OLYMPIC MEDICAL CENTER

11.21 - End of Life Care

Group	Process	Approved Date
Administrative	Patient Care	2/1/2019

Note: Printed copies are for reference only. Please refer to SharePoint for the latest version.

PHILOSOPHY

Dying patients have unique needs for respectful, responsive care. It is important to properly evaluate and treat pain and suffering, and be sensitive to emotional issues of the patient, family and friends, care givers, and other staff. Emotional support for the dying patient and his or her family is a key element of end of life care. Sensitively addressing issues such as autopsy and organ donation can assist families in making these difficult decisions.

It is the intent of Olympic Medical Center to deliver patient care that safeguards patient dignity and respects the patient's values, religion, identified cultural needs, and philosophy. The relief of pain and suffering, whether physical or emotional, is a fundamental component of the care we deliver.

POLICY

Patients and families will be involved in decisions regarding their care. A patient care conference involving the patient and family is recommended so that the goals of care are understood by all care team members and clearly documented. The patient's spiritual, cultural, and philosophical values are an important part of the decision-making process and will be respected to the greatest degree possible.

Effective pain management is a goal for all patients. Hospital staff will work closely with physicians to facilitate achieving this goal. Interventions such as positioning, comfort measures, emotional support, and education about pain and its management may be indicated.

Should the patient be enrolled in a hospice program, hospital staff and providers will work closely with the hospice staff to ensure that the patient's stated goals are met.

PROCEDURE

A. **Physical Needs**

1. Assess pain and comfort level frequently. Treat pain as needed and evaluate patient response. Intravenous pain medication is often indicated.
2. Assess hydration status. If patient can swallow, offer fluids as tolerated. Keeping the patient's lips and mouth well lubricated will help to avoid skin breakdown.
3. If a comatose patient's eyes are open, appropriate eye care (i.e., liquid tears) is needed to keep corneas moist.
4. Position the patient for comfort. If the patient is flat on his or her back, keep the head of the bed elevated slightly to assist in breathing and avoid aspiration. Reposition the patient at least every 2 hours, taking care to avoid pressure spots or linen traction on the skin, both of which may lead to skin breakdown.
5. Keep the patient's skin clean and dry. Include the patient and/or family in discussions about how to best manage this, if possible.

6. Be aware of the patient's sensory status. Continue to talk to the patient, explaining procedures each time. Touching the patient may provide support and human warmth as vision and hearing fail.
7. A multidisciplinary patient care conference may be convened to ensure that patient and family needs are coordinated.

B. **Emotional Needs**

1. Explain activities and care to the patient, even if he or she is unconscious--the patient may be able to hear you.
2. Answer patient/family questions as candidly as possible, being sensitive to the patient's emotional needs.
3. Encourage patients and families to express their feelings. Provide a supportive, listening environment. If there are questions or conflicts regarding care, provide patients and families with information/options for having those conflicts explored (examples: facilitating communication between families and physicians, requesting assistance from Administration, convening a patient care conference with team members, accessing members of the Ethics Committee).
4. When family members are present, include them in explanations of patient care and treatment. If appropriate, offer to teach them how to assist with patient comfort measures. Let them know their efforts are important. Work with the family, allowing them to stay with the patient as much as possible, if that is important to them.
5. Determine whether the patient or family wishes spiritual support (i.e., contacting their clergyman). Identify any particular religious or cultural needs the patient or family might have, and facilitate meeting those needs when possible. This might include administration of last rites, for example.
6. As the patient's death approaches, determine patient and family wishes regarding notification of death. If the family wishes to be present, attempt to notify them as quickly as possible so they can be with their loved one.

Approval & Review Tracking:		**Next Review: 3/31/2022**
Approved By:	3/26/2019 X Eric Lewis Chief Executive Officer Signed by: Eric Lewis **Eric Lewis**	
Reviewed by: (Name/Date)	*6/98, 02/01, L. Minor, Reviewed 7/03 by: J. Cardinal, CON; 06/05 P. Miller, 02/08 L. Wall, 5/11 L. Wall, 3/14 L. Wall, 3/16 L.Wall* *D. Maden transition next review date change 3/31/19 L.Wall 2/1/19*	
Committees Review	[Committee 1]	[Review 1]
	[Committee 2]	[Review 2]
	[Committee 3]	[Review 3]
	[Committee 4]	[Review 4]

OLYMPIC MEDICAL CENTER

11.21.01 - Death with Dignity Act - OMC Position

Group	Process	Approved Date
Administrative	Patient Care	7/18/2019

Note: Printed copies are for reference only. Please refer to SharePoint for the latest version.

PURPOSE

To recognize the Washington State "Death with Dignity Act," herein referred to as the "Act" (RCW 70.245/WAC 246-978), and the Board of Commissioners Resolution No. 428 regarding this Act.

POLICY

OMC will allow its health care providers to participate in the process set forth in the Act if they so choose and respects the right of any health care provider to decline to participate in activities specific to the Act, subject to the provisions of this and any other applicable hospital policies.

This means that health care providers (defined by the Act as a doctor of medicine or osteopathy licensed to practice medicine in Washington) who are willing to participate, are employed and properly credentialed by OMC may, as otherwise allowed:

- Perform the duties of an attending physician;
- Perform the duties of a consulting physician;
- Prescribe a life-ending dose of medication;
- Provide counseling in connection with the provision of a life-ending dose of medication; and/or
- Perform other duties as provided for in the Act.

Health Care providers who decline to participate may:

- Refer the patient to other resources that can provide such support

DISPENSING AND INGESTING OF A LETHAL DOSE OF MEDICATION:

The OMC position is that its acute care hospital and its clinics are not the appropriate setting for patients who are at the stage of taking life-ending medications.

