



**Whidbey General Hospital and Clinics**  
**Advance Directives**

Policy

Administrative Policies

10115

(Rev: 1)Official

## POLICY:

Whidbey General Hospital recognizes the autonomy of adult patients and their right to consent to or refuse medical care. Patient choices regarding care may be expressed verbally or via written Advance Directives. Advance Directives may include any or all of the following:

- Living Will (or Directive to Physicians)
- Durable Power of Attorney for Healthcare designating surrogate decision maker(s) or proxy
- POLST (Physician Order for Life Sustaining Treatment) form

Registration personnel will verify if the patient has an advanced directive at the time of admission to Inpatient, Observation, Ambulatory Surgery (OPS), Emergency Department. Home Health Care and Hospice services clinical staff will ask adult patients whether or not they have an Advance Directive. Documentation will be recorded in the medical record stating whether or not the patient has executed an Advance Directive and, whenever possible, copies of applicable Advance Directives will be obtained, reviewed, and placed in the medical record. Individuals who have never been a patient at Whidbey General Hospital may send a copy of their Advance Directives and the hospital will initiate a medical record to ensure documents are available for future admissions.

Patients will be provided care at Whidbey General Hospital regardless of the presence or absence of an Advance Directive. A patient may revoke or change an Advance Directive at any time, either verbally or in writing. Documentation is to be included in the medical record regarding any revocation or change. If multiple forms of an Advance Directive are present in the medical record, the current copy will be considered the one with the most recent date.

At the time of admission to Inpatient, Observation, Ambulatory Surgery (OPS), Home Health Care, or Hospice services, adult patients will receive written information, if not previously provided, on their right to make decisions concerning medical care they are to receive. This information will include their right to accept or refuse medical or surgical treatment and their right to formulate Advance Directives regarding the implementation of their decisions.

The Community Clinics and Outpatient services are not required to determine the status of Advance Directives on admission but are encouraged to do so as part of the patient assessment/intake process. Advance Directives are ideally formulated in the outpatient setting which allows time for patient/family education and discussion with professional caregivers.

Professional staff will provide education to patients/families regarding Advance Directives and provide assistance in completing them as much as possible. If there is question as to the patient's decision-making capacity at the time an Advance Directive is being completed, the attending physician will make the determination. Whidbey General Hospital staff and physicians may not be witnesses for Advance Directives or designated as a patient's proxy.

Conflict resolution: if conflicts arise, or concerns are raised that Advance Directives are not being addressed, communication is to take place between the clinical staff, attending physicians/providers, and patient/family.

If conflict resolution is not accomplished successfully, the following avenues are available:

1. **Clinical staff** may activate the policy for "Ensuring Appropriate Patient Care" (in the Administrative Policy Manual) or seek consultation from Nursing Executive(s) and/or the Clinical Ethics Committee.
2. **Medical staff** may seek consultation from Chief of Service, Chief of Staff, the Clinical Ethics

Committee, another physician, or Nursing Executive(s) as needed.

3. **Patients/families** may be referred to Department Manager or Nursing Executive(s). If a conflict remains unresolved, arrangement may be made to have the patient’s care transferred to another physician or to another institution as necessary. If such action is requested by patient/family, assistance will be provided by hospital staff as needed.

Education on Advance Directives, including relevant policies and procedures, is provided to hospital staff at the time of hire and on an annual basis. Education will be provided to the community at periodic intervals at least annually.

## Referenced Documents

Reference Type	Title	Notes
<b>Documents which reference this document</b>		
Applicable Documents	<a href="#">Advance Directive, staff nurse role</a>	
<b>Effective</b>	03/25/2014	<b>Document Owner</b> Gipson, Linda
<p><i>Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at .</i></p> <p><a href="https://www.lucidoc.com/cgi/doc-gw.pl?ref=wgh:10115">https://www.lucidoc.com/cgi/doc-gw.pl?ref=wgh:10115</a></p>		


