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 Advance Directived 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?			

Arkansas Innovative Performance Program
Enhancing Nursing Home Care in Arkansas

Resources

www.caringinfo.com
www.arkbar.com

APPOINTMENT OF HEALTH CARE AGENT

(Arkansas)

I, ________________________________, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:

____
Name

____
Address

____
City State Zip Code

(______)______________________________
Area Code Home Phone Number

(______)______________________________
Area Code Work Phone Number

(______)______________________________
Area Code Mobile Phone Number

Alternate:

____
Name

____
Address

____
City State Zip Code

(______)______________________________
Area Code Home Phone Number

(______)______________________________
Area Code Work Phone Number

(______)______________________________
Area Code Mobile Phone Number

____
Patient's name (please print or type) Date

____
Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form.

____
Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

____
Signature of witness number 2

Block B Notarization

STATE OF ARKANSAS
COUNTY OF __________________

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: ______________________________

____
Signature of Notary Public

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Full Name	Date of Birth	Gender

Physician

Printed Name	Phone Number

Patient's Additional Contact

Printed Name	Phone Number

Directions for Physician Completing POLST Form

Completing the POLST Form

- **No patient is required to complete a POLST form.** The patient (or legal representative) signs the form to indicate the voluntary nature of the form and that the contents of the form are consistent with the patient's desires and values.
- **Upon arrival at or admission to a hospital or other facility, the POLST establishes initial treatment of the patient.** After evaluation of the patient in the hospital or other facility, additional appropriate orders may be issued consistent with the patient's preferences.
- **POLST does not replace a living will or other advance directive.** When available, review the advance directive and POLST form to ensure consistency and update forms appropriately to resolve any conflicts.
- **POLST must be completed by a physician based on patient preferences and values and medical indications.**
- **The legal representative of a patient may sign the POLST form if the patient lacks capacity.** A legal representative may include a court-appointed guardian, an agent designated in an advance directive, a spouse, an adult child, an adult sibling, an adult relative, or another surrogate whom the physician believes has exhibited special care and concern for the patient, is familiar with the patient's values, and will make decisions according to the patient's wishes and values.
- **To be valid, a POLST form must be signed by a physician and the patient or legal representative.** Both signatures are required.
- **If a translated POLST form is used with the patient or legal representative, attach the translation to the signed English POLST form.**
- **It is recommended that the POLST form be printed on bright pink paper, so it can be easily recognized among the patient's paperwork.** Use of the original POLST form is encouraged, but photocopies and faxes are legal and valid under Arkansas law.
- **To avoid any potential misunderstanding about nutrition and hydration, it is strongly recommended that physicians include the following statement in Section C , Additional Orders: "Offer food and drink by mouth, if feasible and desired."**

Using POLST

- An incomplete section of the POLST form implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment." If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."

Section C:

- **To avoid any potential misunderstanding about nutrition and hydration, it is strongly recommended that physicians include the following statement in Section C , Additional Orders: "Offer food and drink by mouth, if feasible and desired."**
- Depending on local EMS protocol, "Additional Orders" written in Section C may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. In addition, review is recommended when:

- The patient is transferred from one care setting or care level to another; <u>or</u>
- There is a substantial change in the patient's health status; <u>or</u>
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means indicating intent to revoke.
- It is recommended that revocation be documented by drawing a line through Sections A through C, writing "VOID" in large letters, and signing and dating this line. A legal representative of a patient who lacks capacity may request to modify the orders after consulting with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

For more information or a copy of the POLST form, visit www. healthy.arkansas.gov.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Arkansas Department of Health

54815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Sarah Huckabee Sanders
Renee Mallory, RN, BSN, Secretary of Health
Jennifer Dillaha, MD, Director

http://www.healthy.arkansas.gov

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

First follow these orders, then contact **Physician**.
A copy of the executed POLST form is a legally binding, valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	

A — CARDIOPULMONARY RESUSCITATION (CPR):

Check One

If patient has no pulse and is not breathing.
NOTE ... If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS:

Check One

If patient is found with a pulse and/or is breathing.

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort Treatment, use medical treatment and IVs as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

C — ADDITIONAL ORDERS:

____

____

____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legal Representative

☐ Advance Directive dated ____________, available and reviewed
☐ Advance Directive not available.
☐ No Advance Directive.

Signature of Physician My signature below indicates to the best of my knowledge these orders are consistent with the patient's intentions and medical condition.

Print Physician Name:	Physician Phone Number:	Physician License #:
Physician Signature: *(required)*		Date:

Signature of Patient or Legal Representative I am aware my consent to this form is voluntary. By signing this form, a legal representative acknowledges this request regarding resuscitative measures is consistent with the known wishes of, and with the best interest of, the individual who is the subject of the form.

Print Name:	Relationship: *(write self if patient)*
Signature: *(required)*	Date:
Mailing Address:	Phone:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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.