In accordance with Resolution No. 428, the final actions ending a patient's life, under the specifications of this Death with Dignity Act, shall **not** occur on or within the premises of the hospital or in clinics operated by the District. Not permitted on the District's premises is the patient's self-administration of the lethal medication. Also, the medication for this purpose will **not** be dispensed from the hospital pharmacy.

PROCEDURE

Patients who ask about the Death with Dignity Act may be given *The Washington State Death with Dignity Act* brochure or *Washington State Department of Health – Frequently Asked Questions – Death with Dignity Act*. Found at: (https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/FrequentlyAskedQuestions

Patients will be directed to talk with their primary care physician about various options for care at the time of terminal illness. These may include treatment options, palliative care measures, and advance directives. Should the patient request support for Death with Dignity process and the primary care provider is unable to provide this, the patient will be referred to other resources that can provide such support.

In the course of diagnosis and treatment attending physicians may:

- provide information for informed consent decision-making;
- assess the patient's medical decision-making competency;
- refer the patient to a consulting physician for prognosis and competency evaluation;
- refer the patient for psychiatric consult, if deemed appropriate;
- listen to a patient's initial oral request for participation in the Death with Dignity Act process, which may include a request for lethal medication;
- advise the patient that they may rescind the request at any time;
- advise the patient that they would want someone with them;
- advise the patient to discuss this with their their next of kin.

These are all verbal components in a discussion between a physician and their patient that may occur with respect to end of life care. These discussions would be documented in the patient's medical record.

If an Olympic Medical Center employed or contracted physician chooses to work with a patient in these efforts, then the physician (or designee) is required to contact the OMC Compliance Department who will assist in ensuring all mandated forms (Found at http://www.doh.wa.gov/dwda) per state regulations are completed and followed, as appropriate (form may change, please print forms from **website ONLY**). It is the responsibility of the attending physician "to ensure that all appropriate steps are carried out in accordance with the law **BEFORE** writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner.

CHECKLIST FOR PARTICIPATING PROVIDERS	
ALL PHYSICIANS:	
	Continue to provide all appropriate care to patient within standard of care.
	Make choice whether to participate in fulfilling patient request for assistance with the DWD process.
	Document required steps on DOH forms and include copy of forms in medical record.
ATTENDING PHYSICIAN – STAGE ONE:	
	Document patient first oral request in medical record/DOH Form 422-064 "ATTENDING PHYSICIAN'S COMPLIANCE FORM (continue to use form to track completion of required steps) (Found at: https://www.doh.wa.gov/portals/1/Documents/Pubs/422-064-AttendingPhysicianComplia nceForm.pdf) THIS FORM MUST BE FOLLOWED, COMPLETED AND SCANNED INTO PATIENT'S OMC MEDICAL RECORD EACH TIME IT IS UPDATED.
	Evaluate patient's competency and determine patient is competent to make an informed decision about self-administration of lethal medication.
	Refer patient to licensed psychiatrist or psychologist for counseling **IF** patient may have depression or psychiatric or psychological disorder causing impaired judgment (do not

	prescribe lethal mediation until you have received the completed DOH Form 422-066 **IF** you referred them to a psychiatric or psychological consultant)
	Refer the patient to consulting physician for medical confirmation of diagnosis and determination that patient is competent to make informed decision and acting voluntarily.
	Provide patient with the DOH written form 422-063 for making final written request and explain time frame. (Found at: https://www.doh.wa.gov/portals/1/Documents/Pubs/422-063-RequestMedicationEndMyLifeHumaneDignifiedManner.pdf)
CONSULTING PHYSICIAN:	
	Obtain required DOH Form 422-065 "CONSULTING PHYSICIANS'S COMPLIANCE FORM" (Found at: https://www.doh.wa.gov/portals/1/Documents/Pubs/422-065-ConsultingPhysicianComplianceForm.pdf)
	Refer patient to licensed psychiatrist or psychologist for counseling **IF** patient may have depression or psychiatric or psychological disorder causing impaired judgment (do not prescribe lethal mediation until you have received the completed DOH Form 422-066 **IF** you referred them to a psychiatric or psychological consultant)
	Complete CONSULTING PHYSICIAN'S COMPLIANCE FORM, retain copy for medical record; provide original to attending physician.
PSYCHIATRIC CONSULTANT:	
	Obtain required DOH Form 422.066 "PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM" (Found at: https://www.doh.wa.gov/portals/1/Documents/Pubs/422-066-PsychiatricPsychologicalConsultantComplianceForm.pdf)
	Document evaluation on PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM, retain copy for medical record; provide original to primay physician.
ATTENDING PHYSICIAN – STAGE TWO: (Continue following DOH Form 422-064)	
	Document patient's second oral request in medical record (Confirm **15 days** or more have passed since patient's first oral request)
	Review psychiatric provider's completed (DOH Form 422.066 "PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM" **IF applicable**) and completed consultant form (DOH Form 422-065 "CONSULTING PHYSICIANS'S COMPLIANCE FORM" **required**)
	Receive patient's completed written request on DOH form422-063 "WRITTEN REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER" (or in a written form that is substantially the same form as described in Act). (signed by patient and witnessed at least **48 hours** before physician writes prescription)
	Confirm patient is Washington resident (make copy of factors(s) used to determine residency and retain in medical record) • Washington state driver's license; • Registration to vote in Washinton state; or • Evidence that the person owns or leases property in Washington State.
	Confirm patient is at least 18 years of age
	Specifically offer patient options to rescind request. Verify that patient is still competent to make an informed decision. Verify that patient is acting voluntarily. Specifically document offer and response.
	BEFORE writing prescription, determine that all required steps have been carried out and documented on required DOH forms and that copies are in the clinical record.
	Write prescription for self-administered lethal medication.
	Instruct patient that any unused medication must be disposed of legally.

