TITLE: **END OF LIFE CARE DECISIONS**

PURPOSE: To define the process to support decision-making and provide for end of life care for patients with a terminal or an irreversible condition.

POLICY STATEMENTS:

The Harris County Hospital District (HCHD) supports patients, their families, and other patient surrogate decision makers in making choices about changing, limiting, declining, or discontinuing life-sustaining treatment(s).

The HCHD recognizes the authority of a duly executed Advance Directive, or a duly authorized surrogate decision maker to make health care decisions on behalf of a patient who is incompetent or otherwise unable to communicate.

Patients, who are diagnosed with a terminal condition, or irreversible condition, shall have an individualized End of Life Care Plan. All healthcare workers along with the patient, their family, and other persons designated by the patient, will be involved in the development of the patient's End of Life Care Plan.

POLICY ELABORATION(S):

I. DEFINITIONS:

A. **ADVANCE DIRECTIVE:** An appropriately witnessed document or statement that expresses a patient's wishes with regard to care when he or she is no longer able to communicate with care providers. The Texas Advance Directives Act recognizes the following three distinct types of Advance Directives:

1. *Medical Power of Attorney:* A document that designates an adult as an agent to make health care decisions for a patient in the event the patient is physically or mentally unable to communicate. In general, subject to limitations contained in the document and the statute, the agent is authorized to make any health care decision on the patient's behalf that the patient could have made, if competent. An agent under a Medical

Power of Attorney may not consent to:

a. Voluntary inpatient mental health services;
b. Convulsive treatment;
c. Psychosurgery;
d. Abortion; or
e. Neglect of the patient through omission of care primarily intended to provide for the comfort of the patient.

2. *Directive to Physicians (Directive):* An instruction to administer, withhold, or withdraw life-sustaining treatment in the event of a terminal or irreversible condition.

3. *Out-Of-Hospital Do Not Resuscitate (OOHDNR) Order:* A document, in the form specified by the State, prepared and signed by the Attending physician of a patient that documents the instructions of the patient or the patient's legally authorized representative and directs health care professionals acting in an out-of-hospital setting not to initiate or continue the following life-sustaining treatment:

a. Cardiopulmonary resuscitation;
b. Advanced airway management;
c. Artificial ventilation;
d. Defibrillation;
e. Transcutaneous cardiac pacing; and
f. Other life-sustaining treatment specified by the State.

This does not include authorization to withhold medical interventions or therapies considered necessary to provide comfort care, to alleviate pain, or to provide water or nutrition.

B. **ADULT:** A person eighteen (18) years of age or older or a person under eighteen (18) years of age who has had the disabilities of minority removed.

C. **AGENT:** An adult to whom authority to make health care decisions is delegated under a Medical Power of Attorney.

D. **ALLOW NATURAL DEATH:** Terminology used to replace "Do Not Resuscitate" as a part of a physician's order set to describe a means of treatment that does not interfere with the natural dying process while providing care directed at keeping the patient as comfortable as possible, while in the hospital. This terminology indicates an order to withhold provision of resuscitation to individuals for whom resuscitation would otherwise be warranted.

E. **COMPETENT:** Possessing the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to a proposed treatment decision.

F. **GOAL OF CARE:** Determination of the patient's end of life wishes which include, but are not limited to, the use of feeding tubes; methods of resuscitation or to be resuscitated at all; which may include palliative care referral.

G. **INCOMPETENT/INCAPACITATED:** Lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to a proposed treatment decision.

H. **INTUBATION ONLY (NO CPR) ORDER:** Terminology used when selecting a physician's order during a hospital visit that describes a limitation in the provision of resuscitation to individuals for whom resuscitation is warranted.

I. **IRREVERSIBLE CONDITION:** A condition, injury or illness that:

1. May be treated but is never cured or eliminated;
2. Leaves a person unable to care for or make decisions for his or her own self; and;
3. Without life-sustaining treatment provided in accordance with the prevailing standard of medical care is fatal.

J. **LIFE–SUSTAINING TREATMENT:** Treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as, mechanical breathing machines; kidney dialysis treatment; and artificial nutrition and hydration. The term does not include the administration of pain

management medication or the performance of a medical procedure considered necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

K. **OUT-OF-HOSPITAL SETTING:** A location where health care professionals are called for assistance, including long-term care facilities; in-patient hospice facilities; private homes; hospital outpatient clinics or emergency departments; physician's offices; and vehicles used during transport.

L. **PALLIATIVE CARE:** An approach that improves the quality of life for patients and their families facing the problems associated with a terminal or an irreversible condition, through the prevention and relief of suffering by means of early identification and goal-setting with the patients and families. Palliative care supports a medical treatment plan for pain and other issues, such as, physical, psychosocial, spiritual and bereavement, along with coordination of other identified medical and social support.

