Effective: 9/80
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Reviewer: _____ (Initial) (Date)

Policy No.: YR-ADMIN 016 PATIENT
Responsibility: ADMINISTRATION
Approved: _____
Dept. Mgr. _____
Medical Staff: _____

YAKIMA REGIONAL
The Valley's Regional Medical & Cardiac Center

SUBJECT: WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENTS

I. OBJECTIVE OF THIS POLICY

A. To provide guidelines for withholding and withdrawing life-sustaining treatments.

B. To define code status orders and provide guidelines for the use of Code/No Code designations.

C. To promote responsible, ethical, and sensitive communication among those involved in the care and support of patients.

II. TEXT OF THIS POLICY

A. Philosophy and General Principles

Yakima Regional is dedicated to the provision of healing, restorative, and palliative care to people who are sick and injured and to the care of those who are suffering or are dying. Both human and technological resources are offered. To restore health and support life are among the hospital's principal goals. This means that every appropriate effort is made to cure the sick and rehabilitate the injured. Helping terminally ill patients to live the end of their lives in a responsible and dignified manner is a valuable goal. We should not treat the terminally ill as if they were curable; they are more in need of comfort and company than of life-sustaining treatments.

Yakima Regional respects the rights of patients to make decisions regarding their health care, including decisions regarding withholding or withdrawing life-sustaining treatment. The patient must possess appropriate information to make an informed decision. It is the usual and customary responsibility of the health care team to provide such information in a clear, sensitive, and balanced manner.

B. Definitions

1. **Life-Sustaining Treatment** is any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition or hydration to sustain, restore or replace a vital function, which, when applied to a qualified patient would serve only to prolong the process of dying. Life sustaining treatment shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.

Life-sustaining treatments may include but are not limited to the following; cardiopulmonary resuscitation (CPR), mechanical ventilation, electrical cardiac shock for arrhythmias, transfer to an Intensive Care Unit, dialysis, and artificially administered nutrition and hydration.

2. **Withdrawing Life-Sustaining Treatment** is termination of treatment already in progress.

3. **Withholding Life-Sustaining Treatment** means not initiating life-sustaining treatment. It is consistent with the written NO CODE or DO NOT RESUSCITATE order.

4. **Terminal Condition** means an incurable and irreversible condition caused by injury, disease, or illness that within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

5. **Permanent Unconscious Condition** means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

6. **Qualified patient** means an adult person who is a patient diagnosed in writing to have a terminal condition by the patient's attending physician, who has personally examined the patient or a patient who is diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient.

C. Definition of Code Status Orders (see physician order stamp)

1. **Code Blue:** A summons of the Code Blue team to provide emergency care for a patient following sudden, unexpected cardiac and/or pulmonary arrest. In all instances of a cardiopulmonary arrest, a Code Blue will be called unless one of the following applies:

   a. The attending or on-call physician's order for "No-Code" is present on the patient's chart.
   b. The patient's physician is present during the arrest and makes a clinical judgment that resuscitation is futile.
   c. The attending physician can order a "No-Code" by telephone if the order is witnessed by two professional nurses. The telephone order should be signed by the attending physician within 24 hours.

2. **No Code:** Basic and advanced life support is withheld; automatic initiation of cardiopulmonary resuscitation suspended.

3. **Modified Code:** One or more of the following measures can be used: CPR, intubation, electrical cardioversion, chemical treatment of arrhythmias, and pressor support.