**Whidbey General Hospital and Clinics**

Policy

**Do Not Resuscitate (DNR)/Do Not Attempt Resuscitation (DNAR)**

Administrative Policies

11749

(Rev: 1)Official

**I. Do Not Resuscitate Orders/Do Not Attempt Resuscitation (Allow Natural Death)**

- A. Do Not Resuscitate (DNR)/Do Not Attempt Resuscitation (DNAR) is defined as the withholding of cardiopulmonary resuscitation (CPR) in the event of a patient's sudden cardiopulmonary arrest. CPR may include closed chest compression, tracheal intubation and ventilation, and electrical and pharmacologic cardiac stimulation according to Advanced Cardiac Life Support (ACLS) standards.
- B. A DNR/DNAR order is applicable only in the event of a cardiopulmonary arrest and does not refer to withholding or discontinuing other supportive therapies that may be in place (such as the ongoing administration of cardiotoxic drugs, an endotracheal tube, etc.).
- C. The attending physician/provider must provide the DNR/DNAR order, either in writing or verbally. A verbal DNR/DNAR order may be taken by a licensed nurse and co-signed by the physician/provider within 24 hours.
- D. The physician/provider may write a DNR/DNAR order only when:
  1. Agreed to by a fully informed patient with decision-making capacity, *or*
  2. In accordance with an advance directive or the expressed wishes of the patient, *or*
  3. Agreed to by the designated health care agent(s), for a patient without decision-making capacity. Washington State law defines the order of priority for designated health care agent(s) as:
    - a. a legal guardian with health care decision-making authority.
    - b. the person with health care decision-making authority named in the Durable Power of Attorney.
    - c. the spouse
    - d. adult children (when more than one person, all must agree)
    - e. parents (when more than one person, all must agree)
    - f. adult brothers and sisters (when more than one person, all must agree)
  4. He/she deems CPR to be futile and life-sustaining treatments would be of no benefit to the patient. There is no obligation to render futile care. Futile care is any treatment that is not likely to benefit the patient, is one that the patient does not have the capacity to appreciate and/or is very likely to require permanent dependence on medical care with the burden outweighing any benefits.
- E. If a patient is admitted to the hospital with a valid Physician Orders for Life-Sustaining Treatment (POLST) form, the orders therein are to be honored until the attending physician writes the admitting order and clarifies patient's DNR/DNAR status.
- F. The physician/provider will ensure documentation in the medical record reflects the evaluation, discussion, and decision-making process.
- G. The DNR/DNAR order may only be rescinded by the attending physician/provider, in consultation with the patient or designated health care agent(s).
- H. The DNR/DNAR order itself should be clearly documented and communicated.
  - I. Unless otherwise clarified and documented, a DNR/DNAR order is temporarily suspended while a patient is undergoing a surgical procedure and receiving care within the surgical operatory. If DNR/DNAR is present, there will be clarification of wishes with patient/designated health care agent(s) prior to surgery. The DNR order is again in full force when the patient leaves the surgical operatory.
- J. Modifications to Full Resuscitation (Full Code) or DNR/DNAR orders will not be accepted.
- K. Under specific circumstances, limited interventions may be ordered.

**II. Patient Care with DNR/DNAR Order in Place**

- A. Patient's may have DNR/DNAR and still receive curative or restorative interventions related to their disease process and/or a new diagnosis or problem. The extent of any supportive care

and/or interventions is defined by a patient's goals of care.

- B. The focus of care for the patient where the goals of care is comfort only, the DNR/DNAR is to provide support for comfort measures, assist with pain and symptom management, and create a supportive environment for the patient and family.
- C. The attending physician is to be notified of:
  - 1. any communication from the patient, family, or designated health care agent(s) regarding a desire to change DNR status, or
  - 2. any change in patient condition that may relate to establishing, clarifying or rescinding DNR status.

