



ADVANCE DIRECTIVES AND CPR PREFERENCE

Clinical Policy and Procedure	
Approved: October 2016	Next Review: October 2019
Clinical Area: All clinical areas	
Population Covered: All patients	
Campus: Ballard, Cherry Hill, Edmonds, First Hill, Issaquah, Mill Creek, Redmond	Implementation Date: February 2002

Related Policies, Procedures, and Job Aids:

[Advance Directive Status: Documentation](#)

[Bloodless Program: Adult](#)

[Code Blue: Cardiac/Respiratory Arrest in the Operating Room](#)

[Conditions of Admission Form and Consent](#)

[Management of Resuscitation Preferences](#)

[Patient Rights](#)

Purpose

To define the process for facilitating communication between patients and licensed independent practitioners (LIP) in order to obtain appropriate individualized care orders concerning Advance Directives and resuscitation.

Policy Statement

All patients who have a cardiac or respiratory arrest are resuscitated unless LIP orders to *not* resuscitate are obtained. If a patient is classified as “Do Not Resuscitate” (DNR), the attending LIP enters the resuscitation status order. Verbal resuscitation orders must be dated and signed or electronically authenticated by signature of the LIP within 24 hours. Until the resuscitation status order is obtained, all patients are considered full code. The Resuscitation Order Sheet is completed by the LIP, including identifying with whom (patient or legal next-of-kin) he/she discussed the orders. (See also *Medical Rules and Regulations*.)

If the patient arrives to a Swedish Medical Center (SMC) facility and provides a completed Physician Order for Life-Sustaining Treatment (POLST) form, these orders will be honored for up to 24 hours or until the content can be reviewed and converted into a resuscitation status order by the attending LIP or his/her designee.

Upon emergency department, ambulatory surgery, observation admission and/or inpatient admission, patients or their surrogates are also asked by nursing staff whether they have Advance Directives and/or have expressed wishes concerning cardiopulmonary resuscitation (CPR) or other care issues in order to develop an individualized plan of care that accurately reflects the patient’s wishes.

No employee, hospital volunteer, attending physician, or physician’s employee will act as a witness for any patient executing Advance Directives.

Every attempt is made to honor Advance Directives. If the clinical team has concerns related to the directives, resources such as the Ethics Consultation Committee are used to reach resolution. If the

provider believes the care directed by the patient or surrogate is futile, the process within the [Withdrawal or Withholding of Life Sustaining Care](#) policy is followed.

LIP Order Requirement

Elements of this procedure require a licensed independent practitioner’s (LIP) order.

Responsible Persons

Registered nurses (RN), LIPs, licensed practical nurses (LPN), and nursing technicians (NT).

Prerequisite Information

CFR §489.102 requires the hospital to provide written notice of its policies regarding the implementation of patients’ rights to make decisions concerning medical care, such as the right to formulate Advance Directives. If an individual is incapacitated or otherwise unable to communicate, the hospital may provide the Advance Directive information required to the individual’s family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with state law.

Although both inpatients and outpatients have the same rights, §489.102(b)(1) requires that notice of the hospital’s Advance Directive policy be provided at the time an individual is admitted as an inpatient. However, in view of the broader notice requirements, the hospital should also provide the Advance Directive notice to outpatients (or their representatives) who are in the emergency department, who are in an observation status, or who are undergoing surgery. The notice should be presented at the time of registration. Notice is not required for other outpatients, given that they are unlikely to become incapacitated. ([CMS State Operations Manual](#)).

