VALLEY GENERAL HOSPITAL TRUE COMMUNITY MEDICINE

Header Information

Policy		Deployment	
Policy Name:	Advance Directives	Institution:	Valley General Hospital
Supercedes:		Division:	Hospital
Policy Level:	Hospital wide	Department:	Administration
Owner(s):	Teri Cook/VGH	Contributing Departments:	Health Information Services Utilization Management
Priority:		Manual Name:	Administration
Identification Number:	3.9	Manual Category / Chapter:	General
Status:	4. Approved	Restricted to Groups:	
Approval Date:	03/21/2014	Policy Start Date:	12/01/1991
Version Number:	12	Monthly Review Interval:	12
		Policy Review Date:	03/24/2015

Policy

PURPOSE

To delineate how Valley General Hospital uses advance directives and to direct employees in the procedures for advance directive management. This policy complies with Federal law in the Patient Self-Determination Act (PSDA, 1991), OBRA 1990, and Washington State Law in the Natural Death Act. (RCW 70.122).

POLICY

It is the policy of Valley General Hospital to respect the patient's wishes concerning their health care. Advance Directives are honored for all inpatients:

- DNR status is rescinded during the operative and phase I recovery periods.
- For procedure or clinic related reversible complications that can be treated medically unless otherwise specified by the ordering physician.

SUPPORTIVE DATA

Guiding Principles

- All people have the right to decide what will be done with their bodies.
- All individuals are presumed to have decision-making capacity until deemed otherwise.
- All patients who can participate in a conversation, either verbally or through alternative means of communication, should be approached to discuss and record their treatment preferences and wishes.
- Health care professionals can improve the end-of-life care for patients by encouraging the use of advance directives.

Advance Directives

- Allow individuals to provide directions about the kind of medical care they do or do not want if they become unable to make decisions or communicate their wishes (Rodriguez & Young, 2006 [Level V]).
- They are called "advance" directives because they are signed in advance to let your doctor and other health care providers know your wishes concerning medical treatment.
- Provide guidance for health care professionals, families, and substitute decision makers about health care decision making that reflects the person's wishes.
- Provide immunity for health care professionals, families, and appointed proxies from civil and criminal liability when health care professionals follow the advance directive in good faith.

Valley General Hospital is expected to take reasonable steps to determine the patient's wishes concerning designation of a representative.

Responsive / Coherent Patient
When a patient is not incapacitated has designated, either orally to hospital staff or in writing, another individual to be his/her representative, the hospital must provide the designated individual with the required notice of patients' rights in addition to the patient. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient's inpatient stay or outpatient visit, unless expressly withdrawn, either orally or in writing, by the patient.

Unresponsive / Incapacitated Patient
In the case of a patient who is incapacitated, when an individual presents the hospital with an advance directive, medical power of attorney or similar document executed by the patient and designating an individual to make medical decisions for the patient when incapacitated, then the hospital must, when presented with the document, provide the required notice of its policies to the designated representative. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient's inpatient stay or outpatient visit, unless the patient ceases to be incapacitated and expressly withdraws the designation, either orally or in writing.

When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is no written advance directive on file or presented, and an individual asserts that he or she is the patient's spouse, domestic partner (whether or not formally established and including a same-sex domestic partner), parent (including someone who has stood in *loco parentis* for the patient who is a minor child), or other family member and thus is the patient's representative, the hospital is expected to accept his assertion, without demanding supporting documentation, and provide the required notice to the individual.

Two Types of Advance Directives: Durable Power of Attorney for Health Care (DPAHC) (also called a Health Care Proxy) and Living Will (LW)

- A *Durable Power of Attorney* allows individuals to appoint someone, called a health care proxy, agent, or surrogate, to make health care decisions for them should they lose the ability to make decisions or communicate their wishes.
- A *Living Will* provides specific instructions to health care providers about particular kinds of health care treatment an individual would or would not want to prolong life. Living Wills are often used to declare a wish to refuse, limit, or withhold life-sustaining treatment.
- Instructional or Medical Directive (POLST): Intended to compensate for the weaknesses of Living Wills, this kind of directive identifies specific interventions that are acceptable to a patient in specific clinical situations.

PROCEDURE

1. Admission/Medical Records Procedure

a. Admitting personnel will ask all legal adults upon admission or during the pre-admitting process for inpatient services if they have an advance directive. Legal adults are defined as age 18 and greater and emancipated minors.

b. Discussions about advance directives should be conducted in the patient's preferred language to enable information transfer and questions and answers.