D. Procedure for withholding or withdrawing life-sustaining treatment

1. **General Guidelines**

a. The attending physician, or in the case of a permanent unconscious condition, the attending and one other physician, shall determine whether the patient has a terminal condition.

b. The physician is responsible for communicating the diagnosis and prognosis to the patient and/or surrogate decision maker and coordinating the effort toward making the decision to write the “No-Code” order or the order withdrawing life-sustaining treatment.

c. A "No-Code" order should be reviewed periodically, particularly if there is a significant change in the patient's status.

d. A "No-Code" status is compatible with maximal medical and nursing care and does not imply that supportive comfort care and/or adequate analgesia will not be continued.

e. No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in withholding or withdrawal of life-sustaining treatment if such person objects to so doing. No person may be discriminated against employment or professional privileges because of the person's participation or refusal to participate in the withholding or withdrawal of life-sustaining treatment.

f. In the event that a hospital employee feels he/she cannot, in good conscience, participate in the withholding or withdrawing of life-sustaining procedures, he/she should communicate this to his/her immediate supervisor. The supervisor will assign other employees to assist the physician in carrying out the patient's wishes.

2. **Competent Patients**

a. A competent patient may give verbal or written request to withhold or withdraw life-sustaining treatments. It is important that this decision be made on an informed basis. Any such request should be documented in the patient's medical record. It is the responsibility of other caregivers to notify the attending physician as soon as possible that such a request has been made.

b. In those situations where initiating a Code Blue or applying other life-sustaining treatments is not medically indicated, but the patient has not requested the treatments be withheld, it is the attending physician's responsibility to discuss the application of life-sustaining treatments with the competent patient and appropriate staff members.

Documentation of such discussion should be recorded in the patient's medical records. A "Code/No Code" decision may be requested of the physician by nursing staff.

3. **Incompetent Patients**

a. An incompetent patient retains his/her right to refuse life-sustaining treatment as expressed through a HEALTH CARE Directive executed when the patient was competent.

b. An incompetent patient retains his/her right to refuse life-sustaining treatment as expressed through a surrogate decision-maker. Surrogate decision-makers, listed in order of priority according to state law, are (1) a duly-appointed guardian; (2) a person appointed by a durable power of attorney with applicable health care decision provisions; (3) a spouse; (4) a consensus among children age 18 or over (5) parents; (6) a consensus among adult brothers and sisters.

If the surrogate decision-maker requests withholding or withdrawing life-sustaining treatment and the attending physician agrees, or if the attending physician suggests withholding or withdrawing treatment and the surrogate agrees, the agreed upon treatment plan and appropriate "Code" status should be recorded in the medical chart. (In the event that there is no Health Care Directive and no available surrogate decision maker, a guardian ad litem may be considered.)

c. The Supreme Court of the State of Washington has required under certain conditions that the attending physician obtain verification in writing of the diagnosis and prognosis of the incompetent patient from two additional physicians who maintain qualifications relevant to the patient's condition in cases such as In Re Colyer (1983) 99 Wn. 2d 114, In Re Hamlin (1984) 102 Wn. 2d 810, and In Re Grant (1987) 109 Wn. 2d 545. However, it is important to note that in all of these cases there were no Advance Directives. “It is the duty of the Staff, through its department chairperson and MEC, to insure that a practitioner seeks consultation when indicated (Medical Staff Rules and Regulations Section on Consultation, p. 12).”

E. Conflict Situations

1. If the competent patient and the attending physician disagree about the treatment plan or code status after all other avenues of reconciliation have been tried, the physician may either (1) accept the competent patient's request or (2) make reasonable efforts to assist the patient in his/her efforts to find another physician.

2. If the surrogate decision-maker and the attending physician disagree about the treatment plan or code status after all other avenues of reconciliation have been tried, the physician may either (1) accept the surrogate decision-maker's request, (2) make a reasonable effort to assist the surrogate in his/her efforts to find another physician, or (3) seek judicial review in consultation with Administration.

3. In any case of conflict, if the physician is uncertain about the ethical underpinnings of the case, he/she may discuss the case with the Consultative Ethics Committee.
(Also see Addendum A #IIB)

F. Discharge of Patient to Die at Home

If a patient is capable of making health care decisions and indicates he/she wishes to die at home, the patient must be discharged as soon as reasonably possible. The attending physician or hospital staff (in the absence of the attending physician) has an obligation to explain the medical risks of an immediate discharge to the patient.

