies unexpectedly.

b. Where the death of the patient occurs during the performance of a procedure, or during the immediate post-operative period, and the patient's condition was not considered to be life-threatening prior to the initiation of the procedure.

b. Acute Care setting Deaths. The following cases are reportable deaths as defined by Washington State Law:

1. Deaths within twenty-four (24) hours of admission to the hospital; or
2. Persons who die suddenly when in apparent good health without medical attendance within the thirty-six (36) hours preceding death; or
3. Circumstances of death indicate death was caused by unnatural or unlawful means; pr
4. Where death occurs under suspicious circumstances; or
5. Where death results from unknown or obscure causes; or
6. Where death occurs within one (1) year following an accident; or
7. Where death is caused by any violence whatsoever; or
8. Where death results from known or suspected abortion, whether self-induced or otherwise; or
9. Where death apparently results from drowning, hanging, burns, electrocution, gunshot wound(s), stab(s), or cut(s), lightening, starvation, radiation, exposure, alcoholism, narcotics, or other addiction(s), tetanus, strangulation, suffocation or smothering; or
10. Where death is due to premature birth or stillbirth; or
11. Where death is due to a violent contagious disease or suspected contagious disease which may be a public health hazard; or
12. Where death results from an alleged rape, carnal knowledge or sodomy; or
13. Where death occurs in a jail or prison; or
14. Where a body is found dead; or

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15. Bodies that are not claimed (*limit to cases where no next-of-kin or other legally responsible representative can by identified for disposition of the body).*
16. Sudden Infant Death Syndrome (SIDS) cases:
    a. If there is any question regarding the cause of death, an autopsy will be done with or without the parents' consent.
    b. This will be coordinated by he Coroner.

3. When the deceased is a victim of severe trauma (homicide, motor vehicle accident (MVA), etc.) the Coroner requests that tubes (i.e. endotracheal tubes (ET), chest, drainage tubes, intravenous (IV), etc. be left in place until the patient is released by the Coroner, to assist the pathologist who performs the autopsy in determining what injuries occurred at the time of the incident.
    a. If a question exists, tubes should be left in place and the Administrative Supervisor contacted.
    b. Ask the Coroner if the body may be moved to the morgue area.
4. Do not clean the body or clothing after death until released by the Coroner.
5. Every effort will be made to locate the next of kin or "responsible party" when a patient expires.
    a. If the effort is unsuccessful, notify the Coroner.
        1. Coroner will designate to which mortuary the body is to be released.
    b. The hospital employee releasing the body should provide the mortuary representative with as much information as possible regarding efforts to locate the next of kin/responsible party to aid them in continuing the search.
6. Protected health information (PHI) including medical records, may be disclosed to a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties as authorized by law.

3. Post Mortem Care
    A. Gather equipment:
        1. Report of Death form
        2. Authorization for Autopsy, 2 copies (if applicable)
        3. Patient Belongings Bag
        4. Post Mortem Kit
        5. Gloves and any other personal protective equipment (PPE) that is appropriate

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B. Confirm that the body has an ID band in place. If not, follow policy "Patient Identification" and place an ID band on the body.

C. If the coroner takes jurisdiction of the body, refer to section "2.Notifications; B Coroner" of this policy.

D. If the coroner releases the body, or the deceased is not a coroner's case:

1. Use Standard Precautions
    a. Clean body as necessary.
    b. Apply dressings to contain drainage as needed.
    c. Place disposable protective pad under perineal area as appropriate.
    d. Remove all tubes, catheters, and IVS.
    e. Place dentures in mouth, if possible. Otherwise, send dentures with body.
    f. Straighten body, close eyes, elevate head slightly and drape arms across chest. To decrease the chance of discoloration or pressure deformities from occurring, do not cross arms.
    g. Put a gown on the patient is the family is going to view.
2. Place all personal belongings in a patient belonging bag. Label with patient's name.
    a. Complete the Admission Valuables Checklist, of applicable.
    b. Release belongings and valuables to patient's family/legal representative, if present.
    c. If family requests certain jewelry items (I.e. wedding band) left on the patient, tape to the body so it will not slip off during transport and document in the EMR.
    d. Any personal belongings and/or valuables that are not released to the family/legal representative will be sent with the body to the mortuary.
    e. If family is undecided on mortuary, body can remain in our holding area for up to 24 hours. If a decision is not likely to occur by family prior to that time, body can be sent to Cattermole Funeral Home for extended holding. Contact Cattermole Funeral Home at 360-785-3881 to pick up body. Cattermole will then coordinate with family to send body to mortuary of choice.
3. Allow time for the family to help prepare or view the body as desired. Maintain environment of comfort, warmth, and caring. Provide comfort to family as needs arise. Spiritual Care and Social Services staff is available to offer support or consultation Before the family leaves, request a phone number where they may be reached in the next few hours. Record the number on the Report of Death form. Send belongings home with family.

