

Advanced Directives – Aging with Dignity



Approaches based on “best practices”

- Developed by professionals in geriatrics and nursing home care
- Steps detailed in easy-to-use checklist
- Facility staff may use this information to assist residents in the implementation of Arkansas specific advanced directives

Brought to you by the Best Practices Process Indicators Workgroup representing these agencies and institutions:

- Arkansas Innovative Performance Program
- Arkansas Health Care Association
- Arkansas Office of Long Term Care



Working together to enhance quality of life in Arkansas nursing homes.

ACKNOWLEDGEMENTS

Arkansas Innovative Performance Program

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Advanced Directives Process Indicator (Aging With Dignity)

Advanced Directives are specific instructions to health care providers, prepared in advance of a specific circumstance or condition, that states the care or treatment a person will receive when the specific circumstance or condition occurs. An Advanced Directive may also name a person as having the authority to make medical decisions on behalf of the resident when the specific condition or circumstance occurs. That person is commonly called a surrogate.

Advanced Directives become effective only when the condition or circumstances stated in the Advanced Directive occur. The most common conditions or circumstances are when the resident has a terminal illness and is expected to die in a short time or the resident is permanently unconscious, and the resident is unable to make his or her own medical decisions in the opinion of the treating physician. However, note that the circumstance or condition stated in the Advanced Directive can be anything – the facility **MUST** read and understand the Advanced Directive to know what condition or circumstance causes the Advanced Directive to become effective. Until that condition or circumstance occurs, the Advanced Directive is not effective and is not followed.

When the Advanced Directive names another person to make decisions on behalf of the resident, the facility must follow the directions of that surrogate in a manner that is consistent with the authority given to the surrogate. Facilities must read and understand what decision-making authority the surrogate has under the Advanced Directive.

If a resident has a valid Advanced Directive, the facility's care must follow a resident's wishes as expressed in the Directive, in accordance with state law. However, the presence of an Advanced Directive does not absolve the facility from giving supportive and other pertinent care that is not prohibited by the Advanced Directive

Note: The presence of a “Do Not Resuscitate” (DNR) order does not indicate the resident is declining other appropriate treatment and services. It only indicates that the resident should not be resuscitated if respirations and/or cardiac function cease.

Revoking an Advanced Directive

An Advanced Directive can be revoked by the resident at any time and in any manner. It does not require a resident to sign a paper. A resident can revoke an Advanced Directive simply by saying so. For example, if the Advanced Directive states that the resident is to not have hydration or nutrition and the resident states that he or she wants liquids or food, the resident has revoked the Advanced Directive's instruction refusing hydration, nutrition, or both.

Resident Choice

In order for a resident to exercise his or her right appropriately to make informed choices about care and treatment or to refuse treatment, the facility and the resident (or the resident's legal representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. The facility is expected to address the resident's concerns and offer relevant alternatives, if the resident has refused specific treatments. (See Resident Rights at 42 CFR 483.10(b)(3) and (4), F154 and F155.)

Nursing facilities must notify all new residents of their right to execute an Advanced Directive. This will be accomplished by ensuring the staff has a complete and thorough understanding of the importance of an Advanced Directive. Advanced Directives clearly identify the extent of medical care that a resident wishes to receive if they are unable to speak for themselves. They include living wills, durable powers of attorney, do not resuscitate orders (DNRs) and appointments of health care surrogates. Upon a new resident's admission, a health care facility must provide written information on their policies concerning Advanced Directives. Documentation of any Advanced Directives must be included in the resident's medical record to be effective.

Advanced Directives can Reduce:

- Personal worry
- Futile, costly, specialized interventions that a resident does not want
- Overall health care costs
- Feelings of helplessness and guilt for family
- Legal concerns for everyone involved

Barriers to Completion of Advanced Directives

- Belief that physicians should initiate discussions
- Procrastination
- Apathy
- Belief that family should decide
- Family would be upset by the planning process
- Fear of burdening family members
- Discomfort with the topic
- Lack of understanding as to what an Advanced Directive is, when it is effective and when a facility should follow the requirements of an Advanced Directive, and the specific care or treatment to be offered when the Advanced Directive is effective

Fostering Advanced Directive Discussions

- Make it a routine
- Make it part of the preadmission/admission process
- Identify important values
- Address a limited number of issues
 - CPR
 - Artificial nutrition and hydration

- Pain relief through medication
- Complete documents
- Review/update documents regularly
- Consult with the facility attorney
- Utilize the resources of the Ombudsman

Lessons to Learn

- Dying is part of living
 - Need to approach it openly despite its difficulty
- Advanced Directives empower residents to reflect on their values, meaning of life, and illness experiences
- Advanced Directives help clarify residents' wishes relating to care planning
- Setting clear goals helps guide direction in the plan of care, avoids confusion and conflict.