PROCEDURE	
▶ Requires an LIP order	
Responsible Person	Steps
LIP, Nursing Staff	<p>GENERAL CONSIDERATIONS</p> <ol style="list-style-type: none"> 1. SMC provides all patients or their surrogates with information about their rights under Washington State law, as well as policies regarding a patient's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and to formulate Advance Directives. 2. SMC assigns responsibility to Nursing to inquire of all patients or a designated surrogate whether written directions exist for medical treatment near the end of life. It is the responsibility of a patient or surrogate to inform staff and attending LIP of any directives. 3. It is documented in the emergency department, ambulatory surgery, observation admission and/or inpatient’s medical record whether the individual has or has not executed Advance Directives. If the patient does not have advance directives, information regarding Advance Directives is offered to adult patients. If the patient cannot respond or refuses information, staff documents this in their respective clinical admission workflow. 4. SMC does not place any conditions concerning the provision of care or otherwise limit, withdraw, or refuse care to any individual based solely on whether or not the individual has Advance Directives. 5. The Advance Directives are used in concert with further assessment to assure that the patient's intent and interests are accurately addressed. 6. Specific procedures are outlined below to ensure that patients have the right to determine their course of treatment.

<p>Patient Registration, Nursing Staff, Health Information Management</p>	<p>PREADMISSION</p> <ol style="list-style-type: none"> 1. All pre-admitted surgical adult patients are advised in the preadmission packet to bring a copy of any signed Advance Directives, living will, or durable power-of-attorney for health care to the hospital with them. 2. Patient Registration or delegated unit staff faxes the documents to Health Information Management (HIM) for scanning into the electronic medical record (EMR) (see Forms Cover Sheet for Scanning Advance Directives or Cover Sheet for Scanning Advance Directives: Swedish Edmonds). 3. Each patient receives and signs the Condition of Admission form which describes the SMC policy for emergent care, namely to resuscitate all patients if a medical emergency occurs unless SMC has an LIP order stating otherwise. During this process, patients are given an opportunity to express their wishes surrounding emergent resuscitation.
<p>LIP, Clinical Staff</p>	<p>EMERGENCY DEPARTMENTS (ED)</p> <ol style="list-style-type: none"> 1. Each ED patient receives and signs the Condition of Admission form which describes SMC policy for emergent care, namely to resuscitate all patients if a medical emergency occurs unless SMC has an LIP order stating otherwise. 2. Upon admit or when the patient is stabilized, a clinical ED staff member asks the patient or his/her surrogate decision maker whether they have an Advance Directive(s). 3. If the patient/surrogate indicates he/she has an Advance Directive(s), the ED staff member verifies that the Advance Directive(s) is in the EMR. If not found in the EMR, the patient/surrogate is asked that a copy be provided, which will be faxed to HIM for scanning into the patient's EMR (for Swedish Edmonds, fax to ER Patient Registration). <ol style="list-style-type: none"> a. If the patient has an Advance Directive but failed to bring a copy into the hospital, ED clinical staff documents that the patient indicated he/she has an Advance Directive but it is not available. b. If the patient is incapacitated and no representative is available, ED clinical staff documents their effort to obtain the patient's Advance Directive status. 4. If the patient has not completed these documents, he/she is offered an Advance Directive pamphlet Advance Care Planning to provide information regarding the patient's rights and choices. 5. If the patient refuses this information, the refusal is documented in the EMR. <p>NOTE: Advance Directive status(es) entered at ED admission carries forward to the patient's observation and/or inpatient admission when applicable.</p>
<p>Patient Registration, Nursing Staff, Health Information Management</p>	<p>AMBULATORY SURGERIES, OBSERVATION ADMISSIONS, INPATIENTS</p> <ol style="list-style-type: none"> 1. Each patient receives and signs the Condition of Admission form which describes the SMC policy for emergent care, namely to resuscitate all patients if a medical emergency occurs unless SMC has an LIP order stating otherwise. During this process, patients are given an opportunity to express their wishes surrounding emergent resuscitation. 2. Upon admitting or preadmitting the patient, the caregiver also asks the patient or his/her surrogate decision maker whether he/she has completed Advance Directives [a living will or a Durable Power of Attorney for Health Care (DPOA)]. 3. If he/she has completed these documents, the caregiver asks that a copy be provided for scanning into the patient's medical record. (The original stays with the patient.) If copies are not readily available, documentation of key information (designates, DPOA, etc.) is written on the admit database. The patient or family is encouraged to bring a copy into the hospital for scanning and reference.

