

**Rehabilitation Hospital**POLICY SECTION: **Leadership**Effective Date: **1/9/2018**

Review Date:

POLICY TITLE: **Advanced Directives**

Revised Date:

POLICY NUMBER: **LD 315**

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**PURPOSE**

The purpose of this policy is 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 as a result of their hospital admission for patient care. Additionally, this policy is to assure compliance with the Patient Self-Determination Act (PSDA) in such a manner as to expand the patient, personnel and community knowledge base regarding Advance Directives and the process by which patient participation in medical decision-making is carried out at this Hospital. The Hospital recognizes the right of the patient to execute an Advance Directive (AD) including the right to accept, to refuse or to withdraw from treatment. The Hospital complies with all state and federal regulations, accreditation requirements and court decisions, regarding the right of an adult patient (or emancipated minor or minor with a legal guardian) to make determinations about his or her medical treatment.

**POLICY**

It is the policy of this Hospital to respect and encourage patient self-determination. Patients are encouraged and assisted to be active participants in the decision-making process regarding their care through education, inquiry, and assistance as requested. Patients are encouraged to communicate their desires in regard to Advance Directives to their significant others. This allows for guidance of significant others and healthcare providers in following the patient's wishes should the patient become incapacitated or otherwise rendered unable to make decisions.

**DEFINITION**

An Advance Directive (AD) or advance health care directive (AHCD) is a document or documents that allow a person to give directions about future medical care or to designate another person(s) to make medical decisions if the individual loses decision-making capacity. Examples of Advance Directives are living wills, durable power of attorney for health care (DPAHC); do not resuscitate (DNR) orders, right to die, or similar documents listed in the PSDA which expresses the person's preferences.

**PROCEDURE**

- I. An inquiry is made by the designated hospital staff during the admissions process of the patient, or if the patient is incapacitated, to the patient's significant other, as to whether or not the patient has completed an Advance Directive. The Hospital shall not condition the provision of care or otherwise discriminate against any individual based on whether or not the individual has executed a n Advance Directive for health care.
  - A. A request of the patient/significant other to provide a copy of the Advance Directive for

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- medical record entry is made by the designated hospital staff during the admission process. As part of the admission process, the patient/significant other are provided with an information packet outlining the individual's rights to make decisions concerning medical care.
- B. The designated hospital personnel document in the medical record whether the patient has completed an Advance Directive and that information concerning Advance Directives has been given to the patient/significant other during the admission process. When the patient does not have an Advance Directive, but wishes to execute one, the Hospital facilitates the process for the patient and a referral is made to Case Management/ Social Service for follow-up interaction with patient and significant others, as appropriate.
- II. When the patient has an Advance Directive, the nursing staff and physician have the responsibility to review the existing Advance Directive with the patient/significant other to validate its current status.
- A. In the event the patient/significant other indicates that the current Advance Directive does not accurately reflect the patient's wishes, a revised Advance Directive is obtained from the patient that meet all Advance Directive regulations. Any expression by the patient of a revision in their Advance Directive desires is documented by the nurse and/or physician in the progress notes.
- B. The interdisciplinary team is informed of the Advance Directive and its contents and the team honors the directive within the limits of applicable laws, rules, and regulations.
- C. A copy of the Advance Directive is in a designated space within the medical record, if available.
- III. To the extent that the patient/significant other requests additional information or further explanation regarding the PSDA or Advance Directive, referrals are made to Case Management/Social Service for follow-up interaction with patient and significant others, as appropriate.
- A. All follow-up education and interaction with the patient/significant other is documented in the medical record by the individual designated to interact with the patient/significant other regarding their concerns surrounding Advance Directives.
- B. The Ethics Committee may also be made available to discuss patient rights issues as needed through Hospital Administration. All requests from patients/significant others, hospital personnel and/or medical staff members to institute the Ethics Committee process is honored.

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- IV. In some cases, it must be verified whether the person is incapacitated. A person is deemed “incapacitated” if and for as long as a court of competent jurisdiction has made a finding to that effect, or a guardian or conservator of that person’s estate or person has been appointed by the court or a competent jurisdiction.
- A. Certification by two physicians (licensed to practice under the laws of the state where the person resides at the time of certification) describes whether the person is able to properly care for him/herself, manage his/her property and financial affairs, and/or handle the routine activities of daily living.
- B. A person may be found to have Testamentary capacity but not have the ability to manage their finances, health, and personal care needs. The question of capacity must be determined before an individual makes or changes an Advance Directive.

(NOTE: Discontinuation of all treatment modalities does not imply discontinuation of care. All measures will be taken to provide comfort and pain relief for the patient.)

**USE OF ARTIFICIAL NUTRITION AND HYDRATION**

- V. Provision of nutrition and hydration is basic to the care we owe to one another and symbolizes bonds of nurturance. There is a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration.
- A. Artificial nutrition and hydration are medical treatments and are morally evaluated in the same manner as other medical treatments. Therefore, artificial nutrition and hydration may become disproportionate or no longer morally obligatory and therefore may be withheld or withdrawn.
- B. Examples of medical conditions in which it may be appropriate to withhold or withdraw artificial nutrition and hydration are terminal illnesses. For the purpose of this policy, terminal illness refers to an incurable or irreversible condition that has a high probability of causing death within one year or less. Examples include, but are not limited to:
1. A medical condition for which there is no reasonable hope of recovery
  2. Untreatable coma with no reasonable chance of recovery
  3. A condition of irreversible brain damage

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VI. Appropriate criteria for determining the moral obligation of utilizing artificial nutrition and hydration are as follows:

- A. The required procedures are unlikely to achieve improved nutritional and fluid status. However, when there is uncertainty as to the likely benefits of the treatment, time limited trials may be appropriate.
- B. Improvement in nutritional and fluid status, though medically achievable, may extend the patient's life but would not alter the quality of life for the patient.
- C. The risks and burdens of receiving treatment are disproportionate to the benefits experienced by the patient.
  - 1. Examples of potential risks are infections of indwelling catheters, thrombosed veins, absence of suitable veins requiring surgical placement
  - 2. Examples of potential burdens are a patient's impaired mental status resulting in frequent removal of IVs and NG tubes, thus necessitating physically restraining the patient in order to continue the artificial nutrition and hydration
- D. When the total clinical outlook has become so poor that treatment has been judged to be meaningless and may prolong dying rather than prolong life, artificial nutrition and hydration may be withheld or withdrawn.
- E. When a patient's hope of biological cure diminishes, the emphasis in therapy often shifts towards comforting modalities of treatment: alleviation of pain and suffering though spiritual and psychological support of the patient, family, and staff, and appropriate use of analgesic drugs

VII. In order to ensure that an opportunity for patient participation in medical decision-making is maximized and that care provided is consistent with patient values and directives, educational information about Advance Directives is provided to all hospital staff.

- A. The hospital's policies, mission, and value statements regarding Advance Directives and withholding of life-sustaining measures are provided to the medical, allied health professional, and Hospital staff on a periodic basis and as necessary.



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- B. Information is provided through a collaborative effort with all disciplines via educational programs as well as written newsletters, memorandums, orientation processes, and annual personnel reviews.