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Owner:	*Teresa Lynch: Dir Spiritual Care*
Policy Area:	*Patient Care Services*
References:	
Applicability:	*WA - SWSA - St. Peter Hospital, Centralia Hospital*

Advance Directives - SWSA

PURPOSE:

To outline advance care planning practices that support patient self-determination and receipt of preferred end-of-life care for adult patients. This includes getting, maintaining, accessing, and honoring patient advance directives that (1) name the patient's chosen health care agent (also called durable power of attorney for healthcare) and/or (2) state the patient's wishes and preferred health care treatments.

POLICY STATEMENT:

Providence participates in shared decision-making with patients and honors patient care decisions, within the limits of applicable law, regulations, and the Ethical and Religious Directives for Catholic Health Care. Efforts to know and honor patient preferences include all patients, regardless of whether there is an advance directive, however documents can help ensure care consistent with wishes.

Patients can actively make and update care decisions except when they lack capacity, including the ability to communicate. At that time, information provided in written advance directive documents will guide caregivers to engage the patient's chosen health care agent and to provide care consistent with patient wishes. Providence follows the Washington State Law defining a hierarchy of decision-makers for providing informed consent (RCW 7.70.065) that identifies specific individuals as decision-makers if the patient does not have an advance directive naming a health care agent, and there is no court-appointed guardian.

PROCEDURE:

Caregivers involved in scheduling, admitting, treating, caring, supporting, and discharging patients, share responsibility for making sure patients know their rights and how advance directives provide a tool to help them receive the care they want. Successful processes to get, maintain, access, and honor advance directives depend on various caregivers and a robust Electronic Medical Record (EMR) system. Below are steps and guidelines to help with advance care planning during some facets of a patient visit to a hospital or hospital clinic. Additional steps might be taken with the patient in other care settings or in the community.

Pre-admit Clinic process (for adult patients with scheduled admissions or hospital clinic visits; normally conducted by phone) by perioperative caregivers

1. Ask adult patients to bring up-to-date advance directive for on-site admission or registration.
2. Inform or confirm with patients that an advance directive:

A. Is a document we ask all adult patients to provide

B. Allows the patient to legally name a health care agent, who is a person he/she trusts to speak for them if there is a time when he/she cannot communicate

C. Can include specific and general information about care preferences

D. Can be updated at any time, as long as patient can make decisions

E. Is encouraged for all adult patients to complete with, at a minimum, a health care agent named, however is not a requirement for receiving services

3. Provide information on Washington law for giving informed consent if patient is not able to do so for themselves. (see RCW 7.70.068)

Note: *Pre-admit staff can access advance directive information relevant to the patient in the Advance Care Planning (ACP) Summary as is helpful to customize conversation with patient.*

Registration process – Check-In (for all adult patients served by the hospital or a hospital clinic) by Patient Access caregivers

1. Offer all patients advance care planning information and ask for an up-to-date advance directive.
2. Check to see if patient has an advance directive in the EMR (includes document types advance directive and power of attorney).
   A. If yes, check if patient's document is the same one already in the EMR.
      I. If advance directive is the same as the document in the EMR, do not add.
      II. If document is different, verify the date signed is later than the document in the EMR, and continue to item 3. (Document in EMR should be the most current and up-to-date)
   B. If yes, and patient does not provide printed advance directive, ask patient to verify if document in EMR is accurate and health care agent is up-to-date. If advance directive is not current per patient, request patient bring current advance directive and continue to item 5.
   C. If there is no advance directive in EMR and patient provides printed advance directive, continue to item 3.
   D. If there is no advance directive in EMR and patient did not bring an advance directive, encourage the patient to provide up-to-date advance directive. Document on the documents screen under Advance Directives reason and continue to item 5.
3. Scan advance directive to EMR as an "advance directive" document type. Include relevant descriptors such as the date the patient signed the document and any additional title on the document.
4. Verify the health care agent named in the advance directive is listed as a contact in the Demographics section of the EMR, with a descriptor included. If patient does not have an advance directive and provides contact information for a person they say they plan to name as a health care agent, add that information as a descriptor (e.g. planned HC agent). (This is not a legal designation however it can help in follow-up for the patient.)
5. Provide postage-paid business reply envelope to patients without an advance directive in the EMR if they plan to mail one to the hospital. Alternately, patients can deliver a copy to the Health Information Management Unit (HIM). During inpatient visit, caregivers who provide direct services can fax a patient's advance directive to HIM.
6. Offer information on the Washington law for giving informed consent if patient is not able to do so for

themselves. (RCW 7.70.065)

7. Patients wanting more advance care planning information and conversation can get services from the Spiritual Care Unit after admission to the hospital or by calling a hospital operator to be connected to the Spiritual Care Unit when not an inpatient.
8. If patient provides a POLST (physician orders for life sustaining treatment; often printed on bright green paper), this document should be either faxed to HIM to be added to the patient EMR or given to the admitting nurse to review and fax. The POLST is NOT an advance directive, however it does provide guidance on patient preferences for care.