- Interpreter / Translation Services - #1-800-945-7889 (Policy #3.16)

c. The patient's advance directive status will be recorded on Form #VGH 1776 and in the ADT system (AS400), resulting in an entry on the medical record face sheet.

- The patient has an advance directive - A "yes" entry will be recorded in the ADT system when the patient has an advance directive available at the time of admission, or already has one on file in the patient's historical chart at Valley General Hospital.

  - If the patient has a copy of the Advance Directive with him/her, Admitting staff will scan the document into EDM (Electronic Document Management system) at the Medical Record Number level. Send a copy to medical records. A copy will be placed in the patient's current chart on the designated clinical unit. (Place the copy under the "Advance Directives" tab.)

  - If Advance Directive is already present in the patient's historical chart, print a copy of the advance directive from EDM and place a copy with admitting paperwork for inclusion into the patient's unit chart.

  Medical Records - If directives are on file in the patient's historical chart, Medical Records will pull, copy, stamp "copy", and place in the current chart on the floor, as close to the time of admission as possible. At the same time, Medical Records will complete their section of VGH form #1776, under #4. Medical Records designated section. Scan to Medical Record Number level of EDM.

- The patient **does not** have an advance directive A "no" entry will be documented if the patient does not have an advance directive.

  - Admitting will offer an Advance Directive booklet to patient or family and indicate with a check mark on form #1776 under #1. Admitting designated section - "Advance Directive booklet accepted by patient / family" OR "Booklet refused".

d. When the patient has an advance directive but a copy is not available at the time of admission, and no copy is on file in the patient's historical chart, Admitting personnel will ask the patient/family to provide a copy as soon as possible. The location of the advance directive will be entered into the "Comments" field on the Advance Directives page of the AS400 admitting screens (i.e.home, med rec)

e. If a copy is brought to Medical Records, the advance directive will be

stamped with the date received and will file the copy of the advance directive under the "Advance Directive" tab in the current patient chart. Scan to Medical Record Number level of EDM.

f. When changes to a patient's advance directive are received, a revised copy will be placed on the patient's current chart by Medical Records. Scan to Medical Record Number level of EDM.

2. Utilization Review / Discharge Planning

a. Discharge Planning will review every face sheet to see if the field for advanced directive indicated a "no" or "yes" value.

b. For every "no" value, Utilization Review / Discharge Planning will speak with the patient to provide additional information about the advance directive, provide the Booklet (if not already given), and to answer questions the patient, family, and guardian may have.

c. For every "Yes" value, Utilization Review / Discharge Planning will request that a copy be brought to the hospital for placement in the patient's current chart. Two attempts will be made to request the advance directive copy. (DNV, 2013)

d. If brought in during hospitalization, Disharge Planning will place a copy under the Advance Directive tab in the current patient chart.

e. Utilization Review / Discharge Planning will document on form #1776, under #2 or #3 UR/Discharge Planning designated section.

REFERENCES

AHRQ (Agency for Healthcare Research and Quality) National Guideline Clearinghouse / Advance Directives www.ahrg.gov (Updated / Verified August 4, 2008).

CMS Manual System: Hospital Interpretive Guidelines: Appendix A, Rev. 75, Implementation: 12/02/2011; Interpretive Guidelines: 482.12(a)(7),(b)(2).

NIAHO Accreditation Requirements, Rev. 10, Patient Rights, PR.2.

Mitty EL, Ramsey G. Advance directives. In: Capezuti E, Zwicker, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 539-63. [62 references].

Washington State Hospital Association. Federal and State Law on Advance Directives. www.wsha.org/EOL-FedState.cfm.

Washington State Medical Association, 2014, https://www.wsma.org/advancedirectives.

Washington State RCW 13.64.060, Power and Capacity of Emancipated Minor.

