Limitation of Resuscitation Documentation and Orders, 11647

Policy/Procedure

PURPOSE:

1. To allow for and encourage documentation of discussions regarding goals of medical care, limitation of resuscitation, and/or end of life decisions for each individual child and family.

2. To provide an easily accessible written record of these discussions in order to avoid unnecessary repetition of emotional and complex discussions for families.

3. To provide guidance to health care providers about the rationale and procedure for writing limitation of resuscitation orders.

4. To provide medical providers with a clear and explicit plan for resuscitation prior to a medical emergency.

Note: This policy refers to limitation of resuscitation rather than "Do Not Resuscitate" or "Do Not Attempt Resuscitation" to avoid the connotation of discontinuing care or commitment to our patients.

POLICY:

Cardiopulmonary resuscitation (CPR) is a potentially life saving, emergency intervention that should be initiated when cardiopulmonary function is physiologically inadequate to sustain life. However, there are circumstances where the burdens of these emergent resuscitation measures potentially outweigh the benefits within the context of the goals of care. Under these circumstances, Attending Physicians should review the goals of care with families, discuss the potential burdens and benefits of these emergent measures, and document these conversations in the Patient's medical record. Decisions regarding specific interventions should be provided within the limitation of resuscitation order set.

PROCEDURE:

I. DEFINITIONS

A. Cardiopulmonary Resuscitation (CPR): An attempt to restore cardiac and pulmonary function when cardiopulmonary function is physiologically inadequate to sustain life. Procedures may include placement of an artificial airway, artificial respiration, chest compressions or cardiac massage, electrical cardioversion, and the administration of resuscitative medications. These efforts are...
implemented under the guidelines of the American Heart Association for different patient populations, including neonates (NRP), pediatric patients (PALS) and adults (ACLS).

B. Limitation of Resuscitation Order: An order to describe the emergent resuscitative interventions that should be provided when cardiopulmonary function is physiologically inadequate to sustain life. This order is compatible with maximal efforts, other than resuscitation or other identified life sustaining interventions, to treat the patient with therapeutic measures including, but not exclusive of, surgery, medicines, intensive care or other interventions aimed at palliation or cure. It is not a signal to abandon or ignore the patient; rather, it implies a previously identified and alternative supportive care plan.

C. Code Status: Descriptive term used to provide an overview of the goal-directed approach to providing emergent resuscitative measures when cardiopulmonary function is physiologically inadequate to sustain life. This term is posted on the Patient Summary Page in the electronic health records. Options include "Full Code", indicating that all resuscitative efforts should be performed and "Modified Code", indicating that specific resuscitative efforts or comfort care should be provided according to the goals of care. The Code Status of each Patient should be reviewed by all health care providers caring for the Patient.

D. Patient/Parent(s): Throughout this document, the term "Parent(s)" refers to the Surrogate Decision Maker for the Patient when the Patient is a Minor or is incapacitated. Please refer to Administrative P&P, Legally Authorized Person for Informed Consent Decision-Making When a Patient is a Minor for full details. "Patient" acknowledges that Patients 18 years and older and Emancipated Minors are the legal decision maker, unless they are incapacitated. Patients 18 years and older may make decisions to limit resuscitation in conjunction with an Advance Directive or in isolation. Please see Bioethics P&P, Advance Directives for more information. Furthermore, when the Patient is a Minor, considerations should be made to include the Patient, when developmentally and neurocognitively appropriate, in the decision making process.

II. PROCEDURE FOR DISCUSSING AND DETERMINING CODE STATUS
(See Appendix II.)

A. Establish goals of care:
Under all circumstances of hospitalization, the Attending Physician should facilitate a conversation with the Patient/Parent(s) to:

a. Ascertaining the Patient/Parent(s) understanding of the disease process.

b. Review options for treatment, including the potential risks, benefits, and alternatives.

c. Elicit the values and preferences of the Patient/Parent(s).

d. Based on the recommendations of the Attending Physician and within the context of the values and preferences of the Patient/Parent(s), identify the goals of medical care. These discussions are likely iterative and ongoing, as the goals of care evolve and change over time throughout the course of an illness.