	With Patient written consent, contact pharmacist (at pharmacy that will dispense self-administered lethal medication) and inform pharmacist of prescription AND then **deliver prescription in person, by fax, or by mail to the pharmacist. The prescription can not be handed to the patient to bring to the Pharmacy.**
	Complete and sign DOH Form 422-064 "ATTENDING PHYSICIAN'S COMPLIANCE FORM" (Form you started during Stage One).
	The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as cause of death (and not the ingestion of lethal medication)
	Within 30 days after patient death, gather and submit required DOH Forms: 1. DOH Form 422-064 "ATTENDING PHYSICIAN'S COMPLIANCE FORM 2. DOH form 422-063 "WRITTEN REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER" 3. DOH Form 422.066 "PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S COMPLIANCE FORM" 4. DOH Form 422-065 "CONSULTING PHYSICIANS'S COMPLIANCE FORM" 5. DOH Form 422-069 "ATTENDING PHYSICIAN'S AFTER DEATH REPORTING FORM" OMC does not dispense medication – it is the responsibility of the pharmacist/pharmacy that dispensed the lethal medication to complete and submit the DOH Form 422-067 "PHARMACY DISPENSING RECORD FORM" (Found at: https://www.doh.wa.gov/portals/1/Documents/Pubs/422-067-PharmacyDispensingRecord.pdf)
	Within 30 days after patient death or within 30 days after patient ingestion of lethal medication obtained pursuant to the Act (whichever comes first) complete and submit required DOH Form 422-069 "ATTENDING PHYSICIAN'S AFTER DEATH REPORTING FORM" (Found at: https://www.doh.wa.gov/portals/1/Documents/Pubs/422-068-AttendingPhysicianAfterDeathReportingForm.pdf) This Form asks for very specific details about the patient's death and form instructs physician to contact the family or patient's representative if physician does not know the answers to any of the questions.
	OMC Compliance Department will ensure all documents are copied into medical record/EHR then Mail original forms to: State Registrar, Center for Health Statistics, P.O. Box 47856, Olympia, WA 98504-7856

Approval & Review Tracking:		**Next Review: 3/31/2022**
Approved By:	7/18/2019 X Eric Lewis Chief Executive Officer Signed by: Eric Lewis **Eric Lewis**	
Reviewed by: (Name/Date)	*D. Davison 6/09, 5/12, 9/14, 11/15, 1/18, J.Volkman 6/19; J. Jones, MD 7/19* **3/26/19 ZRETIRED. M.Nikolaisen** **6/17/2019 UNRETIRED**	
Committees Review	[Committee 1]	[Review 1]
	[Committee 2]	[Review 2]

OLYMPIC MEDICAL CENTER
RESOLUTION NO. 428

A RESOLUTION OF THE BOARD OF COMMISSIONERS OF OLYMPIC MEDICAL CENTER AMENDING RESOLUTION NO. 425 REGARDING PARTICIPATION IN THE WASHINGTON STATE DEATH WITH DIGNITY ACT, INITIATIVE-1000

WHEREAS, the Washington State Death with Dignity Act ("the Act") was passed by voters, and codified to the Revised Code of Washington (RCW Chapter 70.245) and the Washington Administrative Code (WAC 246-978);

WHEREAS, while the Act provides for certain rights and responsibilities of qualified patients and willing health care providers, the Board of Commissioners does not endorse any course of action for anyone, either patient or provider, by passing this Resolution, and ;

WHEREAS, the Board previously adopted Resolution No. 425 choosing not to participate in the Death with Dignity Act;

WHEREAS, The Board has received further input from the Medical Staff and the Public in consideration of end of life issues;

WHEREAS, the Board recognizes the privacy and personal nature of the patient-physician relationship; and that much of the dialog, information, and requirements of the Act may occur in the course of comprehensive care for a patient in a physician clinic, yet believes, however, that the Hospital setting or OMC Clinics is not the appropriate location for the final step of this Act as an end of life option;

NOW, THEREFORE, BE IT RESOLVED, that Olympic Medical Center will not prohibit willing OMC physicians, employees, independent contractors, and volunteers from assisting a patient within the scope and requirements of the Act; nor will it require participation by OMC physicians, employees, independent contractors and volunteers.

BE IT FURTHER RESOLVED that the final step of self-administration of the medication will not be permitted on the premises of the Hospital or in clinics operated by OMC.

BE IT FURTHER RESOLVED except as specified in this resolution all provisions of Resolution No. 425 relating to the requirements that OMC make available of future education on end of life issues, palliative care measures, and develop internal policies in compliance with the Death with Dignity Act and this resolution remain in effect.

ADOPTED and APPROVED by the Board of Commissioners of Olympic Medical Center, at an open public meeting thereof this 3rd day of June 2009, the following Commissioners being present and voting in favor of the Resolution.

ATTEST:

President and Commissioner

Commissioner

Secretary and Commissioner

Commissioner

Commissioner

Commissioner

Commissioner

OLYMPIC MEDICAL CENTER

11.12 - Advance Directives

Group	Process	Approved Date
Administrative	Patient Care	11/22/2019

Note: Printed copies are for reference only. Please refer to SharePoint for the latest version.

TABLE OF CONTENTS – CLICK TO JUMP TO A SECTION

POLICY

Olympic Medical Center (OMC) makes every effort to provide person-centered care. This includes educating patients about Advance Care Planning (ACP), assisting patients with documenting ACP plans and securing those plans in the electronic medical record. Patients 18 years of age or older, at the time of inpatient admission or during the pre-admission process, receive written information regarding an individual's rights under state and federal law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.

