AHC Media

November 12, 2015

Advance Directives Update:

What Every Healthcare Provider Should Know

The information provided in AHC Media Webinars does not, and is not intended to constitute medical or legal advice. Opinions, references and links provided by our speakers are provided for your convenience and do not represent our endorsement of such opinions, products or services.

Speaker

- Sue Dill Calloway RN, Esq. CPHRM CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468
- sdill1@columbus.rr.com

Objectives

- Explain the CMS and TJC standards and requirements for advance directives.
- Identify what is required of hospitals under the Patient Self Determination Act.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

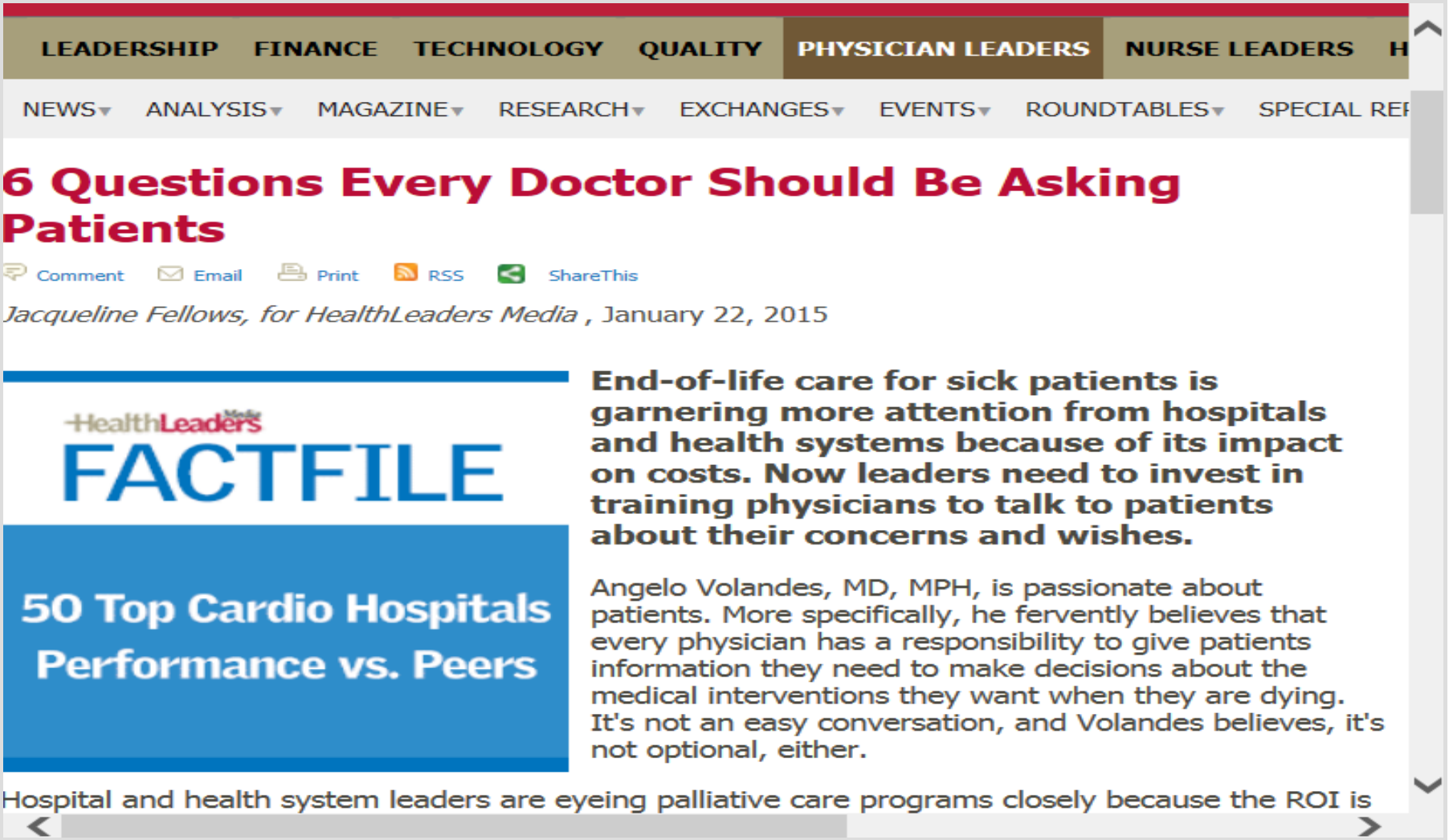
Advance Directives

- Know your specific state law on advance directives
- Know the federal law on advance directives
- Know the CMS hospital CoP on advance directives
- Know the Joint Commission standards on advance directives (or your accreditation organization: AOA HFAP, DNV or CIHQ)
  - Including the TJC Tracer
- Know what to do if a patient shows up with a visitation advance directive

Types of Advance Directives

- Living wills
- Durable Power of Attorney (DPOA)
- DNR
- Patient advocate/support person declaration
- Declaration of Mental Health Directive
- Organ donor card
- Visitation advance directive
- Declaration to dispose of body after death

Ask Patients About End of Life Wishes



LEADERSHIP FINANCE TECHNOLOGY QUALITY PHYSICIAN LEADERS NURSE LEADERS H

NEWS ANALYSIS MAGAZINE RESEARCH EXCHANGES EVENTS ROUNDTABLES SPECIAL REP

6 Questions Every Doctor Should Be Asking Patients

Comment Email Print RSS ShareThis

Jacqueline Fellows, for HealthLeaders Media , January 22, 2015

HealthLeaders Media

FACTFILE

50 Top Cardio Hospitals Performance vs. Peers

End-of-life care for sick patients is garnering more attention from hospitals and health systems because of its impact on costs. Now leaders need to invest in training physicians to talk to patients about their concerns and wishes.

Angelo Volandes, MD, MPH, is passionate about patients. More specifically, he fervently believes that every physician has a responsibility to give patients information they need to make decisions about the medical interventions they want when they are dying. It's not an easy conversation, and Volandes believes, it's not optional, either.

Hospital and health system leaders are eyeing palliative care programs closely because the ROI is

Ask Patients About End of Life Wishes

- Physician has responsibility to give patients information they need about decisions about medical interventions they want when they are dying
- Many hospitals require a code status on all admitted patients
- Many hospitals now have palliative care departments and studies show those that do have few ICU admissions and fewer use of ventilators
- Talk to patients about how they want to die
  - Advance Care Planning Decisions to help provide education

Resources from Advanced Care Planning

Toolkit CriSTAL to Identify Dying Patient

- Checklist to help identify patients for end-of-life care
- To help identify patients who are likely to die soon who would not benefit from costly interventions
- To determine when patients are dying so honest communication can occur and so palliative care can be provided
- Most patients express a preference for dying at home but the majority will die in the hospital
- CriSTAL stands for Criteria for Screening and Triaging to Appropriate Alternative Care

Toolkit CriSTAL to Identify Dying Patient

Downloaded from http://spcare.bmj.com/ on January 27, 2015 - Published by group.bmj.com

OPEN ACCESS

Development of a tool for defining and identifying the dying patient in hospital: Criteria for Screening and Triaging to Appropriate aLternative care (CriSTAL)

Magnolia Cardona-Morrell,[1] Ken Hillman[2]

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjspcare-2014-000770).

[1]The Simpson Centre for Health Services Research, South Western Sydney Clinical School, The University of New South

ABSTRACT

Objective To develop a screening tool to identify elderly patients at the end of life and quantify the risk of death in hospital or soon after discharge for to minimise prognostic uncertainty and avoid potentially harmful and futile treatments.

Design Narrative literature review of definitions, tools and measurements that could be combined

BACKGROUND

The natural progression of chronic disease involves periods of apparent remission interspersed by exacerbations and, in the year leading to death, multiple hospitalisations.[1] Some indicators of poor prognosis can suggest a patient is nearing the *end of life*.[2] and have been found useful

Checklist has 29 Predictors

They came up with a checklist of 29 predictors of death, including:

- Age 65 years or older, plus either emergency admission for the current hospitalization (associated with 25% mortality within 1 year) or two or more deterioration criteria, including change on the Glasgow Coma Score, low systolic blood pressure, slow or rapid respiration, low or high pulse rate, need for oxygen therapy or oxygen saturation less than 90%, hypoglycemia, or repeat or prolonged seizures.

- Additional risk factors or predictors of short- to medium-term death, including personal history of active disease (advanced malignancy, chronic kidney disease, chronic heart failure, chronic obstructive pulmonary disease, new cerebrovascular disease, myocardial infarction, moderate or severe liver disease, cognitive impairment), as well as previous hospitalization within the last year, or repeat intensive care unit admission at the previous hospitalization.

- Other factors, such as evidence of frailty, residence in a nursing home or supported-living facility, proteinuria, and abnormal electrocardiogram findings.

Case Law

Related to Advance Directives

Overview of Law

- A mentally competent adult has the legal right to refuse treatment even if that refusal would result in their death
- Both TJC (Joint Commission) and CMS (Center for Medicare and Medicaid Services) require that hospitals honor the patient's right to refuse treatment
- However, it must be an educated right with knowledge of risks and benefits
- Estimated that only 15-25% of patients have an advance directive

Matter of Quinlan

- This case and the Cruzan case helped to establish the right to refuse life sustaining treatment, including the right for non-competent patients
- In earlier cases, the court appointed a guardian to assert the wishes of the unconscious patient
  - Family and patient together would make decisions without intervention of the court
- First case to mention PVS (permanent vegetative state)
- Karen took an overdose and arrested at age 21
  - 348 A.2d 801 (N.J. Super Ct 1975)

Matter of Quinlan

- Judge found she could never return to a cognitive or sapient state
- Parents wanted her ventilator removed
- Karen quoted as saying she never wanted to be kept alive by extraordinary means
- Found the right to privacy
- Court allowed removal of her ventilator
  - Interestingly enough she lived nine more years dying June 11, 1985 of pneumonia

Nancy Beth Cruzan

- This case illustrates why it is so important for every adult to have advance directives and to ensure their family is aware of their wishes
- 25 year old in single car accident
- Found 35 feet from car in ditch not breathing
- Without oxygen for 15-20 minutes
- Feeding tube inserted
- Requested tube be removed after five years ($130,000 a year cost in state hospital)

Nancy Beth Cruzan

- Spastic quadriplegic, contractures, fingers cut into her wrists, CT scan severe irreversible brain damage with brain degenerating, fluid in brain where there is no more brain tissue
- US Supreme Court held that patient's right to refuse medical treatment is protected by US Constitution
- Right to refuse medical treatment is a liberty interest protected by 14th amendment

Nancy Beth Cruzan

- However, state's interest in preserving life and guarding against abuse of surrogate decision maker's powers allows state to regulate in this area
- Right to end life-sustaining treatment must be established by clear and convincing evidence
  - 474 U.S, 261, 110 S. Ct. 2841 (1990)
- This is why it is important for every person to have advance directives so that their wishes are known and followed
  - Patients may end up with a feeding tube in if in a permanent comatose state so is this what they wanted?