- Compliance Monitoring
- Process Cycle Information
- Logs

VALLEY GENERAL HOSPITAL TRUE COMMUNITY MEDICINE

Header Information

Policy		Deployment	
Policy Name:	Death with Dignity Act/Initiative 1000	Institution:	Valley General Hospital
Supercedes:		Division:	Hospital
Policy Level:	Hospital wide	Department:	Administration
Owner(s):	Teri Cook/VGH	Contributing Departments:	Medical Staff
Priority:		Manual Name:	
Identification Number:	3.50	Manual Category / Chapter:	
Status:	4. Approved	Restricted to Groups:	
Approval Date:	03/13/2014	Policy Start Date:	06/12/2009
Version Number:	3	Monthly Review Interval:	24
		Policy Review Date:	03/21/2016

Policy

POLICY

Hospitals exist to heal, educate and provide comfort, including pain relief. When a patient has been diagnosed with a terminal illness, the patient and his/her family need time to grieve and to plan for the end of life and the loved one's future. Decisions related to death and dying, especially choosing to end life, should be made with a clear mind, with full knowledge of the options and consequences involved, and with the support and advice of family and trusted, long standing advisors.

Acute care hospitalizations by nature are of short term duration. Healthcare providers in the hospital setting have become increasingly specialized and do not have an established, long term relationship with the patient to understand all of the issues the patient may be facing. The hospital healthcare providers can provide support and education, but that does not take the place of an on-going developed physician/patient relationship. Therefore, Valley General Hospital will not participate under the Death with Dignity Act.

Valley General Hospital believes in the principle of autonomy and the individual's right to choose. We recognize that some patients may desire to seek physician advice and consultation regarding the ending of life. We recommend that the hospital not interfere between a patient and his/her primary care physician, but would encourage the physician and patient to consider all options including Hospice and other end of life comfort measures.

1. Washington law recognizes certain rights and responsibilities of qualified patients and health care providers under the Death with Dignity Act ("Act"). Under Washington law, a health care provider, including Valley General Hospital is not required to assist a qualified patient in ending that patient's life.

2. Valley General Hospital has chosen to not participate under the Death with Dignity Act.

This means that in the performance of their duties, Valley General Hospital physicians, employees, independent contractors and volunteers shall not assist a patient in ending the patient's life under the Act on hospital premises. Valley General Hospital pharmacists will not dispense medications for the purpose of ending life.

3. No patient will be denied other medical care or treatment because of the patient's participation under the Act. The patient will be treated in the same manner as all other Valley General Hospital patients. The appropriate standard of care will be followed.

4. Any patient wishing to receive life-ending medication while a patient at this hospital will be assisted in transfer to another facility of the patient's choice. The transfer will assure continuity of care.

5. All providers at Valley General Hospital are expected to respond to any patient's query about life-ending medication with openness and compassion. We believe our providers have an obligation to openly discuss the patient's concerns, unmet needs, feelings, and desires about the dying process. Providers should seek to learn the meaning behind the patient's questions and help the patient understand the range of available options, including but not limited to comfort care, hospice care, and pain control. Ultimately, Valley General Hospital's goal is to help patients make informed decisions about end-of-life care.

PROCEDURE

1. All patients will be provided with educational materials about end-of-life options. These materials will include a statement that Valley General Hospital does not participate in the Act.

2. If, as a result of learning of Valley General Hospital's decision not to participate in the Act, the patient wishes to have care transferred to another hospital of the patient's choice, Hospital staff will assist in making arrangements for the transfer. If the patient wishes to remain at Valley General, staff will discuss what end of life care will be provided consistent with hospital policy.

3. If a patient requests a referral to a physician who will fully participate under the Act or expresses the desire to take medication that will result in the patient's death, the provider may choose to provide the patient with a referral, or may instruct the patient that he or she must find a participating provider on his or her own. The relevant medical records will be transferred to the physician taking over the patient's care. The patient's primary clinical care giver (nurse or social worker) will be responsible for:

   a. Informing the patient's attending physician that the patient wishes to take life-ending medications.

   b. Ensuring that the medical record is complete and all required documentation is included. A copy of the Resuscitation Status (DNR) order, copies of advance directives, and POLST (Physician Orders for Life Sustaining Treatment) form are to be included.

   c. Communicating with other clinicians involved with the patient to ensure continuity of care.

   d. Documenting all communication in the patient's medical record.

4. Nothing in this policy prevents a physician or provider from making an initial determination that the patient has a terminal disease and informing the patient of the

medical prognosis.

5. Nothing in this policy prevents a physician or provider from providing information about the "Washington State Death with Dignity Act" to a patient when the patient requests information.

6. Nothing in this policy prohibits a physician who is employed by or who is an independent contractor of Valley General Hospital from participating under the Act when not functioning within the Hospital.

