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 Owner: Teresa Lynch: Director,
 Spiritual Care SWR
 Policy Area: Patient's Rights and Ethics
 References:
 Applicability: WA - Providence St. Peter
 Hospital

Advanced Care Planning

Policy Number: 86100-PRE-038

PURPOSE:

The goal of this policy is to ensure the rights of all patients to participate in and direct their own healthcare decisions, consistent with our Mission and Core Values, the *Ethical and Religious Directives for Catholic Health Care Services* (nos. 23-28) and with applicable state and federal law. Those laws include the Patient Self-Determination Act and the Medicare and Medicaid hospital conditions of participation for patient rights.

Providence believes that compassionate care should neither prolong nor hasten the natural dying process and that advanced care planning is an important communication tool for patients, physicians and healthcare providers.

APPLIES TO:

This policy applies to Providence Health & Services Washington caregivers (all employees) and clinicians.

POLICY STATEMENT:

In aligning and keeping with our Mission and Core Values, Providence supports patient and family rights to participate in healthcare decision-making. Advance care planning supports patient-centered and shared decision making, including times when the patient is no longer able to participate. Providence caregivers will ensure that patient wishes or directives are followed as appropriate to the medical situation and the law, and will turn to the patient's chosen health care representative/agent to make decisions if the patient cannot communicate. Providence encourages patient self-determination and will facilitate active participation by patients in decision-making concerning their care.

OBSERVATION & SAFETY FACTORS:

N/A

PROCEDURE:

REQUIREMENTS:

1. All adult inpatient, observation and same-day surgery patients will be informed of their right to make

decisions regarding their medical care.

- A. Advance care planning information will be provided to any patient, including outpatients, upon request. This includes written materials, forms, and other resources that support the process of individual choosing a health care representative/agent and considering future healthcare preferences.
 - B. Care provided by Providence will not have any conditions based on whether or not the individual completes any form of advance care planning documents. Providence also supports the right of all adult persons to refuse treatment(s) unless otherwise legally ordered.
2. Documentation: When possible Providence will obtain a copy of a patient's advance care planning document(s). These document can include the designation of a healthcare representative/agent to be a surrogate decision-maker and/or state the patient's health care preference(s). Advance directives can be called "Advance Directive", "Durable Power of Attorney for Healthcare", "Healthcare Directive", or "Living Will". An additional advance care planning document is the Physician Orders for Life Sustaining Treatment (POLST) which states current medical preferences for the patient. All documents need to be clearly identified in the patient's electronic medical record (EMR). In addition to or when documents are not available, the patient's wishes may be documented in the medical record.
 3. Every effort must be made (by Providence Health and Services caregivers) to review and honor advance care planning documents when patients are not able to actively communicate wishes and preferences for their healthcare treatment, including the selection of a healthcare representative/agent.

AGE-RELATED CONSIDERATIONS:

N/A

CONTRIBUTING DEPARTMENT/COMMITTEE APPROVAL:

- WA Council (5/2017)

DEFINITIONS:

- **Adult Person:** A person who has attained the age of 18 or is an emancipated minor under Washington state law and who has the capacity to make healthcare decisions.
- **Advance Care Planning:** The process of individuals 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. Documents are then needed to make sure goals of care and preferences are honored.
- **Advance Directive:** A document that provides information about goals and preferences for healthcare when an individual becomes incapacitated or is declared incompetent, and/or identifies and appoints a healthcare representative/agent (see below) to make those decisions. An advance directive is a signed, dated, and legally witnessed and or notarized document. Restrictions on who can witness the advance directive includes 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.
- **Durable Power of Attorney for Healthcare (DPOAH):** The Healthcare Representative or Agent named by an individual in their advance directive documentation who is the chosen surrogate healthcare decision

maker. That person is sometimes called the DPOAH.

- **Electronic Medical Record (EMR):** Patient chart that includes comprehensive information for medical care, including advance care planning documents.
- **Healthcare Representative/Agent:** A person appointed by the patient to make healthcare decisions in cases of decisional incapacity. This person is called a Durable Power of Attorney for Healthcare. The Advance Directive form normally includes naming of a healthcare representative/agent and is sometimes on a form labeled Durable Power of Attorney for Healthcare.

Incapacitated Patient: A patient who is temporarily or permanently unable to make informed decisions regarding care and treatment. This may be due to the patient's medical condition and or treatment received.

- **Incompetent Person:** A person is judged to be incompetent by a court of law, thus finding that a person is not capable of managing their own affairs appoints a guardian. This guardian may or may not have healthcare decision-making authority and this finding may come after a person has competently completed some form of advance directive. It is important to check and confirm this information.
- **Living Will:** This is another name for an Advance Directive and can document wishes regarding the type of life-prolonging medical treatment wanted, in case of the loss of ability to communicate these preferences at the end of life.
- **Physician Orders for Life Sustaining Treatment (POLST):** A physician or provider order that details the treatment wishes of seriously frail or chronically critically ill patients to have or to limit life-sustaining medical treatment as they move from one care setting to another. This document is not an advance directive but is an advance care planning document.

ATTACHMENT:

N/A

OWNER:

Chief Administrative Officer, SWSA

Prior Policy History:

- Implementation Date: 3/2014
- Reviewed Date:
- Revision Date: 3/2020

REFERENCES:

- The Patient Self-Determination Act
- United States Conference of Catholic Bishops (USCCB) Ethical and Religious Directives for Catholic Healthcare Services (nos.23-28)
- Joint Commission
- Centers for Medicare and Medicaid (CMS)
- Omnibus Budget Reconciliation Act of 1990
- Per WAC 246-320-141 this policy must be publicly posted on Providence Health and Services internet site, any updates must be reported to the state and updated on the internet site within 30 days of update

ADMINISTRATIVE APPROVAL:

Chief Administrative Officer, SWSA

All revision dates:

6/6/2017, 3/1/2014

Attachments:

No Attachments

Approval Signatures

Approver	Date
Medrice Coluccio: Chief Administrative Officer, Southwest Washington [PA]	6/6/2017
Teresa Lynch: Director, Spiritual Care SWSA	6/1/2017
Catherine Schwartz: Policy Coordinator	5/31/2017

Applicability

WA - Providence St. Peter Hospital

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