B. Review and documentation of Code Status: Depending on the underlying disease process, potential therapies and treatments, preferences and values of the Patient/Parent(s), and goals of medical care, there are two circumstances in which Attending Physicians should consider reviewing and discussing with Patient/Parent(s) the possibility of limiting resuscitation. In both of these circumstances, it is imperative to remember that unique personal, familial, religious, or cultural factors may make attempting CPR unusually beneficial.
1. **Relative benefits and burdens of attempting CPR are uncertain (i.e. life limiting diseases that have not reached terminal stages):** Based on the goals of care as discussed with the Patient/Parent(s), prior experience, medical knowledge, and empirical data, the Attending Physician may determine that attempting CPR is a plausible option, however there is a great level of uncertainty in outcome, and CPR potentially could be more burdensome than beneficial.

   a. The Attending Physician should review the goals of care, discuss the potential benefits and burdens of attempting CPR, acknowledge the uncertainty in outcome with the Patient/Parent(s), and offer **CPR as a plausible option**.

   b. The Attending Physician should assist, guide, and support the Patient/Parent(s) with the decision to either attempt or limit resuscitation depending on the goals and values of the Patient/Parent(s). Reasonable efforts should be made to effectively communicate information necessary to enable a reasoned evaluation and voluntary decision.

   c. The discussion should be documented and the limitation of resuscitation order should be completed by the Attending Physician according to the discussion. See **Section III**.

2. **Burdens of attempting CPR likely outweigh the benefits (i.e. life limiting diseases in the terminal stages):** Based on the goals of care as discussed with the Patient/Parent(s), prior experience, medical knowledge, and empirical data, the Attending Physician may determine that the burdens of attempting CPR likely outweigh the benefits.

   i. The Attending Physician should review the goals of care and discuss with the Patient/Parent(s) that the burdens of attempting CPR likely outweigh the benefits. To prevent causing unnecessary harm to the patient, the Attending Physician should recommend against attempting CPR.

   ii. If the Patient/Parent(s) assent to limiting resuscitation, the discussion should be documented and a limitation of resuscitation order should be written. See **Section III**.

   iii. If the Patient/Parent(s) do not assent to limiting resuscitation, the discussion should be documented and full or modified resuscitation orders should remain in place, according to the wishes and preferences of the Patient/Parent(s). See **Section III**.

### III. DOCUMENTATION OF CODE STATUS AND WRITING LIMITATION OF RESUSCITATION ORDERS

A. Under either of the circumstances described in section II, the Attending Physician should document the key aspects of the conversation(s) and decision(s) using the format provided in the electronic health record.

1. These conversations should be documented regardless of the decision to limit resuscitation. For example, if full resuscitative efforts should be attempted, the conversations, decisions, values and goals should be documented and orders for attempting full resuscitation should be placed.

2. Documentation of key components of the conversation and decisions should include:

   a. Names and roles of Individuals who participated in the conversation. If two or more Attending Physicians were involved, all names should be listed.

   b. Current medical diagnoses and expected prognosis of patient.

   c. General content of the conversation(s) including the goals of medical care, values and preferences of the Patient/Parent(s).
d. Rationale for limiting CPR (if applicable), including the Attending Physician and Patient/Parent(s) perspectives.

3. Concise and clear description of medical interventions to be attempted or withheld, primarily determined by the Attending Physician within the context of the goals of care as discussed with the Patient/Parent(s).

4. The wording of documentation should be reviewed directly with the Patient/Parent(s) if possible to ensure clarity and understanding prior to finalizing.

5. Code Status should be clearly documented in the electronic health record and should be congruent with the Limitation of Resuscitation Order.

6. During a single hospitalization, Limitation of Resuscitation Orders do not expire. However, they should be reviewed periodically when determined appropriate by the Attending Physician and Patient/Parent(s).

IV. COMMUNICATION REGARDING CODE STATUS AND LIMITATION OF RESUSCITATION ORDERS:

A. The Attending Physician should verbally notify, in a timely manner, the Bedside Nurse and other involved medical providers, including Fellows and Resident Physicians, of the conversation and decision to limit attempting CPR.

1. The Bedside Nurse verbally should notify the Charge Nurse.

2. The Bedside Nurse verbally should notify the Unit Coordinator, who should print a hard copy of the Limitation of Resuscitation Order to place with the Code Blue Resuscitation Sheet. These two documents should be available at the Patient's bedside at all times.

3. The Bedside Nurse verbally should notify the Respiratory Therapist and other Ancillary Services involved in the Patient's medical care.