**III. Individual's Rights and Duties**

- A. The patient's autonomy and expressed wishes are to be honored. In the case of the patient without decision-making capacity the designated health care agent(s) will make decisions guided by the patient's prior directives and best interest.
- B. The informed decision of a patient with decision-making capacity will prevail over that of others. The patient or the designated health care agent(s) has the duty to communicate truthfully with caregivers.
- C. The medical, nursing, and clinical staff has the duty to render care according to their professional standards and to respect the patient's wishes whether expressed by the patient directly, or through an advance directive or the designated health care agent(s). Whenever possible, these discussions should be held in a timely fashion and not when the patient is in extremis.
- D. Doctors, nurses, and clinical staff may not be coerced to act in a way that is not in accordance with their value systems. (See Conflict Resolution below).

**IV. Conflict Resolution**

- A. End-of-Life/DNR decision making is often stressful and conflicts may arise. Ideally conflicts are resolved via discussion between identified parties. If conflict resolution is not accomplished successfully, the following avenues are available:
  - 1. **Clinical staff** may activate the policy for "Ensuring Appropriate Patient Care" (in the Administrative Policy Manual) or seek consultation from Nursing Executive and/or the Clinical Ethics Committee.
  - 2. **Medical staff** may seek consultation from Chief of Service, Chief of Staff, the Clinical Ethics Committee, another physician, or Nursing Executive as needed.
  - 3. **Patients/families** may be referred to Department Manager or Nursing Executive.
- B. If a conflict remains unresolved, arrangement may be made to have the patient's care transferred to another physician or to another institution as necessary. If such action is requested by patient/family, assistance will be provided by hospital staff as needed.

**Referenced Documents**

Reference Type	Title	Notes
<b>Documents which reference this document</b>		
Applicable Documents	Advance Directive, staff nurse role	

Effective	03/25/2014	Document Owner	Gipson, Linda
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**Whidbey General Hospital and Clinics**

Policy

**POLST (Physician Orders for Life-Sustaining Treatment) Form  
Completion and Use**

Practice Council of Nursing

10812

(Rev: 1) Official

**POLST (Physician Orders for Life-Sustaining Treatment) Form  
Completion and Use**

Med/Surg, Emergency, Intensive Care Unit, Whidbey Family Birthplace, Ambulatory Surgery, Rehabilitation Services, Diagnostic Imaging, Care Management, Home Health, Hospice, Life Center, Medical Ambulatory Care, Laboratory, Pharmacy, Rural Health Clinics

**Summary/Purpose:**

This describes the steps and key points when assisting a patient or surrogate for filling out the POLST form. The POLST form represents a way of summarizing wishes of an individual regarding life-sustaining treatment. The form is intended for use in a patient that has advanced life-limiting illness. It is portable from setting to setting and it translates the patient wishes into physician orders. For the admission to the emergency department and/or inpatient this serves as an order until provider orders written in these settings regarding code status.

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The POLST form facilitates the process of translating end-of-life discussions with patients into actual treatment decisions, and the intent is to provide security for the individual and health care provider that the expressed wishes will be carried out. Any healthcare provider may assist the patient or durable power of attorney for health care (if appropriate) to fill it out. To be valid though, the attending physician, ARNP, or PA-C must sign the form and take full responsibility for its accuracy.

To complete the form.

Patient information must be completed with name, date of birth, last four numbers of #social security number and gender marked.

Medical Condition/Goals:

This should include a short statement about the cause of the advanced illness or the life-limiting disease process along with the patient's goals to give context to the decision-making.

Example statements might be:

End stage heart disease and wishes to be kept comfortable at home with hospice care  
Small Cell Lung Cancer still getting chemo for palliation, wants continued treatment for infections and dehydration until after June wedding  
Advanced age, wants a peaceful death and to avoid hospitalization  
Renal failure, want to be comfortable and treated with dignity  
Metastatic pancreatic cancer; priority is relationship with family  
End stage COPD, no acute care setting but hoping to make daughter graduation 0609

Part A. Cardiopulmonary Resuscitation (CPR). Mark either CPR/Attempt Resuscitation or DNAR/Do not attempt resuscitation (Allow Natural Death)

No defibrillator (including AED's) should be used on a person who has chosen DNAR

An Implantable Cardioverter Defibrillator (ICD) may be inconsistent with a "Do-Not-Resuscitate" order since ICDs attempt to resuscitate the patient by shocking the heart back into a life-sustaining rhythm.