Adopted by the Medical Staff

June 15, 1993 (DATE)

YAKIMA REGIONAL

General Administrative Policy

Withholding and Withdrawing Life-Sustaining Treatments
Policy #YR-ADMIN 016 PATIENT

Addendum A

Health Care Directive

The patient is the ultimate decision-maker for his/her own health care and must understand and approve the course of medical treatment whenever possible. If a conscious, competent adult patient has not previously executed a Health Care Directive according to the Washington State Natural Death Act of 1979 (amended 1992) thereby authorizing the withholding or withdrawal of life-sustaining treatment, have the patient execute a Health Care Directive if possible (form attached).

I. Prerequisites to Withholding or Withdrawing Under the Act

A. The patient must be 18 years or older and competent to make health care decisions before executing a Directive.

B. The form in which a Directive may be worded is set forth in the statue (RCW 70.122.020) but may, in addition, include other specific direction.

C. The patient's signing must be witnessed by two qualified adults. The following persons may not serve as witnesses:

1. Anyone related to the patient by blood or marriage;

2. Anyone mentioned in the patient's then-existing will, or by law entitled to a portion of the patient's estate;

3. Anyone who is a creditor or would otherwise have any claim on any portion of the patient's estate at the time the Directive is signed;

4. An attending physician of the patient;

5. An employee of an attending physician of the patient; or

6. An employee of the health care facility in which the declarant is a patient.

D. The patient must have been diagnosed in writing to have a terminal condition by the patient's attending physician, or to be in a permanent unconscious condition by the patient's attending physician and one other physician. Each of the diagnosing physicians must have personally examined the patient.

E. Before any life-sustaining treatment is withheld or withdrawn, the attending physician must make a reasonable effort to determine that the Directive complies with the Act, and to ensure, if the patient is capable of making a health care decision, that the Directive and all steps proposed by the physician are in accord

with the desires of the patient. If the patient is comatose or otherwise incapable of communicating, the Directive (unless revoked) is conclusively presumed to represent the wishes of the patient.

II. Attending Physician's Obligations

A. If the Directive is on file in the physician's office a copy must be forwarded to the hospital and be made part of the patient's medical record prior to the withholding or withdrawing of the life-sustaining treatment.

B. If the Physician or hospital becomes aware of any circumstances in which a patient Advance Directive can not be honored due to conflict with hospital policy, a physician, or the Washington State Natural Death Act the patient/surrogate decision maker will be advised.

Discussion and documentation will include:

- the difference, if any, between limitations that apply to the hospital versus those raised by the patient's physician.
- Any reference to the Washington State Natural Death Act which authorized the limitation.
- the medical condition and procedures affected by the limitation.

1. If the patient elects to continue care at Yakima Regional, the physician or hospital staff, with the patient or patient's representative, shall prepare a written plan to be filed with the patient's directive outlining the physician's or hospital's intended actions to be taken should the patient's medical status change so that the directive would become operative.

2. After complying with the steps outlined, the hospital and/or physician are not otherwise obligated to carry out the patient’s directives.

3. If the hospital/physician will not honor an Advance Directive, they will make a good faith effort, if desired by the patient, to transfer the patient to a provider that will.

III. Revocation of a Directive

A. A directive may be revoked at any time by the declarer regardless of mental competency or state of health, by:

1. Canceling, defacing, obliterating, burning, tearing, or otherwise destroying the Directive, personally or by someone else in the presence and at the direction of the declarer, or

2. Signing and dating a written statement (in any form) indicating intent to revoke, or

3. Verbal expression of intent to revoke.

B. Written or verbal revocation does not become effective until communicated to the

patient's attending physician, whether by the patient or someone on the patient's behalf, or until the physician otherwise has actual or constructive knowledge of the revocation.

C. Time, date, and place of revocation (and the time, date, and place, if different, when notice thereof was received by the physician), must be entered in the patient's medical record by the attending physician.

D. A revocation which comes to the attention of the hospital, in the absence of the attending physician, should be promptly communicated to the physician and entered in the patient's medical record.