DEFINITIONS

A. Advance Care Planning

Advance care planning is a process to help patients:

1. Understand possible future healthcare choices
2. Make a plan for future healthcare situations
3. Discuss choices with those close to the patient and his/her health professionals
4. Document religious, spiritual and personal beliefs which may impact care received.
5. Record preferences for medical treatment, life-sustaining treatment, and end-of-life preferences

B. Advance Directive

Advance Directives are written instructions, as to goals, values, and preferences, related to healthcare treatment decisions. These written instruction guide patients, families, and the entire healthcare team in order to honor patients' wishes. Advance Directives are recognized under state law (whether statutory or as recognized by the courts of the state), and relating to the provision of such care when the individual is incapacitated.

Examples of Advance Directives include:

1. Healthcare Directive (Living Will)

   A written document or recording which describes an individual's personal values, goals and preferences for treatment. It will guide the health care agent and providers to make the best possible decisions on behalf of the individual when that person is unable to make decisions for themselves.

2. Durable Power of Attorney for Health Care(DPOAHC)

   A written or recorded document which designates a proxy/healthcare agent to make treatment decisions when a person is incapacitated and unable to make informed health care decisions for him/herself. DPOAHs require either two witnesses or notarization. Legal witness requirements can be found in RCW 11.125.050and RCW 11.125.400 Notary publics will be maintained on staff for notarization purposes.

3. Physician Orders for Life Sustaining Treatment (POLST)

   A POLST is a written agreement between a physician and a patient who is 18 or older with a serious health condition. The POLST consists of certain advance orders the physician makes for treatment to be received in specific situations. The POLST form is a uniform medical order sheet addressing resuscitation, antibiotics, and artificially administered fluids and nutrition. The POLST follows previously expressed wishes of the patient/legal surrogate and translates them into medical orders to guide treatment by health professionals in care settings throughout the community. Patients either 1) presenting for care with a signed POLST or 2) who have a POLST scanned into their medical records will have those wishes honored for the first 24 hours of their care or subsequent orders are written. A patient presenting to the hospital with a signed POLST form will have these outlined wishes honored but a physician order must be obtained within 24 hours of admission.

4. Dementia Directive

   A written disease-specific advance directive that can be a stand alone document or used in conjunction with other advance directives documents. It more specifically covers the stages of dementia, decision making capacity and goals of care and treatment preferences.

5. Mental Health Advance Directive

   A written document in which a patient makes a declaration of instructions or preferences, or appoints an agent to make decisions on their behalf, regarding the patient's mental health treatment which is consistent with the provisions of Washington's mental health advance directive statute. Persons with mental illness may fluctuate between periods of capacity and incapacity. Mental Health Advance Directives provide a method of expressing instructions and preferences for treatment in advance of a period of incapacity and providing advance consent to or refusal of treatment.

   It is the policy of Olympic Medical Center to honor Mental Health Advance Directives that meet state law requirements, medical and ethical practice standards, and the policies and procedures of this hospital. The hospital and medical staff shall presume a properly executed Mental Health Advance Directive is valid and will honor it to the best of their ability, even if one or more provisions of the directive are deemed to be invalid. However, in those circumstances where it is not appropriate or permissible to honor Mental Health Advance Directives, the patient and/or their designated agent will be advised and appropriate documentation will be made in the patient's medical record.

   Washington State Mental Health Advance Directives

C. Death With Dignity Act

The Death with Dignity Act allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents how have less than six months to live. See procedure for more information.

D. Witness

A witness to an Advance Directive shall not be an employee of the health care facility, attending physician, employee of the attending physician, or any person who has claim against any portion of the estate of the declarer upon the declarer's death at the time of the execution of the directive.

E. Capacity for Decision Making

Medical decision making capacity is the ability of a patient to understand the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment).

F. Surrogate Decision Making Hierarchy

A surrogate decision maker is necessary for incapacitated patients as determined by the attending physician, or with the assistance from a psychiatrist or an Ethics Advisory Committee consult.

The surrogate decision making hierarchy is defined as follows in Washington (RCW 7.70.065):

- ☐ The appointed guardian of the patient, if any
- ☐ The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions
- ☐ The patient's spouse or state registered domestic partner
- ☐ Children of the patient who are at least 18 years of age, if unanimous
- ☐ Parents of the patient, if unanimous
- ☐ Adult brothers and sisters of the patient, if unanimous
- ☐ Adult grandchildren, if unanimous
- ☐ Adult nieces and nephews, if unanimous
- ☐ Adult aunts & uncles, if unanimous
- ☐ A close friend who meets certain criteria and completes a declaration, can be accepted at the discretion of the provider, see health care decision declaration: http://sharepoint/docucenter/Forms/Health%20Care%20Decision%20Declaration.pdf

PROCEDURE

Resuscitation

All patients are considered full code status unless otherwise directed in an Advance Directive form.

Death with Dignity Act (RCW 70.725/WAC 246-978)

Refer to 11.21.01 Death with Dignity Act.

Advance Directives (Including POLST)

Inpatient

A. Refer to Appendix A for a flow chart of this process

B. At the time of admission or during the pre-admission process, Advance Care Planning information is made available to all patients. The Patient Information Packet is provided on admission and is a primary source of Advance Directive literature.