	<ol style="list-style-type: none"> a. A new patient list column is available to track the status of the advance directive. The column displays the status of the document and the time the initial screening question was asked. b. Fax Advance Directive to HIM for scanning into the EMR (see Fax Cover Sheet for Swedish or Fax Cover Sheet for Swedish Edmonds). <ol style="list-style-type: none"> 4. If the patient has not completed these documents, information (Advance Directive Booklet) is provided. 5. If the patient refuses this information, the refusal is documented.
LIP, Clinical Staff	<p>POLST</p> <ol style="list-style-type: none"> 1. If the patient or surrogate brings a completed POLST form (or a copy) into the facility, this is honored until the LIP incorporates these decisions/directions into the patient's orders, which must occur within 24 hours.
Patient Registration	<p>HOSPITAL OUTPATIENT DEPARTMENTS</p> <ol style="list-style-type: none"> 1. Each patient is given and signs the Conditions of Admission form which describes the SMC policy for emergent care, namely to resuscitate all patients if a medical emergency occurs unless we have a LIP order stating otherwise.
LIP, Clinical Staff	<p>HONORING PATIENT WISHES FOR NO EMERGENT CARE</p> <ol style="list-style-type: none"> 1. If a patient expresses a wish for no emergent care, the clinical staff of the unit alerts the LIP. 2. The LIP then has a conversation with the patient and documents the outcomes of the discussion in the progress notes. 3. If an order for Do Not Resuscitate is warranted, the LIP provides the order for staff. DNR must be signed/dated or e-authenticated within 24 hours by the LIP. (See Medical Staff Rules & Regulations.)
LIP, Clinical Staff	<p>REVOCAION</p> <ol style="list-style-type: none"> 1. If a patient wishes to revoke an Advance Directive, he or she may do so by indicating this verbally. The appropriate staff member: <ol style="list-style-type: none"> a. Documents in the medical record what the patient stated. ▶ b. Notifies the attending LIP (calls directly to obtain an order) and documents the conversation in a Progress Note in the EMR. c. Returns any related document(s) in the medical record to the patient. d. If original documents were scanned into the EMR, alert Health Information Management to change the description in the EMR under scanned documents to "Void as of xxx date".
LIP, Clinical Staff	<p>TRANSFER OF PATIENTS TO OTHER FACILITIES</p> <ol style="list-style-type: none"> 1. Nursing staff makes copies of any Advance Directives in the patient's chart when the patient is transferred to a nursing home, other hospital, skilled nursing facility, or hospice organization. 2. A copy of any Advance Directive is sent with other transfer documentation. ▶ 3. The LIP carries over any Do Not Resuscitate orders as part of the transfer orders.

Definitions

Advance Directives. A document in which an individual either states choices for medical treatment or designates who should make treatment choices if the person loses decision-making capacity. Examples of Advance Directives include a living will and durable power-of-attorney for health care.

Living Will. A document in which an individual can stipulate the kind of life-prolonging medical care he or she would want if terminally ill and unable to make medical decisions.

Durable Power-of-Attorney for Health Care (DPOA). A document in which an individual names someone else (the "agent" or "proxy") to make health care decisions in the event the individual becomes unable to make them him/herself.

Resuscitation. Full application of CPR, including intubation, electrical therapy, and appropriate medications.

POLST. Physician Orders for Life Sustaining Treatment. This is a document, signed by the patient and the physician that outlines the patient's wishes for life-sustaining medical treatment.

Forms

- ◆ [POLST form](#)
- ◆ [Cover Sheet for Scanning Advance Directives \(Fax cover sheet\)](#)
- ◆ [Cover Sheet for Scanning Advance Directives: Swedish Edmonds \(Fax cover sheet\)](#)

Supplemental Information

The Code Blue Committee reviews all resuscitation codes and establishes appropriate performance improvement actions and feedback.

Regulatory Requirements

Det Norske Veritas (DNV) (NIAHO) standard PR.2.

