

 HARRISON MEDICAL CENTER	Advance Directives	Page 1 of 4	Next Review Date
	Organizational	Creation: 10/25/1991 Update/Review 6/97, 3/2000, 3/10/06, 3/31/10, 07/11/2013	07/11/2016
	Owner(s): Compliance Auditor, Legal Services		
	Policy Category: Patient Rights & Responsibilities/Advance Directives		
Required Signature(s): Vice President, Chief Legal Officer & General Counsel, Legal Services			

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. Additionally, the purpose of 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 Harrison Medical Center (HMC).

POLICY:

HMC recognizes and respects the right of all of its patients to participate in the course of their healthcare treatment and to have their wishes honored in the event that they become incapacitated. HMC supports and protects the rights of its patients to formulate written or oral instructions regarding their health care. Patients will be encouraged and assisted to be active participants in the decision making process regarding their care through education, inquiry and assistance as requested. Patients will be encouraged to communicate their desires in regard to advance directives to their significant others, to allow for guidance of significant others and healthcare providers in following the patient's wishes should the patient become incapacitated, rendering them unable to make decisions. HMC will not discriminate against patients based on whether or not they have advance directives.

DEFINITIONS:

1. Advance Directive: A type of written or oral instructions relating to the provision of healthcare when an adult becomes incapacitated including, but not limited to, a durable power of attorney for healthcare, consent for an order not to resuscitate (DNR), or a living will.

In an advance directive the patient may provide guidance as to his/her wishes in certain situations, or may delegate decision making to another individual as permitted by state law. If such an individual has been selected by the patient, or if a person willing and able under applicable state law is available to make treatment decisions, relevant information should be provided to the representative so that informed healthcare decisions can be made for the patient.

However, as soon as the patient is able to be informed of his/her rights, this facility shall provide that information to the patient.

- A. Durable Power of Attorney for Healthcare: A document created which delegates the authority to another adult known as the power of attorney to make healthcare decisions on behalf of the adult when that adult is incapacitated.
- B. Do Not Resuscitate Order: A DNR order means specifically that IF **cardiac and/or respiratory arrest** occurs 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.
- C. Health Care Directive (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.

PROCEDURE:

