Advance Directives and End of Life Considerations in Acute and Ambulatory Care

Purpose:

To ensure patient understanding of his/her right to accept or refuse medical or surgical treatments.

To provide guidance to staff and to promote increased support and recognition of the ethical concept of autonomy or the individual person's or patient's right of self-determination.

To encourage patients and their health care providers to make plans regarding treatment in situations in which patients lose the capacity to participate in medical decision making.

To ensure patient understanding of their right to accept or refuse medical or surgical treatments.

Policy:

Jefferson Healthcare (JH) supports the fundamental right of adult, qualified patients to control decisions relating to their medical care including the decision to have life-sustaining procedures provided, withheld, or withdrawn in instances of a terminal condition. JH recognizes and supports the patient's right to have an advance directive and to accept or refuse treatment with or without life sustaining medical interventions. The existence or lack of an advance directive does not determine the individual patient's right to access care, treatment, and services. JH provides education to its staff and to the community on issues related to advance directives.

Support Data:

1. Information regarding the Advance Directives is available to all patient care areas, including the emergency room.
2. A notary is not required for completion of an Advance or Health Care Directive.

Definitions:

1. **Advance Directive (AD):** Is also called in Washington State, "Health Care Directive":
   a. A written instruction or directive, such as a living will or durable power of attorney for health care;
   b. Voluntarily executed by the declarer;
   c. Relating to the provision of health care when the individual is incapacitated;
   d. Directive regarding withholding or withdrawal of life-sustaining treatment when the individual is in:
      i. A terminal condition; or
      ii. Permanent unconscious condition.

2. **Life-Sustaining Treatment:** Any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function which, when applied to a qualified patient, would serve only to prolong the process of dying. Life-Sustaining Treatment does not include:
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a. Administration of a medication; or
b. The performance of any medical or surgical intervention deemed necessary solely to alleviate pain or provide comfort.

3. **Living Will** (Advance Directive; Living Will; Health Care Directive): A document in which a person can stipulate the treatment choices they would/would not want if they became a qualified patient and unable to make medical decisions.

4. **Palliative Care**: Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms, rather than striving to halt, delay, or reverse progression of the disease itself or provide a cure.
   a. The goal is to prevent and relieve suffering and to improve quality of life for people facing serious, complex illness.
   b. Unlike hospice, palliative care is not dependent on prognosis and is offered in conjunction with curative and all other appropriate forms of medical treatment.

5. **Permanent Unconscious Condition**: An incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

6. **Qualified Patient**: An adult person who is a patient diagnosed in writing to have a terminal condition by the patient's attending physician, who has personally examined the patient, or a patient who is diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient.

7. **Terminal Condition**: An incurable and irreversible condition caused by injury, disease, or illness that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

**Procedure:**

**Patient Access Responsibilities**

1. During the pre-registration process for adult scheduled admissions, patients will be asked if they have an Advance Directives.
2. If Advance Directives are in place, the patient will be encouraged to bring them at the time of their scheduled admission for inclusion in their medical record.
3. The patient's responses will be documented by entry into their medical record. The responses available will be "Y" for yes, and "N" for no. When No is entered, the applicable reason must also be entered:
   a. Information refused;
   b. Patient not available;
   c. Asked for more information; and
   d. Written information given at registration.
4. The Ambulatory Care Grid included below provides more information regarding outpatient departments and Advanced Directives.
5. If the patient has an AD, but it is not in his/her medical record, registration staff members are to request the family to bring a copy of the Advanced Directive to JH.
6. Advance Directives are to be placed in the medical record as soon as available.
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7. For those patients requesting more information about Advance Directives at registration, staff will provide a Washington State Medical Association (WSMA) pamphlet entitled "Who Will Decide if You Can't?" containing the forms and information on ADs.

8. A notation will be made in the medical record as to whether or not the patient has executed an Advance Directive or if they have a psychiatric advance directive.

9. If an Advance Directive is presented, it will be added to the patient's hospital chart:
   a. If patient is being admitted, the document will be sent to the nursing unit where it will be added to the chart;
   b. If presented by a person not being admitted, the documents will be forwarded to medical records where it will be added to the chart.

Patient Care Staff Responsibilities

1. Nursing and support staff will document whether the patient has an AD.
2. If the patient has an AD but it is not in the chart or with the patient, the inpatient staff will document the patient's code status.
3. If the AD is not in the chart, patient care staff will ask the family to bring in the AD to place in the patient's chart.
4. For Ambulatory Care settings, see the chart below regarding AD status documentation.
5. Advance Directors are to be placed in the medical record as soon as available.
6. Case Management may assist in obtaining or completing an Advance Directive.
7. If a clinical situation arises which may result in withholding or withdrawing of life-sustaining treatment (including artificially administered nutrition and hydration if selected by the declarant), nursing will verify the existence of an AD:
   a. If existence is verified, nursing will ensure that a copy is acquired if not already in the chart;
   b. The attending physician will be notified, and the notification documented in the patient chart;
8. JH staff may not witness an Advance Directive in his/her professional caregiver role at JH.

Attending Physician Responsibilities:

1. The attending physician must provide the level of care consistent with the wishes of the patient as stated in an Advance Directive.
2. If the attending physician is unwilling to provide that level of care, the physician must transfer the patient to a physician who will comply with the patient's wishes, documenting this in the medical record.
3. The Advance Directive becomes operative when:
   a. It is communicated to the attending physician; and
   b. The patient is in a terminal condition and no longer able to make or communicate decisions regarding administration of life-sustaining treatment;
   c. This status is determined and documented by the attending physician and one other physician not caring for the patient, who both:
      i. Have examined the patient;
      ii. Have diagnosed the terminal condition or the inability to make or communicate health care decisions; and
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iii. Have certified this status in writing. If the patient should ask that the Advance Directives be revoked, the patient will honor the request immediately and document as listed under the nursing responsibility.

