ICU Advance Directive QI Project

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Housestaff Rounding Protocol

Prior to rounds:

- Review Advance Care Planning (ACP) flowsheet: yes/no for HCPOA and POLST
- Verify if any ACP documents are in the chart (either paper chart or "media" tab)

On rounds:

- Presenting resident will be expected to review ACP flowsheet with ICU attending, accurately report if patients have HCPOA and/or POLST
    - If patient reports to have HCPOA or POLST, resident will be expected to report where the documents exist in the chart (Media tab? Paper chart?)
- At bedside rounds: team to recommend to any appropriate patient that they complete HCPOA and/or POLST (see FAQ section below for more details)
- Resident will be assigned to complete HCPOA/POLST during or immediately after rounds

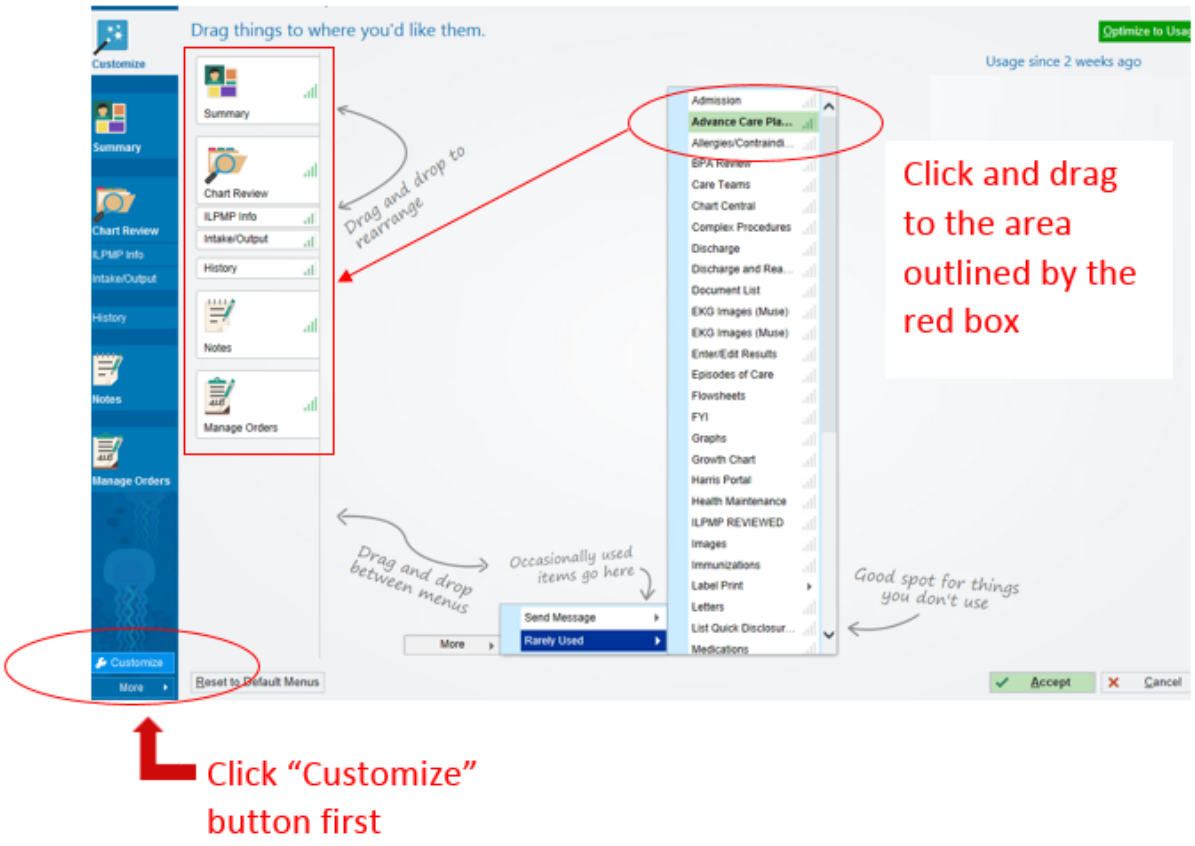
After rounds:

- Assigned resident to complete ACP document at bedside
    - For witness signatures, make RN aware prior to speaking with patient and **please be respectful to nursing workflow**
- For all newly completed ACP documents
    - Resident to complete associated ACP note utilizing Epic Smartphrase
        - .ICUHCPOA and/or .ICUPOLST
        - If a patient completes both, please write 2 separate notes
    - Resident to leave copy in paper chart and give original + 1 copy to patient
- For patients that declined to complete directives OR lack capacity to do so: declare as a note in flowsheet under "AD comments" (see FAQ section for more details)