M. **LICENSED INDEPENDENT PRACTITIONER:** Any individual permitted by law and by the HCHD to provide care and services, without relevant direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

N. **QUALIFIED PATIENT:** A patient with a terminal or irreversible condition that has been diagnosed and certified in writing by the Attending physician.

O. **SUPPORTIVE CARE:** Medical care and comfort measures meant to improve the quality of life of patients who have a terminal or an irreversible condition with the goal to prevent or treat, as early as possible, the symptoms; side effects caused by a treatment; and psychological, social and spiritual problems related to a terminal or irreversible condition. This may include decisions related to withdrawing or withholding of life-sustaining treatment to protect and promote the goals of care important to the patient's dignity and comfort.

P. **TERMINAL CONDITION:** An incurable condition caused by injury, disease, or illness that, according to reasonable medical judgment, will produce death within six (6) months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

II. PROVIDING CARE TO THE PATIENT:

A. The medical record of a hospitalized patient's defaults to "Inactive Status" or "Prior" as a code determination until a new order is entered for code determination by a physician. Without a new order, the term "Inactive Status or Prior" will mean the patient will be provided full code resuscitation, should it be warranted.

B. A physician's order is required with each hospitalization or to update the patient's code determination. As a part of review of the patient's medical history, any previous code determinations ordered from previous HCHD hospitalizations is stored in the Code Status History section of the patient's medical record.

C. Consideration of end of life decisions and care shall be part of the patient's Interdisciplinary Plan of Care.

D. The physician, when possible, in collaboration with the interdisciplinary team, will develop the goals of care through the discussion of the medical assessment, end of life issues, and medical services with the patient and family. The patient's resuscitation status is documented in the medical record, along with any comfort or limitation orders and serves as ordered related to resuscitation, as determined by the patient's Attending physician.

E. A physician or nurse may make referrals to the palliative care team; social worker case manager; pastoral care team; respiratory care; dietitian; and other team members as appropriate to facilitate discussions with the patient, family, or others involved in the care and treatment decisions of a hospitalized patient in accordance with the patient's wishes.

F. Palliative care and other end of life planning should be based on discussions with the patient regarding his or her condition and communication of his or her wishes. If the patient is not able to communicate his or her wishes, the interdisciplinary team will speak to the patient's family or surrogate decision maker to determine what the patient's wishes were, (if expressed), prior to the terminal or end-stage condition.

G. The palliative care team, when consulted, or other members of the interdisciplinary care team shall educate the patient and their family on end of life concerns, including the availability of community resources.

III. WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING TREATMENT:

A. *COMPETENT ADULT PATIENT*: A competent adult patient is the ultimate judge of the benefits and burdens of life-sustaining treatments. If a competent adult patient chooses to forgo life-sustaining treatment, that decision must be honored. The physician shall discuss the decision with the patient to ensure that the patient has not decided to forgo life-sustaining treatment in order to obtain relief from pain or suffering that can be alleviated without forgoing life-sustaining treatment.

B. *ADULT PATIENT WHO HAS EXECUTED OR ISSUED A DIRECTIVE:* If an adult, qualified patient has executed or issued a Directive and is unconscious, incompetent, or otherwise mentally or physically incapable of communication, the Directive shall be complied with unless the physician believes the Directive does not reflect the patient's present desire or what is stated in the Directive is medically inappropriate. If the physician believes the wishes expressed in the patient's Directive are medically inappropriate or does not reflect the patient's present desire, the case should be referred to the pavilion Ethics Committee.

C. *ADULT PATIENT WITHOUT A DIRECTIVE:* The fact that an adult qualified patient has not executed or issued a Directive does not create a presumption that the patient does not want a treatment decision to be made to withhold or withdraw life-sustaining treatment. If an adult patient has not issued or executed a Directive and is unconscious, incompetent, or otherwise mentally or physically incapable of communication, the Attending physician and the patient's legal guardian or agent under a Medical Power of Attorney may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the patient, provided that the agent under the Medical Power of Attorney has been given the authority to make such decisions.

A treatment decision must be based on knowledge of what the patient would desire, if known.

Treatment may not be given to or withheld from a patient if the patient objects regardless of whether, at the time of the objection a Medical Power of Attorney is in effect or the patient is competent.

D. *ADULT PATIENT WITHOUT A DIRECTIVE WHO HAS NO MEDICAL POWER OF ATTORNEY AND DOES NOT HAVE A LEGAL GUARDIAN:*

If an adult, qualified patient has not executed or issued a Directive and is incompetent or otherwise mentally or physically incapable of communication and does not have a legal guardian or an agent under a Medial Power of Attorney, the Attending physician and a least one person, if available, from one of the following categories, and in the following order of priority, may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the patient:

1. Patient's spouse;
2. Patient's reasonably available adult children;
3. Patient's parents; or
4. Patient's nearest living relative;

A treatment decision made under this section must be based on knowledge of what the patient would desire, if known.