Health Information Systems (HIM) Staff Responsibilities:

1. Upon presentation of Advance Directives, HIM staff will scan the document into the electronic medical record under the title Advanced Directives.
2. If the patient does not have a medical record, the patient registration form designed for this purpose will be used to acquire the data needed to create a patient file.
3. A medical record number will be established for the individual and the documents will be placed there.
4. If the Advance Directive is revoked, the document will be removed from the medical record.

Execution of an Advance Directive:

1. The Advance Directive must be signed by the declarer in the presence of two witnesses not related to the declared by blood or marriage and who would not be entitled to any portion of the estate of the declarer (patient) upon the declarer's demise under any will of the declarer.
2. **Staff May Not Act as Witnesses:** The attending physician, an employee of the attending physician, or employee of JH acting in the role of care provider may not witness an Advance Directive.
3. A notary is not required.
4. The fully signed document or a copy of the completed directive shall become part of the permanent medical record.
5. If there are questions about ability to consent, Risk Management is available for consultation.

Acting on an Advance Directive:

1. If the patient becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition, or until such time as the patient's condition renders them able to communicate with the attending physician.
2. If there are ethical concerns regarding end of life decisions, the Risk Manager is available for consultation.
3. The patient's family members should be informed of the existence of the Directive and that the Directive reflects the patient's wishes.

Advance Directive in the Perioperative Period:

1. JH recognizes there are situations where an Advance Directive may be suspended for a specific time or specific reason, such as while the patient is in Surgery where certain emergency conditions would be the result of care and potentially or totally reversible.
2. In such cases, the patient is informed that the AD will be suspended during the perioperative period.
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Revocation of an Advance Directive:

1. A directive may be revoked at any time by the patient, without regard to the patient's mental state
   of competency, by any of the following methods:
   a. By being canceled, defaced, obliterated, torn, or otherwise destroyed by the patient or by
      some person in the patient's presence;
   b. By the patient expressing his/her intent to revoke; and
   c. By verbal expression by the patient of his/her intent to revoke the directive.
2. Such revocation shall become effective only upon communication to the attending physician by
   the patient or by a person acting on behalf of the patient.
3. The attending physician shall record in the patient's medical record the time, date, and place
   when the physician received notification of the revocation.
4. There shall be no criminal or civil liability on the part of any person for failure to act upon a
   revocation made pursuant to this section unless that person has actual or constructive knowledge
   of the revocation.
5. If the patient/declarer becomes comatose or is rendered incapable of communicating with the
   attending physician, the directive must remain in effect for the duration of the comatose condition
   or until such time as the declarer's condition renders the declarer able to communicate with the
   attending physician.

Complaints:

Patient will be notified that complaints concerning the advance directive requirements may be filed with
the state survey and certification agency.

Educational Materials (these materials inform the public of their rights under state law):

1. WSMA pamphlet for patients and community entitled "Who Will Decide if You Can't?"
2. Advance directive forms.
3. Consultation with a social worker is available to the patient and family upon request.

Staff Education:

Staff working in patient access and in clinical care areas with patients receive initial and annual training
on advance directives.

Documentation:

1. Patient Access staff initiates the AD questionnaire for appropriate inpatient admissions and out-
   patient areas.
2. Document whether the individual has or does not have an Advance Directive.
3. The attending physician is responsible for documenting the determination of terminal condition or
   inability to participate in health care decisions, in the medical record as well as documenting the
   terms of the Advance Directive in the medical record.
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Advance Directives in Ambulatory Care Settings:

<table>
<thead>
<tr>
<th>Ambulatory Care Area</th>
<th>Initial Ask About Advance Directives</th>
<th>If Do Not Have but Interested</th>
<th>If Have AD but Not Here</th>
<th>Follow-Up After Initial Request for AD When On-going Care</th>
<th>Use of Information From AD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>During registration, at the front or the back</td>
<td>Registration can provide brochure</td>
<td>Admitting nurse will discuss AD status and request copies if available</td>
<td>Not applicable for ambulatory care patients</td>
<td>ED physician present; RN would follow-up with order</td>
</tr>
<tr>
<td>MSS</td>
<td>During registration</td>
<td>Registration can provide brochure</td>
<td>Registration ask patient or family to bring in if being admitted, or is a series patient</td>
<td>Only applicable if patient is a series patient in this department</td>
<td></td>
</tr>
<tr>
<td>Day Surgery</td>
<td>During registration; most patients are pre-registered for this services and with the inpatient admit reassessment</td>
<td>Check in staff can provide brochure or refer to care management.</td>
<td>Check in staff or registration asks patient or family to bring in if the patient will be admitted post-operatively.</td>
<td>Not applicable to ambulatory care patients. Request patient/family to bring in if patient is a known admission</td>
<td>AD will not be followed during OR or in PACU. Patient given information regarding this.</td>
</tr>
<tr>
<td>Imaging</td>
<td>During registration</td>
<td>Registration can provide written information</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>During registration</td>
<td>Registration can provide written information</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>ENDO</td>
<td>During pre-registration (ENDO staff to verify)</td>
<td>ENDO staff can provide written information</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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</tbody>
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