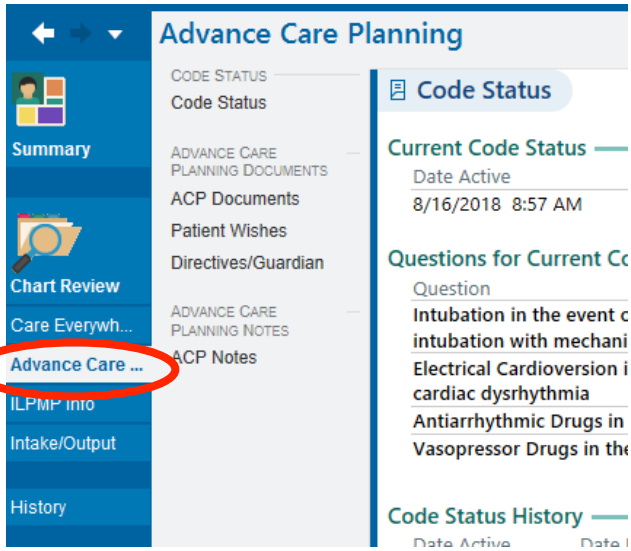
FAQs

1. How do I get the ACP tab?
2. Where is the ACP flowsheet?
3. Who are the “appropriate” patients to discuss HCPOA and/or POLST?
4. Who can determine whether a patient has decision making capacity to complete a HCPOA or a POLST?
5. How do I indicate when a patient declined to do HCPOA or POLST (or lacked capacity)?
6. Who can serve as a “witness” for HCPOA/POLST?
7. Who can serve as an “authorized provider” for a POLST?

1. **How do I get the Advance Care Planning (ACP) tab?**
    - In Epic, click “Customize” button on left hand navigational bar
    - A list of unused tabs will appear; click and drag “Advance Care Planning” to the left of the “customize” area
    - Click accept



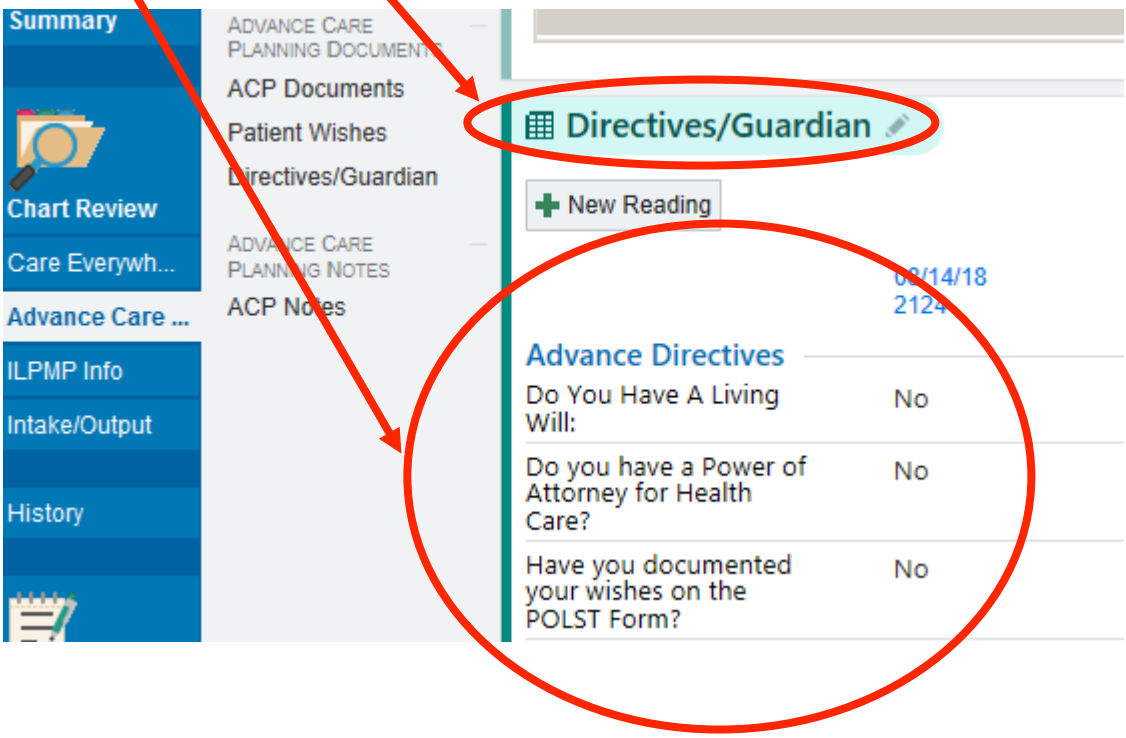
2. Where is the “ACP flowsheet”?