B. When the Patient is transferred between different health care providers within the same hospital stay, the Attending Physician is responsible for communicating during Hand Off the plan of care based on the Limitation of Resuscitation Orders to the receiving Attending Physician. Nurse to Nurse communication should occur in parallel to the Physician communication.

C. A member of the medical team (Attending Physician, Fellow, or Resident Physician) should notify the Patient's Primary Care Provider in a timely fashion to ensure continuity of these discussions between the inpatient and outpatient setting.

V. WRITING LIMITATION OF RESUSCITATION ORDERS AND CODE STATUS AT ADMISSION

A. Patient with NO prior history of a Limitation of Resuscitation Order

a. In circumstances in which the Attending Physician has a high level of concern for a possible life threatening emergency during a hospitalization, the Attending Physician should follow the procedure for discussing and determining Code Status in a timely manner according to Section II and Section III. In the absence of such documentation at the time of a medical emergency, the treating medical team should provide appropriate medical care.

B. Patient WITH a prior history of a Limitation of Resuscitation Order, Physician Order for Life-Sustaining Treatment (POLST), or Advance Directive

1. The Admitting Physician or Emergency Medicine Physician should review the Code Status of the Patient with the Patient/Parent(s) upon admission according to the prior Limitation of
Resuscitation Order, Physician Order for Life-Sustaining Treatment (POLST), or Advance Directive.

2. If there are not substantial changes to the Code Status or Limitation of Resuscitation Order AND if the Attending Physician is not immediately available in person at the time of the admission, the Fellow, Resident Physician or Nurse Practitioner may enter the Code Status and Limitation of Resuscitation Order based on a brief conversation with the Patient/Parent(s).
   a. The Attending Physician should be notified of this documentation with a phone conversation.
   b. The Attending Physician must co-sign the order within twenty four hours of admission to remain valid.
   c. Documentation of the conversation with the Patient/Parent(s) may refer to prior conversation(s) regarding Code Status and should include any novel aspects of subsequent conversations.

3. If the Patient/Parent(s) request substantial changes to the Code Status or Limitation of Resuscitation Order, the Attending Physician must formally have a conversation in person with the Patient/Parent(s) to clarify the goals of care and wishes, values, and preferences of the Patient/Parent(s). The Attending Physician should follow Section II, Section III, and Section IV of this Policy accordingly.

VI. LIMITATION OF RESUSCITATION ORDERS AND CODE STATUS AT DISCHARGE

A. At the time of discharge, the Code Status and Limitation of Resuscitation Orders should be reviewed by the Attending Physician and Patient/Parent(s). The conversation and implications of the Limitation of Resuscitation Order should be documented in the Discharge Summary. This documentation should be clearly communicated with the Primary Care Provider.

B. The Patient/Parent(s) should be assisted by the Attending Physician or Consulting Service (i.e. Pediatric Advance Care Team and/or Palliative Care or Hospice Providers) to develop a plan to manage the child if he or she suffers from cardiopulmonary arrest following discharge. Appropriate supportive resources, such as palliative care and hospice, should be in place prior to discharge if appropriate and consistent with family wishes and goals of care.

C. Attending Physicians may consider completing a Physician Order for Life Sustaining Treatment (POLST) form at the time of discharge. The POLST form is a set of portable physician orders that allow an individual to communicate his or her wishes regarding resuscitation, medical interventions, antibiotics, and artificial feedings in a variety of health care settings. Refer to Appendix I for specific guidelines for use of the Washington State POLST.

VII. DISCONTINUATION OR AMENDMENT OF LIMITATION OF RESUSCITATION ORDERS

A. Limitation of Resuscitation Orders may be rescinded or amended by the Attending Physician and Patient/Parent(s) at any time. Prior to rescinding or amending the order, however, a detailed conversation between the Attending Physician and Patient/Parent(s) should occur. This conversation, including the rationale for rescinding or amending the order, should be documented in the electronic medical record by the Attending Physician. This documentation should be reviewed by the Patient/Parent(s) if possible prior to finalizing in the electronic records.

B. The Attending Physician should notify the Bedside Nurse and other members of the health care team of the modification in the Code Status and Limitation of Resuscitation Order as if a new Order were placed, as described in Section II, Section III and Section IV.
C. The Bedside Nurse should notify the Unit Coordinator and remove and/or replace the hard copy of the Limitation of Resuscitation Order at the Patient's bedside. Additionally, the Bedside Nurse should notify the other members of the health care team, as described in Section III.