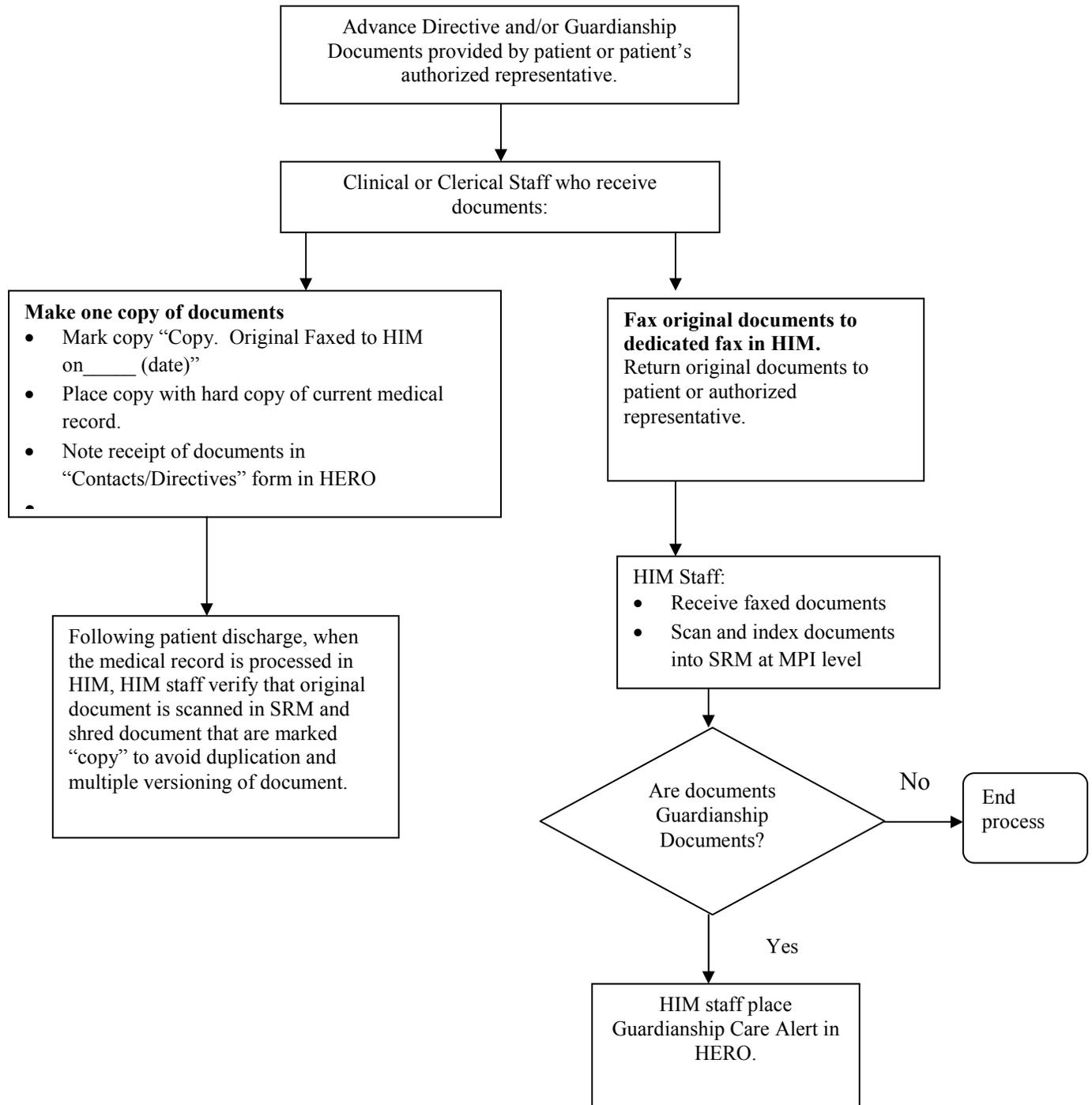
1. An inquiry will be made by registration staff during the patient admission process, or if the patient is incapacitated, to the patient's significant other, as to whether or not the patient has completed an advance directive. HMC shall not condition the provision of care or otherwise discriminate against any individual based on whether or not the individual has executed an advance directive.
2. A request of the patient/significant other to provide a copy of the advance directive for medical record entry will be made by the registration staff during the admission process.
3. As part of the intake process the patient/ authorized representative will be provided with an information packet outlining the individual's rights to make decisions concerning medical care. The information packet provided will include:
 - A. The right to make decision concerning the patient's care
 - B. The right to accept or refuse medical or surgical treatment, even if the treatment is life-sustaining
 - C. The right to execute an advance directive and revoke it at any time
 - D. That the existence of an advance directive, or lack thereof, will not determine the patient's right to care, treatment or services
 - E. The right to participate in the development and implementation of plan and treatment
 - F. Information about how to voice a complaint related to advance directive requirements to the State Department of Health
 - G. Contact personnel available to assist those interested in creating an advance directive
4. Registration personnel will document in the medical record whether the patient has completed an advance directive and whether information concerning advance directives has been given to the patient/ authorized representative during the admission process.
5. The RN responsible for the initial patient assessment reviews the patient's medical record and advance directive documentation at the time of admission to determine if the process to obtain the directive(s) is complete. The RN reviews the Advance Directive(s) with the patient and ensures that documentation of the Directive(s) status is completed in the medical record. Any needed follow up is included in the care planning process.
6. If the patient wishes to formulate an Advance Directive, the staff will consult with the Case Management staff, who will meet with the patient as soon as is feasible. Any significant conversations regarding specific care decisions will be documented in the patient's record and the patient's provider will be notified. In addition, the patient may choose to verbally provide his/her care wishes to his/her provider. The provider will document all such conversations in the patient's medical record.
7. It is the responsibility of the patient or surrogate to provide the hospital with a new or revised Advance Directive documents.
8. If a HMC staff member cannot, as a matter of conscience, fulfill a patient's advance directive, he or she must immediately inform HMC. HMC will arrange for the transfer of the patient's care to an alternate staff member. No HMC staff member will be discriminated against in employment or professional privileges because of the staff member's fulfillment or refusal to fulfill a patient's advance directive.
9. HMC will provide periodic education for HMC staff members concerning the requirements of this Advance Directive Policy. HMC will document all staff education efforts.

10. HMC will educate members of the community about this Advance Directive Policy. In order to meet this requirement, HMC may provide medical staff physicians with information on Advance Directives and encourage such physicians to distribute the information to patients in their offices. HMC will document all community education efforts.