A treatment decision made under this section must be documented in the patient's medical record and signed by the Attending physician.

A family member who wishes to challenge a treatment decision made by the individual authorized to make such decisions must apply for temporary guardianship under the Texas Probate Code.

E. *ADULT PATIENT WITHOUT FAMILY MEMBERS:* If an adult, qualified patient who has not executed or issued a Directive is incompetent or otherwise mentally or physically incapable of communication and does not have a legal guardian or an agent under a Medical Power of Attorney or a family member available, the Attending physician with the concurrence of another consulting, Attending physician who is a member of the pavilion Ethics Committee may make treatment decisions that may include a decision to withhold or withdraw life-sustaining treatment. If assistance is needed, an Ethics Committee consultation

may be warranted.

F. *MINOR PATIENT:*

The following persons may execute a directive on behalf of a qualified patient who is younger than eighteen (18) years of age:

1. The patient's spouse, if the spouse is an adult;
2. The patient's parents; or,
3. The patient's legal guardian.

G. *PERIOPERATIVE OR INVASIVE PROCEDURE PREPARATION OF A PATIENT WHO HAS AN ALLOW NATURAL DEATH (DNR) ORDER:*

A consultation will occur, prior to an invasive procedure or anesthetic care, between the patient's primary physician; the surgeon or the anesthesiologist, as applicable; and the patient or the patient's authorized surrogate decision maker to discuss the appropriate use of therapeutic modalities to correct deviations of hemodynamic and respiratory variables predictably resulting from complications of the procedure or the anesthesia. Relevant aspects of this discussion are entered into the patient's medical record together with any exceptions to the Allow Natural Death Order. After the time period of the exception has expired, the original Allow Natural Death Order may be resumed by re-entry of the order into the medical record.

H. *OOHDNR FORM*:

The patient's end of life planning needs to be considered when:

1. A completed OOHDNR form, when presented in the following settings, will be honored:

    a. Emergency Center;
    b. Ambulatory Care Clinic; and
    c. Community Health Program (Center).

    The OOHDNR form applies only to cardiopulmonary resuscitation, advanced airway management, artificial ventilation, defibrillation,

transcutaneous cardiac pacing, and other life-sustaining treatments specified by the State. All other appropriate medical treatments should be provided.

2. A patient who is hospitalized and has a completed OOHDNR form may retain the OOHDNR status during their stay, unless it is no longer medically appropriate for the patient to have the OOHDNR status or the OOHDNR form has been revoked.

3. Patients with a completed OOHDNR form who are hospitalized will have this form scanned into the documents section of their medical record and an appropriate code determination ordered by the physician following discussions with the patient and their family. The code determination order should include a notation of the patient's OOHDNR status at the time of previous discharge.

4. The desires of a competent patient, including a competent patient younger than eighteen (18) years of age, supersede the effect of an OOHDNR order executed or issued by or on behalf of the patient when the desire is communicated to responding health care professionals. An OOHDNR may be revoked at any time without regard to the patient's mental state or competency.

5. An OOHDNR form may be provided to patients who have an "Allow Natural Death or Intubation Only, No CPR" status while hospitalized and who would like to continue this status following discharge.

6. Documentation in the patient's medical record must include the following:

   a. Confirmation that an OOHDNR form was presented and what format was accepted;
   b. Assessment of patient's condition;
   c. Name of the patient's Attending physician;
   d. Name, address and phone number of witnesses, if any, present during discussions; and
   e. Documented authority related to a surrogate decision-maker who presents with an OOHDNR form on the patient's behalf.

I. *PREGNANT PATIENT*: Sections 166.049 and 166.098 of the Texas Health and Safety Code (Subchapters B and C of Chapter 166, Advance Directives Act), provide that a person may not withdraw or withhold life-sustaining treatment from pregnant persons. In cases involving supportive care treatment for a pregnant patient with a terminal or irreversible condition, the case should be referred for a pavilion Ethics Committee consultation.

IV. GENERAL INFORMATION FOR ALL CASES REGARDING END OF LIFE CARE:

A. If a Directive was executed prior to September 1, 1999, two (2) physicians, one (1) of whom must be the Attending physician, must diagnose and certify in the patient's medical record that the patient has a terminal condition before the Directive may be invoked. For Directives issued after that date; the Attending physician's certification is sufficient.

