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Advance Directives and End of Life Considerations in Acute and Ambulatory Care

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POLICY:

Jefferson Healthcare (JH) supports the fundamental right of adult, qualified patients to control decisions relating to their medical care including the decision to have life-sustaining procedures provided, withheld, or withdrawn in instances of a terminal condition.

JH recognizes and abides by the patient's right to have an advance directive and to accept or refuse treatment with or without life sustaining medical interventions.

The existence or lack of an advance directive does not determine the individual patient's right to access care, treatment, and services.

PURPOSE:

To help patients and/or loved ones give direction about the end of life care, and to ensure that patients understand their right to accept or refuse medical or surgical treatments.

To provide the patient with the ability to live the remainder of his or her life with as much dignity, control, and comfort as possible.

To provide guidance to staff and to promote increased support and recognition of the ethical concept of autonomy or the individual person's or patient's right of self-determination.

To encourage patients and their health care providers to make plans regarding treatment in situations in which patients are unable to participate in medical decision making.

DEFINITIONS:

1. **Advance Directive (AD):** Is also called in Washington State, "Health Care Directive":
    a. Written instruction or directive, such as a living will or durable power of attorney for health care;
    b. Voluntarily executed by the declarer;
    c. Relating to the provision of health care when the individual is incapacitated;
    d. Directive regarding withholding or withdrawal of life-sustaining treatment when the individual is in:
        i. A terminal condition; or
        ii. Permanent unconscious condition.
2. **Life-Sustaining Treatment:** Any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function which, when applied to a qualified patient, would serve only to prolong the process of dying. Life-Sustaining Treatment does not include:
    a. Administration of a medication; or
    b. The performance of any medical or surgical intervention deemed necessary solely to alleviate pain or provide comfort.
3. **Living Will** (Advance Directive; Living Will; Heath Care Directive): A document in which a person can stipulate the treatment choices they would/would not want if they became a qualified patient and unable to make medical decisions.
4. **Palliative Care:** Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms, rather than striving to halt, delay, or reverse progression of the disease itself or provide a cure.
    a. The goal is to prevent and relieve suffering and to improve quality of life for people facing serious, complex illness.
    b. Unlike hospice, palliative care is not dependent on prognosis and is offered in conjunction with curative and all other appropriate forms of medical treatment.
5. **Permanent Unconscious Condition:** An incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.
6. **Qualified Patient:** An adult person who is a patient diagnosed in writing to have a terminal condition by the patient's attending physician, who has personally examined the patient, or a patient who is diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient.
7. **Terminal Condition:** An incurable and irreversible condition caused by injury, disease, or illness that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

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SCOPE:

This policy applies to all areas of Jefferson Healthcare, inpatient and ambulatory settings.

RESPONSIBILITY:

AMBULATORY CARE:

A. During registration, patients will be asked if they have an Advance Directive by the registrar or intake coordinator.

B. The patient's responses will be documented by entry into their medical record. The responses available will be 'Y' for yes, and 'No' for no. When no is entered, the applicable reason must also be entered:

   1. Information refused;
   2. Patient not available;
   3. Asked for more information; and
   4. A written information given at registration.

C. Registration may provide additional information to the patient upon request.

D. If the patient has an AD, but it is not in his/her medical record, registration staff members may request the family to bring a copy of the Advanced Directive to JH.

E. For those patients requesting more information about Advance Directives at registration, staff will provide a Washington State Medical Association (WSMA) pamphlet entitled "Who Will Decide if You Can't?" containing the forms and information on ADs.

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Ambulatory Department Staff:

A. Emergency Department:

   1. When an AD is not present and the patient is unable to communicate, the patient care team will assume that the patient is a full code.
   2. If the patient's AD is not present and the patient is able to communicate, the provider will interview the patient and document the code status in the medical record.
   3. When the patient has an AD but it is not available, the emergency department staff may encourage the patient and/or family members to bring a copy of the AD to be scanned into the medical record.

B. Medical Short Stay:

   1. For patients who are scheduled for a series of treatments, the medical short stay staff will review the advance directive.
      a. If the AD is not available, the medical short stay staff members will encourage him or her to bring a copy in to be scanned into the medical record.

C. Ambulatory Surgery/Endoscopy:

1. During pre-registration, AD status will be reviewed and documented. If the AD is not available, the patient will be encouraged to bring it with him or her on the day of the procedure.
2. On the day of the procedure: if the AD is not available, check-in staff will encourage the patient and/or family members to bring a copy of the AD to be scanned into the medical record.

D. All other ambulatory settings will review AD status upon registration. Patients will be encouraged to bring a copy of their AD to be scanned into the medical record.

INPATIENT ADMISSIONS

A. During registration, patients will be asked if they have an Advance Directive by the registrar or intake coordinator.

B. The patient's responses will be documented by entry into their medical record. The responses available will be "Y" for yes, and "N" for no. When No is entered, the applicable reason must also be entered:

1. Information refused;
2. Patient not available;
3. Asked for more information; and
4. Written information given at registration.Advance Directives are to be scanned into the medical record.

