Advance Directives Policy and Procedure

Purpose

- To provide an atmosphere of respect and caring and to ensure that each patient's ability and right to participate in medical decision making is maximized and not compromised.
- To assure compliance with the Patient Self-Determination Act (PSDA) in such a manner for both the patient and healthcare personnel will be involved regarding advance directives and the process by which patient participation in medical decision making is carried out at this facility
- Advance Directives can protect patient's rights and wishes in the event the patient becomes physically or mentally unstable to make healthcare decisions. Physician's honor a patient's advanced directive does not determine an individual's access to care, treatment and services.
- A valid advance directive is followed regardless of the patient's race, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay and source of payment.
- No patient will be discriminated against with regard to the provision of care or based on whether the patient has executed an advance directive.

Audience

All Clinical Staff

Key Concepts and Terms

Adult: Any person eighteen years of age or older, or emancipated minor.

Advance Directive: a type of written or oral instruction relating to the provision of healthcare when an adult becomes incapacitated including, but not limited to, a healthcare proxy, consent for an order not to resuscitate (DNR) and a living will.

Healthcare Proxy: a document created pursuant to Article 29-C of the Public Health Law which delegates the authority to another adult known as the healthcare agent to make healthcare decisions on behalf of the adult when that adult is incapacitated.

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Do Not Resuscitate Order: a DNR order means specifically that IF *cardiac and/or respiratory arrest* occurs- that is, if a person stops breathing and/or his/her heart stops beating- then

cardiopulmonary resuscitation (CPR) will *not* be performed to revive the person. However, if the person is not in cardiac or respiratory arrest, appropriate medical treatment for all injuries, pain, difficult or insufficient breathing, hemorrhage and/or other medical conditions must be provided.

Living Will: a document which contains specific instructions concerning an adult's wishes about the type of health care choices and treatments that an adult does or does not want to receive, but which does not designate an agent to make health care decisions. A living will may be considered clear and convincing evidence of a patient's wishes

Medical Durable Power of Attorney for Health Care Decisions: a written declaration signed by the patient designating a person to make health care decisions for the patient in the event the patient loses decision-making capacity

Physician Orders for Life Sustaining Treatment (POLST) Form: is a document created by you and your doctor that informs emergency care Physicians what kinds of treatments you want (and don't want) in a medical emergency

Proxy Decision-Maker: when the patient has no Advance Directive, a medical durable power of attorney or guardian with medical decision-making authority, health care Physicians and facilities may rely on a proxy substitute decision maker if the patient is not capable of making his/her own decision. The attending physician or designee shall make reasonable efforts to notify "interested persons" including: spouse, parent, adult child, sibling, grandchild, or "close friend." These persons may, by consensus, select the proxy.

Substitute Decision Maker: A substitute decision maker is a person authorized to make health care decisions for a patient. If a court appointed guardian has been assigned for the purpose of making healthcare decisions, the substitute decision maker will be the court appointed guardian. In the absence of a guardian, the agent designated as the Medical Durable Power of Attorney for Healthcare Decisions will be the substitute decision maker. If neither of these situations applies, the facility and healthcare Physicians may rely on a PROXY Decision Maker.

Terminal Condition**:** An incurable or irreversible condition for which the administration of life-sustaining procedures will only prolong the dying process.
Perioperative Period: "perioperative period" will refer to the time when an anesthetist accepts responsibility for the patient's care until responsibility is relinquished back to another service or

practitioner. This period is usually pre-op holding, the O.R., the PACU and the immediate post-op ICU period.

Endotracheal Intubation: Endotracheal intubation is to be considered a modality of support under anesthesia, therefore patients reluctant to agree to the possibility of endotracheal intubation in the operating room for fear of prolonged ventilator support postoperatively should address the issue of "time limited therapeutic intervention" and extubation with the involved practitioners, especially their primary care physician.

Policy

To supply ASH Physicians and staff with the resources needed to better assist patients and their families who need or request Advanced Directive information or forms to prepare an Advanced Directive.