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4. If the family is unable to arrive in a timely manner, request that the body be viewed at the mortuary.
5. At the discretion of the Administrative Supervisor, if the body remains on the unit/department rather than going to the morgue, all notifications must be documented. Administrative Supervisor and licensed nurse are responsible for release of the body to the mortuary from the unit/department.
6. Complete and sign the Report of Death form.

4. Release of Body
   A. Release of Body from Unit/Department
      1. Before releasing a body to the coroner or mortuary, the Administrative Supervisor and licensed nurse will confirm the body's identity, confirm that an ID band is in place, and will verify that the face sheet information matches. Once the information is confirmed, the Administrative Supervisor or designee and the nurse will co-sign the Report of Death form.
      2. The coroner or mortuary attendant and licensed nurse on the unit will sign the Report of Death form, confirm the patient's ID band and face sheet match and give the yellow copy of the face sheet to the coroner or mortuary attendant.
      3. If the patient valuables and belongings are sent with the body, the coroner or mortuary attendant will sign the Admission Valuable Checklist to confirm disposition.
      4. Administrative supervisor will return the completed original Report of Death form to the patient's chart

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   B. Transport to Morgue
      1. Before the body leaves the unit/department, two licensed nurses will:
         a. Confirm the body's identify
         b. ID band is in place
         c. Verify that the face information matches.
         d. After information is confirmed, the nurses will co-sign the Report of Death form
      2. When the body is is ready to move to the morgue, notify Security staff to bring the morgue cart from the morgue room. Transfer the body, belongings (if applicable), complete Report of Death form, a copy of the patient's face sheet, and signed autopsy consent (if applicable) too the morgue cart.
      3. Security staff will transport the body to the morgue room. Have Security document that they are moving the body.
      4. The "occupied" sign will be placed on the the morgue room door and the door will be locked.

C. Release of Body from Morgue

1. When the coroner or mortuary attendant arrives at the defined pick-up site, he/she will notify the switchboard operator, who will notify the Administrative Supervisor of the coroner or mortuary attendants arrival.
2. Administrative Supervisor will open the door for the coroner or mortuary attendant and assist with transferring the body.
3. The coroner or mortuary attendent and Administrative Supervisor will sign the Report of Death form, confirm that the patient's ID band and face sheet match, and give the coroner or mortuary attendent the yellow copy and the copy of the face sheet.
4. If patient valuables and belongings are sent the coroner or mortuary attendant will sign the Admission Valuables Checklist to confirm disposition.
5. The Administrative Supervisor will return the completed original Report of Death form to the patient's chart.
6. Administrative Supervisor is responsible for Contacting Environmental Services (EVS) to clean the morgue cart.

AGE-RELATED CONSIDERATIONS:

No

CONTRIBUTING DEPARTMENTS/COMMITTEE APPROVALS:

- Emergency Dept
- Nursing Supervision
- Unit Managers/Directors
    - Operating Room/PACU, Family Birth Center, Surgical Care Unit, Medical Unit, Progressive Care Unit, Intensive/Critical Care Unit, Recovery Care Unit
- Lewis County Coroner

DEFINITIONS:

ATTACHMENTS:

Report of Death form

None

OWNER:

Director, Inpatient Care and Nursing Support Services

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REFERENCES:

- CDC Biosafety Level Recommendations
- PCH policies:
    - Organ & Tissue Donation (86100-PCS-077)
    - Autopsy (86100-PCS-141)
    - Patient Identification (86100-PCS-159)
- WAC 388-877B-0120

ADMINISTRATIVE APPROVAL:

VP / Chief Nursing Officer, SWR

All Revision Dates

4/18/2022, 8/31/2021, 11/12/2018, 8/14/2018, 5/27/2015, 3/1/2012, 1/1/2009, 3/1/2006, 12/1/2002

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Approval Signatures

Step Description	Approver	Date
Site Administrator	Erika Sherie Luat: Accred Pol Mgmt Prog Analyst	4/18/2022
Regional Chief Nursing Officer SWR	Suzanne Scott: Chief Nursing Officer SWSA	4/15/2022
	Sharlene Higa: Dir Nrsg Inpt and Spec Svcs	4/15/2022

Standards

No standards are associated with this document

Status Active PolicyStat ID 11374637

Origination	8/1/2010	Owner	Teresa Lynch: Senior Manager Spiritual Care
Last Approved	10/12/2022	Policy Area	Patient's Rights and Ethics
Effective	10/12/2022	Applicability	WA - SPS - St. Peter Hospital, Centralia Hospital
Last Revised	10/12/2022		
Next Review Due	10/11/2025		

No One Dies Alone - NODA - SWSA

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Policy Number: 86100-PRE-034

PURPOSE:

No One Dies Alone (NODA) and Relief Care Services are provided in response to our Mission and Core Values such as dignity and compassion in honoring the dying patient. There is no fee for this service.