Centers for Medicare & Medicaid Services. CFR §482.13(b)(3), §489.100 (Advance Directive Definition), §489.102(b)(1) (Advance Directive Notification Requirements for Providers).

WAC 246-320-141 (1)(k).

The Patient Self-Determination Act. Sections 4206 and 4761 of the Omnibus Budget Reconciliation Act of 1990.

Washington State's Natural Death Act (1992). [RCW 70.122](#).

Addenda

[Advance Care Planning](#) (ADMN-13-12500)

[Advance Directive Booklet](#) (NU-04-04398)

[Welcome To Swedish](#) brochure. Specific pages educate the patient about CPR and general policy statements.

[Patient Rights](#) (poster, flyers or online). Describes the many rights patients have during their healthcare stay, including "To make advance treatment directives, such as Durable Power of Attorney for Health Care and Living Wills, or Physician Order for Life Sustaining Treatment (POLST), and to have caregivers follow your wishes."

STAKEHOLDERS

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None.

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INITIATIVE-1000 POSITION STATEMENT

Initiative 1000, Washington's version of the Death With Dignity Act, became effective March 4, 2009. The requirements of the Act and the approach Swedish should take in responding to these patient choices was a subject of discussion throughout the organization, including the Ethics Committee, Medical Staff and medical leadership, pharmacy staff, home care and hospice staff, senior leaders and the Board of Trustees. We also reviewed the experience of hospitals and physicians in Oregon. We worked with the Washington Hospital Association and individual hospitals in Washington to better understand the approach that others have taken.

Based upon the foregoing, the following position statement summarizes the organization's position with respect to I-1000:

- Swedish is committed to improving end of life care for patients, including assuring access to effective pain and symptom management, and expanding access to hospice and palliative care.
- Swedish recognizes and respects patient autonomy and the right of patients to make choices related to their care at the end of life.
- Swedish recognizes and respects the right of any health care provider to counsel patients on their options and to participate, if they so choose, in activities under I-1000. Swedish also recognizes and respects the right of any health care provider to decline to participate in activities specific to I-1000.
- Swedish works with its entire team, including its palliative medicine team, its pain management team, and its home care and hospice partners, to ensure that patients are informed of their rights and options available to them relating to end of life decisions.
- Educational materials specific to patient rights under I-1000 are available to patients who request such materials and will include a list of I-1000 resources for use by patients and our care management team.
- Swedish believes that its acute care hospitals are not the appropriate setting for patients taking life ending medications. The need for active engagement of the patient's primary physician, documentation requirements, right of staff to opt-out, and the required waiting periods and reporting requirements, all present operational challenges and make the process inconsistent with Swedish's focus on providing quality care for those in need of acute care, tertiary services.

- Because the primary purpose of the Swedish pharmacies is to provide services to inpatients, the Swedish pharmacies will not fill prescriptions for life-ending medications. Swedish will assist patients in identifying other community pharmacies willing to participate in dispensing medications under I-1000.
- Where appropriate, referrals to other community providers will be made if requested by patients whose needs cannot be met within Swedish.
- Physicians, including physicians working in Swedish clinics and other facilities, will need to make an individual decision to participate or not participate under I-1000, either as an Attending Physician or a Consulting Physician, as those terms are defined in the Act. We urge those who wish to participate to become familiar with the requirements of the Act. To the extent there is counseling, discussions with patients regarding options, etc. those discussions should be documented in accordance with the requirements of I-1000 and Swedish policies. Patients will not be permitted to self-administer life ending medication within Swedish clinics or other facilities.
- We believe Swedish's decision to not participate under I-1000, except as described above, is consistent with the experience in Oregon and consistent with the position taken by other hospitals in Washington. It is also consistent with the statutory freedom of choice of all health care providers to opt-out of participation. Further, we believe it is consistent with the expectation of the public, our patients and their physicians, that Swedish hospitals will remain focused on the provision of acute care and tertiary services for those in need.