Patients of ASH will be provided Advanced Directive information and forms for use upon their request or by the request of the physician. In all instances where a Physician may reasonably anticipate impending circumstances requiring decisions about future medical care, the Physician should discuss these issues with the patient and family in advance to allow the patient to document their wishes before they become unable to make their wishes known about future medical care, including end-of-life decisions

- No ASH employee, volunteer, attending physician, or employee of the attending physician is permitted to witness any patient's Advance Directive. Employees who have been appointed as a notary public may use their notary seal to notarize signatures (RCW 70.122.030].
- No ASH employee, volunteer or attending physician shall be required under any circumstances to participate in the withholding or withdrawing of life-sustaining treatment if such person objects to so doing. No such person shall be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the withholding or withdrawing of life-sustaining treatment [RCW 70.122.060(4)].
- Staff and attending physicians may presume that the patient's Advance Directive is legally valid unless the Advance Directive has been revoked. No staff or attending physician will be liable for failing to act upon a revocation unless that person has knowledge of the revocation (RCW 70.122.040).

***NOTE: At no time will hospital/clinic personnel or healthcare provider give legal opinions or advice suggesting the appropriate decision in executing any of these documents.**

The Physician who anticipates impending circumstances requiring decisions regarding future medical care will discuss these issues with the patient and family and provide the appropriate

information for completion by the patient. The Physician may not require that any particular form be executed. If the patient fails to document his wishes, the Physician should document any specific wishes voiced by the patient in the medical record in the presence of two witnesses.

The Physician should document specific orders in the patient's medical record consistent with the patient's directive (DNR, pain medications only, etc.).

An anesthetist may withdraw from a DNR case any time prior to the induction of anesthesia if the shared plan is ethically, morally or emotionally unacceptable to that individual practitioner. But an anesthetist who elects to withdraw from a DNR case must assist the patient and surgeon in their search for another anesthetist from within the department who is amenable to the DNR plan. If the second anesthetist finds the proposed DNR plan objectionable, the case must then be referred to the Surgery Department Chairperson. Cases of DNR status disputes, which remain unresolved by the Surgery Department Chairperson must then be referred to the Chief of Staff

Key Points:

- *POLST Forms* and *Advance Directive Forms* serve different purposes but can be complementary for advance care planning.
- *POLST Forms* provide medical orders during an emergency that can be followed by EMS. Advance directives cannot be followed by EMS.
- Health care professionals complete the *POLST Form* after having a conversation with the patient about his/her diagnosis, prognosis, treatment options and goals of care.
- State specific information is available by clicking www.or.polst.org or www.wsma.org/POLST.

Procedure

Admitting:

Adult patients will be asked if they have an advance directive at their point of entry into Astria Sunnyside Hospital.

A. Determine for persons 18 years of age or older admitted as an inpatient, outpatient or for short stay whether an Advance Directive has been completed.

1. Obtain copy if available.
2. Request a copy to be brought to nursing unit or to outpatient clinician if patient possesses Directive.
3. Place in patient record.
4. Refer patient/designee to social services if patient/designee has questions regarding advance directives or patient is unable to be questioned about advance directives

B. Provide patient/designee with Patient Rights information and ASH information pertaining to Advance Directives.
**Alert nursing staff or outpatient clinician if patient or designee is unable to be questioned when the patient was admitted.

<u>NURSING'S ROLE (Inpatients):</u>

1. Review the admission paper work for Advance Directive information
2. Place advanced directive behind face sheet in chart under tab "advance directive"
3. If advance directives are brought to the hospital after the patient's admission, document in the EMR receipt date and time and scan document into chart.
4. If the patient does not have advance directives and desires to discuss and/or initiate one, make a referral to Social Services. Document in the patient record the date, time and reason for referral.
5. Note that advance directives are a guide to the patient's wishes regarding end of life situations. A No Code/Limited Code Order must be completed when the patient's condition warrants. This allows the patient to reconsider specific directives based on his current situation.
6. A copy of the advance directive is a permanent part of the patient medical record.

