Klickitat Valley Health			
Policy/Procedure Name:	Advance Directives		
Department/Scope:	District Wide		
Most recent review/revision date:	09/20/2025	**Pages:**	3

Purpose Statement:

The purpose of this policy is to provide guidance for the initiation of advance directives by patients or their authorized representatives, and to ensure that hospital staff respects and honors the choices made by patients regarding their medical care.

Definitions:

- Advance Directives: Legal documents that allow patients to make decisions about their medical care in advance, in case they become unable to communicate their wishes later. These may include Living Wills, Durable Power of Attorney for Health Care, Physician Orders for Life-Sustaining Treatment (POLST), Mental Health Advance Directives (MHAD), and Five Wishes.
- Living Will: A document specifying the medical treatments an individual would or would not want if they become unable to make decisions due to serious illness or injury.
- Five Wishes: An advance directive that addresses medical, spiritual, emotional, and personal needs, allowing individuals to specify preferences for comfort care, support, and how they wish to be remembered.
- Power of Attorney for Health Care: A legal document allowing an individual (the principal) to designate another person (the agent) to make medical decisions on their behalf if they are unable to do so.
- Physician Orders for Life-Sustaining Treatment (POLST): A medical order form that translates a patient's end-of-life care preferences into specific medical orders, signed by a physician or authorized medical professional.
- Mental Health Advance Directive (MHAD): A legal document outlining a person's preferences and instructions for mental health treatment if they become unable to make decisions due to mental illness.

Procedure:

- **Patient Information on Admission**
  - Upon registration, all patients are provided with KVH's *Rights and Responsibilities* document, which includes information on their right to formulate advance directives and the assistance available for doing so(Patient Rights and Resp…).
  - Patients are asked to sign KVH's *Advance Directive Acknowledgement* form, where they confirm understanding of their rights to accept or refuse treatment, formulate an advance directive, and indicate their advance directive status (Advance Directive Ackno…).

- For Emergency Department (ED) patients, information on advance directives is documented within the *Past Medical/Social/Family History* section of the EHR. For Med/Surg patients, this information is documented within the *Admission Assessment* intervention.

- **Assistance with Advance Directives**

  - If a patient expresses interest in creating an advance directive, staff provide the necessary forms and support in completing the document. Staff ensure that the patient understands the purpose and implications before finalizing the document.

- **Authorized Representatives**
  - If a patient is unable to create an advance directive due to a physical or mental condition, staff work with the patient's authorized representative, ensuring they are informed and understand the patient's wishes.

- **Documentation**
  - Document the existence and type of advance directive (e.g., Living Will, Durable Power of Attorney for Health Care, POLST, MHAD) in the patient's EHR. Ensure this documentation is accessible for all care team members.

- **Honoring Advance Directives**
  - Staff are required to honor advance directives within the bounds of the law and accepted medical practice, ensuring that the patient's wishes are respected.

- **Follow-up for Med/Surg Patients Without Advance Directives**
  - For Med/Surg patients (all status types) who do not have an advance directive on file and wish to formulate one, the following steps are taken:

    - Upon arrival to the Med/Surg unit, patients identifying as not having an advance directive are offered assistance to create one. The primary nurse prepares a POLST form, which is then given to the Hospitalist or placed at their workstation for completion at the next available opportunity.

    - At discharge, the completed POLST form is scanned into the patient's electronic medical record to ensure it is on file.

  - The discharge planner, or their designee, reviews each patient's advance directive status during their stay to ensure:

    - An advance directive order has been input into the EHR for every patient.

    - A POLST form has been initiated, if appropriate.

  - For patients whose advance directive paperwork is not immediately available but exists at another location (e.g., the patient's home), the discharge planner (or designee) coordinates with the patient's support person to bring a copy, preferably during the patient's stay.
  - Attempts to obtain copies of external advance directives are documented by the discharge planner in the patient's EHR, noting efforts to secure these documents during the patient's care on the Med/Surg unit.

- **Revocation of Advance Directives**
  - Patients may revoke their advance directive at any time, either orally or in writing. Staff document the revocation in the patient's record and notify the attending provider immediately.

- **Staff Training and Education**
  - All staff involved in patient care receive training on the Advance Directives policy, with an emphasis on respecting patient rights and ensuring accurate documentation in the EHR.

- **Non-Discrimination**
  - KVH staff ensure that the presence or absence of an advance directive does not influence the provision of care.

References:

Aging with Dignity: Five Wishes

Centers for Medicare & Medicaid Services: *Appendix W - Advance Directives*

National Alliance on Mental Illness: Mental Health Advance Directives

Washington State Department of Health: Advance Directives

RCW 70.122.030: *Advance directives — Hospital and other health care provider requirements*

WAC 246-320-141: *Patient Rights*

Washington State Medical Association: Physician Orders for Life-Sustaining Treatment (POLST)