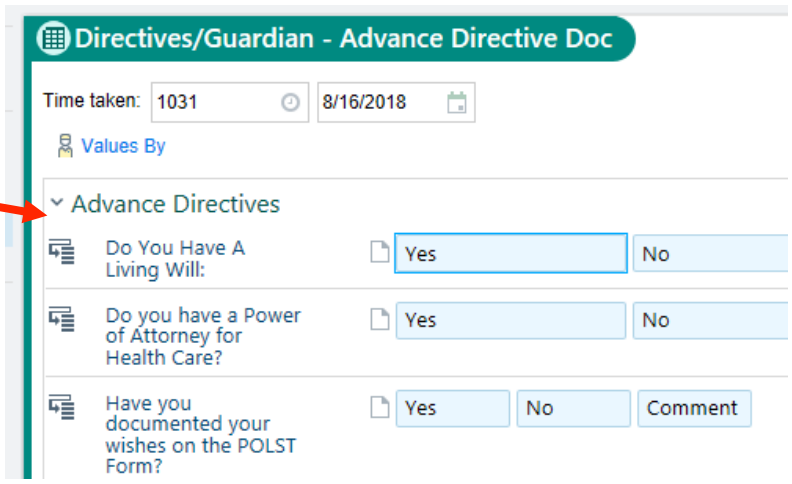
Click the ACP tab

Scroll (without clicking anything!) to here

This is the info you need! Use the most recent entry



If you see this screen instead, scroll down until you see the “X Cancel” button and click it!



3. **Who are the "appropriate" patients to discuss HCPOA and/or POLST?**
    - Generally, any person 18 years or older should have a healthcare power of attorney (HCPOA)
    - Only a patient can complete a HCPOA document for themselves
        - Must have decisional capacity to name a proxy decision maker!
            - Some patients may acutely lack capacity to name a HCPOA (eg pneumonia with encephalopathy) or may chronically lack capacity to do so (patient with anoxic brain injury who is non-communicative)
        - If a non-decisional patient needs a decision maker acutely to advance a medical plan, then a surrogate decision maker must be found

    - A POLST document is primarily helpful for patients who wish to set limits on escalation of care and/or avoid particular aggressive interventions such as intubation or placement of a feeding tube
    - That is, the "appropriate" patient to complete a POLST is someone who at least already has a code status of "no CPR"
        - *Note: The POLST has an option for "Full Code", but we advise against using a POLST for "Full Code" patients as this is the default option in our healthcare system. More importantly, a "full code" POLST may be misread as a "DNR" form by healthcare providers – which could be disastrous!*
    - A patient OR their proxy decision maker (or surrogate, or guardian) can complete a POLST form
        - A decisional patient always has priority, unless they already have a guardian

>>> The intent of this project is NOT to encourage patients to change code status beyond the normal scope of your work. The intent is to provide patients WHO ALREADY HAVE A "NO CPR" CODE STATUS with the appropriate documentation of their wishes <<<

4. **Who can determine whether a patient has decision making capacity to complete a HCPOA or a POLST?**

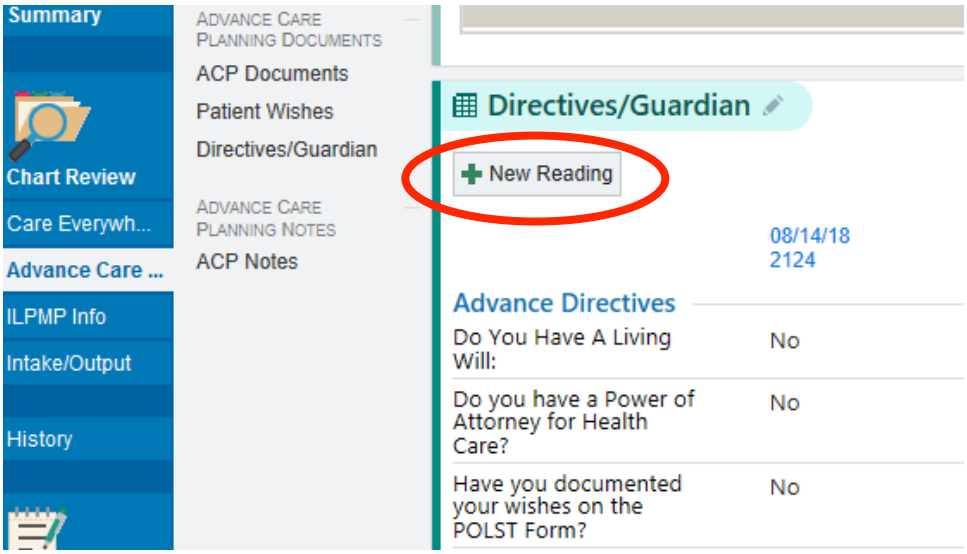
    - Any physician can determine whether a patient has the capacity to make their own medical decisions
        - *A psychiatry consult is **NOT** required to evaluate capacity*