1. The Admitting Nurse will obtain a 'yes' or 'no' in response to whether the patient has an Advance Directive.
   - If the answer is yes, a request will be made to obtain a copy to have scanned into the EHR and a comment will be entered in EPIC by the admitting nurse. Healthcare team members will follow up with the patient as needed to document requests made to obtain the patient's Advance Directive. Priority scanning of these documents is done when a copy is sent to Health Information Management – refer to Appendix B on the scanning process.
2. Case Management will see adults 18 years of age or older to answer any questions, provide educational information, and give the Advance Care Planning brochure and forms, if the patient requests this.
3. Patients admitted to the hospital are automatically placed in a full resuscitating status, *unless*:
   - Patient has executed an Advance Directive and it is in the medical record
   - Consultation of the M.D. with the patient regarding wishes and M.D. documents this as a Physicians order
   - Consultation of the M.D. with the patient representative regarding wishes and M.D. documents this as a Physicians order

C. When a patient is **incapacitated** at the time of admission, Case Management will:
   1. Try to determine from DPOAHC, guardian / family member accompanying the patient if an Advance Directive has been executed.
   2. Document in patient's electronic medical record what the decision-maker stated was 'the substance' of the directive if they do not have a copy with them to provide for the medical record.

D. If the patient revokes the Advance Directive, then document the revocation in the *Progress Notes* of the electronic medical record, stamp or write 'revoked', date and initial, send a copy of the revoked document to HIM and give the original back to the patient.

E. Notary service will be provided, if the patient /family requests.

POLST – Inpatient

A. A POLST provides valid initial medical orders when there are not more recent hospital orders to address resuscitation, antibiotics, and artificially administered fluids and nutrition (unless the patient/surrogate indicates the POLST no longer represents their wishes).
   - An original, bright green POLST or a copy of this completed form is valid for the first 24 hours of hospitalization, if signed by both the patient/legal surrogate and a physician or advanced registered nurse practitioner licensed in the state of Washington. The POLST must be reviewed by the admitting/managing physician within 24 hours of admission in order for POLST to remain valid during inpatient hospitalization. The most recent wishes of the patient/surrogate prevail, regardless of information on the POLST.

B. When a patient with POLST form orders is discharged from OMC, the copied form is scanned into the electronic medical record by the HIM department for record retention – refer to Appendix B on the scanning process. The form will be readily accessible for future hospitalizations; though it will be subject to review to ensure patient's wishes have not changed.

C. At the time of inpatient admission to the patient's room nursing will:
   - Make a copy of the patient's POLST, returning the one provided for copying to the patient or family member
   - Place this copy in the chart cover to be scanned into the electronic medical record by HIM staff – refer to Appendix B on the scanning process

D. With POLST forms presented by family or patient's representative for an inpatient after initial admission the nurse will follow steps a-c above. The nurse then contacts the managing physician to notify him/her of the recently obtained POLST form content and solicit any necessary change in existing orders.
   - If the POLST form specifies Do Not Resuscitate status, refer to Admin Policy 11.08 - Code Status for proper completion.

E. The patient or their legal representative may revoke or void the POLST at any time, either verbally or in writing. Voiding of the POLST is documented in the Review section on the back of the form, and new medical orders are obtained by nursing

F. Upon referral Case Management will provide patients or family members with information pertaining to POLST. This information is to be reviewed by the patient and/or their representative and will be discussed with their physicians.

Outpatient

Patients presenting to the OMP Outpatient Clinics may be queried as to the existence of Advanced Directives. If one exists, all efforts will be made to secure a copy for the medical record. Advance Care Planning brochures will be available in OMC outpatient settings. These will include resources of additional information and assistance for patients.

In the Short Stay Unit of the Hospital, the patient will be queried during nursing assessment about the availability of an Advanced Directive.

In the Emergency Department, upon presentation of POLST forms at emergency registration or in the emergency department, the physician will provide treatment and orders reflective of the patient's wishes and needs.

Medical Emergency Response - Outpatient

In the ambulatory outpatient care settings, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situation, the signed consent for treatment or services that day implies consent for resuscitation and transfer to a higher level of care.

For outpatient settings not on the hospital campus, "911" will be called for patient transport to the Hospital Emergency Department where the Hospital Code Blue is called. Exceptions are:

A. Short Stay Unit of the Hospital – the patient's wishes based on available Advanced Directives will be honored.

B. Cancer Center, Specialty Clinics, and Primary Care Clinics – when the patient's physician is present and a copy of the Advanced Directive or POLST is immediately available and verified, then the physician will direct the type of care and/or transport necessary to comply with the patient's wishes.

Home Health

A. Upon admission, the admitting clinician will provide information regarding a patient's right to make decisions concerning health care, which include the right to accept or refuse medical or surgical treatment, even if that treatment is life sustaining and the right to execute advance directives. Written information designed for this purpose will be provided to the patient in the OMHH Admit Booklet. The clinician will document in the clinical record that the information was provided. The clinician will document resuscitation status in the patient's clinical record. Resuscitation status will be present on Plan of Care.

B. If the patient lacks decision making capacity, the admitting clinician will provide information and direct inquiry about advance directives to the patient's representative. The clinician will document that the patient representative received information and his/her name and responses will be noted in the patient's clinical record.

C. During the admission/evaluation visit, the admitting clinician will ask the patient and/or his/her representative whether or not he/she has completed an advance directive in the form of a living will and/or a POLST order, and whether or not the patient has named a durable power of attorney and/or a health care surrogate. If an advance directive has been completed, the clinician will ask for a copy of the advance directive. If a copy is available, it will be placed in the clinical record.

D. All patients are considered full code status unless otherwise directed in an Advance Directive or POLST form.

E. If the patient has an advance directive and the patient has not made his/her physician aware of it, the clinician will instruct the patient to update the physician at his/her next appointment.

F. The patient will be encouraged to participate in all aspects of decision making regarding home care and treatment. Statements by a competent patient of his/her desire to accept or refuse treatment will be documented in the patient's clinical record.

