Title: Advanced Directives
Section: Rights and Ethics
Policy #: RI-03
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Approval: Sr. Leadership

Purpose

To inform adult patients and authorized individuals of their rights under state law to make and direct decisions concerning medical care.

To guide staff in implementing the provisions of the Patient Self-Determination Act.

To provide for education of staff, patients, and community on issues concerning advance directives and related care documents.

Policy

Well Care recognizes that all adult persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. It is the policy of Well Care to encourage individuals and their family/caregivers to participate in decisions regarding care and treatment. Valid Advance Directives, such as living wills, Durable Power Of Attorney for Health Care, and DNR (Do Not Resuscitate) orders will be followed to the extent permitted and required by law. In the absence of Advance Directives, Well Care will provide appropriate care according to the plan of care or as authorized by the attending physician. Well Care will not determine the provision of care or otherwise discriminate against an individual based on whether the individual has executed an Advance Directive.

Definitions

1. *Adult:* A person 18 years or older, or a person legally capable of consenting to his/her own medical treatment.

2. *Advance Directives:* A document in which a person states choices for medical treatment.

3. *Attending Physician:* The physician who is primarily responsible for the medical care of a patient receiving home health services.

4. *DNR (Do Not Resuscitate):* A medical order to refrain from cardiopulmonary resuscitation if the patient's heart stops beating.

5. *Patient Self-determination Act:* A federal statute enacted as part of the 1990 Omnibus Budget Reconciliation Act (OBRA) (PL 101-508) which requires, among other things, that health care facilities provide information regarding the right to formulate Advance Directives concerning health care decisions.

6. *Patient Representative:* A person appointed to make decisions for someone else. He/she may be formally appointed (as in a Durable Power of Attorney for Health Care) or, in the absence of a formal appointment, may be recognized by virtue of a relationship with the patient (such as the patient's next of kin or close family/caregiver).

7. *Terminal Condition:* An incurable condition caused by an injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would within reasonable medical judgment produce death, and where the application of life-sustaining procedures only postpones the moment of death of the patient.

8. *POLST/MOLST:* Physician (Medical) Orders for Life-Sustaining Treatment is a physician order that helps give seriously ill patients more control over their end-of-life care. It does not replace an Advance Directive.

Policy Detail

1. Upon admission, the clinician will provide information regarding a patient's right to make decisions concerning health care, which include the right to accept or refuse medical or surgical treatment, even if that treatment is life-sustaining, the right to execute Advance Directives, and applicable organization policies. Written information designed for this purpose will be provided to the adult patient. The clinician will document in the clinical record that the information was provided and record all discussions concerning Advance Directives.

2. If the patient lacks decision-making capacity, the admitting clinician will provide information and direct inquiry about Advance Directives to the patient's representative. The clinician will document that the patient representative received information, and his/her name and responses will be noted in the clinical record.

3. If conditions are such that it is not practical to provide information to the patient or his/her representative at the time of admission, such information will be provided as soon as feasible after admission.

4. During the admission visit, the clinician will ask the patient or his/her representative whether he/she has completed an Advance Directive, Durable Power of Attorney (DPOA), living will, or DNR order. If an Advance Directive has been completed, the clinician will ask for a copy of the Advance Directive so it will be placed in the clinical record. If a copy is not immediately available, the patient will be informed that it is his/her responsibility to provide a copy of the Advance Directive to the organization as soon as possible.

5. If a copy of the patient's Advance Directive is not available to the organization, the clinician will discuss the contents of the Advance Directive with the patient and/or patient representative and document the contents of the Advance Directive in the clinical record and communicate the contents to other home health providers.

6. When applicable, the admitting clinician will document on the clinical record and notify the attending physician verbally of the physician's (or other authorized licensed independent practitioner's) order if the patient has executed an Advance Directive.

7. The patient will be encouraged to participate in all aspects of decision-making regarding home health care and treatment. Statements by a competent patient regarding his/her desire to accept or refuse treatment will be documented in the patient's clinical record.

8. The patient will be informed of any limitations Well Care Home Health, Inc. has in respecting the patient's Advance Directive.

9. The patient will be informed that the existence of or lack of advance directive does not determine a patient's access to care or services.

10. All clinicians providing care for the patient will:

    a) Patient care staff will not complete or witness an advance care document or participate in the decision-making process relating to whether to have an advance care document.

    b) Review the Advance Directive and report any discrepancies between the Directive and current treatment plan to the attending physician, clinical supervisor, and the patient.

    c) Utilize available educational materials to answer the patient's questions about Advance Directives, durable power of attorney, or living wills.

    d) Encourage the patient to discuss questions and concerns with appropriate individuals such as the physician, family/caregiver, and his/her selected advocate.

    e) Assist the patient who wants to develop an Advance Directive by obtaining a form and providing access to the outside individuals as necessary to execute the directive.

    f) If a patient refuses medical treatment, the patient care staff shall discuss the refusal with the physician and document both the refusal and the physician notification in the medical record.
    g) Patient care staff will not provide any medical treatment that the patient has not consented to receive.
    h) Patient care staff will notify the physician of the patient's desire to have medical treatment withheld or discontinued. Physician orders may be necessary to withhold or discontinue specific treatments.

11. An Advance Directive will be implemented as follows:

    a) The Durable Power of Attorney for Health Care/Advance Directive is effective *only* when the patient is unable to participate in his/her own medical treatment decisions.

b) The attending physician and another physician or a licensed psychologist must document in the patient's clinical record that the patient is unable to participate in medical treatment decisions.

c) The patient's designated advocate can then make medical treatment choices based on the Advance Directive. The patient advocate may decide to withhold or withdraw treatment that allows the patient to die. This is done *only* if the patient expressed, in a clear and convincing manner, that the advocate is authorized to make such a decision and acknowledges that such a decision would or could allow the patient's death.

d) Executing and implementing an Advance Directive is a process, not a one (1)-time event. On an ongoing basis, the clinical staff will keep the patient, family/caregiver, and patient's representative up to date concerning the patient's medical condition. They will discuss the patient's preferred course of treatment as his/her condition changes. The discussions will be documented in the clinical record.

12. In the event the patient has executed an advance directive, which is not recognized under applicable state statutes, the agency or staff may raise an objection to implementing the advance directive based on conscience. If the agency or an individual health care worker raises a conscience objection to an advance directive executed by the patient but not recognized by state law, the health care worker will:

    a) Discuss the objection with the RN Case Manager and Clinical Manager.

    b) The RN Case Manager or Clinical Manager will discuss the objection with the patient and their physician.

    c) A request for an ethics consult for recommendations may be made in accordance with the Ethical Issues Policy within the Rights and Ethics chapter of the policy manual.

    d) If the agency/health care worker is not able to honor the wishes of the patient based on the conscience objection, the health care worker will be removed from the case or the patient will be assisted to obtain services from another agency.

13. Educational information about Advance Directives and Well Care Home Health, Inc.'s policies and procedures regarding Advance Directives will be provided to the medical, nursing and allied health professionals, as well as home health personnel and volunteers during the orientation period.