B. Prior to honoring a patient's Directive or the request of an authorized surrogate decision maker to withhold or withdraw life-sustaining treatment from a patient with a terminal or irreversible condition, the Attending physician shall:

1. Document in the patient's medical record that the patient has a terminal or irreversible condition to include the name of the condition;
2. Evaluate the patient's competence or the capacity of the patient to make treatment decisions and document his or her findings in the patient's medical record;
3. Explain the patient's condition, prognosis, and the effect of various treatment decisions to the competent patient or the authorized surrogate decision-maker of an incompetent patient;
4. Make the patient or the patient's legal representative aware that an Advance Directive can be initiated when a competent, qualified patient or the patient's legal representative has indicated a desire to request or refuse life-sustaining treatment. Such a Directive will not be required as a condition for the provision of healthcare services; and
5. Document in the patient's medical record:

    a. Scanned documents relevant to aspects of these discussions and the outcome;
    b. Assessment of patient's condition;

c. Name of the patient's Attending physician;
d. Name, address and phone number of witnesses, if any present during these discussions;
e. The name and documents provided by the surrogate decision maker that validates the authority of a surrogate decision maker(s) to represent the patient on healthcare decisions.

D. Orders to withhold Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS) to individuals for whom resuscitation is warranted requires by physician order to Allow Natural Death or Intubation only, no Cardiopulmonary Resuscitation (CPR). The order is entered in the patient's medical record during the patient's hospitalization by the physician. If the physician is a resident or fellow, a co-authorization by the Attending physician is required within twenty-four (24) hours. Orders for Allow Natural Death or Intubation only, no Cardiopulmonary Resuscitation (CPR) must be accompanied by a note in the patient's medical record explaining the decision/rationale, along with any patient's and family input.

E. A Code Determination Order shall remain in effect for the duration of the patient's hospitalization, unless replaced with a new physician's order regarding code determination.

F. An order for "Allow Natural Death or Intubation only, no CPR" shall include any discussions and decisions regarding limitations or special measures such as dialysis, enteral feedings, electrical cardioversion, cardiac pacemaker, hyperalimentation, or other care decisions. These comfort measures can be addressed using the Palliative Care/Comfort Care Order Set or individually ordered in the patient's medical record.

G. With each patient's hospitalization, the Code Status History of the patient shall be viewed. Orders related to hospital resuscitation shall be reviewed and up-dated with each encounter and adjusted as appropriate to the patient's condition during their hospitalization.

V. CONFLICTS OR CONTROVERSIES:

In the event of controversy or conflict over the appropriate use of supportive care for the patient, the physicians, staff, patient, and his or her family may seek consultation with the pavilion Ethics Committee.

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HCHD Policy and Procedure 7.04: Pain Management

HCHD Policy and Procedure 7.06: Discharge Planning

HCHD Policy and Procedure 3465: Staff Request for Non Participation in Patient Care

HCHD Policy and Procedure 4128: Advanced Directive

HCHD Nursing Policy and Procedure 468: Interdisciplinary Plan of Care

HCHD Policy and Procedure 4310: Ethics Advisory Committee

HCHD Policy and Procedure 4315: Surrogate Decision-Maker

HCHD Policy and Procedure 4500: Organ/Tissue Donation

OFFICE OF PRIMARY RESPONSIBILITY:

HCHD Department of Nursing Services.

REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Review or Approved by: (If Board of Managers Approved, include Board Motion #)
12/01/2003	1.0	Approved 12/02/3003	HCHD Board Of Managers (Board Motion Number 0.310-461)
		Reviewed/Approved 12/06/2006	Chief Operating Officer
	2.0	Revised/Reviewed for EMR 07/01/2010	HCHD Clinical Case Management
		Approved 07/08/2010	District Nursing Policy and Procedures Committee
		Approved 07/15/2010	Nursing Executive Council
		Approved 08/10/2010	HCHD Interdisciplinary Clinical Committee
	3.0	Revised/Reviewed: 12/02/2010	Clinical Case Management, Senior Leadership
		Reviewed: 12/08/2010	HCHD, Critical Care Committee
		Reviewed: 02/10/2011	HCHD, Nursing Policy& Procedure Committee
		Reviewed: 08/24/2011	County Attorney's Office
		Reviewed: 08/24/2011	University of Texas, Legal Department
		Reviewed: 09/09/2011	County Attorney's Office
		Approved: 10/13/2011	District Nursing Policy and Procedures Committee
		Approved: 10/19/2011	Nursing Executive Committee
		Reviewed: 10/28/2011	CHP Medical Executive
		Approved: 11/01/2011	BTGH Medical Executive
		Approved: 11/03/2011	LBJ Medical Executive
		Approved: 11/09/2011	Interdisciplinary Clinical Committee
		Approved: 11/09/2011	Medical Executive Committee