Matter of Theresa Schiavo

- Suffered cardiac arrest at age 27 from potassium imbalance
- Was in PVS since Feb 1990
- After waiting for 6 years to recover her husband petitioned court to remove feeding tube
- Individuals have the right to decide if they want to be kept alive by artificial hydration and nutrition
- Her parents, Schindler family, fought for nine years in court

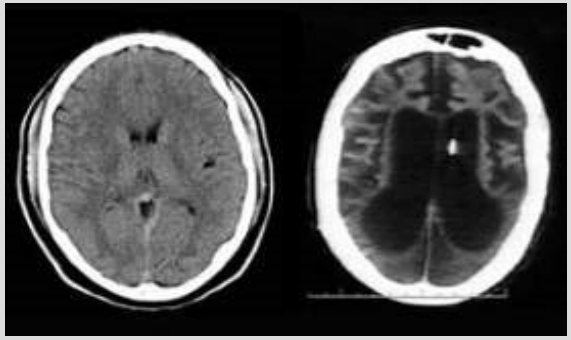
Matter of Theresa Schiavo

- Evidence supported in court that she had previously stated that she did not want to live that way
- Court ordered removal of her feeding tube
- Feeding tube removed on March 18, 2005
- There was clear and convincing evidence that this is what the patient wanted
- Remember a single piece of paper could have prevented this controversy
- Leaving no written direction left her parents and husband to argue her fate in the courts

Matter of Theresa Schiavo

Autopsy Report

- Left: CT scan of normal brain
- Right: Schiavo's 2002 CT scan showing loss of brain tissue. The black area is liquid, indicating hydrocephalus ex vacuo. Shows extensive brain damage. Brain half the weight of a normal brain.



Linda Scheible vs Morse Geriatric Center

- Florida nursing home found negligent for failing to honor resident's advance directive for $150,000 in 2007
  - Granddaughter brought the lawsuit
- Resident died at age 92
  - Madeline Neuman was competent when she entered the nursing home
- She completed a living will saying she did not want CPR and foregoing any life prolonging care or feeding tubings, surgery or respirators
- Doctor wrote a DNR order in her chart

Linda Scheible vs Morse Geriatric Center

- When she became unresponsive the LTC facility called paramedics
- They intubated here and did CPR and sent her to the hospital
- Patient had history of seizures and Altzheimer's
- Jurors felt the nursing home lacked procedures for ensuring that the patient wishes would be followed in the event the patient was unable to speak for her or himself
  - Did not have a good way to communicate patient was a DNR

Glenwood Gardens California

- Central California retirement home (independent living facility) refuses to do CPR on a 87 YO patient Lorraine Bayless on May 4, 2013
  - Not LTC or assisted living
- Nurse said facility policy prevented her from giving CPR after she collapsed in the dining room
  - Patient did not have a DNR order
  - Said their policy is to call 911 and wait
  - Family said their were happy with call
- CMS issues memo that LTC must do CPR unless patient is a DNR October 14, 2013

Know Who is a DNR and Who is Not

Nurse refuses to perform CPR despite 911 dispatcher's plea

older

newer

Jami McMath Case

- 13 YO in California was declared with total brain death after massive blood lose and cardiac arrest
  - Occurred after having a adenotonsillectomy, uvulopalatopharyngoplasty and submucous resection of bilateral inferior turbinates for sleep apnea on December 9, 2013
  - No activity on an electroencephalogram, no blood flow to the brain and did not breathe when removed from mechanical ventilation
  - Coroner issues death certificate January 5, 2014
  - Court found patient brain dead but allowed ventilator to continue
  - Family moves to LTC to get a feeding tube and trach
  - Files medical malpractice case March 2015 against hospital and surgeon

Brain Dead Girl Moved From Ca Hospital

Lawyer: Brain dead girl moved from Calif. hospital

5:11 AM, Jan 6, 2014 | 0 comments

This undated file photo provided by the McMath family and Omari Sealey shows Jahi McMath. (Photo: AP Photo/Courtesy of McMath Family and Omari Sealey)

Recommend 0 Tweet 0 +1 0 Pin it - A A A +

USA Today

FILED UNDER

OAKLAND, Calif. (AP) - The 13-year-old California girl declared brain dead after a tonsillectomy has been taken out of Children's Hospital of Oakland, her family's attorney said late Sunday.

Jahi McMath left the hospital in a private ambulance shortly before 8 p.m. Sunday, Christopher Dolan told The Associated Press.

She was taken by a critical care team while attached to a ventilator but without a feeding tube, Dolan said. Her destination was not immediately disclosed.

MOST VIEWE

SEE MORE

MOST WATCI

Pregnant Patient Declared Brain Dead

Husband of brain dead woman who sued to have pregnant wife's life support turned off may be forced to pay for her hospital stay

- Erick Munoz told Anderson Cooper that he's been getting hospital bills for his wife's care
- Marlise Munoz was declared brain-dead after collapsing at her Texas home
- But she was kept on life support for the sake of her 23-week-old fetus
- Recent report said average cost per hospital stay was $9,700 in 2010
- Before her death, Mrs Munoz had made it clear to her husband that she would not want to be kept on life support
- Doctors refused to comply with her wishes as Texas law that says life-sustaining treatment cannot be withdrawn from a pregnant patient
- Erick Munoz launched a court battle for his wife to be taken off life support
- A judge ruled in his favor Friday and Mrs Munoz died last Sunday
- Both hospital staff and attorneys agreed the fetus, which had abnormalities, could not have been born alive this early into a pregnancy

By DAILY MAIL REPORTER

PUBLISHED: 21:40 EST, 1 February 2014 | UPDATED: 02:37 EST, 2 February 2014

Share Tweet +1 Share | 149 shares 92 View comments

After losing his wife and unborn baby daughter, and then spending weeks locked in a legal battle to have the brain-dead woman taken off life support, Erick Munoz may now be forced to pay thousands of dollars in medical bills.

Marlise Munoz was declared legally dead after her paramedic husband found her unconscious at their Texas family home November 26, possibly due to a blood clot. But because she was 14 weeks pregnant, doctors refused to take her off life support under a pro-life state law.

After winning a lengthy court battle, Mrs Munoz's life support was switched off Sunday and both she and the 23-week-old fetus, which was said to have abnormalities because of oxygen deprivation, died at John Peter Smith Hospital in Fort Worth.

Speaking with **CNN's Anderson Cooper** Wednesday, Mr Munoz revealed that he has been receiving hospital bills at his home, although he is not sure at this time what he will be expected to pay for his wife's forced medical care.

$16.5 Million Failure to Honor Advance Directive

- Mother, Ramona Johnson, and daughter, Brenda Young, win $16.5 million for failing to honor patient's advance directive in Michigan
- Patient had seizure disorder and physician said would get worse
- Patient makes advance directives to give her mother DPOA to stop treatment is she became incapacitated
- Hospital intubated her against their wishes when she arrested and patient was in a coma for two months

$16.5 Million for Ignoring Advance Directive

- Patient total care and completely disabled
- Michigan case is apparently first of its kind to have a jury award substantial damages
- Many experts are saying this is a new wave of lawsuits if a hospital fails to honor the AD
- Hospitals that do honor them have immunity
- AHA Richard Wade says “it will take us a while to learn to deal with these end of life issues”
- Choices in Dying attorney Anna Moretti says this is a new area of law and the legal theories are still developing

Living Wills Protect Providers

twitter FOLLOW US

Find us on Facebook

join us on LinkedIn

54 Top Blogs BUZZING Health

Hospital Impact has been ranked one of the top 50 healthcare blogs by Wikio.

Get the RSS Feed

Search Hospital Impact...

Search

Blogs we like:

» The ACP Advocate Blog
» Action for Better Healthcare
» Adventures of GuitarGirlRN
» Candid CIO
» db's Medical Rants
» Disruptive Women in Health Care
» Healing Hospitals
» HealthBlawg
» HISTalk
» John Goodman's Health Policy Blog
» Kevin, MD
» Manage My Practice
» Managed Care Matters
» MD Whistleblower
» Mind the Gap
» The Patient Experience Blog
» RangelMD.com

Texas case a reminder that living wills protect patients, providers

February 12th, 2014

by Jenn Riggle

An advance medical directive, or living will, is a written document that gives instructions about the medical treatment a patient can receive if he or she is terminally ill or unconscious.

However, there are times when hospitals choose to ignore them, such as:

» When a woman is pregnant
» When family members disagree with advance directives
» When a physician or facility objects to an advance directive based on reasons of conscience

John Peter Smith Hospital, a 527-bed hospital in Fort Worth, Texas, was at the epicenter of this discussion when it kept Marlise Munoz, a 33-year-old pregnant woman who was declared brain-dead, on life support against her wishes and those of her family.

[More:]

The American Bar Association Commission on Law and Aging notes that a number of myths exist about advanced directives, with the biggest being that they are legally binding and doctors have to follow them. In reality, they give doctors and hospitals immunity if they follow the directives.

More than half of U.S. states, including Texas, do not allow life support to be withdrawn from a pregnant woman, even if she has a living will. It seems only natural that hospitals want to give an infant every possible chance to survive, no matter how

ABA Myths and Facts about AD

Commission on Law & Aging

Myths and Facts About *Health Care Advance Directives*

www.americanbar.org/content/dam/aba/migrated/Commissions/myths_fact_hc_ad.authcheckdam.pdf