G. All clinicians providing care for the patient will:
   1. Review the advance directive and report any discrepancies between the directive and current treatment plan to the attending physician, supervisor, and patient.
   2. Utilize available educational materials to answer the patient's questions about advance directives/living wills, or durable powers of attorney.
      - OMHH Admit Booklet
      - POLST form
   3. Encourage the patient to discuss questions and concerns with appropriate individuals, such as: the physician, family/caregiver(s), and his/her selected advocate.
   4. Refer the patient who wants to develop an advance directive to the OMHH Medical Social Worker or other appropriate resource.

Mental Health Advance Directives

A. Each patient shall be asked whether he or she has made any form of healthcare advance directives and if they would like information about them. If the patient requests information, handouts will be provided: one is a copy of the Advance Care Planning brochure about Health Care Directives (living wills), and Durable Powers of Attorney for Health Care and the other is a brochure on Mental Health Advance Directives. These will be provided by the Case Management staff.

B. On receipt of a mental health advance directive, a copy of the directive shall be sent to HIM to be scanned in to the patient's electronic medical record.

C. On receipt of a directive, a medical staff member shall determine the validity of the directive. To be valid it must:
   1. Be in writing;
   2. Include language that shows an intent to create a mental health advance directive;
   3. Be dated and signed by the patient or be dated and signed in the patient's presence at his or her direction;
   4. State whether the directive may or may not be revoked during a period of incapacity; and
   5. Contain the signatures of two witnesses following a declaration that the witnesses personally know the patient, were present when the patient dated and signed the directive, and that the patient did not appear to be incapacitated or acting under fraud, undue influence, or duress. (Witnesses cannot be healthcare providers of the patient).

D. The following areas of the directive shall also be reviewed for validity:
   1. Appointment of agent: If the directive includes appointment of an agent it must contain the words "This power of attorney shall not be affected by the incapacity of the principal," or "This power of attorney shall become effective upon the incapacity of the principal or similar words.
   2. Effective date: A directive may be effective immediately after it is executed or it may become effective at a later time.
   3. Directives created outside Washington State: A directive validly executed in another political jurisdiction is valid to the extent it is permitted under Washington state law.
   4. Witnesses: Hospital staff and employees, medical staff members or any other person involved in the patient's care are not permitted to witness a mental health advance directive.

E. The patient shall be asked whether he or she is subject to any court orders that would affect the implementation of his or her directive. If so, a copy of the court order must be obtained and placed in the patient's chart.

F. On admission the admitting medical staff member shall ascertain whether compliance with the directive, or portions of it, is possible.

G. During treatment the attending medical staff member shall ascertain on an ongoing basis whether compliance with the directive, or portions of it, is possible.

H. On receipt of an agent's notice of withdrawal, the notice and the effective date shall be noted in the patient's chart. If there is no effective date, the notice is effective immediately.

I. A revocation of a mental health advance directive is effective upon receipt and shall be made part of the medical record immediately. A copy of the mental health advance directive will have the word 'revoked' written or stamped across it, date, time and initial will be added and the original given back to the patient. It will then be placed in the progress notes of the patient's medical record.

J. Non-Compliance with Directive Instructions:
   1. Ability to object on initial receipt of directive:
      - If unable or unwilling to comply with any part or parts of the directive for any reason, an objection can be made to that part or those parts of the directive.
      - Notify the patient of the objection, and, if applicable his or her agent and document the part or parts of the directive that are objectionable and the reason in the patient's medical chart.
   2. Ability to object once acting under authority of a directive:
      - Unless an objection to treatment in accordance with the advance directive has been noted on receiving the directive, treatment shall follow the directive.
      - When acting under the authority of a directive, the provisions of the directive shall be followed to the fullest extent possible, except for the following reasons:
        - compliance with the provision of the mental health advance directive would violate the accepted standard of care;
        - the requested treatment is not available;
        - compliance would violate the law; or,
        - the situation constitutes an emergency and compliance would endanger any person's life or health.
   3. If unable to comply with any part or parts of the directive for the reasons cited above, the patient, and if applicable, his or her agent shall be notified and the reason documented in the medical record. All other parts of the directive shall be followed.

K. If a patient is involuntarily committed or detained for involuntary treatment and provisions of the mental health advance directive are inconsistent with either the purpose of the commitment or any court order relating to the commitment, those provisions may be treated as invalid during the commitment. However, the remaining provisions of the directive are advisory while the patient is committed or detained.

L. Agent Authority:
   1. Unless the directive has been revoked, the decisions of an appointed agent must be consistent with the instructions and preferences expressed in the directive or if not expressed, otherwise known to the agent. If the patient's instructions or preferences are not known, the agent must make a decision he or she determines is in the best interests of the patient.
   2. Except as may be limited by state or federal law, the agent has the same right as the patient to receive, review, and authorize the use and disclosure of the patient's health care information when the agent is acting on behalf of the patient and to the extent required for the agent to carry out his or her duties.
   3. A directive may give the agent authority to act while the patient has capacity. Even if the directive gives such authority to the agent, the decisions of the patient supersede those of the agent at any time the patient has capacity.
   4. On receipt of an agent's notice of withdrawal, the notice, and effective date if one is provided, shall be noted in the patient's chart. If no effective date is specified, the notice is effective immediately.

M. Revocation/Expiration of a Directive:
   1. A patient with capacity may revoke a directive in whole or in part by a written statement. An incapacitated patient may revoke his or her directive only if he or she elected at the time of executing the directive to be able to revoke when incapacitated.
   2. The revocation is effective immediately upon receipt and shall be made part of the medical record.