Resident Rights and Advanced Directives

Federal law requires nursing homes and other institutions that receive Medicare or Medicaid funds to provide written information regarding Advanced Directives to all residents upon admissions.

Regulation requires that nursing facilities have in place systems or policies and procedures that ensure resident Advanced Directives regarding basic life support will be identified, known, and honored.

Facilities do not always understand the law and regulations as they relate to Advanced Directives and Power of Attorney for health care matters, or they do not apply what they know in a systematic manner. This should be a matter of concern to all health care facilities. Each nursing facility should review its policies and procedures relating to Advanced Directives and determine if changes are necessary to comply with State law and Federal Regulations. (This is an area to which our surveyors have been advised to pay particular attention.) In particular, facilities should consult with their attorneys to be sure that facilities understand when specific Advanced Directives become effective, what treatment or care is to be offered or denied, and to determine who will make decisions for a resident and what those decisions may be.

“ If medicine takes aim at death prevention, rather than at health and relief of suffering, if it regards every death as premature, as a failure of today’s medicine – but avoidable by tomorrow’s- then it is tacitly asserting that its true goal is bodily immortality.....Physicians should try to keep their eyes on the main business, restoring and correcting what can be corrected and restored, always acknowledging that death will and must come, that health is a mortal good, and that as embodied beings we are fragile beings that must stop sooner or later, medicine or no medicine.” (Kass LR. JAMA 1980; 244:1947)

Code Status Identification

The ease of identifying a resident's code status is an essential part of the care process. If a resident goes into arrest, it is critical that all staff act quickly to ensure that the resident's wishes are honored; therefore the code status **must** be clearly identified to all staff. Here is a list of Best Practices for Code Status Identification:

- Nursing facilities should have in place policies and procedures that govern the identification, documentation, and implementation of residents' advance directives. Staff **must** be knowledgeable about these policies and procedures.
- The policies and procedures **must** be communicated to prospective residents and their representatives prior to and upon admission to the facility.
- The receipt of the policy by residents and their representatives **must** be acknowledged in writing by the receiver and documented in the resident chart.
- Resident Advanced Directives will be identified on the day of admission. They should be communicated to direct care staff who are responsible for caring for the resident immediately upon admission. Delays in identifying the resident's resuscitative wishes are not acceptable and will almost certainly lead to a deficient practice at some point.
- Any changes in the resident's wishes will be communicated to staff.
- Each nursing facility will have in place a system of identifying resident resuscitative status. The system may include more than one method: e.g., list at the nurses' station, DNR written on chart, etc. However, the system must be consistent throughout the facility, and at least one identifier will be in the resident's room.
- The resuscitative status information will be reviewed frequently to ensure that it is up to date. If more than one identification method is used, the information must be reviewed frequently to ensure that the information from each method is consistent.
- The resident's resuscitation status information shall accompany the resident when the resident is transported from one location to another. If the resident has a Do Not Resuscitate (DNR) order, that order must accompany the resident when the resident leaves the facility **for any reason**.
- Staff with direct care responsibilities shall be aware of the location of the resident resuscitation status information in all areas of the facility.
- All facility staff, including non-direct care employees (e.g., temporary agency staff) shall be aware of what to do if they encounter a resident without vital signs.
- The facility will maintain a record of any staff who are trained and capable of providing CPR and able to demonstrate current competency.
- Each nursing facility will have at least one person with documented training who is capable of providing CPR, each shift, every day.