Terms to Know

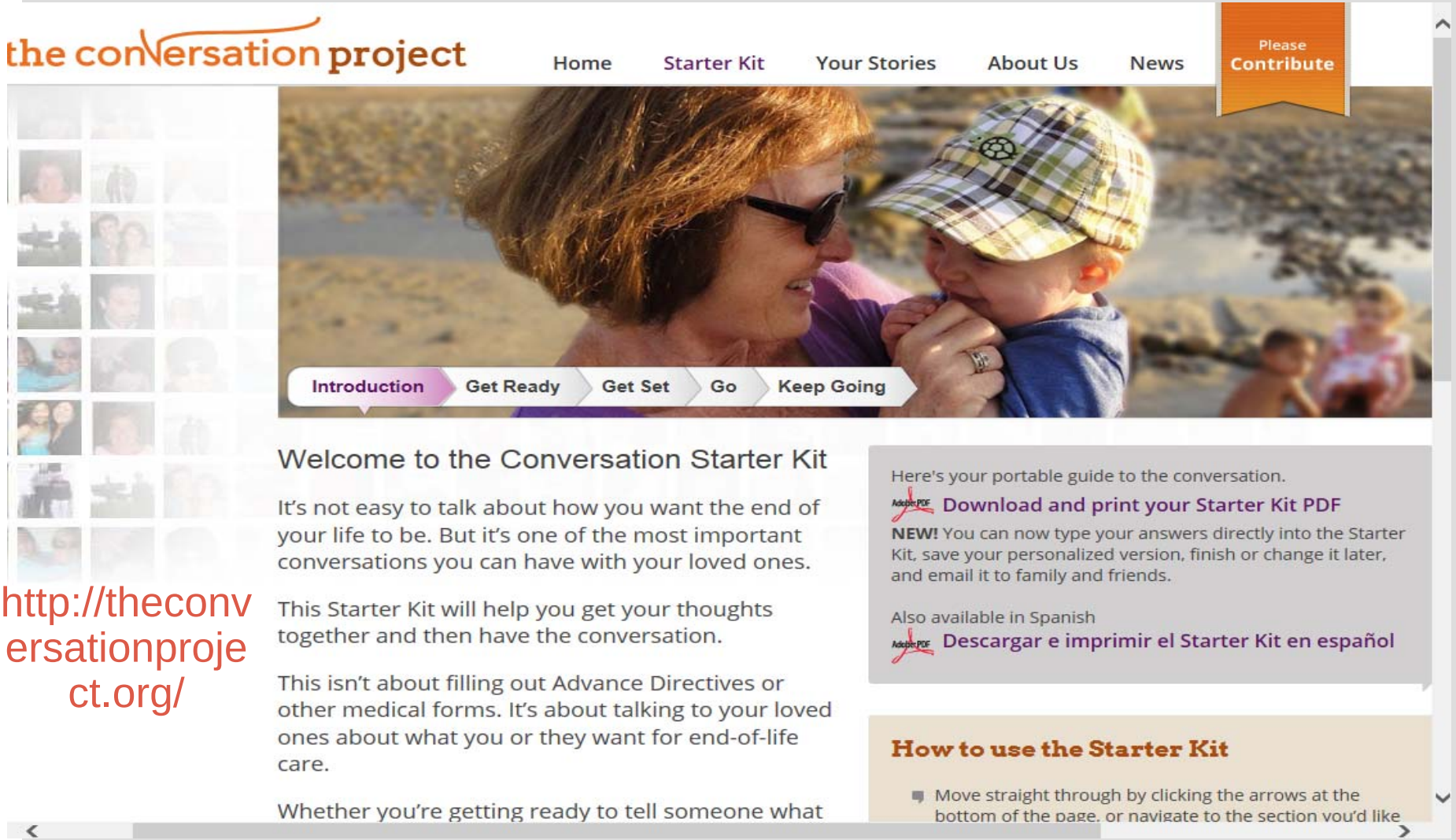
- **Health Care Advance Directive** – The generic term for any document that gives instructions about your health care and/or appoints someone to make medical treatment decisions for you if you cannot make them for yourself. Living Wills and Durable Powers of Attorney for Health Care are both types of Health Care Advance Directives.
- **Living Will** – A document in which you state your wishes about life-sustaining medical treatment if you are terminally ill, permanently unconscious, or in the end-stage of a fatal illness.
- **Durable Power of Attorney for Health Care** (or Health Care Proxy) – A document in which you appoint someone else to make medical treatment decisions for you if you cannot make them for yourself. The person you name is called your agent, proxy, representative, or surrogate. You can also include instructions for decision-making.

	Myth	Fact
1.	You must have a Living Will to stop treatment near the end of life.	▪ Treatment can be stopped without a Living Will if everyone involved agrees. However, without some kind of advance directive, decisions may be more difficult and disputes more likely ▪ The Durable Power of Attorney for Health Care is the more useful and versatile advance directive, because it applies to all health care decisions and empowers the person you name to make decisions for you in the way you want them made. ▪ Over 2/3 of the adult population have no Living Will or other advance directive.
2.	You have to use your state's statutory form for your advance directive to be valid.	▪ Most states do not require a particular form, but do require witnessing or other specific signing formalities. ▪ Even if your state requires a specific form, doctors still have a legal obligation to respect your treatment wishes, regardless of the form you

IHI Conversation Starter Kit

- IHI has a free conversation starter kit
- It has been downloaded over 100,000 times
- To help facilitate having the essential conversation about the patient's end of life wishes with their loved ones
- Now patient can type their answers directly into the starter kit and email it to family
- Has helped inspire the conversation between the patient and their loved ones so they know their wishes

IHI The Conversation Project



http://theconversationproject.org/

Conversation Starter Kit

Your Conversation Starter Kit

The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care.

We know that no guide and no single conversation can cover all the decisions that you and your family may face. What a conversation can do is provide a shared understanding of what matters most to you and your loved ones. This can make it easier to make decisions when the time comes.

Name: _____

Date: _____

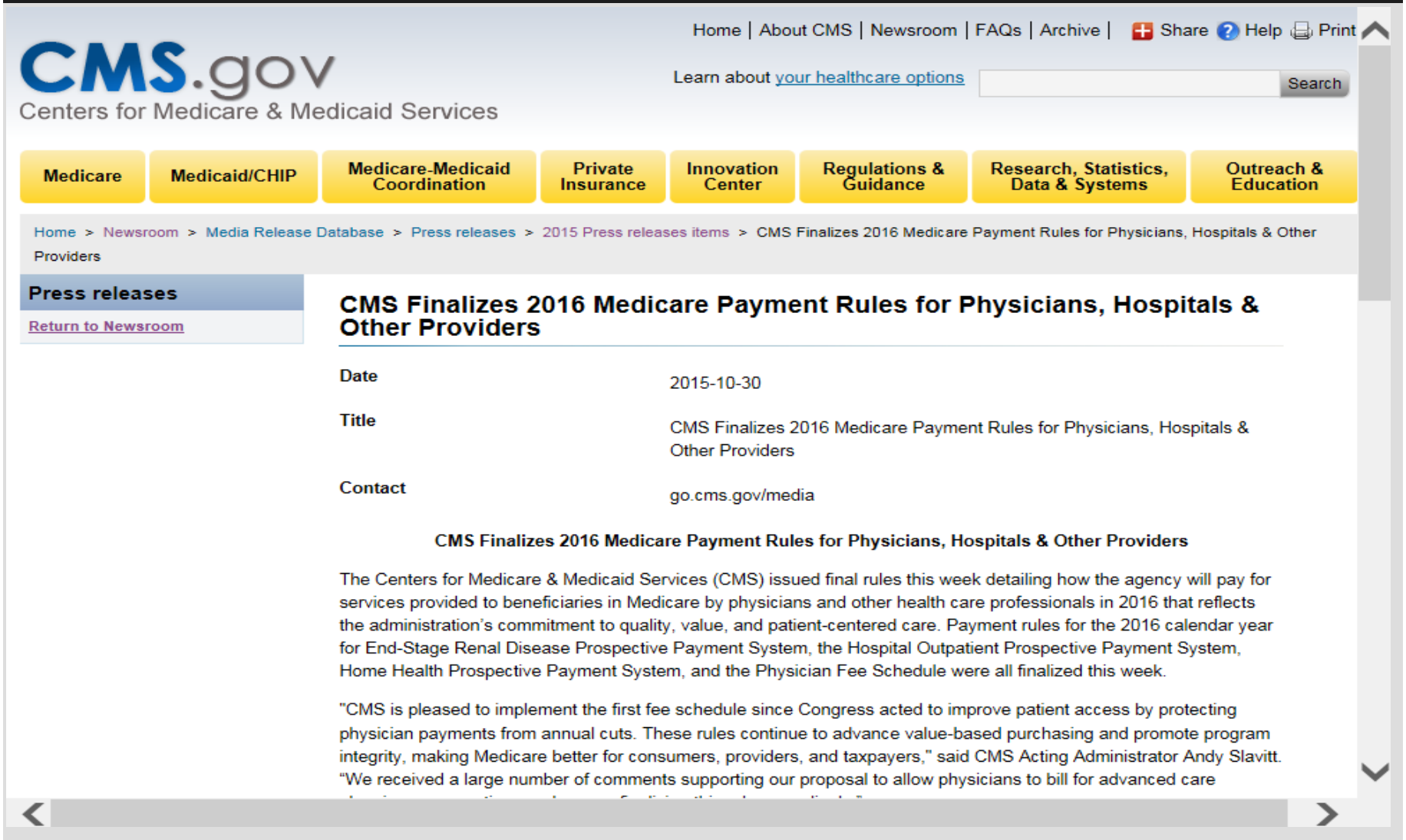
Conversation Starter Kit

- 90% of people think it is important to know about their loved ones wishes for end-of-life
- But less than 30% have actually discussed this according to the National Survey by the Conversation Project 2013
- 60% of people says that making sure their family is not burdened by the tough decisions is important
- 70% of patients would prefer to die at home
- 82% say it is important but only 23% have actually done it
  - California HealthCare Foundation (2012)

Doctors May Get Paid for End-Of-Life Planning

- Article in USS Today June 2014 and 2015 CMS adds to proposed physician payment rules January 1, 2016 to discuss end-of-life choices
- October 30, 2015, a final rule was issued authorizing Medicare to pay doctors for consultation on how they would like to be cared for as they are dying
- Now patients and families can have the discussion of what and when the want treatment before becoming ill or after having received a diagnosis of cancer
- This new regulation creates a benefit to advanced care planning for Medicare patients and is consistent with recommendations from the AMA

CMS Press Release



Home | About CMS | Newsroom | FAQs | Archive | Share Help Print

CMS.gov
Centers for Medicare & Medicaid Services

Learn about your healthcare options

Search

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Home > Newsroom > Media Release Database > Press releases > 2015 Press releases items > CMS Finalizes 2016 Medicare Payment Rules for Physicians, Hospitals & Other Providers

Press releases

Return to Newsroom

CMS Finalizes 2016 Medicare Payment Rules for Physicians, Hospitals & Other Providers

Date 2015-10-30

Title CMS Finalizes 2016 Medicare Payment Rules for Physicians, Hospitals & Other Providers

Contact go.cms.gov/media

CMS Finalizes 2016 Medicare Payment Rules for Physicians, Hospitals & Other Providers

The Centers for Medicare & Medicaid Services (CMS) issued final rules this week detailing how the agency will pay for services provided to beneficiaries in Medicare by physicians and other health care professionals in 2016 that reflects the administration's commitment to quality, value, and patient-centered care. Payment rules for the 2016 calendar year for End-Stage Renal Disease Prospective Payment System, the Hospital Outpatient Prospective Payment System, Home Health Prospective Payment System, and the Physician Fee Schedule were all finalized this week.

"CMS is pleased to implement the first fee schedule since Congress acted to improve patient access by protecting physician payments from annual cuts. These rules continue to advance value-based purchasing and promote program integrity, making Medicare better for consumers, providers, and taxpayers," said CMS Acting Administrator Andy Slavitt. "We received a large number of comments supporting our proposal to allow physicians to bill for advanced care

Federal Register Nov 16, 2015

This document is scheduled to be published in the Federal Register on 11/16/2015 and available online at http://federalregister.gov/a/2015-28005, and on FDsys.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 414, 425, and 495

[CMS-1631-FC]

RIN 0938-AS40

Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period.