E. There is no civil or criminal liability for any person who fails to act on revocation of a Directive unless that person had actual or constructive knowledge of the revocation.

F. If, after consideration of these statutory criteria, there is ever a doubt about whether a patient's Directive has been revoked, a “Do Not Resuscitate” order should not be given. Even if a patient has already signed a Directive, the family should be told of the patient’s condition and expected outcome of the present treatment.

* Related Policy: PATIENT SELF DETERMINATION ACT - POLICY# HMA-ADMIN-024

YAKIMA REGIONAL
The Valley's Regional Medical & Cardiac Center

Patient Care Services Policy

Effective: 10/86	Policy #: HMA-NUR-0013
Revised: 03/97; 07/98; 4/99; 10/00; 9/03; 3/04; 08/08; 11/10	Responsibility: Nursing
Dept Mgr:	Approved:
(Signature) (Date)	

SUBJECT: **CARE FOR THE TERMINALLY ILL NATIVE AMERICAN PATIENT**

CARING FOR THE DECEASED NATIVE AMERICAN PATIENT

OBJECTIVE:

The purpose of this policy is to better understand the religious practices and traditional beliefs of the terminally ill Indian patient.
The belief of the American Indian is that when you die, your spirit, your soul still exists. The body organs have, in fact, ceased functioning, but the soul, the spirit is still here.

TEXT:

The Yakama Indian and the neighboring tribes, practice two types of religion, which the Indian People feel to be unique to this area. They are the Washat (Seven Drum) religion and the Shaker religion.

The Washat (Seven Drum) is a form of religion that the Indian People in this area have practiced from the beginning of time. Washat teachings involve a Creator and all living entities.

The Shaker religion has also been practiced by the Indian People in this area for many generations. The Shaker religious teachings are death with in the same manner traditionally. Both religions go hand in hand with their beliefs of having a Creator. When a terminally ill patient is a member of the Washat or Shaker religion, the following procedures are allowed to take place in the hospital.

1. Elders, requested by the family, will be allowed in the room with the patient. Elders help through prayer, song or both for the patient. This assists the patient belief about their upcoming journey. The Indian People believe they are making a journey to the other world when they are dying. Through the Elders being present, and providing songs and prayers, both family and patient feel that he/she is being taken care of. If the elder is still present at the time of death let him/her finish with his/her ceremony.

2. The patient and family will feel the need to have someone with the patient at all times. One reason is that in the patients' unconsciousness, his/her senses are coming and going, and he/she may suddenly remember something that is unfinished and needs to be done. If the patient has somebody familiar to tell, the patient will feel better knowing the request has been heard by someone he/she knows.

3. In the Washat and Shaker religion, the bells and candle are used for part of the ceremony or worship service. The Elders, who are allowed in at the family's request, may want to take these items in the room with them. Neither instrument used should disturb other patients. The bell is usually used quietly along with the singing and prayers.

4. Save all hair (cut or combed) and fingernails. When the hair is combed and family members have not requested hair to be saved, save it anyway, because in their time of concern for their loved one, they may have forgotten to make this request. These can be put with the personal belongings of the patient's. Make sure all of the patient's belongings or personal items are given to the family.

5. Leave a window, doorway or entryway open if requested.

6. When death occurs, handshakes of sympathy are appropriate.

7. Because the Yakama Indian Nation is an independent nation and has their own laws, Family may ask to take the deceased body with them instead of sending to the funeral home for burial.

   Option A:
   - The primary care physician or his designee must sign a death certificate.
   - The family must be instructed to take the **signed** death certificate to the Heath District, Office of Vital Statistics. **This death certificate must be filed before the burial.**

   Option B:
   - Local funeral homes offer the service of filing the appropriate paperwork with the Heath District. The paperwork includes filing the death certificate and notification of the death to the newspaper.
   - Notify the funeral home chosen by the family. There is no cost for this service.