Code Status Identification Best Practice Check List

Assessment Data	YES	NO	N/A
1. Are systems in place on Advanced Directives?			
2. Is staff knowledgeable of the systems?			
3. Are Advanced Directives communicated to all newly admitted residents on day of admission?			
4. Is receipt of this information documented?			
5. Are all changes in resident's wishes communicated to staff?			
6. Are the Resident code status identifiers in place (two methods)?			
7. Are we frequently reviewing the code status identifier to ensure consistency?			
8. Is staff aware of location of code status identifiers?			
9. Is staff aware of what to do if they encounter a resident without vital signs?			
10. Is there a record of staff trained and capable of providing CPR in place?			
11. When scheduling staff, is at least one person per shift, every day, capable of providing CPR?			

Resources

www.caringinfo.com

www.arkbar.com

ADVANCE DIRECTIVE INFORMATION

NOTE: This Advance Directive Information and the form Living Will and Durable Power of Attorney for Health Care on the Arkansas Bar Association’s website are being provided to you as a public service and are not the substitute for the advice of an attorney. By providing this information and these forms, neither the Arkansas Bar Association nor its Health Law Section is providing legal advice to you. Consult an attorney if you need legal advice of any nature.

1. What are Advance Directives?

You have the right to make decisions about the care you want at the end of your life. If you are conscious and able to make your own decisions when the time comes, you will be able to decide and whether the doctor should withdraw treatment and when that should happen. It is when you do not have the ability to make or explain your own decisions that you need what is called an Advance Directive. An Advance Directive is a legal document in which you tell your choices for medical treatment or name someone to make medical decisions for you when you cannot. A “Living Will” is a type of Advance Directive. A “Durable Power of Attorney for Health Care” is another type of Advance Directive.

2. What is a Living Will?

A Living Will is a document which tells medical professionals and members of your family to what extent special means should or should not be used to keep your body alive if you are incurably ill or permanently unconscious. It allows you to tell others your health care choices in the event that you are unable to express your wishes.

3. Why Should I Have a Living Will?

A Living Will gives you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own wishes, your advance directive will not be used, and you can accept or refuse any medical treatment. But if you are unable to participate in decisions about your own treatment, a Living Will becomes important to ensure that your personal wishes are respected. Also, by preparing a Living Will, you can relieve those closest to you of the burden and stress of trying to guess what your wishes might be at a very emotional time.

4. When Does A Living Will Become Effective?

Your Living Will will become effective only when you are unable to make or communicate decisions about your care and are terminally ill with no hope of recovery or permanently unconscious.

5. Does A Living Will Mean I am Giving Up or Stopping Care?

No. Making a Living Will does not mean that you will be abandoned by your health care providers. A Living Will affects only measures which are deemed useless. Doctors and nurses will continue attending to your needs, and comfort care will continue.

6. How Do I Make a Living Will?

A Living Will must be in writing, signed by you or another person at your direction, and witnessed by two other adults. A form Living Will prepared by the Health Law Section of the Arkansas Bar Association is available on the Arkansas Bar Association’s website at

<http://www.arkbar.com>. You may also ask your attorney or health care provider for a form. It is a good idea to discuss your health care wishes with your loved ones and your physician before signing a Living Will.

7. What is a Durable Power of Attorney for Health Care?

By signing a Durable Power of Attorney for Health Care, you can choose another person as your representative to make health care decisions for you if you should become temporarily or permanently unable to make decisions. Your health care representative must make treatment decisions based on your known wishes. A Durable Power of Attorney for Health Care must be in writing, signed by you or another person at your direction, and witnessed by two other adults. A form Durable Power of Attorney for Health Care prepared by the Health Law Section of the Arkansas Bar Association is available on the Arkansas Bar Association's website at <http://www.arkbar.com>. You may also ask your attorney or health care provider for a form.

8. What Do I Do With My Living Will and Durable Power of Attorney for Health Care?

Keep the original documents in a safe and easily accessible place, and make an extra copy for yourself in case the original is lost or accidentally destroyed. It is important that your doctor and family members know about your Living Will and have a copy of it. Take your Living Will and Durable Power of Attorney for Health Care with you if you are admitted to the hospital.

9. What If I Change My Mind?

Your Living Will and/or Durable Power of Attorney for Health Care can be revoked at any time by telling your doctor and family members that your wishes have changed. You should tear up and throw away all copies of the document you have revoked.

