

# 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 and 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 the HHSC Advance Care Planning educational material, "Frequently Asked Questions about Advance Care Planning", the individual's rights under Texas law to make decisions concerning medical care and to formulate advance directives, and 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.
- Document in the individual's clinical record the oral discussion and the provision of the written information.
- Review within fourteen days after admission, annually, or with a significant change in the person's medical condition.

## References

- HHSC Quality Monitoring Program, Advance Care Planning Focus Area
- Texas Administrative Code §19.419 (FOR CLARIFICATION ON REGULATIONS, CONTACT YOUR PROGRAM MANAGER OR NURSE LIAISON)

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