3. If a patient makes a subsequent directive, it revokes in whole or in part (either by its language or to the extent of any inconsistency) the previous directive.
4. A directive remains effective to the extent it does not conflict with a court order and no other proper basis for refusing to honor the directive or portions of it exists.
5. If a mental health advance directive is scheduled to expire, but the patient is incapacitated, the directive remains in effect unless the directive specifies that the patient is able to revoke while incapacitated and has revoked the directive.

N. Conflicting Directives or Agency Appointments:
1. Discrepancies in directives or in agent appointments shall be reported to the supervisor or nurse manager, who will inform the physician.
2. If an incapacitated patient has more than one valid directive and has not revoked any of his or her directives then the most recently created directive controls any inconsistent provisions unless one of the directives states otherwise.
3. If an incapacitated patient has appointed more than one agent via a durable power of attorney with the authority to make mental health treatment decisions, the most recently appointed agent shall be treated as the patient's agent for mental health treatment decisions unless otherwise provided in the appointment.
4. Any time a patient with capacity consents to or refuses treatment that differs from the provisions of his or her directive, the consent or refusal constitutes a waiver of any provision of the directive that conflicts with the consent or refusal. However, it does not constitute a revocation of that provision unless the patient also revokes that provision or the directive in its entirety.

O. Responsibilities:
1. Registration staff: Be aware that legislation allows for mental health advance directives; and if documents are presented, they would be referred to the patient's nurse or case management representative on duty.
2. Admitting physician or clinician: Determine validity of mental health advance directive and provide care in accordance with directive to the extent possible; document in the medical record accordance with the directives; or document the part(s) of the directive that are objectionable for reasons of violation of standard of care/violation of law/treatment not available/endangerment.
3. Nursing staff: The Admitting Nurse will obtain a 'yes' or 'no' in response to whether the patient has an advance directive (AD). If the answer is yes, a request will be made to obtain a copy to have scanned into the EHR and a comment will be entered in EPIC by the admitting nurse. Healthcare team members will follow up with the patient as needed to document requests made to obtain the patients AD. Priority scanning of these documents is done when a copy is sent to Health Information Management. Also, be aware of mental health advance directive legislation and components, as described in this policy.
4. Case Management: provide patients with information on advanced directives, both general and mental health, upon request.

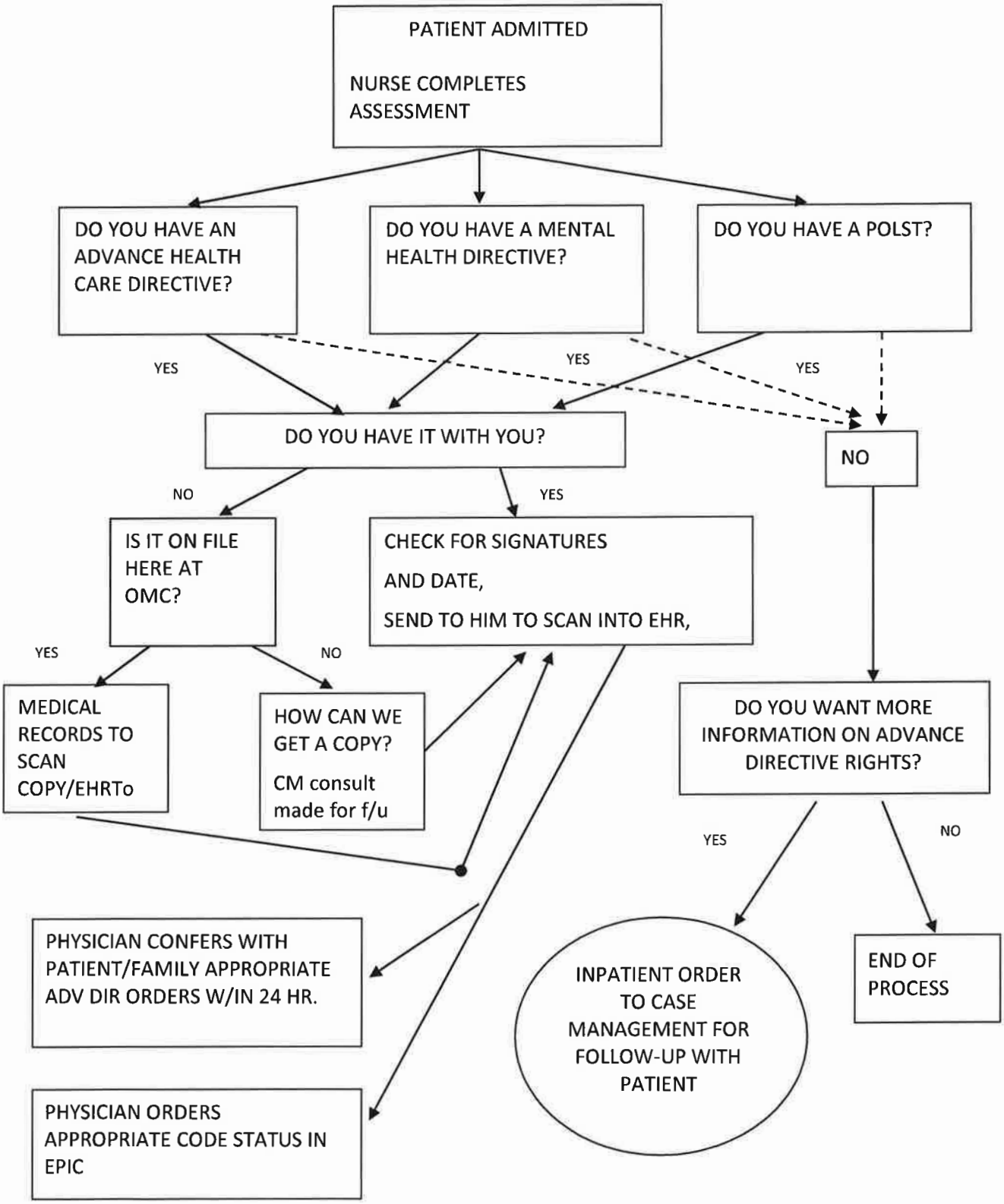
REFERENCES

Engrossed Substitute Senate Bill 5223 (Washington state's mental health advance directive statute), chapter 11.94 RCW, chapter 7.70 RCW, 42 CFR Part 417 *et. seq.*

Washington State Hospital Association Red Head Bulletin and attached materials including mental health advance directives power point presentation for providers, clinician check list, and patient informational brochurehttp://www.wsha.org/Mentalhealth.htm .