Effective:12/91 Policy No.: HMA – ADMIN 024
Revised:10/92,10/93,3/95,1/96,5/99; 08/02; 4/04 Responsibility: Administration
4/06; 10/06; 7/09; 07/11 Approved:
Reviewed: Dept. Mgr.
(initial) (date)

YAKIMA REGIONAL
The Valley's Regional Medical & Cardiac Center

SUBJECT: PATIENT SELF DETERMINATION ACT

I. OBJECTIVES OF THIS POLICY

The purpose of this policy is to enable Yakima Regional Medical and Cardiac Center to comply with the Patient Self Determination Act (the "Act" as contained in the Omnibus Budget Reconciliation Act of 1990, sections 4206 and 4761).

Yakima Regional respects a patient's right to participate actively in his/her health care decision-making, including the right to withhold or withdraw treatment, to informed consent for provision of care and to formulate an Advance Directive. Through education and inquiry about Advance Directives, Yakima Regional will encourage patients to discuss their treatment preferences with their durable power of attorney for health care, guardian, family, physician, nurse, and other significant professionals or friends. Such communication will serve as a guide in decision-making should the patient be unable to make decisions for him/herself.

Yakima Regional will not place any conditions concerning the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive. If a change is made to state law regarding advance directives, the medical center will update and disseminate the amended information within 90 days of the effective date of the change.

Yakima Regional only honors advanced directives in the inpatient setting, although information regarding formulation of advanced directives will be given to outpatients upon request.

II. TEXT OF THIS POLICY

A. Definitions:

1. Advance Directive:
A formal document written in advance of an incapacitating illness that states a patient's choices regarding health care if the patient becomes unable to make decisions for themselves. Advance Directives take two forms:

a. Health Care Directive (Living Will): A document in which a person can stipulate the kind of life-prolonging medical

care he/she would want if terminally ill and unable to make medical decisions. Guidelines related to the Health Care Directive are addressed in the Washington State Natural Death Act and policy #YR-ADMIN-016, Withholding and Withdrawing Life Sustaining Treatments.

b. Durable Power of Attorney for Health Care: A legal document in which a person may give authority for making decisions about his/her health care to someone else. The document is usually written so that this authority is given only if the person becomes unable to make decisions for themselves.

2. Washington Natural Death Act:
Law, which recognizes the right of all adults to control decisions about their own medical care. It allows adults to give written directions about withholding or withdrawing life sustaining procedures in the event of a terminal condition or a permanent unconscious condition.

B. Text:
Yakima Regional will provide each adult individual admitted as an inpatient with written information about:

1. An individual's rights under Washington State Natural Death Act to make decisions concerning such medical care as the right to withhold or withdraw treatment and the right to formulate Advance Directives.

2. The hospital's policies and procedures on implementation of these rights.

3. The law states that no employee or volunteer of Yakima Regional nor the attending physician may witness an Advance Directive.

C. Procedure:

1. Registration:
   a. Registration staff will ask EVERY adult at the time of EVERY admission to the hospital if they have Advance Directives. The Advance Directive Plan form will be completed and sent with the patient to the nursing unit, at this time.

   b. If the patient brings their Advance Directive during the admission process, a copy will be made and included with the patient's chart. Return the original to the patient.

c. If the patient has an advanced directive, an “Advanced Directive” sticker will be sent to the nursing unit with the patient's chart.

d. The patient/surrogate is given a brochure that includes an explanation of Yakima Regional’s policies and procedures concerning informed consent and Advance Directives, and information regarding Washington State Natural Death Act law as it relates to Advance Directives.

e. If, for any reason, the patient is unable to receive the above information or give answers concerning Advance Directives, the representative for the patient will be asked to complete the advanced directive plan and be given the same written materials listed in (d).

f. If the patient/surrogate did not bring their advanced directive to the hospital, ask that they do so within 24 hours and take to the nurses caring for the patient.

2. Medical Records:
   a. Advanced Directives from previous hospital visits are copied and sent, upon request, to the nursing unit upon admission to the hospital.