References

- 1) Joint Commission: RI.01.05.01
- 2) 70.122 RCW Washington State's Natural Death Act Statute
- 3) 71.32 RCW Mental Health Advance Directives Statute
- 4) 11.94 Washington State's Power of Attorney Statute
- 5) WAC 388-501-0125 Washington Regulations for Serving Medical Assistance Clients
- 6) 42 CFR 489.102; 42 CFR 482.13 CMS COP on Participation on Advance Directives and Patients' Rights
- 7) 42 CFR Part-417 et al. Federal Regulations Implementing the Patient Self-Determination Act
- 8) HMC Medical Staff Policy – Conduct of Care

Attachment: Process for Receipt and Handling of Advance Directives and Guardianship Documents



	Patient Rights and Responsibilities	Page 1 of 3	
	Organizational	<u>Creation: 04/12/2012</u> 10/03/2012	
	Owner(s): Danielson, Cris (Director)		09/30/2014
	Policy Category: Patient Rights & Responsibilities/Patient Rights		
Required Signature(s): Bosch, Scott (CEO), Policy Coordinator			

PURPOSE

Harrison Medical Center honors and protects the rights of all patients in every setting, and has established mechanisms to deliver these rights to our patients at the time of their registration. The Medical Center prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression. The Medical Center respects the patient's cultural and personal values, beliefs, and preferences.

PROCEDURE

Patients have the legal right to:

Patient Care:

- Be informed of their rights and receive a written copy before they receive or discontinue patient care whenever possible.
- Personal privacy.
- Participate in the development and implementation of their plan of care.
- Make informed decisions regarding their care including: being informed of their health status; being involved in care planning and treatment; and being able to request or refuse treatment. Patients do not have the right to demand provision of treatment or services deemed medically unnecessary or inappropriate.
- Receive an appropriate medical screening examination or treatment for an emergency medical condition within the capabilities of the hospital, regardless of ability to pay for such services.
- Receive an explanation of our condition and be informed about the outcomes of care, including unanticipated outcomes.
- Understand the choices for treatment, including the right to refuse treatment, and to be informed of the risks and benefits of your choices.
- Obtain a second opinion.
- Receive an assessment of your pain and input on your pain management.
- Choose whether or not to participate in medical research studies. You will receive complete information about the study in order to make an informed decision. Your written consent is necessary if you choose to do so. Your medical care will not be impacted if you choose not to participate.
- Know the name and role of each person participating in your care.
- Receive spiritual counseling and support.
- File a grievance and be informed of the process to review and resolve the grievance.

A Safe Environment:

- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Be free from any form of restraint or seclusion that is not medically necessary or is used as a means of coercion, discipline, convenience, or retaliation by staff.

Information:

- Receive information tailored to your age, language and ability to understand
- Formulate advance directives and have hospital staff and practitioners who provide care in the hospital comply with these directives.
- Have a family member or representative of your choice and your physician notified promptly of your admission to the hospital.
- Have access to an interpreter, free of charge.
- Confidentiality of your personal identifiable health information.
- Access information contained in their medical records within a reasonable time.
- An interpreter, free of charge.
- Have your bill explained.
- Obtain copies of your medical records.
- Determine who may and may not visit you, regardless of whether the visitor is legally related.

SPECIAL RIGHTS OF ADOLESCENT PATIENTS.

In addition to the patient rights granted to adults, the law provides the following rights for adolescent patients:

- o A minor patient 13 years or older may consent to outpatient treatment for mental health and substance abuse issues.
- o A minor patient 14 years or older may consent to outpatient treatment for sexually transmitted diseases.
- o A minor patient, regardless of age, may consent to birth control or pregnancy related care
- o Emancipated minors may consent for their own treatment. Minors with the right to consent to treatment also have the right to determine who has access to their medical record.

PATIENT RESPONSIBILITIES.

Patient responsibilities include the following:

- o To let someone know if you don't understand what you are being told.
- o To tell us everything you know about your health.
- o To let us know if there are changes in your condition.
- o To participate in your healthcare by making decisions, following directions, and accepting responsibility for your choices.
- o To maintain civil language and conduct when interacting with staff and physicians.
- o To respect the rights and privacy of others.
- o To let us know or to cancel an appointment if you will be unable to keep the appointment.
- o To maintain civil language and conduct in interactions with staff and practitioners to support mutual consideration
- o To deal with your bill promptly and to let Patient Financial Services know if special payment arrangements are needed.

Distribution of Patient Rights Information

Patients are offered a brochure containing these rights and responsibilities at the time of registration. In outpatient settings such as Harrison Health Partner clinics, patients are offered the brochure at the time of their initial registration and annually thereafter.

Additional information included in the brochure informs the patient how to file a complaint and lists the contact information for a variety of state and federal agencies who also respond to patient complaints.

Patient/family acknowledgement

- If the patient has any questions regarding their rights or any information contained with the brochure they should speak with their nurse, the unit manager, or be referred to patient advocacy.

References

TJC: RI.02.01.01; RCW 26.28.010; WA246-320-141; CMS 482.13(a)(1)