10. What if I Choose Not To Have a Living Will and Have Not Signed A Durable Power Of Attorney For Health Care?

If you do not have a Living Will or a Durable Power of Attorney for Health Care, then decisions about your care may be made by a "surrogate decision-maker," such as certain relatives, a person appointed by a court, or a court itself. The surrogate decision-maker must make decisions based on what you would have wanted if you were able to express your decisions, but if you have not made your wishes known, then the surrogate decision-maker, together with your physician, will make treatment decisions for you based upon their opinions as to your best interest.

You are strongly encouraged to discuss your advanced directive options and decisions with your physician and family.

Living Will And Durable Power of Attorney for Health Care

**Provided as a public service by
the Health Law Section of the Arkansas Bar Association**

Please read the Advance Directive Information available on the Arkansas Bar Association's website at <http://www.arkbar.com/> carefully before completing these forms.

NOTE: The form Living Will and Durable Power of Attorney for Health Care are being provided to you as a public service. The attached forms are provided "as is" and are not the substitute for the advice of an attorney. By providing these forms and the Advance Directive Information, neither the Arkansas Bar Association nor its Health Law Section is providing legal advice to you. Consult an attorney if you need legal advice of any nature.

DECLARATION OF LIVING WILL OF

[Name of Declarant]

If I should have an incurable or irreversible condition with no hope of recovery that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Common Law and the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Additionally, if I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw life-sustaining treatments that are no longer necessary to my comfort or to alleviate pain.

Section 1: Life-Sustaining Treatments

The life-sustaining treatments which **may be withheld or withdrawn** are (check all that apply):

- Cardiopulmonary Resuscitation.
- Mechanical Breathing.
- Major Surgery.
- Kidney Dialysis.
- Chemotherapy.
- Minor Surgery (unless necessary for my comfort or to alleviate pain).
- Invasive Diagnostic Tests.
- Antibiotics.
- Blood Products.
- Other Medications not Necessary for Alleviation of Pain.

Add other medical directives, if any _____

Section 2: Artificial Nutrition and Hydration

I understand that Arkansas law requires me to make my wishes regarding artificial nutrition and hydration known separately from the above directions. Therefore, by initialing the appropriate line(s) below, I specifically:

_____ DIRECT that **artificial nutrition may be withheld** or withdrawn after consultation with my attending physician.

_____ DIRECT that **artificial hydration may be withheld** or withdrawn after consultation with my attending physician.

SIGNED this _____ day of _____, 20____.

Signature

We, the undersigned, do hereby certify that the Declarant, _____ subscribed this Declaration of Living Will in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

Witness

Witness

Address

Address

City, State and Zip Code

City, State and Zip Code

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE
OF**

[Name of Declarant]

Pursuant to the Arkansas Durable Power of Attorney for Health Care Act (Ark. Code Ann. § 20-13-104) (the “Act”), I hereby designate and appoint _____ as my agent, or attorney in fact, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the power to have access to my medical records for treatment or payment decisions; to disclose medical records to others for purposes of treatment, payment, or health care operations; to employ and discharge physicians; to consent to or refuse to consent to medical procedures, including the withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will, or, if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interests as determined by my physician in consultation with my agent; to admit me to hospitals, including psychiatric hospitals, nursing homes, or hospice care; and to sign all appropriate forms, consents and releases in connection with any of said matters.

If _____ resigns, or is not able or available to make health care decisions for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me, I appoint _____ as successor, with all of the rights and powers and authority herein stated. The term “health care” shall have the meaning set forth in Ark. Code Ann. § 20-13-104(c). This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity.

SIGNED this _____ day of _____, 20_____.

Signature

We, the undersigned, do hereby certify that the Declarant, _____ subscribed this Durable Power of Attorney for Health Care in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

Witness

Address

City, State and Zip Code

Witness

Address

City, State and Zip Code

Other Legal Oversight - Use this category for any other program in your state whereby someone other than the resident participates in or makes decisions about the resident's health care and treatment.

Durable Power of Attorney/Health Care - Documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the resident's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the resident at any time.