Sanctions

If a provider participates in the Act beyond what is allowed in the policy, Valley General Hospital may impose sanctions on that provider. Valley General shall follow due process procedures provided for in the medical staff bylaws. Sanctions may include:

- Loss of medical staff privileges;
- Loss of membership;

Public Notice

Valley General Hospital will provide public notice of this policy in the following ways: posting the policy or information about the hospital's stance on the Death with Dignity Act on the hospital's web page; informing local media; and including information in the hospital's materials regarding advance directives.

Resources

Any patient, employee, independent contractor, volunteer or physician may contact the Ethics Committee, Spiritual Care, or Social Services for assistance.

REFERENCES

Initiative 1000/Washington Death with Dignity Act.
WAC 246-978, Washington State Department of Health Regulations
The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals

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- **Compliance Monitoring**
- **Process Cycle Information**
- **Logs**

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Header Information

Policy		Deployment	
Policy Name:	End of Life Care	Institution:	Valley General Hospital
Supercedes:		Division:	Hospital
Policy Level:	Hospital wide	Department:	Administration
Owner(s):	Teri Cook/VGH	Contributing Departments:	Medical Staff
Priority:		Manual Name:	General
Identification Number:	3.20	Manual Category / Chapter:	
Status:	4. Approved	Restricted to Groups:	
Approval Date:	03/13/2014	Policy Start Date:	05/03/2007
Version Number:	4	Monthly Review Interval:	24
		Policy Review Date:	03/21/2016

Policy

DEFINITION

End of life care is most often defined as the care rendered to terminally ill patients when all treatment options have been exhausted. It is the final stage or task in our lives. End of life turns our focus from cure to care that brings comfort and dignity to the end of life, not abandonment. With this change, we are able to offer patients, families and others support and dignity in their pursuit of the end of life goals. These end of life goals help refocus the care givers attention to pain management, physical comfort, emotional and spiritual support and assisting with the transition toward death, including the role of advanced directives and organ donation.

POLICY

This end of life policy supports compassionate care offered with sensitivity and competence:

- To help patients and their families cope with terminal illness
- To offer physical, spiritual and psychological comfort
- To ensure the patient's dignity is maintained
- To allow the patient and family to retain their decision making authority

PROCEDURES

Assessment

All patients admitted for medical necessity are assessed within 8 hours of admission. The following data is collected:

- Spiritual, religious or cultural beliefs which may influence care
- Physical care/comfort needs

- Presence of pain and current pain management
- Patient's desired level of pain management
- Status of advanced directives
- If needed, a decision maker is identified.

Decision Making

- Patient or decision maker may discuss with the physician any desire to withhold or continue treatment. This may activate the DNR policy and its subsequent actions.
- If there is a conflict with care or treatment decisions, the Ethics Committee may be consulted for a recommendation.
- Lifecenter Northwest will be notified of all deaths, imminent deaths or situations where requests for information regarding organ donation are made.

Plan of Care

- A plan of care will be developed to address end of life issues as needed.
- The patient, family, and surrogate decision makers will be involved in each aspect of care through the assessment of needs, development of interventions and the establishment of mutual goal setting.

Spiritual Needs

- Spiritual needs will be assessed during the admission process.
- Spiritual preferences can be identified.
- Chaplaincy Service may be consulted.
- Clergy of the patient's choice may be contacted.
- The hospital chapel is available as needed.

Pain Management

- Pain level will be assessed on admission and as needed during each shift. The patient's desired level of management will be established.
- Pre-admission pain management plan will be reviewed.
- The pain scale will be taught to patient, family or others.
- Effectiveness of the pain management plan will be assessed according to policy.

Discharge Planning

- The interdisciplinary team, together with the patient, family or significant other, will develop a mutually agreed upon discharge plan.
- Interdisciplinary referrals will be made based on the assessment and the patient's needs and desires.

Physical Needs and Comfort

- Physical needs and desires will be identified through the admission and shift assessments, and a plan of care to address these will be mutually agreed upon.

Grief/Anxiety/Coping

- Grief, anxiety and coping will be assessed on admission and in shift assessments.
- A plan will be developed to assist in meeting the needs identified.
- Resources are available through the interdisciplinary team.
- Chaplaincy Services and/or Social Services are available for bereavement support and limited planning of funeral or related services.

Family/Caregiver Needs

- Assessment of caregiver role strain/coping may be done.
- Information regarding support groups and community services and resources will be made available upon request.
- Family waiting areas will be made available where possible.
- Identify caregiver supports.

- **Compliance Monitoring**
- **Process Cycle Information**
- **Logs**