    - Note that decision making capacity is not a binary "you have it or you don't" state of being, but rather dependent on the particulars of the decision to be made
        - In order words, saying "This patient is not decisional" is NOT clinically meaningful. Instead, one should say "This patient lacks the capacity to [fill in the blank, examples below]"
            - "Discuss risks and benefits of appendectomy"
            - "Name a proxy decision maker"
            - "Independently plan their discharge from the hospital"

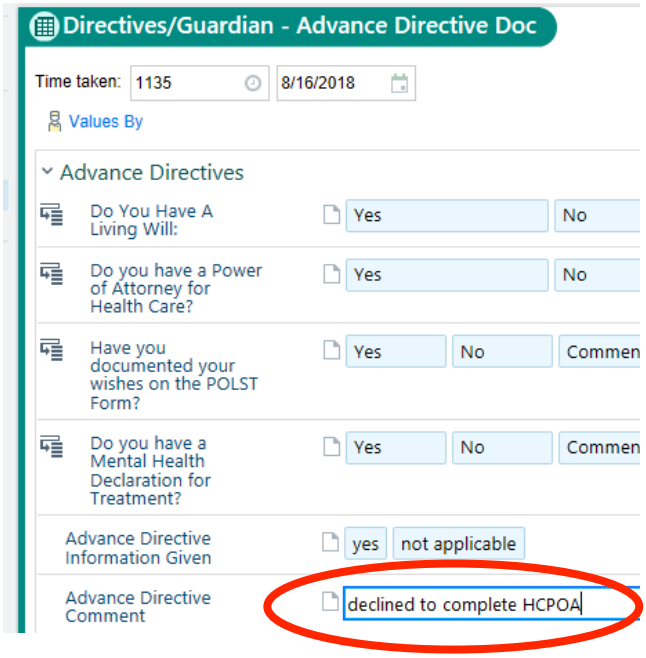
    - To determine whether your patient has capacity to make a particular decision, ask yourself (and your patient!) the following questions:
        - "Can you share in your own words the decision that needs to be made?"
        - "Can you share in your own words why this decision needs to be made?"
        - "How are you thinking about this decision?"
        - "Based on what we've discussed, what is your decision?"

5. How do I indicate when a patient declined to do HCPOA or POLST (or lacked capacity)?

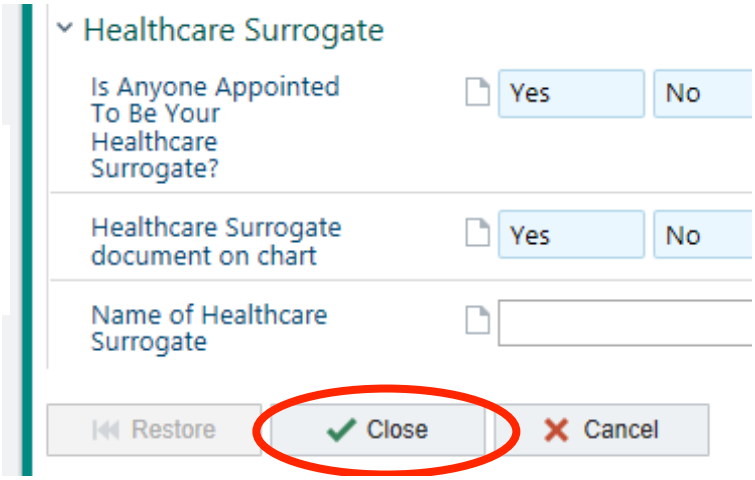
Go to ACP tab, scroll to "Directives/Guardian", and click "+ New Reading"



In the "Advance Directive Comment" field, type "declined to complete HCPOA" (or POLST)



