Protocol

Advance Directives

Nursing Administration 12261 (Rev: 13)**Official**

PURPOSE

To address the management of Advance Directives in the designated settings they will be honored.

All patients in the inpatient setting will honor Advance Directives and manage them as outlined in policy. For patients in these setting, should they not have an Advance Directive, they will be informed of their rights to formulate advance directives and provided information.

All surgical patients (inpatient and outpatient) with an Advance Directive will have a conversation with the physician with regards to suspending their Advance Directive during their surgical phase of care. Should they not have an Advance Directive they will be informed of their rights to formulate one and provided information if they wish it.

All patients in the outpatient setting except Outpatient Surgery will be informed that Advance Directives are not honored in these setting with a posted notice to inform patients that should they experience a medical emergency, emergency medical treatment will be provided. Exception is the emergency department, where if the patient presents with an Advance Directive, it will be honored if needed.

DEFINITIONS

Adult Patient: Any person at least 18 years of age.

Advance Directive *(AD):* Any written document representing the wishes and values of an adult. The document can be written when an adult is a patient or prior to becoming a patient. The Advance Directive designates another person (surrogate) to make health care decisions on his/her behalf if he/she is unable to make decisions for him/ herself. The Advance Directive gives instructions to health care professionals as to the patient's desires regarding health care decisions.

Mental Health Advance Directive For use in Behavioral Health Services: Inpatient Psychiatry and 23 hour Day Hospital or Outpatient Program.

Types of Advance Directives

A. **Living Will (Health Care Directive):** A written declaration of a patient's wishes regarding the use of life-sustaining medical care should they become terminally ill and unable to communicate. A Living Will:
   1. Must be written/signed by a competent adult 18 years of age or older.
   2. Must be witnessed by 2 persons who are not:
      - Related by blood or marriage
      - The patient's attending physician or employee of physician
      - An employee, volunteer or physician of the health care facility where the patient is receiving care
      - Heirs to the patient's estate
   3. May be witnessed by a friend, neighbor, clergy, etc. who personally knows the patient and believes the patient is capable of making health care decisions.
   4. Should state that the patient is emotionally and mentally competent and is voluntarily executing the document.
   5. May be revoked by the patient or surrogate at any time, by destroying it or instructing others to do so.

B. **Values Statement:** A written statement of patient's beliefs and values regarding health care

decisions. If the patient is incapacitated, this can help health professionals and/or the surrogate(s) choose among available treatment options.

C. **Durable Power of Attorney for Health Care:** A written document by the patient appointing another person as his/her agent (attorney-in-fact) to make health care decisions for the patient should he/she become incapacitated
    1. Must be written / signed by a competent adult 18 years of age or older.
    2. Must state that authority is "durable," i.e., is in effect regardless of the capacity of the patient.
    3. Should state that it is for health care decisions.
    4. May not appoint as agent the patient's physician, employee of physician, or employee of the health care facility where the patient is receiving care, UNLESS the individual is also a spouse, registered domestic partner, child, or sibling of the patient.
    5. Does not need to be notarized or witnessed in the state of Washington.
        - **Key Point → It is advisable to have the document notarized in order to meet requirements of other states where the patient may travel**
    6. May be revoked by the patient at any time, by destroying it or instructing others to do so.

D. **POLST (Physician Orders for Life Sustaining Treatment):** A MD order that describes patients wishes concerning resuscitation and other medical interventions. The form is used in addition to and not as a substitute for, any Advance Directive that a patient may have completed. It is intended to be "portable" and travel with the patient from one care setting to another.

SUPPORTIVE INFORMATION

An Advance Directive need not comply with any particular form or formalities, as long as it is in written form, is signed and appears to be authentic.

An adult patient who is capable of making his/her own health care decisions supersedes the effect of an Advance Directive at all times.

The patient/family/representative is informed that Overlake Hospital will provide care whether or not he/she has an Advance Directive.