VIII. OPERATIVE PROCEDURES AND INVASIVE INTERVENTIONS

A. When Patients with Limitation of Resuscitation Orders need to undergo invasive interventions or operative procedures, the Attending Physician, Anesthesiologist, Attending Surgeon(s), Attending Proceduralist(s), and Patient/Parent(s) should review the Code Status and Limitation of Resuscitation Order.

1. In many circumstances, cardiac arrest is more likely reversible when it occurs during anesthesia, meaning that in most circumstances, the patient will benefit from having the Code Status modified and Limitation of Resuscitation Order suspended during the intervention.

2. However, Limitations of Resuscitation Orders do not necessarily need to be rescinded prior to operative or invasive interventions. Several suggested approaches to determine the appropriate level of resuscitation in the OR include full resuscitation, limitation of resuscitation that is procedurally specific, or limitation of resuscitation based on a goal oriented approach, in which the Patient/Parent(s) trust the Attending Anesthesiologist and Attending Surgeon and/or Proceduralist to determine which events are reversible and warrant full resuscitation versus events that are irreversible in which cardiopulmonary resuscitation has limited benefit.

B. Procedural Process:

1. In a Patient with a Modified Code Status, the Patient/Parent(s), Attending Anesthesiologist, Attending Surgeon or Proceduralist, and/or Primary Attending Physician should review and discuss the approach to address the Modified Code Status of the Patient during the operative or procedural intervention. Details of this conversation will be documented in the medical record prior to starting the operative or procedural intervention.

2. Modifications and/or Rescindment of the Limitation of Resuscitation Orders during the operative intervention should be documented on the Pre-Anesthesia Evaluation PowerNote in CIS and reviewed in the time-out procedure.

3. A hard copy of the unchanged or modified Limitation of Resuscitation Order should be printed, placed with the Code Blue Resuscitation Sheet, and accompany the patient to the operative or procedure room.

4. PRIOR to starting the procedure at the time of the Safety Time Out, the Code Status and Limitation of Resuscitation Order should be concisely described by the Attending Anesthesiologist and confirmed by the Attending Proceduralist and/or Attending Surgeon.

5. DURING the procedure or operation, the modified Code Status and Limitation of Resuscitation Order should be followed accordingly.

6. AFTER the operation or procedure, during the Hand Off process, the Attending Anesthesiologist and Primary Attending Physician should communicate any temporary revisions made to the original Limitation of Resuscitation Orders. If changes to the original limitation of resuscitation orders are to continue, the orders will be updated and a new hard copy of the Limitation of Resuscitation Orders will be placed with the Code Blue Resuscitation Sheet at the bedside of the Patient.

IX. LACK OF CONSENSUS REGARDING CODE STATUS AND LIMITATION OF RESUSCITATION ORDERS
A. In rare circumstances, conflict regarding Code Status and the Limitation of Resuscitation Orders may arise due to differing opinions regarding benefits and burdens. This may result in discord between Attending Physicians and Patient/Parent(s). Maximal effort to clarify these differences in opinion through communication and support for all stakeholders should be prioritized. Detailed description(s) of any disagreements regarding the Code Status and Limitation of Resuscitation Order should clearly be documented in the electronic medical record.

B. When the lack of consensus between the Attending Physician and Patient/Parent(s) persists, the approach to resolving the conflict depends on the urgency of the circumstances.

1. Non-emergent: Often time is helpful to allow Patient/Parent(s) and Attending Physicians reach agreement regarding the Code Status.
   a. While allowing time, the Code Status and Limitation of Resuscitation Orders should be documented according to the wishes and goals of the Patient/Parent(s).
   b. If possible, all conversations including, but not limited to, the introductory conversation regarding the possibility of limiting CPR or other interventions, Patient/Parent(s) values and preferences, goals of care, and decisions that are made, should be documented to maintain clarity and continuity throughout the process.
   c. If necessary, explicit conflict resolution using **Bioethics P&P, Withholding and Withdrawing of Life-Sustaining Medical Intervention When Disputes Arise** may be pursued.