Please see procedure for Deactivation of ICD to Allow Natural Death.

Any incomplete section of the POLST implies full treatment for that section

Choosing DNAR will include appropriate comfort measures and may still include the range of treatment filled out if patient not in cardiac arrest.

Part B. Medical Interventions (Person has pulse and/or is breathing)

Choose ONE box that best describes the treatment choice preferred. Comfort measures are provided with any of the other levels of intervention. Explain any terms, procedures necessary to ensure patient/family/caregiver understanding.

Part C. Signatures

Provider and patient or surrogate if indicated, by signing verify the orders are consistent with the patient's medical condition, known preferences and best known information.

Document with whom the discussion was held, have patient or legal surrogate sign as well as attending physician/ARNP/PA-C for it to be valid.

The legal surrogate can only sign if the patient is decisionally incapacitated.

Encourage all advance care planning documents to accompany POLST

Other Contact Information (Optional)

This allows information about whom the surrogate or contact person may be and their contact number.

If someone other than the attending health care provider assists with the process of filling the form out, this allows for this information to be communicated here.

Part D. Additional Patient Preferences (Optional)

May fill out this section at a later date if needed

Antibiotics

Choose ONE box that best describes the treatment choices preferred. Explain any terms, procedures necessary to ensure patient/family/caregiver understanding.

### Medically Assisted Nutrition.

Choose ONE box that best describes the treatment choices preferred. May individualize the instructions in additional orders. Explain any terms, procedures necessary to ensure patient/family/caregiver understanding. The translation of "tube" may be IV administration, nasogastric tubes, or surgically implanted feeding tubes for administration of fluids or food.

Additional decisions may be added in "Additional Orders" to clarify wished

Second signature required for Section D

### Review of the POLST Form

The POLST form is to be reviewed periodically with any significant status changes, and anytime the patient changes care settings. The review should be conducted with the patient or legal surrogate. Record the outcome of the review. If there are changes, the form needs to be voided, and a new one filled out reflecting the new medical orders or treatment choices for the patient. It should be voided by drawing a diagonal line and the word "VOID" and a date across the front of the form.

### Revocation of the POLST

The POLST form may be revoked by:

1. The patient verbally revoking it.
2. The patient destroying the form
3. The attending provider, on the expression the patient's revocation
4. The legal surrogate, at such time the patient cannot speak for him/herself

### Where to Keep the POLST

Outpatient/Home Health Care and Hospice Departments:

Copy POLST and add the copy to patient record, or record patient's wishes on appropriate form. Return original to patient

Inpatient departments:

Copy POLST and add the copy to the patient record.

Place the copy of POLST behind the code status chart form. If possible send original green form with family or place with discharge paperwork in original chart. Staff MUST return the original POLST to the patient at time of transfer or discharge.

## Referenced Documents

Reference Type	Title	Notes
<b>Documents which reference this document</b>		
Applicable Documents	Advance Directive, staff nurse role	

<b>Effective</b>	03/25/2014	<b>Document Owner</b>	Jolley, Carla M
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**Whidbey General Hospital and Clinics**