Click "✓Close" to complete flowsheet entry



6. **Who can serve as a "witness" for HCPOA/POLST?**
    - The following people CAN sign as a witness:
        - RN
        - SW
        - Chaplain
        - Volunteer
        - Patient's friend

    - The following people CANNOT sign as a witness:
        - MD
        - NP
        - PA
        - CEO/CMO of hospital
        - The designated HCPOA
        - The designated secondary HCPOA
        - Any relative of the patient

    - **Bottom line**: You, the resident, **cannot** sign as a witness on the HCPOA or POLST documents! (The nurse or the social worker can, however)

Appendix A: Advance Care Planning Template Examples

Note: Templates created in Epic EMR and have been modified from their original appearance for demonstration purposes only

Healthcare Power of Attorney Completion Note

Met with patient at bedside to discuss appointing a healthcare power of attorney.

[Patient name] is agreeable to naming a proxy agent (select one):

- ☐ to assist in medical decision making in the event they are unable to make their own decisions
- ☐ to start making medical decisions on their behalf starting now

Patient names the following person as their proxy agent:

Name: [HCPOA name]
Phone number: [HCPOA number]

Secondary decision maker (if applicable): [Secondary HCPOA name]
Phone number: [Secondary HCPOA number]

Also discussed patient's option to select a statement that best reflects their healthcare wishes. Patient selected the following option (select one):

- ☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relive me of pain
- ☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of procedures, or how unlikely my chances of recovery are. I want my life prolonged to the greatest extent possible in accordance with reasonable medical standards.
- ☐ Patient declined to complete this section

The above discussion was witnessed by: [Witness name]

[Provider signature]

POLST Completion Note

Met with [Patient name] at bedside to discuss documentation of care preferences via a Practitioner Order for Life-Sustaining Treatment (POLST).

Reviewed POLST document; the following treatment preferences were selected:

Section A (Select only one):

- ☐ Do Not Attempt Resuscitation (DNR)
- ☐ Attempt Resuscitation / CPR (Full Treatment must be selected in Section B)

Section B (Select only one):

- ☐ Full Treatment: use intubation, mechanical ventilation, cardioversion as indicated
- ☐ Selective Treatment: use medical treatment, IV fluids and IV medications as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP)
- ☐ Comfort-Focused Treatment: Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with treatment goal
- ☐ Patient declined to complete this section

Section C (Select only one):

- ☐ Long-term medically administered nutrition, including feeding tubes
- ☐ Trial period of medically administered nutrition, including feeding tubes
- ☐ No medically administered means of nutrition, including feeding tubes
- ☐ Patient declined to complete this section

The above was discussed with:

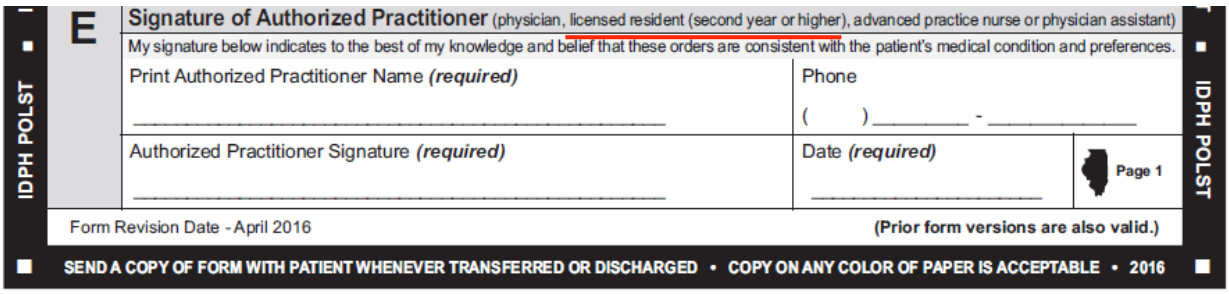
- ☐ Patient
- ☐ Agent under health care power or attorney
- ☐ Health care surrogate decision maker
- ☐ Parent of minor

Discussion witnessed by: [Witness name]

Authorized Practitioner: [Practitioner name]

7. Who can serve as an "authorized provider" for a POLST?

- Generally, an authorized provider is anyone with prescribing capabilities
- Any PGY2 or higher level resident can sign as the "Authorized Practitioner" for a POLST (if you are on the ICU rotation, that probably means you!)



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Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name ***(required)***

_____

Phone

( )_____ - _____

Authorized Practitioner Signature ***(required)***

_____

Date ***(required)***

_____

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Form Revision Date - April 2016

(Prior form versions are also valid.)

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