APPLIES TO:

Inpatients who are expected to die within 12-24 hours and patient (if able to request) or family members desire to receive NODA services.

POLICY STATEMENT:

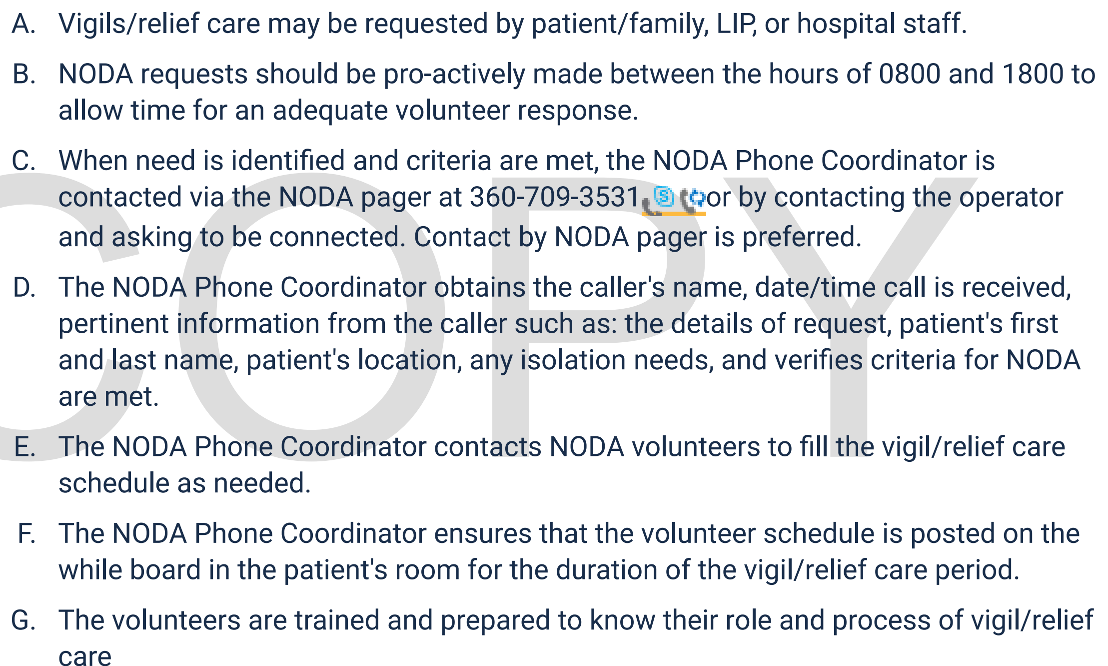
Provide caring and compassionate bedside companionship for dying patients who are alone at the end of life and relief care for patient's family members needing a rest period.

OBSERVATION AND SAFETY FACTORS:

NODA Volunteers are specifically trained as Compassionate Companions for patients in the dying process. In addition to this special training, each volunteer completes and maintains the required regulatory/annual topics identified by the ministry. NODA volunteers do not perform nursing of other specialized care for patients.

PROCEDURE:

1. Patient Criteria for NODA Activation
    - A. Patient is expected to die within 12 to 24 hours
    - B. Patient has no family available for support or family is unable to be present
    - C. Patient and or family must agree to receive the service. If patient is unable to request and there is no family, and all avenues in attempting to contact family have been made, the staff or licensed independent practitioner (LIP) may make the request on behalf of the patient using their best judgment.
    - D. A Do Not Resuscitate (DNR) must be in place before activating NODA
    - E. The patient has been placed on comfort care.
2. Activation Process
    - A. Vigils/relief care may be requested by patient/family, LIP, or hospital staff.
    - B. NODA requests should be pro-actively made between the hours of 0800 and 1800 to allow time for an adequate volunteer response.
    - C. When need is identified and criteria are met, the NODA Phone Coordinator is contacted via the NODA pager at 360-709-3531, or by contacting the operator and asking to be connected. Contact by NODA pager is preferred.



