Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	SUPPORTING END-OF-LIFE DECISIONS FOR CLIENTS RECEIVING COMMUNITY RESIDENTIAL SERVICES	6.09

Authority:	Chapter 70.112 RCW	*Natural Death Act*
	Title 71A RCW	*Developmental Disabilities*
	Chapter 388-101 WAC	*Certified Community Residential Services and Supports*
	Chapter 388-101D WAC	*Requirements for Providers of Residential Supports*
	Chapter 388-825 WAC	*Developmental Disabilities Services*

References: WSMA Portable Orders for Life-Sustaining Treatment

PURPOSE

This policy establishes a process for reviewing Portable Order for Life-Sustaining Treatment (POLST) documents so a provider may support a client's end-of-life decisions.

SCOPE

This policy applies to Developmental Disabilities Administration (DDA) staff and providers who support clients in the following programs:

- Companion homes
- Group homes
- Group training homes
- Staffed residential homes
- Group care facilities for medically fragile children
- Child foster homes
- State-operated living alternatives
- Supported living

DEFINITIONS

Cardiopulmonary resuscitation or CPR means the process of keeping the heart pumping and the blood oxygenated through external means, including chest compressions, electric shock, and artificial breathing.

DNR means "do not resuscitate," and is often noted as "DNAR," "do not attempt resuscitation," or "no CPR."

Healthcare professional means, for the purposes of this policy, a physician, advanced registered nurse practitioner (ARNP), or physician assistant-certified (PA-C).

Hospice or hospice care means items and services provided to a terminally ill person, generally in the person's place of residence, by or under the direction of a hospice agency. Hospice care is a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient, the patient's family, or both.

Incurable or irreversible condition means an illness or disease that, based on reasonable medical judgment, will eventually cause death or for which the application of CPR, intubation, or other life-sustaining measures will only prolong the process of dying or will create a greater risk of death than the condition itself.

Legal representative means a parent of a client if the client is under age eighteen, a court-appointed guardian, if a decision is within the scope of the guardianship order, or, for the purpose of this policy, any other person authorized by law to act for the client.

Life-sustaining treatment means interventions such as CPR, intubation for ventilation, and other medical care that may be limited under a POLST.

Portable orders for life-sustaining treatment or POLST means portable medical orders summarizing the advance directives of a person with a serious illness or frailty regarding life-sustaining treatment.

POLICY

A. Unless limited by the client's POLST, if a client stops breathing or the client's heartbeat stops, the provider must:

1. Deliver CPR and first aid; and
2. Seek other life-sustaining treatment.

B. If a client, or the client's legal representative, wishes to limit life-sustaining treatment, the provider must support the client, and their legal representative if applicable, to work with the healthcare professional to develop a POLST.

C. If the provider is aware and in possession of a POLST that is current, the provider must follow the POLST and inform others under Procedures Section (A)(3) that the POLST exists.

D. A completed POLST is valid until the provider is notified in writing that the POLST is rescinded by the client or the client's legal representative.

PROCEDURES

A. If the provider is aware and in possession of a client's POLST, the provider must:

1. Verify the POLST form is signed by the client, or the client's legal representative if applicable, and the healthcare professional;

2. Instruct staff on how to implement the POLST;

3. Share the POLST form with and ensure the POLST form is readily available to:

   a. The Registered Nurse Delegator, if applicable;
   b. Hospice, if applicable;
   c. First responders;
   d. Medical providers; and
   e. Any other individuals or agencies the client chooses;

4. Record that the client has a POLST in the client's risk assessment section of the Individual Instruction and Support Plan; and

5. Provide a copy of the signed POLST form to the client's DDA case manager.

B. The case manager must:

1. Verify the POLST form is signed by the client, or the client's legal representative if applicable, and the healthcare professional;

2. Record in CARE that the client has a POLST in the medical section of the Support Level Assessment (SLA), or Support Assessment for a client under age 16, pertinent history via an interim assessment by the next working day following receipt of the signed POLST;

3. At the annual assessment, review the client's person-centered service plan to ensure the POLST information is accurate;

4. Include the POLST form in the client's residential services referral packet or application for respite services or admission to a residential habilitation center; and

5. Determine if further action is needed.

    a. No further action is required by DDA if the POLST is for a client who is:

        i. Receiving hospice care;

        ii. Diagnosed with an incurable or irreversible condition that will cause death;

        iii. Diagnosed with a condition where life sustaining treatment will cause more harm than good; or

        iv. Designated on the POLST form to receive all life-sustaining treatment.

    b. For all other POLSTs, the case manager must process the POLST as follows:

        i. Select "POLST acknowledgement" in CARE on the Prior Approval screen; and

        ii. Submit the acknowledgement to the Field Service Administrator no more than three working days after receiving the POLST.

C. The field service administrator or designee submits the acknowledgment to the appropriate program manager (DDA community residential program manager, SOLA program manager, or DDA children's residential services program manager) to determine whether additional follow-up is required.

1. If no additional follow-up is required, the program manager finalizes the acknowledgment.

2. If additional follow-up is required, the program manager facilitates a team meeting. The team meeting must include the client's case manager and may also include the case manager's supervisor, the senior medical director, the office chief for the office of residential, employment, and day programs, and others as

needed. The program manager then determines whether the acknowledgement is forwarded to the office chief or designee for review.

D. The region must notify the provider if DDA recommends additional follow-up before the acknowledgement is finalized.

EXCEPTION

Any exception to this policy must have the prior written approval of the deputy assistant secretary or designee.

SUPERSESSION

DDA Policy 6.09, *Supporting End-of-Life Decisions for Clients Receiving Residential Services* Issued July 1, 2021

Approved: _____ Date: July 1, 2023

Deputy Assistant Secretary
Developmental Disabilities Administration