SUMMARY: This major final rule with comment period addresses changes to the physician fee

Advanced Care Planning Payment

- Federal govt. may reimburse doctors for talking to Medicare patients about their advance care planning including living wills
- AMA Relative Value Scale (RVS) issued recommendation to CMS to include in reimbursement rates and now new codes will be added
  - It is crucial to get the patient's wishes for treatment to allow patients to control the decision making process
  - Some insurers, like Blue Cross of NY, already reimburse doctors for advance care planning

End-Of-Life Planning

- AMA released a CPT code for advance care planning which is a necessary step for Medicare to begin considering reimbursement for end of life discussions
- CMS date of 1-1-2016 for reimbursement
- Billing code is for the first 30 minutes of face to face time with the patient or family to explain and discuss advance directives
  - Can initially do during the welcome to Medicare visit or later when appropriate such as in the annual wellness visit

End-Of-Life Planning

- The CMS finalizes will pay for end-of-life discussions with patients following the IOM report called Dying in America
  - Published in 2014
  - IOM now called National Academy of Medicine
- Payment is proposed on two levels: one for the first 30 minutes of consultation and another for each additional 30 minutes after that. CMS said the figures would be approximately $86 in doctors office and $75 for additional 30 minutes and $80 in hospital
- CMS find 55% of LTC patients had ADs in 2014

Doctors Now Will Get Paid for End-Of-Life Planning

USA TODAY NEWS SPORTS LIFE MONEY TECH TRAVEL OPIN

Doctors may get paid for end-of-life p

Michael Ollove, Pew/Stateline Staff Writer 6:08 p.m. EDT June 4, 2014

www.usatoday.com/story/news/nation/2014/06/02/stateline-end-of-life/9867615/

(Photo: Cliff Owen, AP)

156 CONNECT 83 TWEET 79 LINKEDIN 3 COMMENT EMAIL MORE

Corrections and clarifications: An earlier version of this report mischaracterized how the AMA will issue recommendations. This story also misstated the title for Phillip Rodgers.

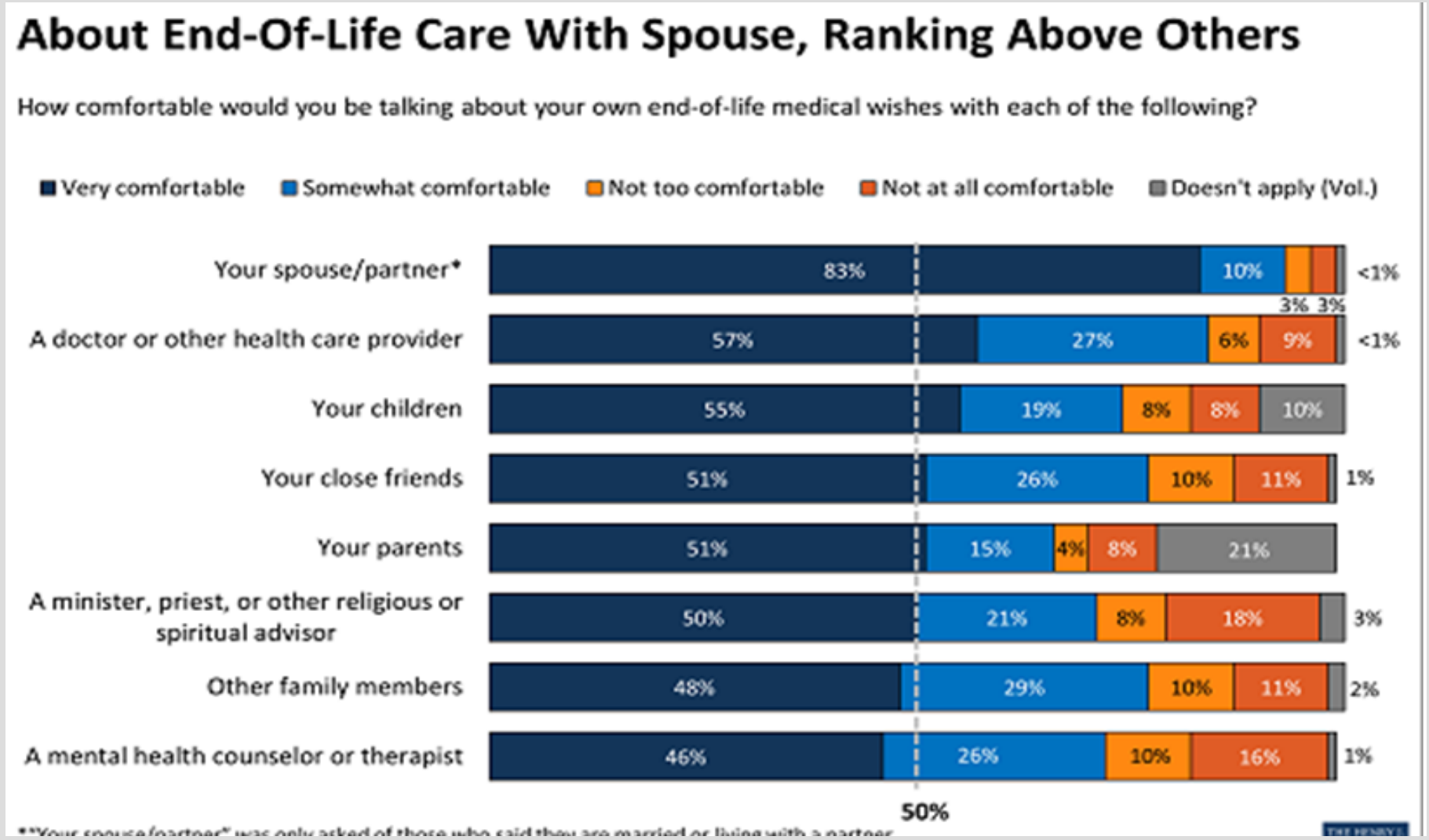
The federal government may reimburse doctors for talking to Medicare patients and their families about "advance care planning," including living wills and end-of-life treatment options — potentially rekindling one of the fiercest storms in the Affordable Care Act debate.

A similar provision was in an early draft of the federal health care law, but in 2009, former Republican vice-presidential candidate Sarah Palin took to Facebook to accuse President Barack Obama of proposing "death panels" to determine who deserved life-sustaining medical care. Amid an outcry on the right, the provision was stripped from the legislation.

Now, quietly, the proposal is headed toward reconsideration — this time through a regulatory procedure rather than legislation.

The American Medical Association's Relative Value Scale Update Committee (RUC) soon will issue recommendations to the federal government regarding the resources doctors expend when they provide advance care planning to patients, or confer with them about the care they would want if they were incapacitated. Every year, the AMA makes such recommendations on a broad range of procedures and services to the

Kaiser End-of Life Care Discussions



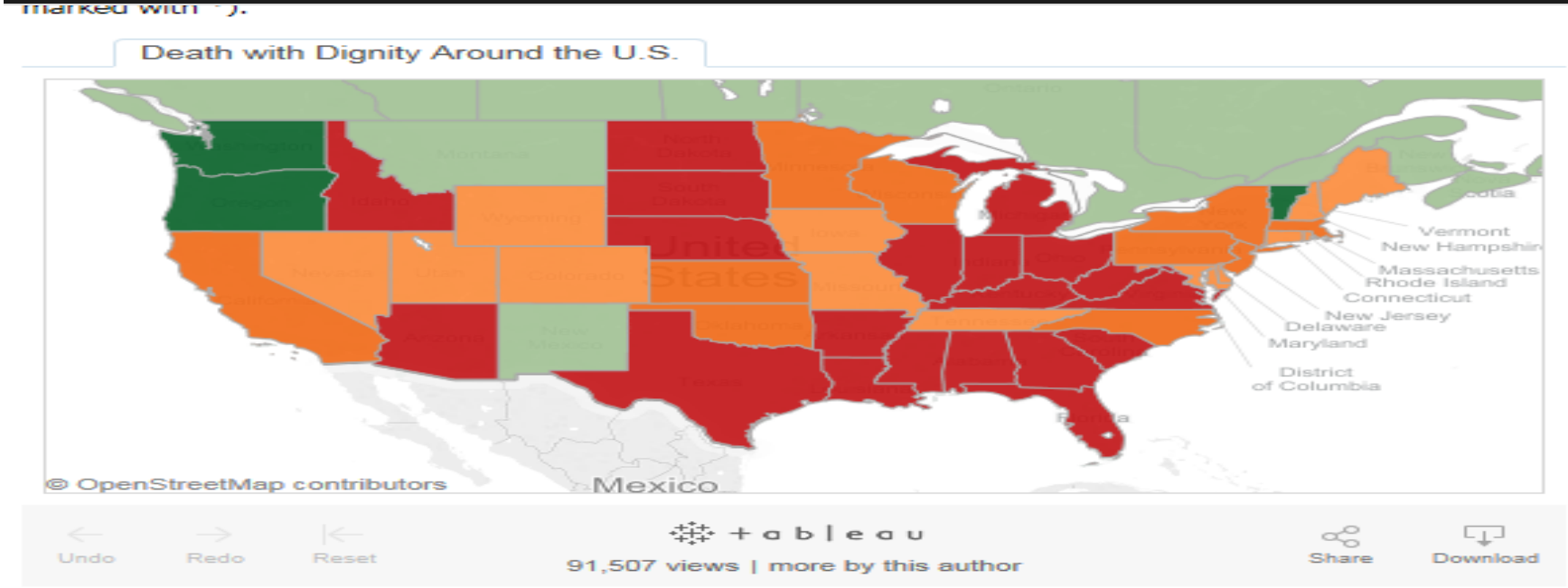
Death with Dignity National Center

- Oregon Death with Dignity law has been in effect since 1997
  - Physicians can prescribe lethal doses to terminally ill patients but not administer
  - Only 1,327 patients have requested prescriptions and 859 used them
- Washington and Vermont has passed similar laws
- Courts in Montana and New Mexico has allowed physician assisted suicide for terminally ill patients
- In 2015, 26 states and DC are considering legislation on end-of-life issues

Death with Dignity National Center

Has List of All States and Proposed Changes

marked with *).

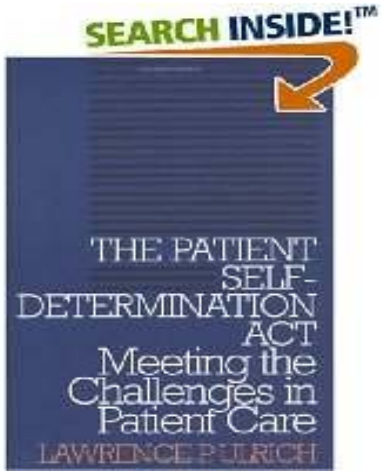


Resources

- List of Legal Cases Involving Right to Die in the United States at http://www.rbs2.com/rtd.pdf
- Physician assisted suicide website at www.willamette.edu/wucl/pas
- Information on Schiavo case at http://www6.miami.edu/ethics/schiavo/timeline.htm and http://abstractappeal.com/schiavo/infopage.html

Federal Laws on Advance Directive

Patient Self Determination Act or PSDA



Definition of Advance Directive

"Advance directive means a written instrument, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), related to the provision of health care when the individual is incapacitated."