Policy

**POLST (Physician Order for Life Sustaining Treatment) Form  
Utilization**

Administrative Policies

11752

(Rev: 0) **Official**
**POLICY:**

- A. POLST (Physician Order for Life Sustaining Treatment) form is a bright lime green physician order sheet which replaces the plain green EMS NO CPR sheet. It is recognized by health care providers in any setting: hospital, home or long term care facility. It is a short summary of treatment orders that are easy to read in an emergency situation. It is designed to be portable from one setting to another.
- B. The form is designed for individuals over the age of eighteen with serious or life threatening illnesses. Any person desiring limited life saving treatment or intervention with a focus on personalized comfort measures may use it. The voluntary use of the POLST is intended to enhance the quality of a person's care and is expected to complement advance directives, not to replace them.
- C. POLST summarizes advance directives into order form, either confirming or clarifying pre-established preferences or documenting the "unwritten" advance directive.
- D. Any section not completed will indicate full treatment for that section.
- E. The issue of resuscitation is the first decision. Further care directives follow in the next sections to clarify specific wishes of the patient for treatment. As conditions change ongoing communication is encouraged and documented especially when the individual is transferring between care settings.
- F. It is appropriate for any health care provider to discuss and assist patient or DPOA to fill out the POLST form with explanations to assure understanding. It is especially important when the patient has a "No Code" status or other specified directives and is being transferred or discharged. POLST insures that a person's wishes for end of life treatment are carried out. Having Advanced Directives alone may not be enough to ensure the person's treatment wishes are honored until Physician orders are written. POLST is the only document that EMS will recognize that will allow people to receive less than the complete ACLS protocol in accordance with their wishes.
- G. **The original form should be with the patient at all times.** If at home, the POLST must be posted in an obvious place. If transferred it must accompany the patient. While a patient is in the hospital (IP or OIB), a copy may be placed in the medical record, but **the original must be returned to the patient at discharge.** A DNR order or specified directive order must be written in each setting despite the presence of the POLST form. The POLST form may be honored as DNR order in outpatient setting if the POLST is marked as "DNR". In the In-Patient setting, the POLST must be reviewed by the physician with each admission.
- H. The POLST Policy & Procedure are applicable to any clinical area, including Emergency Department, Inpatient Services and Outpatient Services.

**POLST Form Number: 7400-064-0703** available from Printing & Duplicating

**RESOURCES:**

1. Washington State Training Curriculum and Provider Protocols
2. Washington State Department of Health
3. Washington State Medical Association

**Referenced Documents**

Reference Type	Title	Notes
<b>Documents which reference this document</b>		
Applicable Documents	<a href="#">Advance Directive, staff nurse role</a>	
<b>Effective</b>	08/03/2004	<b>Document Owner</b>
		Gipson, Linda

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- B. The form is designed for individuals over the age of eighteen with serious or life threatening illnesses. Any person desiring limited life saving treatment or intervention with a focus on personalized comfort measures may use it. The voluntary use of the POLST is intended to enhance the quality of a person's care and is expected to complement advance directives, not to replace them.
- C. POLST summarizes advance directives into order form, either confirming or clarifying pre-established preferences or documenting the "unwritten" advance directive.
- D. Any section not completed will indicate full treatment for that section.
- E. The issue of resuscitation is the first decision. Further care directives follow in the next sections to clarify specific wishes of the patient for treatment. As conditions change ongoing communication is encouraged and documented especially when the individual is transferring between care settings.
- F. It is appropriate for any health care provider to discuss and assist patient or DPOA to fill out the POLST form with explanations to assure understanding. It is especially important when the patient has a "No Code" status or other specified directives and is being transferred or discharged. POLST insures that a person's wishes for end of life treatment are carried out. Having Advanced Directives alone may not be enough to ensure the person's treatment wishes are honored until Physician orders are written. POLST is the only document that EMS will recognize that will allow people to receive less than the complete ACLS protocol in accordance with their wishes.
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**Whidbey General Hospital and Clinics**  
**Withholding or Withdrawing Life Support**  
Administrative Policies 11750

Policy

(Rev: 1)Official

## POLICY:

Whidbey General Hospital recognizes its patients' rights to exercise their autonomy to make decisions about their own health care. This is in accordance with the Patient Self-Determination Act. This policy applies to any patient with decision-making capacity, a valid advance directive, and/or a legally appointed health care representative (proxy).

Any fully informed patient with decision-making capacity has the right to accept or reject or discontinue (withhold or withdraw) any treatment or procedure even if it may be **life-sustaining medical treatment (LSMT)** or life saving. A patient need not be imminently dying for this to apply. Also, patients in any phase of a **terminal illness** may request or provide for withdrawal or non-institution of such therapy. Both withdrawal and withholding requests are treated as ethically equivalent actions.

**Life-sustaining medical treatment (LSMT)** is any treatment that serves to prolong life without reversing the underlying medical condition. LSMT may include, but is not limited to: mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

A **terminal condition** means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will result in death within a reasonable period of time and where the application of LSMT serves only to prolong the process of dying.