WSHA Guidance on Surrogate Decision Makinghttps://www.wsha.org/our-members/projects/end-of-life-care-manual/section-5-surrogate-decision-making

APPENDIX A: INPATIENT ADVANCED DIRECTIVES PROCESS



APPENDIX B: HEALTH INFORMATION MANAGEMENT (HIM) SCANNING OF ADVANCE CARE PLANNING DOCUMENTS

Advance Care Directives and Power of Attorney (POA) Documents

Health Information Management staff will scan in the Advance Directive and Power of Attorney document utilizing the Registration Demographics activity in Epic. This method of scanning will populate fields in Epic that are viewable to clinical and Care Management staff. We will scan these documents into Epic within 1 – 2 hours after receiving them in our department.

1. Go to Epic, Chart Review, select patient
2. Click on "Demographics" on the left activity bar.
3. Click on the Advance Directives tab
4. At "Hospital Advance Directive/Living Will" add in the "description" field the date the form was signed by the patient, change the status to Yes – At Community Connect, add OMC hospital for Location. The "date received" will auto-populate to today's date.
5. At "Power of Attorney" add in the "description" field the month & year document was notarized/date effective, DPOA HC (healthcare) or F (financial) or if both: DPOA-HC/F.

   You need to review the document to see what type of DPOA we have: HC, F or both.

   Sometimes there are multiple POA's they should be marked #1, #2, etc. in the document we have. In the Description field, if you have enough space, you can put all names but if not, the Primary POA/HC is the most crucial.

   EXAMPLE: 11/15 DPOA-HC/F#1 Mary Smith

   Change the status to "Received" and location = OMC Hospital

   Date received will auto-populate to today's date.
6. If you have a document that is a combined Advance Directive and POA, scan it under both headings. (If you scan it under just one heading, it will appear like we do not have the other type of document.)
7. Click on the Scan button at the bottom of the screen. Onbase opens up and the document is automatically indexed to the document type you have selected as "type of document".
8. Verify everything looks correct. If ok, click on "Start Scanning".
9. Once the document shows up, delete any blank pages. If everything looks good, click on "Index".
10. When done, click on "Exit Scan Server".
11. Click on Chart Review, media tab to verify the document is showing up in Epic.

NOTE TO HOSPITAL HIM STAFF: Make sure the Demographic Area for Advance Directives and POA's only contain the most recent documents available. If we see multiple documents listed, make sure we keep the most recent one and print out the older documents.

1. Print out any old documents that should no longer be showing up in the Demographic Area.
2. Delete the old documents & scan in the new revised document.
3. Re-scan the older documents (that you printed out) via OnBase using Document Type: Other, with the Description: Old Advance Directive/POA & date signed. You will need to select a CSN close to the date we received the new document(s), or create a Historical Visit CSN.

POLST Forms

The Health Information Management staff will scan in POLST forms using the document type of "POLST". Epic will then automatically change the POLST indicator in Epic from "None" to "Yes". This indicator shows up at the top of the screen when viewing a patient's medical record. We will scan these documents into Epic within 1 – 2 hours after receiving them in our department.

1. Scan the POLST form using Onbase. Document type is "POLST".
2. Verify the document is showing up in Epic under the Media tab.
3. Verify the POLST indicator now has "Yes" at the top of the screen for the patient. You should also be able to click on the POLST indicator, select an encounter & this should open the "Advance Care Planning Summary". This summary provides links to any scanned POLST forms and Advance Directives on this patient.

NOTE 1: According to WSMA who puts out the POLST form, it must be signed by the patient or POA for Healthcare if activated, for it to be valid.

NOTE 2: The bright green POLST forms should be kept / maintained by the patient. We should mail the original back to the patient (unless expired).

NOTE 3: We should only have one POLST on file for a patient at one time. If scanning in an updated POLST, we need to print the old POLST, send it to Misfile to be deleted, and then re-scan the old POLST form using Document Type: Other, with the Description: Old POLST & date signed. You will need to select a CSN close to the date we received the new document, or create a Historical CSN.

Approval & Review Tracking		**Next Review: 3/31/2023**
Approved By:	11/22/2019 X Eric Lewis Chief Executive Officer Signed by: Eric Lewis **Eric Lewis**	
Reviewed by: (Name/Date)	*03/96, 06/98, 04//9, 02/01, 04/02; by: J. Berry. 03/05, J. Des Rochers; 03/07 L. Wall 3/11 B. Tassie, 8/11 D Davison 3/14 D Davison, J Burkhardt, B Tassie, L. Wall 5/14 B Thompson, B Tassie, H Wickersham, 9/14 B Tassie, 10/16 C. Burke; Transition Re-dated to 2019; S. Ulf, C. Burke, L. Uraga 3/19 (and 6/19 only to add link to Death with Dignity policy instead of text), 11/19 S. Ulf*	
Committees Review	[Committee 1]	[Review 1]
	[Committee 2]	[Review 2]
	[Committee 3]	[Review 3]
	[Committee 4]	[Review 4]