- Examples: Living will, DPOA, visitation, DNR, organ donor card, patient advocate/support, and mental health declaration

Patient Self Determination Act of 1990

- Purpose of the federal law (PSDA)
- To inform patients of their rights regarding decisions toward their own medical care
- To ensure that these rights are communicated by the health care provider
  - Patients should give copies to their physician, hospital when admitted and family members so they know their wishes
- To provide a written summary of their health care decision making rights on admission
- These rights ensure that those of the patient dictate their future care should they become incapacitated

Patient Self Determination Act

- **42 USC Section 1395** (a)(1)(Q) and SSA 1866, Section 4206 (b)(1) of OBRA 90, 42 CFR 489.102
- Applies to Medicare certified hospitals, skilled nursing homes, home health, hospice, and HMO
- Passed by Congress in 1990 to require above organizations to give patients information on state laws regarding advance directives such as living wills or DPOA
- Purpose of law is to ensure patients are informed of their right to make advance directives and based on principles of informed consent
- Law was effective December 1, 1991 and amended July 27, 1995 (FR Vol 60, June 23, 1995) and copy is available on website[1]

[1] http://www.findlaw.com/casecode/uscodes/

Patient Self Determination Act

- Must provide written information to patients on their decision making rights
- Provide written information to patients on organization's implementation of these rights
- Document in medical record whether patient has one
- Ensure compliance with requirements of state law on advance directives
- Provide for education of staff concerning its P&P and community education on advance directives
- Remember the CMS Hospital CoPs on patient rights which discuss patient's right to have advance directives followed

Patient Self Determination Act

- Need written P&P regarding how the hospital or facility is implementing each of their rights
- Including clear and precise limitation if the provider cannot implement an AD on the basis of conscience
- At a minimum, need to clarify any differences between institution wide (the hospital) and those raised by individual physicians
- Identify state legal authority permitting such objections and describe range of medical conditions affected by conscientious objection
- Can’t discriminate against patient if they have or not

FEDERAL PATIENT SELF-DETERMINATION ACT
FINAL REGULATIONS

PART 489-PROVIDER AND SUPPLER AGREEMENTS

The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102,1861. 1864. 1866. 1867, and 1871 of the Social Security Act (42 U.S.C. 1302.1395x. 1395aa. 1395cc. 1395dd. and 1395hh) and sec. 602 (k) of Pub. L. 9621 (42 U.S.C 1395ww note).

Subpart 1 Advance Directives

Section 489.100 Definitions

For the purposes of this part "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Section 489.102 Requirements for providers

(a) Hospitals, rural primary care hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health-care (and for Medicaid purposes, providers of personal care services), and hospices must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the provider and are required to:

(1) Provide written information to such individuals concerning—

(i) An individual's rights under State law (whether statutory or recognized by courts of the State) to make decisions concerning such medical cars, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Providers are to update and disseminate amended information as soon as possible, but no later than 90 days from the effective date of the changes to State law; and

(ii) The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider's statement of limitation should:

(A) Clarify any differences between institution wide conscience objections and those that may be raised by individual physicians:

(B) Identify the state legal authority permitting such objections.

(C) Describe the range of medical conditions or procedures affected by the conscientious objection

Consider Having A Form

PATIENT
SELF-DETERMINATION ACT

According to the Patient Self-Determination Act (a federal law), every adult inpatient must receive a copy of the brochure "Your Right To Make Decisions About Medical Treatment" and also be asked the question "Do you have an Advance Directive"? (See reverse side for definitions.) If the patient does have an Advance Directive, a copy must be requested for the chart. This form is to be completed by the staff member who is admitting the patient.

PLEASE GIVE THE PATIENT / PATIENT'S SIGNIFICANT OTHER A COPY OF "YOUR RIGHT TO MAKE DECISIONS ABOUT MEDICAL TREATMENT."

1. Does the patient have an Advance Directive?
   Yes ☐ * No ☐ Unable to determine ☐

   (*) If No, ask patient if he/she would like a copy of an Advance Directive.

   _____ _____ _____
   Department Date Signature

2. If the patient has brought an Advance Directive with them, please copy and file the copies in the Patient Rights section of the patient's medical record.

   - Document your department name (i.e. Admitting, or specific patient care area), sign and date indicating you photocopied the forms.

   _____ _____ _____
   Department Date Signature

3. If the patient states he/she has an Advance Directive, but did not bring it in, please ask him/her to write / provide the name of their Healthcare Surrogate Decision Maker on his form.

   - Please write name and telephone number of Surrogate Decision Maker

   _____ _____
   Name of Surrogate Decision Maker Telephone Number

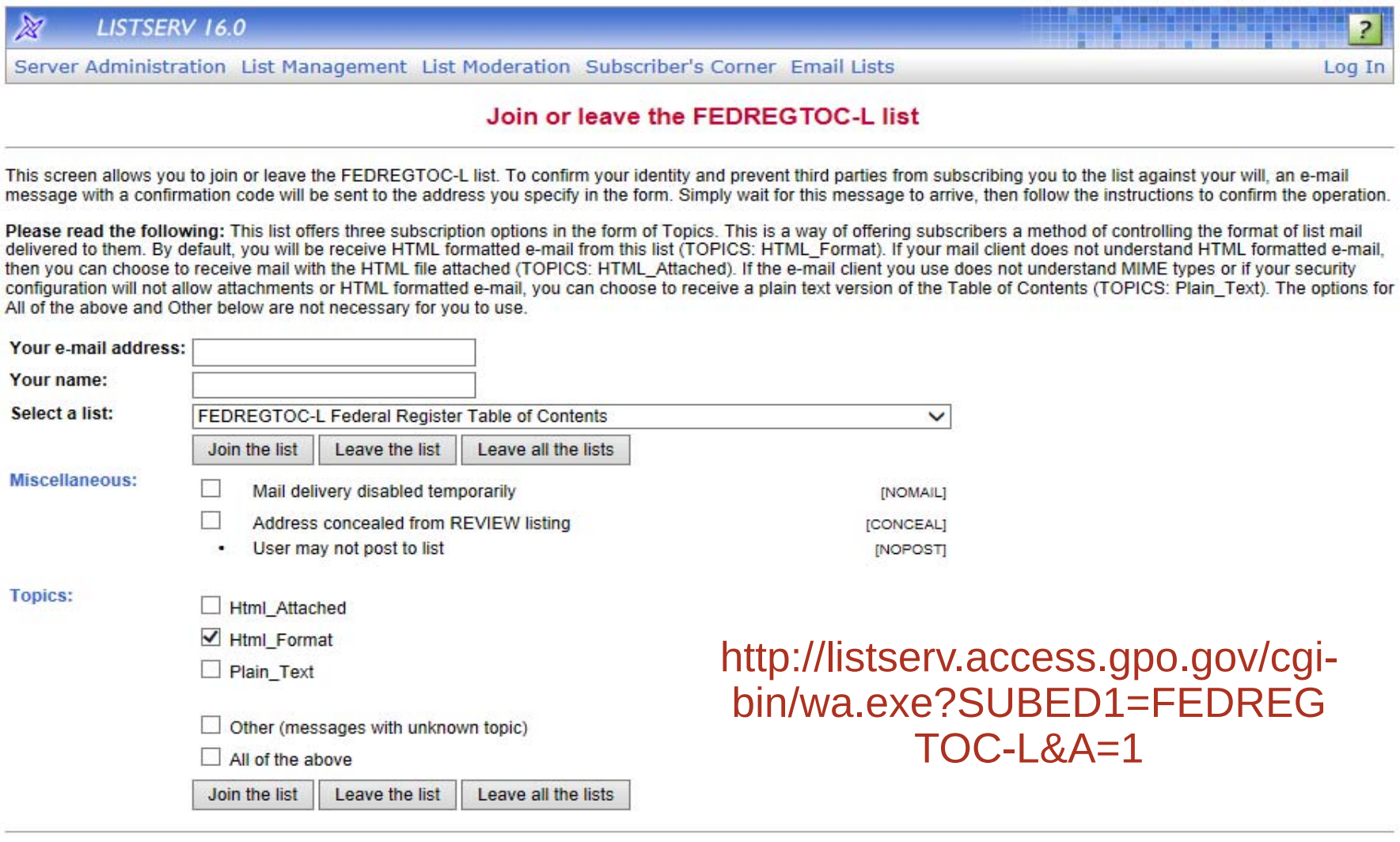
4. If discussed with a person other than the patient, indicate name and relationship:

   _____ _____

Federal Laws

- Can get off internet copies of all federal laws at no expense at www.thomas.gov or federal regulations at www.regulations.gov
- Can also find copies of federal bills
- Another good resource is www.findlaw.com
- You can sign up to get the federal register sent to your computer daily at http://www.gpoaccess.gov/fr/index.html
- CFR is now free off the internet at www.ecfr.gov (Title 42 is public health)

Sign Up to Get the Federal Register Free



http://listserv.access.gpo.gov/cgi-bin/wa.exe?SUBED1=FEDREGTOC-L&A=1

Best Website to Get Copy of Federal Law

GPO Access

LEGISLATIVE / EXECUTIVE / JUDICIAL | HELP | ABOUT

A-Z RESOURCE LIST | FIND A FEDERAL DEPOSITORY LIBRARY | BUY PUBLICATIONS

Home Page > Executive Branch > Code of Federal Regulations

Code of Federal Regulations (CFR): Main Page

The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to Federal regulation. Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis. More.

Most Current 50 Titles (2009-2010)

- Quick Search: (ex: 20CFR404, prescriptions AND "drug enforcement administration")

  Submit [Search Tips]

- Browse and/or search the CFR

1996 through current year

Based on CFR update schedule

- Browse and/or search the CFR
- Retrieve by CFR Citation
- Search tips

www.gpoaccess.gov/cfr/index.html

Other Services

- Purchase individual CFR titles through the U.S. Government Online Bookstore.
- Find issues of the CFR (including issues prior to 1996) at a local Federal depository library.

DATABASE FEATURES

- CFR Main Page
- Browse and/or Search
- Retrieve by CFR Citation
- Search Tips
- How to Link to CFR Documents
- About the CFR

RELATED RESOURCES

- e-CFR
- Federal Register
- Regulations.gov
- Unified Agenda
- List of CFR Sections Affected

Psychiatric Advance Directives

http://www.nrc-pad.org/

State by State Information

Home | Who We Are | Glossary | PAD Stories | Contact Us

NRC·PAD
National Resource Center on Psychiatric Advance Directives

NEWS

Featured State action on PADs: Virginia's Health Care Decisions Act

Featured videos on PADs by Delaney Ruston, MD, documentary filmmaker

- Home
- Getting Started
- State by State Info
- FAQs
- Educational Webcasts
- Links
- Current Research
- In the News
- Legal Issues
- Search
- Feedback

PAD STORIES

"This time, with a PAD, I did not receive any treatments that I did not want. They were very respectful. I really felt like the hospital took better care of me because I had my PAD. In fact, I think it's the best care that I've ever received."

Read More...