2. Emergent: The Attending Physician has the primary responsibility to determine the relative benefits and burdens of medical interventions, including attempting CPR, according to the goals of care. The implementation, duration and cessation of resuscitation are medical interventions to be directed by the Attending Physician in the emergent setting.

X. SPECIAL CIRCUMSTANCES

A. Limitation of Resuscitation Orders in children without a legal decision-maker: non-accidental trauma and maltreatment, abandoned, and unidentified children

   a. For children where there is not a clearly identified legal decision-maker, the SCAN team and social work should assist the Attending Physician with identifying the legal medical decision maker for the child.
   b. Until this person is appropriately identified, CPR should be performed in the setting of cardiopulmonary arrest if the benefits potentially outweigh the burdens as determined by the Attending Physician.
   c. Once the Legal Guardian is identified, the Attending Physician should then communicate with the Legal Guardian(s) as discussed in **Section II** and follow this policy accordingly.

B. Limitation of Resuscitation Orders and the Diagnosis of Brain Death

   a. When making the clinical diagnosis of brain death (see **Clinical P&P, Diagnosis of Brain Death**), the interim period between the first and second brain death examination presents a situation where resuscitation may not be medically appropriate, per the discretion of the Attending Physician. Under these circumstances, the Attending Physician should follow the formal process to write a Limitation of Resuscitation Order as described in **Section II**.
   b. However, the Attending Physician should acknowledge that Parent(s) may have an interest in preserving the child's organs for potential organ donation. Hence, collaborative and explicit
communication between the Attending Physician, the Organ Procurement Agency, and Parent(s) should occur when examining the potential benefits and burdens of attempting CPR.

C. Limitation of Resuscitation Orders and Organ Donation after Cardiac Death

a. When the decision is made to withdraw life sustaining therapy from a critically ill child, the Parent(s) may agree to organ donation after cardiac death, in consultation with the local Organ Procurement Agency. Please see Clinical P&P, Organ Donation after Cardiac Death (DCD).

b. Per the Donation after Cardiac Death protocol, a Limitation of Resuscitation Order is required at the time of withdrawal of the life sustaining therapy. This process should be explicitly explained to the Parent(s) by the Attending Physician in collaboration with the Organ Procurement Agency Representative. Section II should be followed accordingly by the Attending Physician.

REFERENCES:


Blinderman C, Krakauer E, and Solomon M. Time to revise the approach to determining cardiopulmonary resuscitation status. JAMA 2012;307(9):917-918.


APPENDIX I:

A. PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENTS (POLST)

1. The POLST form is a physician order sheet intended for any individual with an advanced life-limiting illness to effectively communicate his or her wishes to request or to limit life-sustaining medical treatment. The expressed wishes regarding resuscitation, medical interventions, antibiotics, and artificial feedings are translated into a set of portable physician orders that can be followed by health care providers in a variety of care settings. It is not an Advance Directive, such as a Health Care Directive, Living Will, or a Durable Power of Attorney for Health Care.

2. An outpatient clinic visit is the optimum setting for end-of-life care planning discussions, including review of the POLST. However, when a Limitation of Resuscitation Order is written during an inpatient stay, the Attending Physician may consider writing (or reviewing if written prior to admission) a POLST at the time of discharge.

3. There are limitations to the validity of using the POLST form for minors. See disclaimer in B.3 (below). However, Attending Physicians and Patients/Parent(s) may find the process of completing the POLST helpful in planning for the possibility of a medical emergency following discharge from the hospital and may choose to use the form as a communication tool.

B. PROCEDURE FOR WRITING A POLST

1. Request a POLST form from the Unit Coordinator.

2. Present the POLST form to the Patient/Parent(s) as an option. Additional patient and family education material, including a brochure on Physician Orders for Life-Sustaining Treatment (POLST) Form published by the WSMA and DOH, is available in the Patient and Family Education Database.

3. Washington statute provides liability protection to emergency personnel who rely on a POLST when the patient is an adult. Pediatric patients and families should be informed by the Attending Physician that Washington law does NOT authorize use of a POLST for Minors and the Washington Department of Health has advised all EMS personnel in the state of Washington that POLST is not applicable to minors.