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C. If the patient has an AD, but it is not in his/her medical record, registration staff members may request the family to bring a copy of the Advanced Directive to JH.

D. For those patients requesting more information about Advance Directives at registration, staff will provide a Washington State Medical Association (WSMA) pamphlet entitled "Who Will Decide if You Can't?" containing the forms and information on ADs.

Patient Care Staff:

A. Nursing staff will review the Advance Directive upon admission if available.

B. If the AD is not in the chart, patient care staff will ask the family to bring in the AD to place in the patient's chart.

C. If the patient has an AD but it is not available, the provider will document the patient's code status.

D. Advance Directives are to be scanned in the medical record as soon as available.

E. Case Management will make a second request to obtain or complete the Advance Directive.

F. If a clinical situation arises which may result in withholding or withdrawing of life-sustaining treatment (including artifically administered nutrition and hydration if selected by the declarant), nursing will verify the existence of an AD:

1. If existence is verified, nursing will ensure that a copy is acquired if not already in the chart;
2. The attending physician will be notified, and the notification documented in the

patient chart;

G. JH staff may not witness an Advance Directive in his/her professional caregiver role at JH.

Attending Physician Responsibilities:

A. The attending physician or provider must provide the level of care consistent with the wishes of the patient as stated in an Advance Directive.

B. If the attending physician/provider is unwilling to provide that level of care, the physician must transfer the patient to a physician who will comply with the patient's wishes, documenting this in the medical record.

C. The Advance Directive becomes operative when:

1. It is communicated to the attending physician; and
2. The patient is in a terminal condition and no longer able to make or communicate decisions regarding administration of life-sustaining treatment;
3. This status is determined and documented by the attending physician and one other physician not caring for the patient, who both:
    a. Have examined the patient;
    b. Have diagnosed the terminal condition or the inability to make or communicate health care decisions; and
    c. Have certified this status in writing. If the patient should ask that the Advance Directives be revoked, the patient will honor the request immediately and document as listed under the nursing responsibility.

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Health Information Management (HIM) Responsibilities:

A. Upon presentation of Advance Directives, HIM staff will scan the document into the electronic medical record under the title Advanced Directives.

B. If the patient does not have a medical record, the patient registration form designed for this purpose will be used to acquire the data needed to create a patient file.

C. A medical record number will be established for the individual and the documents will be placed there.

D. If the Advance Directive is revoked, the document will be removed from the medical record.

PROCEDURE:

Implementing an Advance Directive:

A. The Advance Directive must be signed by the declarer (patient) in the presence of two witnesses not related to the patient by blood or marriage, and who would not be entitled to any portion of the patient's estate upon his or her death under any will.

B. **Staff May Not Act as Witnesses:** The attending physician, an employee of the attending physician, or employee of JH acting in the role of care provider may not witness an Advance Directive.

C. A notary is not required.

D. The fully signed document or a copy of the completed directive shall become part of the permanent medical record.

E. If there are questions about ability to consent, Risk Management is available for consultation.

Acting on an Advance Directive:

A. If the patient becomes comatose or is rendered incapable of communicating with the attending provider, the directive shall remain in effect for the duration of the comatose condition, or until such time as the patient's condition renders them able to communicate with the attending provider.

B. If there are ethical concerns regarding end of life decisions, an Ethics Committee consultation shall be requested by contacting the House Supervisor at (360) 381-0445.

C. The patient's family members should be informed of the existence of the Directive and that the Directive reflects the patient's wishes.

Advance Directive in the Perioperative Period:

A. The patient's physician and anesthesia care provider are responsible for discussing and documenting issues with the patient/or family members to determine whether the do-not-resuscitate orders are maintained or completely or partially suspended during anesthesia and surgery.

B. Appropriate information should be provided to the perioperative team in order to support the patient's or surrogate's health care decision.

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Revocation of an Advance Directive:

A. A directive may be revoked at any time by the patient.

B. Such revocation shall become effective only upon communication to the attending physician by the patient or by a person acting on behalf of the patient.

C. The attending physician shall record in the patient's medical record the time, date, and place when the physician received notification of the revocation.

D. There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual or constructive knowledge of the revocation.

E. If the patient/declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive must remain in effect for the duration of the comatose condition or until such time as the declarer's condition renders the declarer able to communicate with the attending physician.

Complaints:

Patient will be notified that complaints concerning the use and decision making regarding advance directives may be directed to the patient advocates.

Educational Materials (inform the public of their rights under state law):

A. WSMA pamphlet for patients and community entitled "Who Will Decide if You Can't?"

B. Advance directive forms.

C. Consultation with a social worker is available to the patient and family upon request.

Staff Education:

Staff working in patient access and in clinical care areas with patients receive initial and annual training on advance directives.

Approval Signatures

Step Description	Approver	Date
Update JH Website and Send to DOH @HospitalPolicies@doh.wa.gov	Carly Korpi-Cloninger: Executive Assistant - CEO & Marketing	04/2026
Executive Approval	Tina Toner: Chief Nursing Officer	01/2026
Leader Approval	Tina Toner: Chief Nursing Officer	01/2026

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