Admitting process by Physician or Other Provider

1. Review Advance Care Plan (ACP) Summary in EMR for prior code status history, if any, and documentation of patient preferences. The documentation in the Summary might include POLSTs, advance directives, Notes - ACP (advance care planning) or GOC (goals of care), and code status orders.
2. Discuss patient's current preference for code status. If the code status assigned is inconsistent with patient's latest documentation in EMR, or POLST that patient provides during admission, code status orders should include details to explain or acknowledge the discrepancy.
3. If patient is not able to participate in the discussion about code status, provider talks with the health care agent or, if no health care agent is named, other individuals in the hierarchy of decisions makers for providing informed consent. (RCW 7.70.065)
4. If no advance directive and patient has capacity, as possible, provider asks the patient for the name of a "Trusted Decision Maker" and adds that information to the EMR along with an ACP Note with explanation. While this does not serve as a legal designation, provider can engage that person in discussions to ensure the patient receives care consistent with their wishes.

Admitting Process by Nurse

1. Review documentation in Advance Care Plan Summary in EMR for information about the patient's preferences and named health care agent, including notes and code status.
2. If no documentation is found, encourage completion of advance directive that at a minimum names a health care agent.
3. Give patients advance care planning information and resources to access while in hospital or afterwards.
    A. Advance directive forms are in each unit (at HUC/Health Utilization Coordinator station) and at registration/admission sites.
    B. Caregivers can access information about notary services available in the hospital and clinics on Intranet.
        a. PSPH Notary Public Service Policy
        b. PCH Notary Public Service Policy
    C. All hospital TVs have a Channel 80 that shows a 16 minute video loop with information about advance care planning and advance directives.
    D. Spiritual Care Unit accepts referrals for patients who want help with completing an advance directive or to have an advance care planning conversation.
    E. Handout on RCW 7.70.065 provides visual on the family members who will be asked to make decisions if a health care agent is not named in an advance directive.

F. Providence website provides links to other resources: Washington.Providence.org/ACP.

4. Document specific patient care preferences expressed by patient that will help in providing care consistent with wishes, *whether or not the patient has an advance directive*. Add this information as ACP or GOC Note so that the information can be found in the ACP Summary.

Care and Treatment of Patient by providers, care managers, nurses, chaplains, other caregivers:

When patients deal with significant health issues, their care wishes and/or choice of health care agent might change, especially as the patient progresses towards end-of-life. Caregivers takes steps to ensure patient wishes are known and documented – *whether or not the patient has an advance directive.*

1. Engage with patient in on-going shared decision-making concerning health care.
2. When advance directive in EMR is not present or clear, follow steps 1-3 above for the "Admitting Process – Nurse" (check ACP Summary, encourage completion of advance directive, give ACP information)
3. Add ACP or GOC notes to the patient EMR to help communicate important information to other caregivers, including those in Providence primary and specialty care clinics.
4. Prior to discharge:
   A. Discharge Planners review ACP Summary in EMR for gaps and inconsistencies, as possible, and provides patient with ACP resources to them address.
   B. Provider completes, updates, or reviews POLST for patients with significant health conditions or frailty nearing the end-of-life, and those who do not want CPR initiated by emergency responders., as possible.
5. If patient becomes unable to actively participate in shared decision-making, caregivers engage the legal health care decision maker(s**)** per RCW 7.70.065.

CONTRIBUTING DEPARTMENT/COMMITTEE APPROVAL

- Providence Ethics Committee-SW WA
- Mission
- Nursing
- Patient Access
- Care Management
- Medical Staff
- Surgery/Perioperative
- Palliative Care

DEFINITIONS:

Adult: A person who has attained the age of eighteen or is an emancipated minor under Washington state law and has the capacity to make healthcare decisions.
Advance Care Planning (ACP): The process of adults considering healthcare wanted in the future and choosing someone to speak for them if they cannot communicate. It includes conversations with loved ones and healthcare providers about goals, values, and beliefs and completion of **advance directives** to make sure goals of care and preferences are honored.
Advance Care Planning (ACP) Summary: "One Stop" view in a patient's EMR that summarizes all

information about the patient concerning ACP with links to relevant documents (advance directives and POLSTs, code status history and Notes with ACP (advance care planning) or GOC (goals of care) designation. Caregivers get to this view when in a patient chart by clicking on the words "POLST: yes/none" in the banner or wrenching "advance care planning" as a snapshot view.

