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Advance Directives and POLST Policy		

Applicable To:									

APPLICATION

POLICY

The patient has the right to formulate Advance Directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives. An Advance Directive or POLST is not a condition of treatment. Hospital Name does not discriminate in any way or make care decisions based on whether or not an individual has an Advance Directive or POLST.

PROCEDURE

DEFINITIONS:

1. Adult: an individual who is 18 years of age or older, who has been adjudicated an emancipated minor, or who is married. An Adult may designate in writing another competent Adult to serve as their health care representative or attorney-in-fact to make health care decisions or mental health treatment decisions on behalf of the patient if the patient becomes incapable.
2. Advance Directive: A written instruction, such as a durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.
3. Incapable Patient: A Patient admitted to a hospital or in an emergency department who needs assistance to effectively communicate with hospital staff, make health care decisions or engage in activities of daily living due to a disability, including but not limited to:
    A. A physical, intellectual, behavioral or cognitive impairment;
    B. Deafness, being hard of hearing or other communication barrier;
    C. Blindness;
    D. Autism; or
    E. Dementia
4. Portable Orders for Life-Sustaining Treatment (POLST): Designed to improve the quality of care people receive near the end-of-life. The POLST is based on effective communication of Patient wishes, documentation or portable orders for life-sustaining treatments and promise by a health care professional to honor these wishes.
5. Support Person: a family member, guardian, personal care assistant or other paid or unpaid attendant selected by the Incapable Patient to physically or emotionally assist the patient or ensure effective communication.

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IMPLEMENTATION:

Physicians and employees of Hospital Name respect and support the rights of patients to participate in direct health care decisions, including the formulation of an Advance Directive or POLST, the right to accept or refuse medical or surgical care.

- An Incapable Patient has the right to designate at least three Support Persons. One Support Person must be allowed to be present at all times in the emergency department and during the patient's stay, to facilitate the patient's care. For any discussion in which the Incapable Patient is asked to elect hospice or sign an Advanced Directive or POLST, communication with the Support Person(s) will take place, unless the patient asks for the Support Person to not be present. The communication will be documented in the Patient's medical record.
- The Support Person may be held to certain conditions, to ensure the safety of the patient, the Support Person, and staff, such as: wearing personal protective equipment, following hand washing and other protocols, free of symptoms of viruses or contagious disease, etc.

Advance Directive

1. Determine if the patient has a health care directive at the time of admission as an inpatient or observation patient.

2. Nursing is responsible for assessing Advance Directive status upon patient admission assessment and documenting status in the EMR, including requesting a copy of the health care directive.

3. Provide written information about health care directives to patients who are age 18 or older and who do not have a signed directive. Information may be provided as a patient hand-out or through assistance from a chaplain or social worker.
   A. Home Health personnel will provide information about health care directives to all patients receiving home health services who are age 18 or older.
   B. Hospital Name and Center personnel will provide patients with information, including the Health Care Directive Booklet, and will obtain a signed "Health Care Directive Acknowledgment."
   C. Outpatient areas, such as the Emergency Department and clinics, will make general information about health care directives available in a public area. Additional information may be provided to each patient, depending on established procedures for that patient care area.

4. Directives shall be effective when it is signed and witnessed by two Adults who witness either the signing of the instruction by the patient or the patient's acknowledgment of the signature of the patient.
   A. One witness shall be a person who is not:
      1) A relative of the patient by blood, marriage, or adoption.
      2) A person who at the time the health care direction is signed would be entitled to any portion of the estate of the patient upon death under any will or by operation of law.
      3) An owner, operator, or employee of a health care facility where the patient is admitted.
   B. The health care representative may not be a witness.
   C. A hospital employee may be one of the witnesses.

5. The following people cannot be the health care representative/attorney-in-fact (or alternate):
   A. The attending physician or mental health service provider unless related by blood, marriage, or adoption.
   B. An employee of the attending physician or mental health service provider unless related by blood, marriage, or adoption.

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C. The owner, operator, or employee of the health care facility in which the principal lives or is a patient unless related by blood, marriage, or adoption, or unless the health care representative/attorney-in-fact is appointed before the principal's admission to the facility.

6. The health care representative appointed through an Advance Directive for Health Care may not consent for the patient in the following matters:
   A. Commitment to a mental health treatment facility
   B. Convulsive treatment
   C. Psychosurgery
   D. Sterilization
   E. Abortion
   F. Withholding or withdrawing life-sustaining procedures except under certain specified conditions as described in Oregon statutes.

7. In the absence of the actual health care directive, the physician will document the substance of the directive in the medical record.

8. In the event that the patient's attending physician cannot, in good conscience, honor the health care directive, it is the responsibility of the attending physician, in concert with the patient and/or patient's family, to identify, as soon as possible, an alternative member of the medical staff to assume the care of the patient. This alternative medical staff member will agree to abide by the requests in the health care directive. If a transfer of care cannot be made in a timely fashion, the chairman of the Ethics Committee will convene a committee meeting to assist in resolving the dilemma. Health care directives remain in effect as delineated below, or until revoked by a competent patient.

9. The Advance Directive for Health Care remains valid for the patient's entire life unless the patient cancels it or specifies a specific period of years on the form.

POLST

POLST forms should only be offered to patients with advanced illness or frailty who wish to turn their preferences into actionable medical orders.

1. Patients who arrive at an Hospital Name facility with a completed POLST form:
   A. Copy the POLST form into the ePOLST system.
   B. Return the original POLST form to the patient or authorized medical decision-maker.
   C. The physician will review the ePOLST and verify with the patient or authorized decision-maker their current wishes and write orders regarding code status/resuscitation to direct inpatient care.
   D. Prior to discharge, review the ePOLST orders and verify the content with the patient or surrogate.
      1. If the ePOLST remains valid as previously written, the licensed independent practitioner (LIP) will make a notation in the medical record that the ePOLST was reviewed and remains valid.
      2. If the patient/surrogate requests a change in the completed ePOLST form they brought in, ensure the changes are documented in their newly created ePOLST. The current version and/or copy will be noted as rescinded by writing "VOID" across the front of the form.

2. Patients who arrive at SHS without a completed POLST form:

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A. Prior to discharge to another facility (i.e. long-term care facility, hospice, foster home, or another hospital) or to home with a discharge plan that includes at-home hospice services, an ePOLST should be completed in accordance with the wishes of the patient or their authorized medical decision-maker.
B. Print a copy of the ePOLST form and provide to the patient or authorized medical decision-maker to accompany them during transport.

3. Accessing a POLST for the Registry:
A. POLST forms from the Registry are visible via XXX
B. External document access will require users to provide a reason for access
C. Users can select "Access External Document" button in the current POLST section of the dashboard if POLST with latest Physician's signature date is from Oregon POLST registry.

REFERENCES

- Hospital name Policy: Rights and Responsibilities of Patients, Guardians and Healthcare Representatives
- The Patient Self-Determination Act
- 42 CFR 482.13(b)(3)
- 42 CFR 489.102
- ORS 127.505-127.660
- SB 1606, ORS 127.635
- ORS 127.700-127.735
- Oregon POLST Program website: Oregon POLST History
- POLST Guidebook for Health Care Professionals

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