<u>ATTENDING PHYSICIAN</u>

The attending physician's role is crucial to successful implementation of Astria Sunnyside Hospital and Clinics policy on advance directives

1. All attending and primary care physicians are encouraged to raise the issue of Advance Directives with each adult patient at any opportunity (including office visits), preferably when the patient is healthy.
2. Attending and primary care physicians are encouraged to provide information to those patients expressing interest in establishing Advance Directives, including information as to where they may obtain copies of the brochure "Who will decide if you can't." This brochure includes forms for both a Living Will and a Durable Power of Attorney for Health Care.
3. Each time the physician asks a patient to sign an Informed Consent; the physician is encouraged to ask the patient if he or she has an Advance Directive or would like to discuss establishing an Advance Directive.
4. Attending physicians will refer interested patients to Social Services, Pastoral Care, their own legal counsel, or other appropriate physicians or personnel for the purpose of establishing an Advance Directive.
5. Attending physicians will honor the patient's revocation of his or her Advance Directive, document the revocation, and notify appropriate ASH personnel

When the patient's Advance Directive conflicts with the physician or Astria Sunnyside Hospital and Clinics policies:

1. The attending physician shall inform a patient or his or her surrogate decision-maker of the existence of any policy or practice of the physician or ASH that would preclude the honoring of the patient's Advance Directive. If the patient chooses to retain the physician or remain at ASH, the physician shall prepare a written plan to be filed with the patient's Advance Directive that sets forth the physician's or ASH's intended actions should the patient's medical status change so that the Advance Directive would become operative.
2. The physician and/or ASH have no obligation to honor the patient's Advance Directive if they have complied with this notification (RCW 70.122.060).

Peri-Operative Suspension or Continuance of Status

In the case of any patient who has been designated DNR at any time preoperatively it must be clearly stated at the end of the anesthetists preoperative note that the patient falls into one of two categories:

1. Patient has agreed to suspension of DNR status (all resuscitative measures will be employed in the perioperative setting).

2. Patient wishes the DNR status continued in the operating room and the perioperative setting (no resuscitative efforts).

A physician (e.g. anesthetist, surgeon) must designate in the physician's orders that the patient is either "Suspend DNR for Surgery-Anesthesia" or "Continue DNR for Surgery-Anesthesia".

Interventions that are part of routine anesthetic management may be considered to be resuscitation measures in other clinical settings. Furthermore it should be noted that when cardiac arrest occurs during anesthesia, resuscitation is usually successful. Therefore, the treatment of cardiac arrest in the perioperative period carries with it a more favorable prognosis than the treatment of cardiac arrest in other settings.

Recognizing that the resuscitation from cardiac arrest occurring in the operating room or in the perioperative period carries with it a more favorable prognosis than resuscitation from cardiac arrests in other settings, it is therefore the general policy of the operating room that all patients are to be granted the benefit of resuscitative efforts in the event of a cardiac arrest regardless of the underlying disease and circumstances. The Anesthesia Department recognizes that despite careful explanation of the facts and principals outlined above, some patients may insist on the continuation of their DNR status into the operative setting. This policy makes allowance for those patients who wish to continue their DNR status into the operating room.

Maintenance of physiologic function under anesthesia is to be clearly distinguished from resuscitation measures. Interventions to support anesthesia may include the following:

- Drugs to maintain a stable blood pressure
- Drugs to maintain a stable cardiac rhythm
- Drugs used in the support of airway maintenance

- Drugs used to support spontaneous ventilation
- Drugs used to maintain an adequate cardiac output
- Drugs used to treat adverse effects of anesthetic agents or other agents

Assisted or controlled positive pressure ventilation whether by mask or by endotracheal tube

Implementation/Education Plan

Quiz attached

Related Documents

Advanced Directive Form-Washington

POLST Forms:

Washington- www.wsma.org/POLST

State Specific Planning Forms:

Washington- http://www.dshs.wa.gov/dbhr/advdirectives.shtml

Washington State Specific Information:

Washington- http://www.wsma.org/wcm/Patients/Advance_Directives.aspx.

References:

WAC 388-97-065 Advance Directives

WAC 388-97-060 Informed Consent

Patient Self-Determination Act, 42 U.S.C. � 1395cc (2000).

42 U.S.C � 1395cc(f)(3).

A health care advance directive (aka a living will) expresses a competent individual's preferences regarding the withholding or withdrawal of life-sustaining treatment if terminally ill or permanently unconscious, see RCW 70.122. A durable power of attorney for health care appoints an agent to provide informed consent for health care decisions on behalf of the individual who executed the directive, see RCW 11.94.

RCW 70.122.130.

RCW 70.122.130(2)(a).

RCW 70.122.130(2)(b).

RCW 70.122.130(c).

RCW 70.122.051(3).

RCW 70.122.051(4)(a-d).

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