Home • State by State Map

NATIONAL RESOURCE CENTER ON PSYCHIATRIC ADVANCE DIRECTIVES - STATE BY STATE MAP

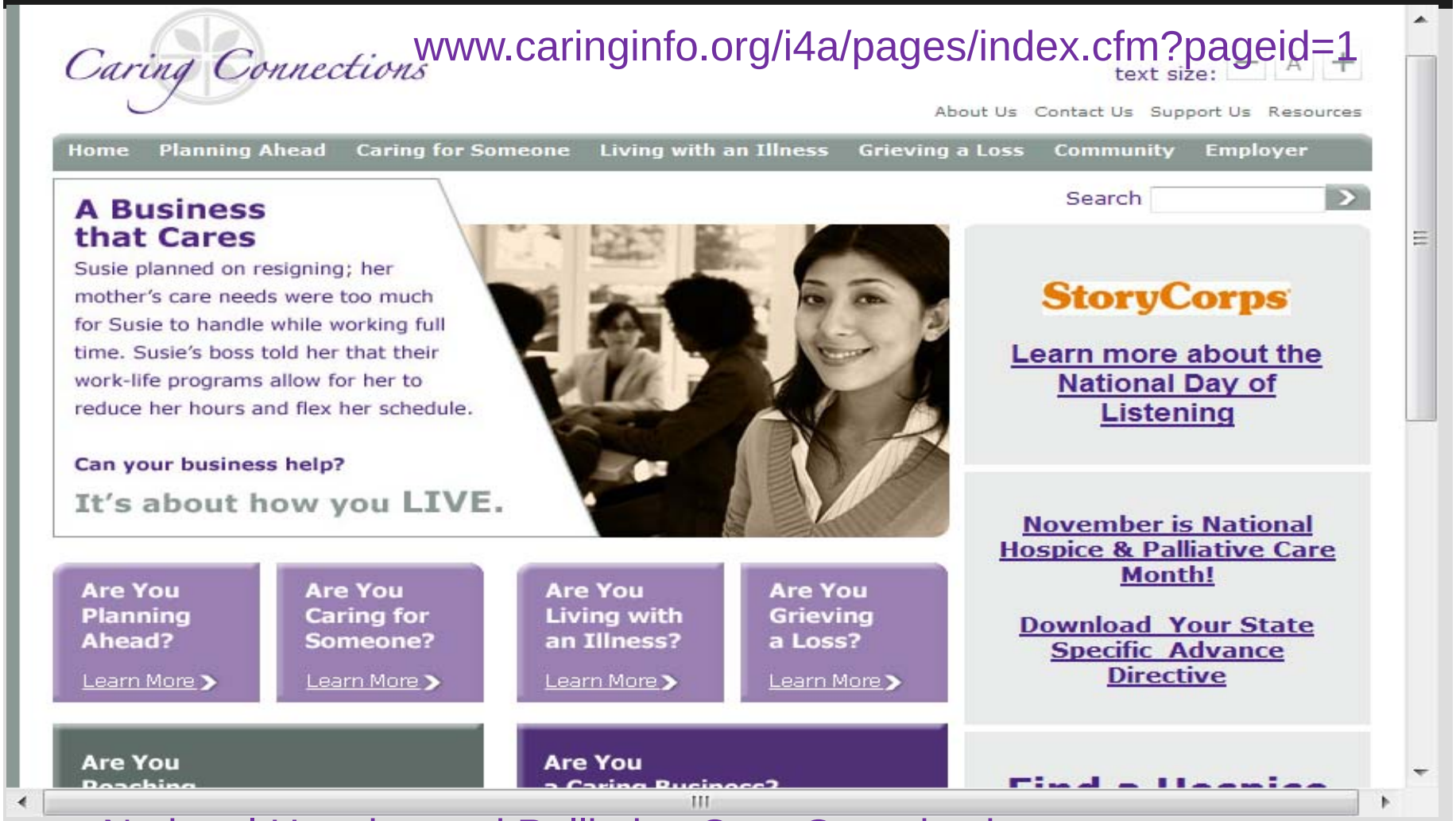
State by State Map

Click state to view statute information.

Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

Almost all states permit advance directives for healthcare, which can be used to direct at least some forms of psychiatric treatment. In the past decade, twenty-five states have adopted specific psychiatric advance directives statutes.

Caring Connections Download State AD



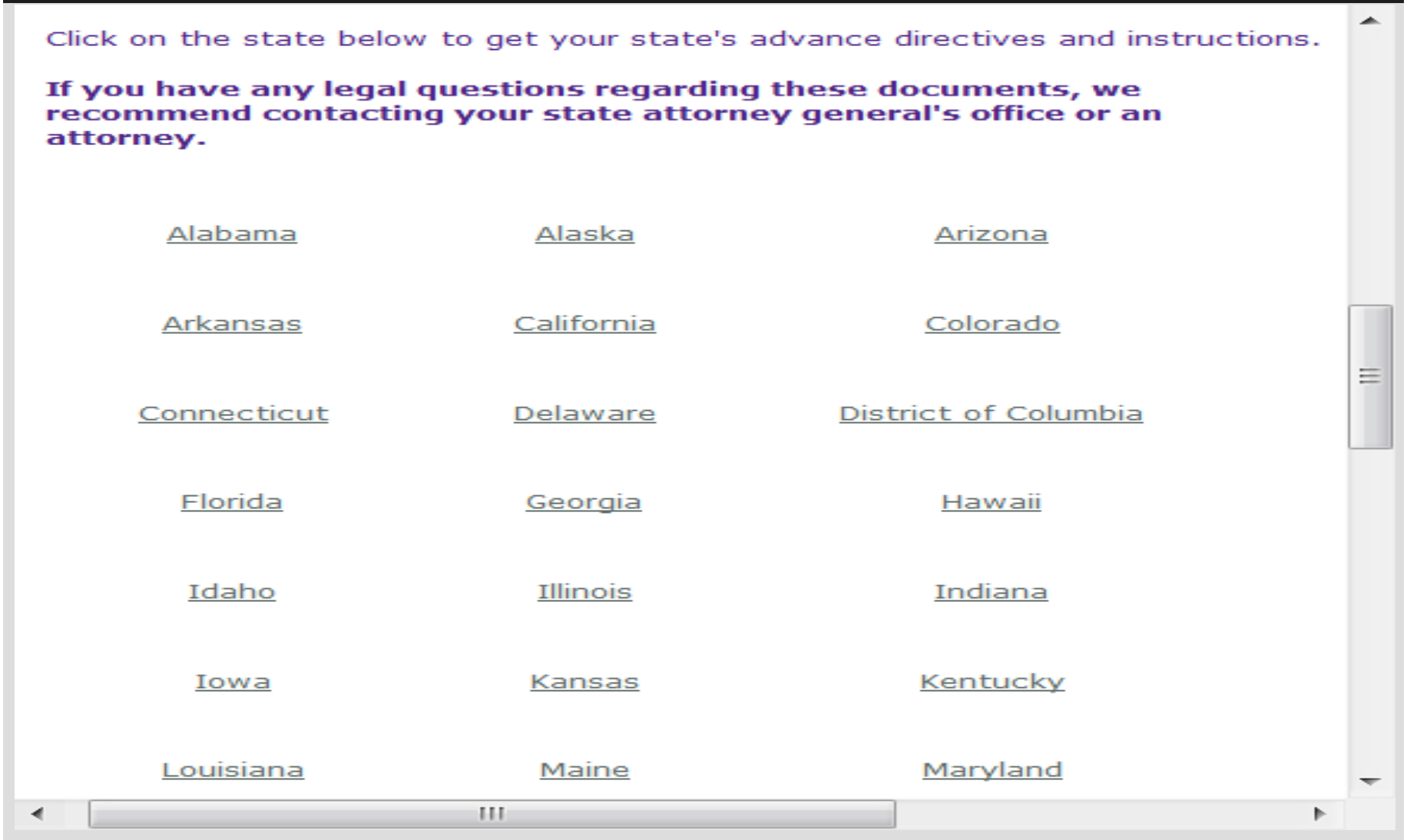
National Hospice and Palliative Care Organization

Caring Connections Download State AD

www.caringinfo.org/i4a/pages/index.cfm?pageid=1

National Hospice and Palliative Care Organization

State Specific Advance Directives



Discuss End of Life Issues with Patients

- 25 years since passage of PSDA and article finds that patients rarely discuss end of life wishes with their doctors
- More than 88% of physicians would opt for DNR if terminal
- However, only 50% of terminal patients have ADs
- National teaching program “Respecting Choices” aims to change this
- Teaches providers to ask patients about their choices and educate them on their options
  - May 22, 2014 Advance Directives: Physician Attitudes Differ From Actions, AGS 2014 Annual Meeting

Advance Directives: Physician Attitudes Differ From Actions

Caroline Helwick

May 22, 2014

EDITORS' RECOMMENDATIONS

End-of-Life Discussion Guide Aids Physician-Patient Planning

End-of-Life Wishes: Lack of Communication Persists

Patients Frequently Change Advance Directives at End of Life

Topic Alert

Receive an email from Medscape whenever new articles on this topic are available.

Add Palliative Care to My Topic Alert

DRUG & REFERENCE INFORMATION

Palliative Care in the Acute Care Setting

Palliative Care of the Patient With Advanced Gynecologic Cancer

ORLANDO, Florida — Physicians continue to provide high-intensity care for terminally ill patients but personally choose to forego such care at the end of life, according to a survey of young physicians.

"There is a striking difference between the end-of-life care that doctors choose for themselves and the care they provide to their patients," said lead investigator Vyjeyanthi Periyakoil, MD, from Stanford University in Palo Alto, California.

"The data are sobering," she added. "It appears that patients don't get preference-sensitive care."

Her team conducted the survey to determine what influences attitudes about advance directives, and whether attitudes have changed since the passage of the Patient Self-Determination Act in 1990.

She presented the results during the plenary session here at the American Geriatrics Society 2014 Annual Scientific Meeting.

Doctors Prefer to "Die Gently"

Of the 1081 survey respondents, 60% were 30 to 39 years of age. All were medical subspecialists finishing their clinical training at 2 academic hospitals. All respondents completed a Web-based form and a 14-item attitude survey on advance directives from March to June 2013.

Respecting Choices

Respecting Choices®

Home About Respecting Choices® Sue Grant Connections

About Respecting Choices®

Respecting Choices® is owned and operated by Gundersen Lutheran Medical Foundation, Inc., a not-for-profit corporation located in La Crosse, Wisconsin.

Mission

To assist organizations, communities, and individuals worldwide in implementing advance care planning practices that support informed healthcare decisions.