Durable Power of Attorney/Financial -Documentation that someone other than the resident is legally responsible for financial decisions if the resident becomes unable to make decisions.

Family Member Responsible - Includes immediate family or significant other(s) as designated by the resident. Responsibility for decision-making may be shared by both resident and family.

Resident Responsible for Self - Resident retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, always assume that the resident is the responsible party.

g. NONE OF ABOVE

Process: Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your state and to the facility's legal counsel, as appropriate, for additional clarification.

Consult the resident and the resident's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the resident's record in order for the item to be checked on the MDS form.

Coding: Check all that apply.

A10. Advanced Directives

Intent: To record the legal existence of directives regarding treatment options for the resident, whether made by the resident or a legal proxy. Documentation must be available in the record for a directive to be considered current and binding. The absence of pre-existing directives for the resident should prompt discussion by clinical staff with the resident and family regarding the resident's wishes. Any

discrepancies between the resident's current stated wishes and what is said in legal documents in the resident's file should be resolved immediately.

Definition: a. Living Will -A document specifying the resident's preferences regarding measures used to prolong life when there is a terminal prognosis.

Do Not Resuscitate -In the event of respiratory or cardiac failure, the resident, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the resident's respiratory or circulatory function.

Do Not Hospitalize -A document specifying that the resident is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

Organ Donation - Instructions indicating that the resident wishes to make organs available for transplantation, research, or medical education upon death.

Autopsy Request - Document indicating that the resident, family or legal guardian has requested that an autopsy be performed upon death. The family or responsible party must still be contacted upon the resident's death and re-asked if they want an autopsy to be performed.

Feeding Restrictions - The resident or responsible party (family or legal guardian) does not wish the resident to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means.

Medication Restrictions - The resident or responsible party (family or legal guardian) does not wish the resident to receive life-sustaining medications (e.g., antibiotics, chemotherapy). These restrictions may not be appropriate, however, when such medications could be used to ensure the resident's comfort. In these cases, the directive should be reviewed with the responsible party.

Other Treatment Restrictions - The resident or responsible party (family or legal guardian) does not wish the resident to receive certain medical treatments. Examples include, but are not limited to, blood transfusion, tracheotomy, respiratory intubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (e.g., reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party.

NONE OF ABOVE

Process: You will need to familiarize yourself with the legal status of each type of directive in your state. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and the appointment of individuals with durable power of attorney for health care decisions. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the resident's wishes until their legal status is determined.

Review the resident's record for documentation of the resident's advance directives. Documentation must be available in the record for a directive to be considered current and binding.

Some residents at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether or not the new resident has ever created an advance directive (e.g., ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the resident's closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

Coding: The following comments provide further guidance on how to code these directives. You will also need to consider State law, legal interpretations, and facility policy.

- The resident (or proxy) should always be involved in the discussion to ensure informed decision-making. If the resident's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS item only after the preference has been documented.
- If the resident's preference is in areas that require supporting orders by the attending physician (e.g., do not resuscitate, do not hospitalize, feeding restrictions, other treatment restrictions), check the MDS item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded, but resident's or proxy's preference is not indicated, discuss with the resident's physician and check the MDS item only after documentation confirming that the resident's or proxy's wishes have been entered into the record.
- If your facility has a standard protocol for withholding particular treatments from all residents (e.g., no facility staff member may resuscitate or perform CPR on any resident; facility does not use feeding tubes), check the MDS item only if the advanced directive is the individual preference of the resident (or legal proxy), regardless of the facility's policy or protocol.

Check all that apply. If none of the directives are verified by documentation in the medical records, check *NONE OF ABOVE*.

42 CFR 483.10 requires facilities to protect and promote the rights of each resident, including the right to “formulate an advanced directive.” There is no regulatory text specifying a location for advanced directive information. Unless there are State codes or regulations regarding this matter, the method of communicating the information is up to the facility. If documentation is not available in the resident’s clinical record, facility staff should be the source of this information, and surveyors will assess whether or not the staff knowledge and actions are in agreement with resident/family wishes. Some facilities elect to maintain the information in the resident’s clinical record and may even verify the advanced directive was properly prepared, i.e., not witnessed by someone who will benefit from the resident’s death. Make sure you are well aware of your facility’s policies.