    - D. The NODA Phone Coordinator obtains the caller's name, date/time call is received, pertinent information from the caller such as: the details of request, patient's first and last name, patient's location, any isolation needs, and verifies criteria for NODA are met.
    - E. The NODA Phone Coordinator contacts NODA volunteers to fill the vigil/relief care schedule as needed.
    - F. The NODA Phone Coordinator ensures that the volunteer schedule is posted on the while board in the patient's room for the duration of the vigil/relief care period.
    - G. The volunteers are trained and prepared to know their role and process of vigil/relief care
3. Ending a Vigil/Relief Care
    - A. The vigil/relief care ends when the patient dies, is transferred from the facility, is determined the patient does not meet criteria and or there is a request from family/patient or staff discontinue the service.

AGE-RELATED CONSIDERATIONS:

Compassionate companions are trained to support individuals of adult age.

CONTRIBUTING DEPARTMENT/COMMITTEE APPROVAL:

- Volunteer Services
- Nursing
- Palliative Care
- Security

DEFINITIONS:

- **NODA – No One Dies Alone:** A hospital program designed to provide NODA companions to support dying patients with a caring compassionate presence during the final stage of their end-of-life journey. To respect and honor a patient in their dying process, the vigil/relief care is provided upon the request of the patient and/or family member, but is not a requirement for all dying patients.
- Compassion Companions- Another name for NODA volunteers who are specially trained to provide this service to dying patients. See position description for Compassionate Companion.
- **NODA Program Coordinator:** The individual responsible for the NODA program development and maintenance. See NODA Program Coordinator position description
- **NODA Phone Coordinator:** An individual such as a NODA volunteer who assists the NODA Program Coordinator for NODA services.

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OWNER:

Director, Spiritual Care

Prior Policy History:

- Implementation Date: 8/2010
- Reviewed Date:
- Revision Date: 11/2013

ADMINISTRATIVE APPROVAL:

VP / Mission

All Revision Dates

10/12/2022, 6/11/2019, 12/8/2015, 11/1/2013

Approval Signatures

Step Description	Approver	Date
Site Administrator	Erika Sherie Luat: Quality Accreditation Analyst	10/12/2022
VP Mission Integration SWR	Tracy Brown: Chief Mission Officer Ministry	10/12/2022
	Teresa Lynch: Dir Spiritual Care	3/11/2022

Standards

No standards are associated with this document

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Status Active PolicyStat ID 13124502

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Last Approved	2/17/2023	Policy Area	Patient Care Services
Effective	2/17/2023	Applicability	WA - SPS - St. Peter Hospital, Centralia Hospital
Last Revised	2/17/2023		
Next Review Due	2/16/2026		

SPS Advance Directives

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PURPOSE:

To outline advance care planning practices that support patient self-determination and receipt of preferred end-of-life care for adult patients. This includes getting, maintaining, accessing, and honoring patient advance directives.

There are two types of advance directives:
(1) A Durable Power of Attorney for Healthcare: a document which names the patient's chosen health care agent and states the patient's general preferences for medical care
(2) Healthcare directive/Living Will: a document which directs medical providers on whether to withdraw or withhold life sustaining treatment if the person were to become permanently unconscious or not expected to recover.The witnessing requirements for these two documents are different.

POLICY STATEMENT:

Providence participates in shared decision-making with patients and honors patient care decisions, within the limits of applicable law, regulations, and the Ethical and Religious Directives for Catholic Health Care. Efforts to know and honor patient preferences include all patients, regardless of whether there is an advance directive, however, documents can help ensure care consistent with wishes.

Patients can actively make and update care decisions except when they have been determined to lack decision making capacity. At that time, information provided in written advance directive documents will guide caregivers to engage the patient's chosen health care agent and to provide care consistent with patient wishes. Providence follows the Washington State Law defining a hierarchy of decision-makers for providing informed consent (RCW 7.70.065) that identifies specific individuals as decision-makers if the

patient does not have an advance directive naming a health care agent, and there is no court-appointed guardian.

PROCEDURE:

Caregivers involved in scheduling, admitting, treating, caring, supporting, and discharging patients, share responsibility for making sure patients know their rights. Advance directives provide a tool to help them receive the care they want. Successful processes to get, maintain, access, and honor advance directives depend on various caregivers and a robust Electronic Medical Record (EMR) system. Below are steps and guidelines to help with advance care planning during some facets of a patient visit to a hospital or hospital clinic. Additional steps might be taken with the patient in other care settings or in the community.