CMS HOSPITAL CONDITIONS OF PARTICIPATION (COPS)

What PPS Hospitals Need to Know about the CMS interpretive guidelines on advance directives

CMS Hospital CoP

- CMS hospital CoP effective in 1986 and manual updated more frequently now
  - CMS has a section on patient rights which contains the requirements for advance directives
  - CMS changes AD interpretive guidelines effective 12-2-2011
- CAH hospitals have a separate CoP (Appendix W, Standards C)
  - Rewrote the advance directive standards at tag 151 effective January 31, 2014
  - All manuals available on the CMS website[1]

[1] www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf

Location of CMS Hospital CoP Manual

Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop. use the browser "back" button. This is because closing the file usually will also close most browsers

CMS CoP Manuals are now located at www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB

L	Ambulatory Surgical Services Interpretive Guidelines and Survey Procedures	263 KB
M	Hospice	720 KB
N	Pharmaceutical Service Requirements in Long-Term Care Facilities	Deleted
P	Survey Protocol for Long-Term Care Facilities	929 KB
PP	Interpretive Guidelines for Long-Term Care Facilities	1,440 KB
Q	Determining Immediate Jeopardy	326 KB
R	Resident Assessment Instrument for Long-Term Care Facilities	38 KB
S	Mammograpy Suppliers	Deleted
T	Swing-Beds	363 KB
U	Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions	452 KB
V	Responsibilities of Medicare Participating Hospitals In Emergency Cases	393 KB
W	Critical Access Hospitals (CAHs)	1,597 KB

CoP Manual Also Called SOM

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 141, 07-10-15)

Transmittals for Appendix A

Survey Protocol

Introduction

Task 1 - Off-Site Survey Preparation

Task 2 - Entrance Activities

Task 3 - Information Gathering/Investigation

Task 4 - Preliminary Decision Making and Analysis of Findings

Task 5 - Exit Conference

Task 6 – Post-Survey Activities

Psychiatric Hospital Survey Module

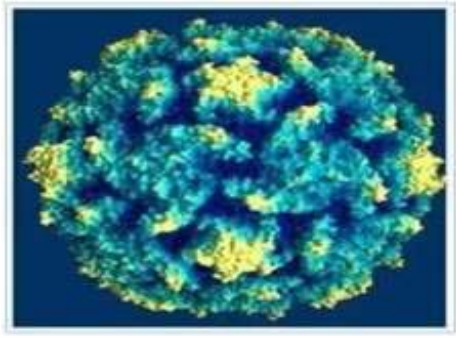
Psychiatric Unit Survey Module

Rehabilitation Hospital Survey Module

Inpatient Rehabilitation Unit Survey Module

Hospital Swing Bed Survey Module

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf



CAH Hospital CoP Manual or SOM

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 143, 07-31-15)

Transmittals for Appendix W

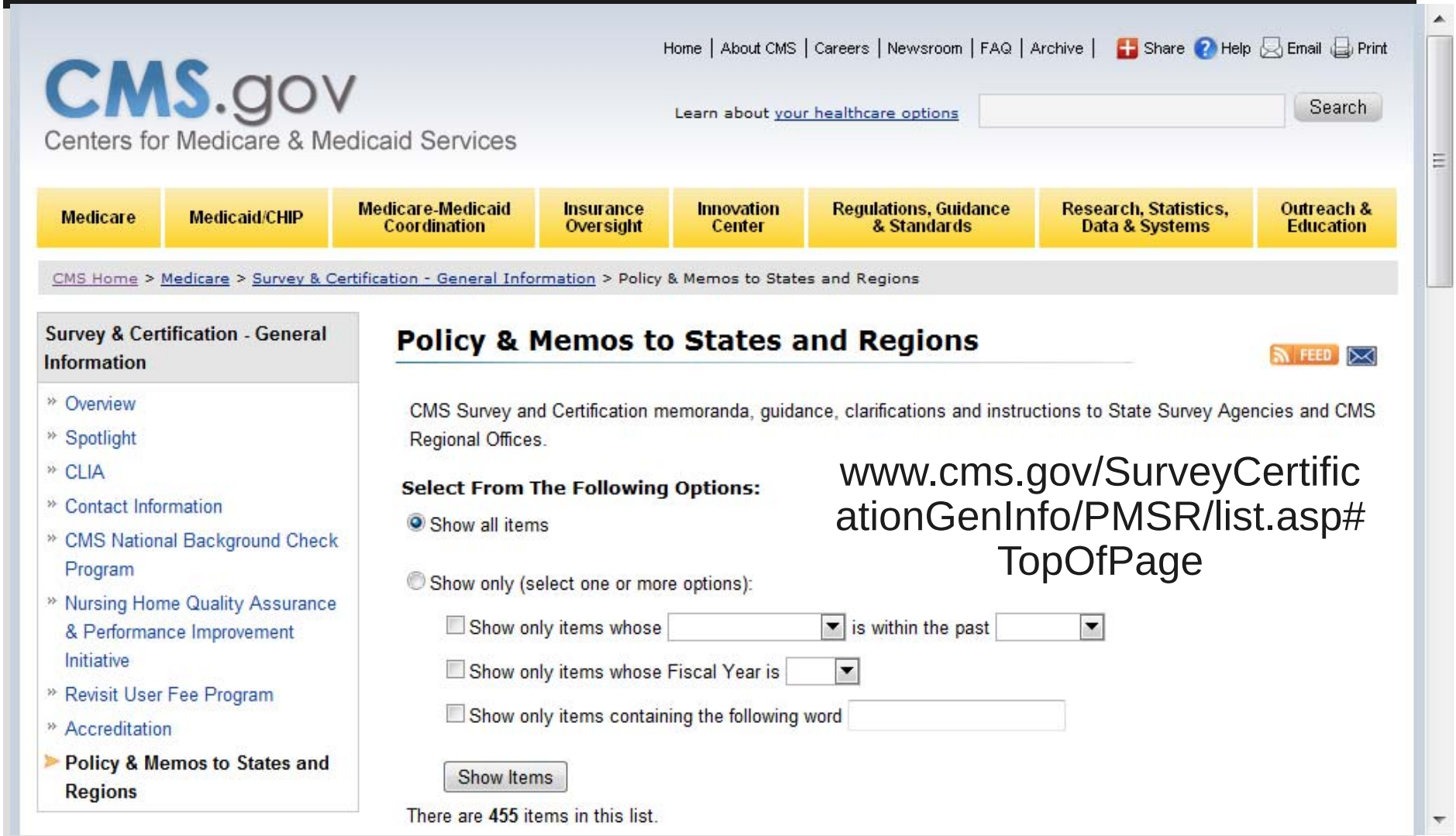
INDEX

Survey Protocol

Introduction
Regulatory and Policy Reference
Tasks in the Survey Protocol
Survey Team
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings

CMS Updated Website www.cms.gov

CMS Survey and Certification Website



www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Show entries: 10

Filter On:

Title	Memo #	Posting Date	Fiscal Year
Infection Control Breaches Which Warrant Referral to Public Health Authorities	14-36-All	2014-05-30	2014
Final Rule - Promoting Program Efficiency, Transparency, and Burden Reduction; Part II - Informational Only	14-33-ALL	2014-05-20	2014
Advance Copy of Revised F371; Interpretive guidance and Procedures for Sanitary Conditions, Preparation of Eggs in Nursing Homes	14-34-NH	2014-05-20	2014
Update of State Operations Manual (SOM) Chapter 5, Triaging Complaints & Referral of Complainants to Accrediting Organizations	14-35-ALL	2014-05-20	2014
Advance Copy – Single Use Device Reprocessing under Tag F441, Revisions to Interpretive Guidance in Appendix PP, State Operations Manual (SOM) on Infection Control	14-25-NH	2014-05-16	2014
Information for Applications to Extend the Due Date for the Installation of Automatic Sprinkler Systems in Existing Nursing Homes	14-29-LSC	2014-05-16	2014
Grant Solicitation for the Reinvestment of Federal Civil Money Penalty (CMP) Funds to Benefit Nursing Home Residents	14-30- NH	2014-05-16	2014
Provision of Electronic Health Record (EHR) "Navigators" during Hospital and Critical Access Hospital (CAH) Surveys	14-31-Hospitals/CAHs	2014-05-16	2014
The CMS Mitigating Factors Process for Solid Organ Transplant Programs – Notice of Proposed Rule-Making (NPRM) - Informational Only	14-32-Transplant	2014-05-16	2014

Number of Deficiencies

- CMS issued its first deficiency report in March 22, 2013 and updates data quarterly
- Advance directive is in patient rights sections which is the most problematic for hospitals
- April 15, 2015 the number of patient rights deficiencies is **4,292**
- Reports lists the name and address of all hospitals receiving deficiencies

Access to Hospital Complaint Data

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13–21- ALL

DATE: **March 22, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing Facilities, Nursing Facilities, Hospitals, & Critical Access Hospitals

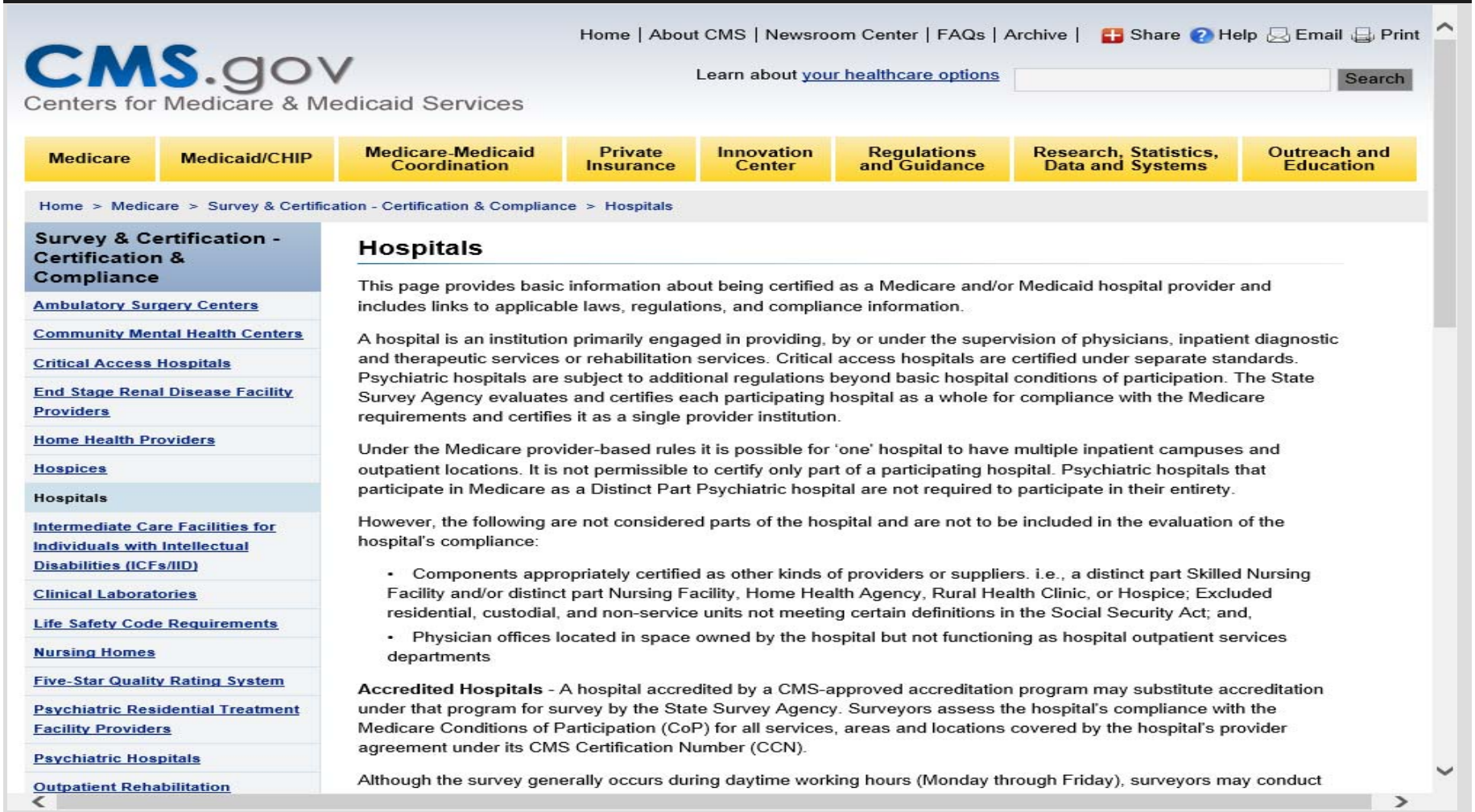
Memorandum Summary

- ***Survey Findings Posted on http://www.cms.gov:*** In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on *Nursing Home Compare*. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of those files.
- ***Other Web-based Tools Based on These Data:*** At least two additional websites, provided by private parties (*ProPublica* and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.
- ***Plans of Correction (POC):*** The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.
- ***Question & Answers:*** We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