3. Unit Secretary:
   a. When the patient arrives on the nursing unit, the Unit Secretary (if applicable) will place the "Advanced Directive" sticker on the front of the chart.

   b. Tell the nurse caring for the patient if an advanced directive is present

   c. The Unit Secretary is responsible to look in the old records or call the Medical Records Department for a copy of the patient's Advance Directive. If present, copy and place it in the patient's current chart.

4. Nursing:
   a. During the admission process, document advanced directive information on the nursing admission form. If the patient has an advance directive, review with patient to determine if it still reflects the patient’s wish

   b. It is important the physician be aware the patient has an Advance Directive. If the patient does not have an Advance Directive but wishes to formulate such a Directive, the patient's physician and Spiritual Care

should be notified. The patient is given a packet of information on formulating an Advance Directive.

c. If a patient has an Advance Directive but a copy of it is not available
   i. arrangements are to be made to obtain a copy of the existing directive, if possible, or
   ii. the patient may be offered the opportunity to formulate a new written Advance Directive. Information packets may be obtained from Administration, Spiritual Care, or Registration Department.
   iii. The patient may discuss treatment preferences that are present in the original directive with their physician. The physician, to the best of their ability, will document this conversation in the patient's medical record.

d. If the medical record contains an existing Directive, the Directive (patient's wishes) should be reviewed with the patient/surrogate during the admission process, at significant changes in the patient's condition, or at the patient's request.

5. All:
   a. If, after receiving the written information the patient requests further information on formulating an Advance Directive, they may be referred to their attending physician, Spiritual Care, social services, or their own legal counsel.

   b. Hospital staff are not permitted to witness advance directives

D. Revocation:
If the patient/surrogate wants to revoke an Advance Directive, the revocation may be accomplished in one of three ways:

1. By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the patient or surrogate in the patient's presence.

2. By written revocation of the patient, signed and dated by the patient. The attending physician will record in the medical records the date and time he/she received notification of the written revocation.

3. By verbal expression of the patient's intent to revoke the directive.

This revocation becomes effective only when the

information is communicated to the physician. The physician will record in the medical records the date, time and place he/she received notification of the revocation.

If a patient wishes to revoke an Advance Directive while hospitalized, the patient's primary physician should be notified as soon as possible.

After the patient has made his/her wishes to revoke the directive known to the physician, a line should be drawn through the Advance Directive with the word REVOKED written on the directive itself. Date and time this writing. The "Living Will on File" sticker should be removed from the front of the chart.

E. Education:

1. Yakima Regional supports the goal to educate health care providers and the community about the value of Advance Directives and to facilitate their appropriate use.

2. The community is served by, written material, and other avenues. The public may obtain information by contacting the hospital Spiritual Care office, Registration department, or Administration.

F. If the hospital becomes aware of any circumstances in which a patient Advance Directive cannot be honored due to conflict with hospital policy, a physician, or the Washington State Natural Death Act the patient/surrogate decision maker will be advised.

Discussion and documentation will include:

- the differences, if any, between limitations that apply to the hospital versus those raised by the patient's physician.
- any reference of the Washington State Natural Death Act which authorizes the limitation.
- the medical condition and procedures affected by the limitation.

1. If the patient elects to continue care at Yakima Regional, the physician or hospital staff, with the patient or patient's representative, shall prepare a written plan to be filed with the patient's directive outlining the physician's or hospital's intended actions to be taken should the patient's medical status change so that the directive would become operative. After complying with the steps above the hospital and/or physician, however, are not otherwise obligated to carry out the patient's directive.

If the hospital will not honor an Advance Directive, it will make a good faith effort, if desired by the patient, to transfer the patient to a provider who will.

G. If the patient has any reason to believe that Yakima Regional is not fully complying with requirements regarding advance directives, they are encouraged to let the hospital know via the patient complaint process.

Patients will be informed, at the time of admission, of the right to file a complaint with the State Agency responsible for Medicare/Medicaid survey and certification about how their advance directives are handled.

Related Policies: #YR-ADMIN-016 Withholding and Withdrawing of Life Sustaining Treatments, and Addendum A