Pre-admit Clinic process (for adult patients with scheduled admissions or hospital clinic visits; normally conducted by phone) by perioperative caregivers

1. Ask adult patients to bring up-to-date advance directive for on-site admission or registration.
2. Inform or confirm with patients that an advance directive:
    A. Is a document we ask all adult patients to provide
    B. Allows the patient to legally name a health care agent, who is a person he/she/they trustto speak for them if there is a time when he/she/they cannot communicate
    C. Can include specific and general information about care preferences
    D. Can be updated at any time, as long as a patient can make decisions
    E. Is encouraged for all adult patients and with a goal to identify their healthcare agent
3. Provide information on Washington law for giving informed consent if patient is not able to do so for themselves. (see RCW 7.70.068)

Note: *Pre-admit staff can access advance directive information relevant to the patient in the Advance Care Planning (ACP) Summary.*

Registration process – Check-In is completed by Patient Access for all adult patients served by the hospital or a hospital clinic.

1. Ask if patient has an advance directive. If no, offer advance care planning information
2. If yes or uncertain, check to see if patient has an advance directive in the EMR (includes document types advance directive and power of attorney).
    A. When advance directive document is accessible, check if patient's document is the same one already in the EMR.
        I. If advance directive is the same as the document in the EMR, do not add.
        II. If document is different, verify the date signed is later than the document in the EMR, and continue to item 3. (Document in EMR should be the most current and up-to-date)
    B. If patient does not provide printed or electronic advance directive, ask patient to

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verify if document in EMR is accurate and health care agent is up-to-date. If advance directive is not current per patient, request patient bring current advance directive and continue to item 5.

C. If there is no advance directive in EMR and patient provides printed advance directive, continue to item 3.

D. If there is no advance directive in EMR and patient did not bring an advance directive, encourage the patient to provide up-to-date advance directive. Document on the documents screen under Advance Directives reason and continue to item 5.

3. Scan advance directive to EMR as an "advance directive" document type. Include relevant descriptors such as the date the patient signed the document and any additional title on the document.
4. Provide postage-paid business reply envelope to patients without an advance directive in the EMR if they plan to mail one to the hospital. Alternately, patients can deliver a copy to the Health Information Management Unit (HIM). During inpatient visit, caregivers who provide direct services can fax a patient's advance directive to HIM.
5. Communicate to patient that there is a Washington State law (RCW 7.70.065) for giving informed consent if/when a patient is not able to do so for themselves. attachment (Hierarchy poster)
6. Patients wanting more advance care planning information and conversation can get services from Spiritual Care services after admission to the hospital or by calling a hospital operator (360-491-9480) to be connected to Spiritual Care services when not an inpatient.
7. If patient provides a POLST (Portable orders for life sustaining treatment; often printed on bright green paper), this document should be faxed to HIM to be added to the patient EMR and returned to patient to give to the admitting nurse to review.. The POLST is NOT an advance directive, it is a medical order and provides guidance on patient preferences for care.

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Admitting process by Physician or Other Provider

1. Review Advance Care Plan (ACP) Summary in EMR for prior code status history, The documentation in the Summary might include POLSTs, advance directives, Notes - ACP (advance care planning) or GOC (goals of care), and code status orders.
2. Discuss patient's current preference for code status. If the code status assigned is inconsistent with patient's latest documentation in EMR, or POLST that patient provides during admission, code status orders should include details to explain or acknowledge the discrepancy.
3. If patient is not able to participate in the discussion about code status, provider talks with the health care agent or, if no health care agent is named, other individuals in the hierarchy of decisions makers for providing informed consent. (RCW 7.70.065)

Admitting Process by Nurse

1. Review documentation in Advance Care Plan Summary in EMR for information about the patient's preferences and named health care agent, including notes and code status.
2. If no documentation is found, encourage completion of advance directive that names a health care agent.

3. Give patients advance care planning information and resources to access while in hospital..
    A. Advance directive: Durable Power of Attorney for Heathcare documents are in each unit (at HUC/Health Utilization Coordinator station) and at registration/admission sites. This document can be witnessed by healthcare employees (caregivers) and does not require a notary.
    B. Healthcare directives/Living Will documents **cannot** be witnessed by healthcare employees (caregivers) and may require a notary. Caregivers can access information about notary services available in the hospital and clinics on Intranet.
        a. PSPH Notary Public Service Policy
        b. PCH Notary Public Service Policy
    C. All hospital TVs have a Channel 80 that shows a 16 minute video loop with information about advance care planning and advance directives.
    D. Spiritual Care Services accepts referrals for patients who want help with completing an advance directive or to have an advance care planning conversation.
    E. Handout on RCW 7.70.065 provides visual on the family members who will be asked to make decisions if a health care agent is not named in an advance directive.
    F. Providence website provides links to other resources: Washington.Providence.org/ACP.
4. Document specific patient care preferences expressed by patient that will help in providing care consistent with wishes in a goals of care note.,

