Advance Care Planning Protocol

Purpose

To ensure that the clinical care of individuals in long term care is consistent with each person's preferences and values, particularly when he/she is unable to participate in the decision-making process.

ACP Documents & Decisions

Medical Power of Attorney
Directive to Physicians and Family or Surrogates
Out-of-Hospital Do-Not-Resuscitate
Cardiopulmonary Resuscitation Wishes
Artificial Respiration Wishes Artificial Nutrition and Hydration Wishes
Palliative Care Wishes

Protocol

Provide the individual or his/her representative with a copy of:

(1) The HHSC Advance Care Planning educational material, "Frequently Asked Questions about Advance Care Planning"
(2) The individual's rights under Texas law to make decisions concerning medical care and to formulate advance directives
(3) The facility policies respecting the implementation of advance directives

Provide the staff and community with education concerning advance directives. Provide the physician, emergency staff and hospital with information relating to the individual's known existing advance directives.

Orally review and discuss all the information listed above with IDT team. Document in the individual's clinical record the discussion and the provision of the written information. Review Advanced Care Planning decisions:

(1) Within fourteen days after admission
(2) Annually
(3) With a significant change in the person's medical condition

References

- HHSC Quality Monitoring Program, Advance Care Planning Focus Area
- Texas Administrative Code §554.419 (FOR CLARIFICATION ON REGULATIONS, CONTACT YOUR LTC REGULATION PROGRAM MANAGER OR NURSE LIAISON)
- HHSC Quality Monitoring Program website