Advance directive: A document that provides information about goals and preferences for health care when an individual becomes incapacitated or is declared incompetent, and/or identifies and appoints a health care agent to make those decisions. An advance directive is a legal document when signed, dated, and executed according to state law with witnesses or notarization. There are restrictions on who can witness the advance directive, including relatives of the patient, Providence caregivers, individuals who will benefit financially, and others (review documents carefully). Providence caregivers who are notaries can provide notary services as allowed by local ministries. [NOTE: Other names for an advance directive include; Living Will, Health Care Directive, Durable Power of Attorney for Healthcare.]

Code Status: Provider-assigned status that identifies whether patient wishes to have cardiopulmonary resuscitation (CPR) attempted or not. EMR for patients who choose CPR are "Full Code" and those who wish to forgo CPR are "No Code." Code status is assigned each time a patient is admitted to the hospital as an inpatient and only applies to inpatients.

EMR (Electronic Medical Record): Patient chart that includes comprehensive information for medical care, including advance care planning documents.

Ethical and Religious Directives for Catholic Health Care: Information providing guidance for health care provision that is consistent with Catholic teachings and beliefs.

Health Care Agent: Person identified in an advance directive to speak for the patient if they are not able to communicate. [Other names for a health care agent include: durable power of attorney for healthcare, DPOAH, HPOA, health care representative, and surrogate healthcare decision-maker.]

Health Information Management (HIM): Unit that maintains up-to-date patient medical records and responds to information requests.

Life-Sustaining Treatment: Any medical or surgical intervention that uses mechanical or other artificial means, to sustain, restore, or replace a vital function, with goal of prolonging the life of a patient. It might include artificially provided nutrition and hydration but does not include interventions needed solely to alleviate pain or provide comfort.

Legal health care decision-maker: Individual consistent with hierarchy in RCW 7.70.065. Patients with decision-making capacity can complete an advance directive to legally name a health care decision-maker who might or might not fall within that hierarchy.

Notes - ACP (advance care planning) or GOC (goals of care): Types of notes that caregivers can put in EMR that will can be accessed in the ACP Summary. The ACP Note is intended to provide information about the patient's choice of health care agent, general preferences for future health care treatments, and other advance care planning information. The GOC Note is intended to document conversations with patients who have serious illness. Both notes stay at the patient level of the EMR instead of tied to an individual health encounter.

Physician Orders for Life-Sustaining Treatment (POLST): Provider orders with specific medical orders about type of life-sustaining treatment a patient wants or does not want at the end-of-life. It is intended for individuals with advanced life-limiting illness or frailty and must be signed by both the provider and the patient. This form, often printed on bright green paper, will normally be honored by emergency medical responders when at home and various care settings. During hospital admissions, the POLST helps providers assign code status.

Power of Attorney: Document type used in EMR that normally means Durable Power of Attorney for Healthcare, which is considered a type of advance directive. There are also Power of Attorney documents for financial purposes and some documents address both financial and heath care decision-making.

RCW (Revised Code of Washington) 7.70.065 with amendments effective 07/28/2019: "Informed consent

– Persons authorized to provide for patients who are not competent – Priority." This Washington State Law defines the order in which an individual is named a legal health care decision-maker(s) when a patient can no longer speak for himself/herself. When more than one individual is at the applicable level, all must agree.

1. Court appointed guardian, if any
2. Health care agent named in advance directive
3. Spouse or state registered domestic partner
4. Adult children
5. Parents
6. Adult siblings
7. Adult grandchildren who are familiar with the patient
8. Adult nieces and nephews of the patient who are familiar with the patient
9. Adult aunts and uncles who are familiar with the patient
10. Adult with special care and concern for the patient who is familiar with the patient's personal values, is reasonably available to make health care decisions, is not providing medical care or facility housing (or associated with), AND provides appropriate declaration. (review RCW for explicit requirements)

Trusted Decision Maker: Person the patient identifies as who they trust, in the absence of an advance directive that legally names a health care agent. A physician or other provider can add this person to the EMR, annotate as a "Trusted Decision Maker," and write an ACP Note of explanation. Patient are encouraged to complete an up-to-date advance directive to make their choice a legal designation, and to revoke any document in conflict with their current wishes.

OWNER:

Director, Spiritual Care

REFERENCE:

- RCW 7.70.065 – Informed Consent – Persons authorized to provide for patients who are not competent - Priority
- RCW 70.122 – Natural Death Act
- RCW 11.125.400 – Agent authority – Health care

ADMINISTRATIVE APPROVAL:

SW WA Director of Mission and Integration

SW WA Chief Medical Officer

All revision dates: 2/18/2020, 8/16/2019, 1/26/2016, 10/1/2012

Attachments

No Attachments

Approval Signatures

Approver	Date
Carol Robinson: Patient Safety Specialist	2/18/2020
Angela Wolle: CMO Svc Area Lob PSJH	2/12/2020
Francois Cady: President, Medical Staff [JP]	2/11/2020
Jane Porter: Mgr Medical Staff Svcs	2/11/2020
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Applicability

WA - Providence Centralia Hospital, WA - Providence St. Peter Hospital