A patient who does not have decision-making capacity and/or is in a **permanent unconscious condition**, has these same rights, they are expressed through advanced directives, by a proxy, or by the actions of another person acting in the patient's best interest.

**Permanent unconscious condition** means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgement as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

## PROCEDURE:

1. The attending physician should determine the patient's **decision making capacity** when Life Sustaining Medical Treatment (LSMT) is deemed necessary. If the patient does not have this capacity, then the physician should follow a written advance directive (if available) or consult a duly appointed health care proxy. In the absence of an advance directive or proxy, the physician should consult with (in this order): a court-appointed guardian, spouse, adult children, parents, adult siblings, grandparents or a significant other. (For children, parents, siblings: when more than one person, all must agree.)
2. When the lack of decision making capacity is related to mental or psychological impairment or developmental disability, the lack of capacity should be confirmed by a consulting physician or a professional with the necessary expertise.
3. The nature of the treatment, the reason for the therapy, the risks and benefits, any alternative therapy and prognosis, are to be explained.
4. The physician will write the appropriate orders and progress notes in the medical record. These notes should address the following:
  - a. For a patient with decision making capacity: State the presence of capacity and basis of the conclusion. Document the nature of the discussion with the patient regarding the diagnosis, prognosis, risks and benefits and outcome of withholding or withdrawing, or refusal of therapy. Document the conversations with the family or a significant other. Inform the patient of his/her right to change this directive.

- b. For a patient without decision making capacity: State the nature of the incapacity. List the wishes of the patient through an advance directive, statements, or letters. State the name and relationship of the proxy. Give the nature of the conversation about the withholding or withdrawal of the treatment. List the names and the professions of the people who partook in the discussion. Define the care plan. Maintain the appropriate medical records.
5. Patients who have had LMST withheld or withdrawn are to be supported with adequate orders for comfort care, pain management, and emotional and spiritual support by the interdisciplinary team.

## SPECIAL CONSIDERATIONS:

1. The attending physician assesses decision-making capacity. If it is not clear that the patient lacks decision-making capacity, confirmation by another physician shall be obtained.
2. A decision to forgo LSMT is acceptable if a treatment or procedure is **futile** or will only delay a dying process as ascertained by the attending physician. **Futile** treatment in a patient with serious, irreversible illness or condition, is any treatment that:
  - a. is unlikely to provide benefit that the patient has the capacity to appreciate, or
  - b. is highly likely to require permanent dependence on medical care where the burdens greatly outweigh any chance of success or benefit to the patient.
3. Recognizing our role as a critical access hospital, patients in a suspected Persistent Vegetative State (PVS) or an irreversible coma would be transferred prior to the need to provide confirmation of Persistent Vegetative State (PVS) or an irreversible coma. But we would comply with patient wishes forgoing LMST if there was agreement with the patient's advanced directives/proxy/and the attending physician.
4. Patients with irreversible conditions in which the risks and burdens of LSMT outweigh any benefit to the patient may have these procedures withdrawn or withheld by the attending physician.
5. In cases declared futile, if the physician feels unable to honor a patient's/family's wishes about the use of LSMT, he/she should transfer the case to a doctor who will, or seek consultation as outlined in the Conflict Resolution section (below).

## CONFLICT RESOLUTION:

Conflicts may arise, and ideally are resolved via discussion between identified parties. If conflict resolution is not accomplished successfully, the following avenues are available:

1. **Clinical staff** may activate the policy for "Ensuring Appropriate Patient Care" (in the Administrative Policy Manual) or seek consultation from Nursing Executive(s) and/or the Clinical Ethics Committee.
2. **Medical staff** may seek consultation from Chief of Service, Chief of Staff, the Clinical Ethics Committee, another physician, or Nursing Executive(s) as needed.
3. **Patients/families** may be referred to Department Manager or Nursing Executive(s). If a conflict remains unresolved, arrangement may be made to have the patient's care transferred to another physician or to another institution as necessary. If such action is requested by patient/family, assistance will be provided by hospital staff as needed.

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