4. The Attending Physician, if appropriate, should complete the document with the Patient/Parent(s). The Attending Physician must sign the form and assume full responsibility for its accuracy.
   a. Upon completion, the POLST should be compared to the Limitation of Resuscitation Order in the electronic medical record. These two documents should be congruent and reflect the wishes of the Patient/Parent(s).
   b. A photocopy of the POLST should be placed in the medical record. The POLST should not replace the Limitation of Resuscitation Order, which needs to be officially documented separately in the medical record.
   c. Similar to the Limitation of Resuscitation Order, the POLST needs to be updated with subsequent admissions and discharges. Outdated POLST forms should be discarded.

C. HONORING POLST

1. When an Adult Patient presents to the Seattle Children's Emergency Department with a valid POLST, Attending Physicians may in good faith rely upon the orders outlined by the POLST until a new Limitation of Resuscitation Order can be entered into the electronic medical record.
2. When a Minor Patient presents to the Seattle Children’s Emergency Department with a completed POLST, full resuscitation will be provided until medical providers review and validate with Parent(s) and a new limitation of resuscitation order can be entered into the electronic medical record.

D. REVIEW, MODIFICATION, AND REVOCATION OF POLST

1. POLST forms should be reviewed in tandem with Code Status and Limitation of Resuscitation Orders among the primary decision makers, including the Attending Physician and Patient/Parent(s).

2. If modifications need to be made to the POLST, a new form should be used.

3. The Patient/Parent(s) can revoke treatment decisions on the POLST at any time. When a Patient's/Parent(s)’ current wishes and the POLST differ, the Patient's/Parent(s)’ current wishes prevail.

APPENDIX II:

APPROVED BY:

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Advance Directive, 10033

PURPOSE:

Children's, as a regional pediatric center, serves children of all ages as well as some adult patients. For these adult patients, and emancipated minors, federal and state law requires certain procedures regarding Advance Directives.

POLICY:

Seattle Children's recognizes the right of adult patients to make certain personal health care decisions through Advance Directives. Children's does not condition the provision of care or otherwise discriminate against an individual on the basis of whether or not the patient has executed an Advance Directive.

PROCEDURE:

I. Definitions

   A. "Adult" means a person age 18 years or older.

   B. "Advance Directive" means a document or documentation allowing a person to give directions about future medical care or to designate another person to make medical decisions if the individual loses his or her decision-making capacity. There are three kinds of Advance Directives:

      1. Living Will (aka., Health Care Directive or Directive to Physicians) – instructions regarding end of life care such as resuscitation efforts, nutrition, and hydration

      2. Durable Power of Attorney for Health Care – the naming of an agent to make health care decisions on behalf of the patient

      3. Mental Health Advance Directive – intended for patients whose mental health leads to variation of their mental capacity, this type of advance directive may include instructions regarding mental health care as well as the naming of an agent to make mental health care decisions on behalf of the patient

   C. "Attorney-in-fact" is a person who exercises decision-making on behalf of an incompetent patient under a Durable Power of Attorney. The attorney-in-fact's power to make health care decisions is set forth in the Durable Power of Attorney Health Care document. It may include the right to consent to the withholding or withdrawal of life-sustaining procedures.
D. "Emancipated minor" means a person age 16 or 17 years with a court-ordered declaration of emancipation that bestows the power and rights of an adult.

II. Formulation of Advance Directive

A. The responsibility for development and execution of an Advance Directive rests with the patient. Children's, however, provides limited assistance to patients who do not have an Advance Directive but indicate a wish to formulate one. This basic assistance will include reviewing the contents of Children's "Advance Directives in the State of Washington" flyer and providing general guidance.

1. Assistance may be obtained by calling the Social Work Intake line at ext. 72760.
2. Additional community education materials regarding Advance Directives may be found in the Family Resource Center's database for patient and family education materials.

B. Because Children's cares for patients with chronic illnesses across a continuum of care, opportunities may exist to discuss Advance Directives on ambulatory visits when a patient or legally authorized representative for the patient expresses a desire to discuss with the ambulatory practitioner. If a patient provides Children's staff with an advance directive during an ambulatory visit, the staff person will make a copy of the document. The copied document will be forwarded to HIM and scanned into the patient's electronic medical record.

III. Notice of Rights and Documentation of Advance Directive upon Admission or Registration to the Emergency Department or Observation Status

A. Upon admission, the Admissions Services Coordinator (ASC) provides a copy of Children's "Advance Directives in the State of Washington" flyer to every patient who is an adult or emancipated minor.