STEPS → KEY POINTS

1. All inpatients, observation and surgical outpatients, 18 years or older, and Senior Health Center patients will be asked if they have an Advance Directive.
    a. If the patient has an Advance Directive with them, PAS(Patient Access Services) will scan the copy to archive it for retrieval at a future hospitalization. If advance directive does not accompany the patient and PAS is able to retrieve a prior copy, the copy is attached to the admitting paperwork.

Key Points → Any retrieved copy is reviewed by the patient for accuracy and dated/signed by patient.

Key Point → Copies of Advance Directives are kept in the "Advance Directive" section of the chart and the original copy is returned to the patient or their representative.

Key Point → Both original and copy of POLST forms for a patient admitted from a SNF, adult home, care facility, will be kept on the chart until transfer to next care facility at which time original copy is sent with the patient. This may also be done for other patients and returned to them at discharge.

Key Point → To ensure that all copied pages of an Advance Directive are not separated from each other, it is recommended that all pages be stapled together.

b. **Key Point → Each page of the Advance Directive will have patient identification information.** For Senior Health Centers: patients are asked and if available, a copy is made and placed in their chart.
c. If the patient does not have an Advance Directive, PAS will offer the patient a copy of the patient education booklet "Starting Points" which informs the patient about Advance Directives. Patient questions will be directed to their nurse upon arrival to the unit.

2. Upon arrival on the nursing unit, the Advance Directive Questionnaire may be completed by the patient or by the nurse with the patient or family representative.
   a. If the patient brings an Advance Directive documentation to the hospital, RN confirms AD is current and has patient sign and date the AD copy and placed in the chart.
      - If AD is not present but is being brought in, document this on care plan. When form is received, make a copy and fax to PAS department. Place copy in the chart. Give the original back to the patient.
      - **Key Point → Every attempt should be made to obtain a hard copy of the AD within 24 hours of admission.**

   b. If no AD, confirm the patient received a copy of "Starting Points". If not received, offer the booklet. Document acceptance or declination of booklet on Advance Directive Questionnaire.

3. If the patient is critically ill and unable to verbalize, or does not have a spokesperson that is aware of an AD, health care providers will provide care as if there is no AD executed.
   - **Key Point → AD Questionnaire will be completed and signed by the nurse to reflect the above situation.**

4. If a patient is unable to give information or answer question regarding the existence of an AD, the nurse will notify the legal next of kin to provide an AD, if one exists. Follow-up documentation will be added to the care plan to ensure that an AD is obtained.
5. The nurse will inform Licensed Independent Practitioner (LIP) Advance Directives, (including a POLST form), are present on the chart.
   - **Key Point** → The original green POLST form is not used as an order form. The LIP must needs to write the patient wishes as an order on Physician Order form or Code Status form.
   - **Key point** → Within 24 hours of admission, the LIP needs to write code status orders either on Physician Order or Code Status form for this hospital admission. to reflect known wishes of patient.
   - **Key Point** → "If a patient is admitted with documentation of their wishes not to be resuscitated in a Living Will or an original POLST form, and no physician order has been written at the time of arrest, a Code Blue is to be initiated. It is the responsibility of the Registered Nurse caring for the patient to inform the responding Physician at the time of arrival of the existence of the documented no code wishes

6. If a patient decides to revoke the AD, document this in the medical record and notify the Physician.
7. Referrals for assistance with health care decisions or completing the forms during hospitalization may be directed to Care Management, Chaplain, Palliative Care Team or Senior Care.
8. Refer to Mental Health Advance Directive policy for information related to persons with mental illness.

DOCUMENTATION

1. Advance Directive Questionnaire is completed by the patient, surrogate and/or nurse on admission.
2. Completion or follow up needs of this process is documented on the care plan within 24 hours of admission.

Documents referenced by this document

Referenced Documents	Mental Health Advance Directive

Documents which reference this document

Referenced Documents	Patient Admission Data Documentation