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***Care and Treatment of Patient by providers, care managers, nurses, chaplains, other caregivers:**

When patients deal with significant health issues, their care wishes and/or choice of health care agent might change, especially as the patient progresses towards end-of-life. Caregivers takes steps to ensure patient wishes are known and documented – *whether or not the patient has an advance directive.*

1. Engage with patient in on-going shared decision-making concerning health care.
2. When advance directive in EMR is not present or clear, follow steps 1-3 above for the "Admitting Process – Nurse" (check ACP Summary, encourage completion of advance directive, give ACP information)
3. Add GOC notes to the patient EMR to help communicate important information to other caregivers, including those in Providence primary and specialty care clinics.
4. Prior to discharge:
    A. Discharge Planners review ACP Summary in EMR for gaps and inconsistencies, as possible, and provides patient with ACP resources to them address.
    B. Provider completes, updates, or reviews POLST for patients with significant health conditions or frailty nearing the end-of-life, and those who do not want CPR initiated by emergency responders, as possible.
5. If patient becomes unable to actively participate in shared decision-making, caregivers engage the legal health care decision maker(s) per RCW 7.70.065.

- **AGE-RELATED CONSIDERATIONS:** Adults the age of eighteen or is an emancipated minor under Washington state law and has the capacity to make healthcare decisions
- **STAKEHOLDERS:**
- Providence Ethics Committee-SW WA
- Mission
- Nursing
- Patient Access
- Care Management
- Medical Staff
- Surgery/Perioperative
- Palliative Care

DEFINITIONS:

Adult: A person who has attained the age of eighteen or is an emancipated minor under Washington state law and has the capacity to make healthcare decisions.

Advance Care Planning (ACP): The process of considering goals and future healthcare preferences. This includes identifying an individual who can serve as a healthcare agent and completing a Durable Power of Attorney for Healthcare document and/or a healthcare directive/living will. An individual can complete one or both documents. Goals of care conversations and POLST completion are part of advance care planning.

Advance Care Planning (ACP) Summary: "One Stop" view in a patient's EMR that summarizes all information about the patient concerning ACP with links to relevant documents (advance directives and POLSTs, code status history and Notes with ACP (advance care planning) or GOC (goals of care) designation. Caregivers get to this view when in a patient chart by clicking on the words "POLST: yes/ none" in the banner or wrenching "advance care planning" as a snapshot view.

Advance directive: There are two types of advance directives. The witnessing requirements are different for each.

Durable Power of Attorney for Healthcare: This document names an individual who is legally authorized to make medical decisions when a person lacks decision making capacity. These surrogate decision makers are called healthcare agents and an attorney-in- fact This document includes a person's general preferences for medical treatment.

1. Any healthcare employee (caregiver) can witness the AD:DPOAH document

- The role of the witness is specific to witnessing the signature. Witnessing is not attached to any verification of mental capacity or professional assessment.
- Witnessing is voluntary for the healthcare employee (caregiver). If the caregiver has any concern or does not feel comfortable being a witness, they have the right to decline.

Healthcare directive/Living will: This document directs medical providers on whether to withdraw or

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withhold life sustaining treatment if the person were to become permanently unconscious or not expected to recover. ***This document cannot be witnessed by healthcare employees(caregivers)***

Code Status: Medical orders for hospitalized individuals indicate what level of interventions, including cardiopulmonary resuscitation (CPR), the individual wishes to have initiated in the event their heart stops beating or lungs stop working. Hospitalized individuals are either (1) **Full Code** – attempt to resuscitate and intervene as needed to live, or (2) **No Code/DNR** – do not attempt resuscitation and allow a natural death. Individuals are sometimes "**Full Code** by default" until a provider can determine the appropriate orders.

Desired Level of Medical Care (DLMC): This order is indicated when a provider designates a **No Code/ DNR** status. It clarifies life sustaining treatment preferences, including intubation, when an individual is decompensating and not in cardiac arrest.

Electronic Medical Record (**EMR)** also referred to as Electronic Health Record **(EHR)**: A comprehensive, longitudinal electronic medical record of individuals health information generated by the health care team, includes advance care planning documents, and is accessible by the patient via Mychart..

Ethical and Religious Directives for Catholic Health Care: Information providing guidance for health care provision that is consistent with Catholic teachings and beliefs.

Health Information Management (HIM): Team of caregivers who manage and maintain up-to-date patient medical records and respond to information requests.