1. If an adult or emancipated minor is incapacitated or developmentally unable to participate in the decision making process at the time of admission, then Children's "Advance Directives in the State of Washington" flyer is provided to the patient's family or surrogate decision maker as specified in Administrative P&P, Legally Authorized Person for Informed Consent Decision-Making When a Patient is a Minor.

B. The ASC asks the adult or emancipated minor patient, at the time of admission, about the existence of an Advance Directive and enters the appropriate option in Children's registration system.

1. Registration options:
   a. Yes, filed in the Children's medical record
   b. Yes, filed elsewhere
   c. No, but information was provided
   d. No, but information was declined
   e. No, surrogate decision maker involved
   f. Unable to discuss

2. Patients who are unable to discuss their Advance Directive wishes at the time of admission will be referred to the Social Work Department by the ASC for follow-up. Social Work will:
   a. Follow-up with the patient or his/her family member within 24 hours.
   b. Inquire about the existence of an Advance Directive.
   c. Request that the document be brought to the hospital for inclusion in the permanent
medical record if it exists.

d. Provide additional information regarding the process for completing an Advance Directive.

e. Provide community resources / referrals as indicated.


3. Because Mental Health Advance Directives have distinct implications on the ability to admit a patient for mental health treatment, Children's registration process requires a separate entry to denote information regarding Mental Health Advance Directives.

   a. The Admitting Facilitator completes this registration field for all adult and emancipated minor patients being admitted into the PBMU.

   b. If a patient is refusing admission and has a Mental Health Advance Directive, staff may consult with the Director of Risk Management or General Counsel. RCW 71.32.140.

C. When obtained, a copy of the Advance Directive is placed in the medical record.

   1. If the patient indicates that he/she has an Advance Directive already filed with Children's, the ASC will review the patient's electronic medical record to confirm the existence of the document. If the document is not there, the ASC will ask that another copy of the document be provided.

   2. If the patient indicates that another provider has the Advance Directive, the ASC will request a copy from the provider and document the attempt to obtain.

   3. If the patient reports that they have an advance directive, but failed to bring a copy to the hospital, ASC staff will document, "Not available, follow-up required". Within 36 hours, ASC staff will follow-up with the patient in an attempt to obtain a copy of the Advance Directive. If after 36 hours, the patient (or family) is still unable to provide a copy, ASC staff will provide a copy of Children's "Advance Directives in the State of Washington" flyer and document "In follow-up, directive still not available. Patient provided information on how to complete a new directive."

D. Upon discharge, the printed Advance Directive is incorporated into the permanent medical record.

IV. Notice of Rights and Documentation of Advance Directive upon Registration for Day Surgery or Admission After Surgery

A. Upon surgery admission, the Family Service Coordinator (FSC) provides a copy of Children's "Advance Directives in the State of Washington" flyer to every patient who is an adult or emancipated minor.

   1. If an adult or emancipated minor is incapacitated or developmentally unable to participate in the decision making process at the time of admission, then Children's "Advance Directives in the State of Washington" flyer is provided to the patient's family or surrogate decision maker as specified in Administrative P&P, Legally Authorized Person for Informed Consent Decision-Making When a Patient is a Minor.

   2. Patients who desire additional education or assistance formulating an Advance Directive will be referred by the FSC to Social Work for assistance.

V. Notice of Rights and Documentation of Mental Health Advance Directives upon Registration for Ambulatory Psychiatry Encounter

1. Upon registration, the Family Service Coordinator (FSC) provides a copy of Children's "Advance Directives in the State of Washington" flyer to every patient who is an adult or emancipated minor and inquires about the existence of a Mental Health Advance Directive.
2. The FSC enters the appropriate option in Children’s registration system for Mental Health Advance Directives.

   1. Registration options:
      a. Yes, filed in the Children’s medical record
      b. Yes, filed elsewhere
      c. No, but information was provided
      d. No, but information was declined
      e. No, surrogate decision maker involved
      f. Unable to discuss

3. When obtained, a copy of the Mental Health Advance Directive is sent to HIM and scanned into the patient's electronic medical record.

   1. If the patient indicates that he/she has a Mental Health Advance Directive filed with the State Living Will Registry, the FSC will attempt to download a copy from the database at http://www.uslivingwillregistry.com and submit it to the patient's medical record.
   2. If the patient indicates that another provider has the Mental Health Advance Directive, the FSC will request a copy from that provider.