Life-Sustaining Treatment: Any medical or surgical intervention that uses mechanical or other artificial means, to sustain, restore, or replace a vital function, with goal of prolonging the life of a patient. It might include antibiotics, and artificially provided nutrition and hydration but does not include interventions needed solely to alleviate pain or provide comfort.

Legal Guardian: Person assigned by legal proceedings to have responsibility for making decisions for an individual who is incapacitated.

Portable Orders for Life-Sustaining Treatment (POLST):A set of medical orders

- Intended to guide medical treatments based on an individual's current medical condition and preferences- goals of care.
- It is a *portable* medical order designed to support individuals transitioning between health care facilities or living in the community.

Surrogate Decision Maker: RCW 7.70.065 describes the hierarchy of the surrogate decision makers. The first priority surrogate decision maker is a legally appointed guardian. The second priority surrogate decision maker is the healthcare agent or attorney-in-fact designated in a durable power of attorney for healthcare document**.**

Trusted Decision Maker: In Washington state, the Trusted Decision Maker is ONLY advisory to the statutory healthcare agent until an advance directive: durable power of attorney form is completed to legally name the individual.

In the Providence system, a trusted decision maker is a Providence approved procedure for documenting

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a patient who is decisional and who verbally expresses a choice of a surrogate decision maker.

OWNER:

Senior Manager Spiritual Care

REFERENCE:

- RCW 7.70.065 – Informed Consent – Persons authorized to provide for patients who are not competent - Priority
- RCW 70.122 – Natural Death Act
- RCW 11.125.400 – Agent authority – Health care

ADMINISTRATIVE APPROVAL:

South Puget Sound WA Chief Mission Officer

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All Revision Dates

2/17/2023, 2/18/2020, 8/16/2019, 1/26/2016, 10/1/2012

Approval Signatures

Step Description	Approver	Date
Site Administrator	Erika Sherie Luat: Quality Accreditation Analyst	2/17/2023
VP Mission Integration SWR	Tracy Brown: Chief Mission Officer Ministry	2/17/2023
Medical Staff President (PROXY)	Devin Sawyer: Residency Director [KP]	2/10/2023
Manager, Medical Staff Svcs	Kim Packer: Manager Medical Staff Services	2/10/2023
	Teresa Lynch: Senior Manager Spiritual Care	2/9/2023

Standards

No standards are associated with this document

Status Active PolicyStat ID 13073692

Origination	9/1/2007	Owner	Kacie Marich: Manager Nursing
Last Approved	2/7/2023	Policy Area	Patient Care Services
Effective	2/7/2023	Applicability	WA - Providence Centralia Hospital
Last Revised	2/7/2023		
Next Review Due	2/7/2024		

Palliative Care Scope of Service

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Policy Number: 86100-PCS-014

POLICY STATEMENT:

The purpose of this policy is to assist providers and caregivers in understanding the scope of practice for palliative care, and outline a procedure for initiating a palliative care consultation for patients with life threatening or serious illness. Palliative care is appropriate for patients requiring expert symptom management and/or clarification of health-related goals. It is permissible for patients to be receiving curative or life-prolonging treatment for advanced illness.

DEFINITIONS:

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a serious illness. Serious Illness refers to an illness that has a high risk of mortality and causes a large burden to the patient and/or their family. The goal of palliative care is to improve quality of life for both the patient and their family.

Palliative care is provided by a specially-trained team of providers, advanced practice nurses, registered nurses, social workers, pharmacists, chaplains and other specialists who work together with a patient's other providers to offer an extra layer of support. It is appropriate at any stage in a serious illness, and it can be provided along with curative treatment.

PROCEDURE / GENERAL INSTRUCTIONS:

Scope of Service

1. The palliative care team will work to:

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A. Optimize management of acute pain and other symptoms related to serious illness
B. Collaborate with attending and consulting providers to determine prognosis and clarify treatment options when indicated
C. Optimize communication between patient, family, and care team
D. Optimize functional status when appropriate
E. Promote the highest quality of life for the patient and family
F. Educate patients and family to promote understanding of the underlying disease process and expected trajectory of the illness
G. Establish an environment that is comforting and healing
H. Educate patients and families on available treatment and care options
I. Collaborate with attending providers and case managers about patient/family priorities as they determine a plan for discharge to the appropriate level of care in a timely manner
J. Assist actively dying patients and their families in preparing for and managing life closure
K. Serve as educators and mentors for staff
L. Promote care that addresses the needs of the whole person: mind, body and spirit