VI. Provision of Patient Care and Implementation of Advance Directives

A. Implementation of an Advance Directive must be by the attending physician.

   1. Before an Advance Directive involving withholding or withdrawing life-sustaining treatment is implemented, physicians or staff may consult with the Director of Risk Management at x7-5165 or General Counsel at x7-2044 to determine whether the directive meets the substantive and procedural requirements of law.
      a. When there is conflict between the terms of an Advance Directive and the patient's intent to provide an anatomical gift, and the patient is no longer competent for consultation, physicians or staff should consult with the organ procurement organization, Risk Management, or General Counsel prior to withholding or withdrawing measures necessary to ensure medical suitability. RCW 68.64.180. See Care at Death, Organ Donation, and Autopsy P&P.


B. The attending physician is responsible for periodically reviewing the Advance Directive with the patient as needed based on changes in the patient's current health status.

C. A patient may present with a medical emergency may preclude an appraisal of an Advance Directive before care is initiated. Under these circumstances, the attending physician should proceed with emergency care to stabilize the patient before evaluating the contents of the directive.

D. The Medical Staff may determine the conditions under which its staff members will not honor Advance Directives for reasons of personal conscience. The Medical Staff may also define a process to allow transfer of a patient to a new attending physician who will honor the directive.

VII. Revocation of an Advance Directive

1. Living Will.
A patient may revoke a Living Will at any time, regardless of the patient’s mental state or competency, by

a. Destroying the directive,

b. Signing and dating a written statement of revocation, or

c. Making a verbal statement of revocation. RCW 70.122.040.

A Durable Power of Attorney for Health Care continues in effect until revoked by the competent patient, by a court-appointed guardian, or by court order. RCW 11.94.043.

Using a written statement, a patient may revoke a mental health advance directive, but the terms of a patient’s mental health advance directive may dictate to what extent the patient may revoke the directive. RCW 71.32.080. Staff may consult with Risk Management or General Counsel.

4. When an attending physician has received communication of revocation, he or she should document the receipt of revocation in the patient’s medical record.

VIII. **Immunity from Liability**
Any health care provider acting without negligence and in good faith in reasonable reliance on an advance directive shall not incur any liability. RCW 70.122.051 (Natural Death Act), 11.94.040 (Power of Attorney), and 71.32.170 (Mental Health Advance Directive).

IX. **Education**
A. Appropriate staff will be provided in-service education on Advance Directives.

B. Community education materials on issues concerning Advance Directives are maintained by the Children’s Family Resource Center.

C. Policies relating to Advance Directives will be provided to new medical staff members during the initial credentialing process.

See also:
- Clinical P&P, [Assessment and Plan of Care for Inpatient and Ambulatory Settings](#)
- Clinical P&P, [Care at Death, Organ Donation, and Autopsy](#)

References:
42 USC 1396a(w)(1)(A)
42 CFR §482.13 Condition of participation: Patient’s rights.
42 CFR §489.100 Definitions.
42 CFR § 489.102 Requirements for providers.
RCW 11.94 Power of attorney.
RCW 13.64 Emancipation of minors.
RCW 68.64 Revised Uniform Anatomical Gift Act.
RCW 70.122 Natural Death Act.
RCW 71.32 Mental health advance directives.
WAC 246-320-141 Patient rights and organizational ethics.
Joint Commission RI.01.05.01, The hospital addresses patient decisions about care, treatment, and services received at the end of life.
Last approved by Medical Executive Committee: Sept. 2010

Attachments: No Attachments

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<th>Step Description</th>
<th>Approver</th>
<th>Date</th>
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<tr>
<td>Release for Publication &amp; Procedures Policies: Policies &amp; Procedures</td>
<td>Russell Williams: Sr. Vice President &amp; COO</td>
<td>8/1/2018</td>
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<td>Madlyn Murrey: Sr VP Chief Clinical Officer</td>
<td>7/17/2018</td>
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<td>Mark Del Beccaro: SVP-Chief Medical Officer</td>
<td>7/3/2018</td>
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<td>Benjamin Wilfond: Principal Investigator, Supv</td>
<td>7/2/2018</td>
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Applicability

Seattle Children's Hospital