2. Palliative Care Consult Process:
   A. Routine palliative care consults are initiated within 24 hours of referral
      1. The palliative care team is on-site 7 days/week, including holidays
      2. Department phones are answered 09 - 1600. There is a 24-hour message line.
   B. Family conferences are arranged as soon as possible, and the date and time are communicated to the care team.
   C. Initial and subsequent assessments may include patient and family interviews, review of medical records, discussion with other providers and caregivers, physical examination, and review of laboratory, diagnostic tests and procedures. Assessment documentation may include:
      I. Options for medical treatment
      II. Pain and symptoms management recommendations
      III. Disease status/treatment history
      IV. Functional status and expected prognosis
      V. Comorbid medical and psychiatric disorders
      VI. Physical, psychological and spiritual symptoms or concerns
      VII. Advance care planning preferences and/or identification of surrogate decision maker(s)
      VIII. Patient/Family communication preference (how they want to receive

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information)

IX. Patient wishes for care across settings, including site of death

X. Cultural preferences (relevant practice, dietary restrictions)

XI. Education and Counseling

   a. Disease process

   b. Benefits versus burdens of diagnostics/procedures

   c. Side effects/risks of medications and treatments

   d. Hospice

   e. Advance care planning and associated documents

   f. Approach to managing symptoms

D. Creating a plan of care that aligns with the patient's goals for treatment

E. Coordination of Care

   A. Collaboration with staff

   B. Discussions with attending and consulting providers

F. The palliative care team will continue to follow as indicated by the palliative care team assessment. Indications for sign-off include:

   1. Patient/family request

   2. Attending provider request

   3. The palliative care has fulfilled the objectives from consult request and confirmed with attending that there is no further need to be involved

   4. Circumstances where a patient's condition may change but goals remain clear.

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Referral Process

1. Making a referral:

   A. A referral to palliative care service may be requested at any time by the patient, family, a provider, or other caregiver; but to initiate the consult, the referring provider will need to place an order into the electronic medical record (EMR). The palliative care team will coordinate with the attending if the referral comes from other specialties.

   B. Formal consultation will follow the process outlined for medical consultations, as delineated in the Medical Staff Bylaws, Policy and Procedures.

   C. The indication for consultation should be written with the order.

   D. The Palliative Care Service will see patients in any inpatient care unit and the Emergency Center at PSPH.

2. Indications for a referral:

   A. Complex symptoms related to a serious illness (high risk of mortality + high burden

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on patient or family)

I. Difficult-to-control physical or emotional symptoms

II. Transition to comfort measures for complex situations

B. Goals of care discussions for patients with serious illness

I. Patient, family or provider uncertainty regarding benefit of treatment options, including life-sustaining treatments

II. Patient, family or provider uncertainty regarding prognosis

III. Patient or family requests for non-beneficial care

IV. Patient has frequent hospitalizations related to a serious illness

V. Patient has functional decline

C. Facilitation of optimal end-of-life treatment and care

I. Collaboration with case management to optimize the transition to hospice when needs are complex

II. Compassionate weaning from life prolonging interventions (mechanical ventilation, artificial airways, pressors, high-flow nasal canula, etc)

III. Comfort medication orders for complex situations

3. Conditions falling outside the scope of service for palliative care
   A. Acute or chronic, non-terminal pain unrelated to a serious/life-limiting illness
   B. Assessment and management of a substance use disorder

4. Special Considerations:
   A. Goals of care discussion are often more of a process than a single conversation. Furthermore, many seriously ill patients lack full decisional capacity and it frequently takes several days to identify and contact a legal surrogate decision maker and to arrange a family meeting. Entering a consult request early during a hospitalization is often beneficial for timely clarification of goals, decisions about treatments, and hospital discharges
   B. The Palliative Care Service provider will function in a consulting capacity, and will not assume attending provider duties during the patient's hospitalization nor become the patient's primary care provider following discharge.

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AGE-RELATED CONSIDERATIONS:

N/A

CONTRIBUTING DEPARTMENT/COMMITTEE APPROVAL:

- Nursing

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ATTACHMENTS:

N/A

OWNER:

Director of Clinical Operations, Palliative Care Services, SWSA

REFERENCE:

N/A

ADMINISTRATIVE APPROVAL:

Medical Staff President

Chief Nursing Officer, SWSA

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All Revision Dates

2/7/2023, 4/14/2021, 4/8/2020, 5/23/2017, 12/1/2013, 10/1/2010

Approval Signatures

Step Description	Approver	Date
Site Administrator	Erika Sherie Luat: Quality Accreditation Analyst	2/7/2023
Regional Chief Nursing Officer SWR	Suzanne Scott: Chief Nursing Officer	2/7/2023
Medical Staff President	Huan Yan: Physician [HM]	2/6/2023
	Keely Janway: Director Palliative Care	2/1/2023

Standards

No standards are associated with this document

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