Background – Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Form

Updated Deficiency Data Reports



www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

Advanced Directive Deficiencies July 2015

Section	Tag Number	Number
Advance Directives and Notice of Patient Rights	117 (and 116)	212
Advance Directive & Care Planning	130	104
Advanced Directives, Consent, Decision Making	131 & 132	327
Advance Directive & Visitation	216	15
Advance Directive & Transfer	837	65
Total		723

CMS Changes to Advance Directives

- CMS issues a 34 pages memo on September 7, 2011and issued transmittal 12-2-2011
- Main focus was on the new interpretive guidelines to comply with the federal law on visitation
- However, this survey and certification memo had several changes to patient rights including advance directives
  - These interpretive guidelines were added to the current CMS CoP manual

Advance Directive Changes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 02-02-38
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C: 11-36-Hospital/CAH

DATE: **September 7, 2011**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

SUBJECT: Hospital Patients' Rights to Delegate Decisions to Representatives; New Hospital and Critical Access Hospital (CAH) Patient Visitation Regulation

Memorandum Summary

- ***President's Directive:*** On April 15, 2010 the President issued a memo concerning hospital visitation and designation of representatives.
- ***Clarification of Patients' Rights Concerning Designation of Representatives:*** Hospitals are obligated under certain circumstances to extend patients' rights to patients' representatives. The Centers for Medicare & Medicaid Services (CMS) expects hospitals to give deference to patients' wishes concerning their representatives, whether expressed in writing, orally, or through other evidence. Hospital Appendix A is being revised to clarify the applicable requirements

Transmittal Dec 2, 2011

CMS Manual System
Pub. 100-07 State Operations
Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 75 | **Date: December 2, 2011**

SUBJECT: Revised Appendix A, Interpretive Guidelines for Hospitals, and Appendix W, Interpretive Guidelines for Critical Access Hospitals (CAHs)

I. SUMMARY OF CHANGES: Clarification is provided for existing hospital regulations 42 CFR 482.13(a) and (b), and new 42 CFR 482.13(h), concerning hospital patients' rights, including advance directives and visitation rights. Clarification is provided for existing CAH regulations at 42 CFR 485.608(a), concerning compliance with Federal laws and regulations, including regulations governing advance directives and required patient disclosures. Guidance is provided for new 42 CFR 485.635(f), concerning CAH patients' visitations rights.

NEW/REVISED MATERIAL - EFFECTIVE DATE: December 2, 2011
IMPLEMENTATION December 2, 2011

The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix A/§482.13(a) Standard: Notice of Rights/A-0117
R	Appendix A/§482.13(b) Standard: Exercise of Rights/A-0130
R	Appendix A/§482.13(b) Standard: Exercise of Rights/A-0131
R	Appendix A/§482.13(b) Standard: Exercise of Rights/A-0132
R	Appendix A/§482.13(b) Standard: Exercise of Rights/A-0133
N	Appendix A/§482.13(h) Standard: Patient Visitation Rights/A-0215
N	Appendix A/§482.13(h) Standard: Patient Visitation Rights/A-0216
N	Appendix A/§482.13(h) Standard: Patient Visitation Rights/A-0217
R	Appendix W/§485.608(a) Standard: Compliance With Federal Laws and Regulations/A-0151
N	Appendix W/§485.635(f) Standard: Patient Visitation Rights/C-1000

Surveyor Conducting Interviews

- CMS CoP also has information on advance directives in the first section on introduction to the survey process
- CoP directs the surveyor on topics for the patient or family interview and includes the topic of advance directives
- CoP manual provides directions to the surveyor during the document review session and states to review the medical record for evidence of advance directives
  - CMS has advance directives standards addressed in tags 117, 130, 131, 132, 216 and 837

Notify Patients of Their Rights 117 12-2-2011

- A hospital must inform the patient, or their representative, of their rights in advance of providing care
- Provide rights in a manner the patient can understand
  - Issue of low health literacy and 20% of patients read at a fifth grade level so make sure it is understandable
- The issue of limited English proficiency is important so use an interpreter when appropriate
  - CMS says it can refer non-compliance to the Office for Civil Rights

Notify Patients of Their Rights 117 12-2-2011

- Discusses extending patient rights to patient representatives
- Reiterated many of the patient rights like notice of patient right must be given to the patient or their representative
- Hospital are expected to take reasonable steps to determine patient wishes regarding designation of a representative
- Discusses the rights of the patient representative who steps into the shoes of the patient when the patient is incapacitated

Who is a Patient Representative?

- Parent of a minor child
- Guardian
- DPOA of a patient who is incapacitated
- Support person/visitation advance directive who is also referred to as the patient advocate by the Joint Commission
- If patient has no advance directives on file it can be whoever shows up and claims to be the patient representative like the spouse, same sex partner, friend, etc.

Patient Representative 117

- If the patient is competent (not incapacitated) can still orally or in writing designate another to be their representative
  - Hospital must give this person **and** the patient the required notice of patient rights
  - Speaker suggest hospital may want to get this in writing
  - The explicit designation of a representative takes precedent over any non-designated relationship
  - This continues through out the admission or outpatient treatment

Patient Representative 117 12-2-11

- If the patient is not competent (incapacitated) then when an individual presents with an AD or durable power of attorney (DPOA) then hospital proceeds with its P&P
  - This designation of a representative takes precedence over any non-designated relationship and continues throughout stay
  - Unless the patient ceases to be incapacitated and especially withdrawals this
  - CMS says can be done orally or in writing
  - Speaker suggests hospitals get it in writing

Patient Representative 117 12-2-11

- If not competent and unable to state wishes and no ADs and person asserts is spouse or domestic partner (including same sex partners), parent of minor child, or other family member, hospital is expected to accept without demanding supporting documentation
  - However, if more than one person claims to be the patient representation (PR) then appropriate to ask for documentation to support their claim
  - Such as proof of marriage, domestic partnership, joint household, co-mingled finances etc

The Exact Language 117

- In the case of a patient who is incapacitated, when an individual presents the hospital with an advance directive, medical power of attorney or similar document executed by the patient and designating an individual to make medical decisions for the patient when incapacitated, then the hospital must, when presented with the document, provide the required notice of its policies to the designated representative. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient's inpatient stay or outpatient visit, unless the patient ceases to be incapacitated and expressly withdraws the designation, either orally or in writing.

- When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is no written advance directive on file or presented, and an individual asserts that he or she is the patient's spouse, domestic partner (whether or not formally established and including a same-sex domestic partner), parent (including someone who has stood in loco parentis for the patient who is a minor child), or other family member and thus is the patient's representative, the hospital is expected to accept this

Patient Representative 117 12-2-11

- State law can specify a procedure for determining who is a patient representative if patient is incapacitated
- A refusal by the hospital of a person requested to be treated as a patient representative must be documented in the medical record along with a specific basis for the refusal

Patient Rights A-0131 12-2-2011

- Patient, or their representative, has a right to make informed decisions regarding his or her care
- This includes the right to be informed of their status and to request or refuse care
- A patient has the right to delegate informed decision making to another person
- Hospitals need to take reasonable steps to determine patient's wishes concerning designation of a representative

Consent Informed Decisions A-0131

- Competent patient asks someone to be their representative, orally or in writing, then person must be given information on informed decisions about patient care
  - This includes getting informed consent from them when required
  - Explicit designation of a representative by the patient takes precedence over any non-designated relationship
  - It continues throughout the inpatient admission or outpatient visit unless withdrawn by the patient

Consent from Competent Pt & PR

Hospitals are expected to take reasonable steps to determine the patient's wishes concerning designation of a representative. Unless prohibited by applicable State law:

- *When a patient who is not incapacitated has designated, either orally to hospital staff or in writing, another individual to be his/her representative, the hospital must provide the designated individual with the information required to make an informed decision about the patient's care. The hospital must also seek the written consent of the patient's representative when informed consent is required for a care decision. The explicit designation of a representative by the patient takes precedence over any non-designated relationship and continues throughout the patient's inpatient stay or outpatient visit, unless expressly withdrawn, either orally or in writing, by the patient.*

Consent Informed Decisions 131

- Patient is not competent and an individual presents the hospital with an advance directive, medical power of attorney (DPOA) or similar document
  - Then informed consent is obtained by this person
- Not competent and no advance directive, then the person who asserts is the spouse, domestic partner (including same sex partner), parent of child, or family member decides and thus is the patient representative
  - Can’t demand documentation unless two people claim to be the patient representative

Patient Rights 131

- The right to make informed decisions presumes the patient has been provided information about their health status, diagnosis, and prognosis
- Hospitals must assure that each patient or their representative is given information about their diagnosis and prognosis
- Patient has a right to formulate advance directives (132) and to have hospital provide care to comply with these directives
- Right to have advance directives consulted when unconscious or incapacitated

Advance Directives 132 12-2-2011

- Advance directive is defined as
  - A written instrument, such as a living will or durable power of attorney for healthcare, recognized under state law (case law or statutory law), relating to the provision of healthcare when the individual is incapacitated
- Inpatients and outpatients have the right to formulate an advance directive and have it followed
- Patients have the right to refuse medical care
  - But remember should be an educated right with risks and benefits disclosed

Advance Directives 132

- In advance directives patient may provide what care they want or do not want
- In advance directive, patient can delegate decision making to another person such as a DPOA
  - This person steps into the shoes of the patient when the patient is unable to speak for themselves and consent is obtained from the DPOA (surrogate decision maker)
- Patient may also delegate support person also in their advance directives for purpose of exercising patient visitation rights
- Designation in the AD takes precedence

Advance Directives 132

- Written notice of the hospital's AD policy must be provided to inpatients when admitted at time of registration
  - Such as right to make an AD
  - A summary and not a copy of the AD P&P
  - Document this in the MR
- Also to outpatients or their representatives in the **ED, observation** or undergoing **same day surgery**

The Exact Language Tag 132

§489.102 also requires the hospital to:

- Provide written notice of its policies regarding the implementation of patients' rights to make decisions concerning medical care, such as the right to formulate advance directives. If an individual is incapacitated or otherwise unable to communicate, the hospital may provide the advance directive information required under §489.102 to the individual's "family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law."(§489.102(e)) The guidance concerning the regulation at §482.13(a)(1) governing notice to the patient or the patient's representative of the patient's rights applies to the required provision of notice concerning the hospital's advance directive policies. Although both inpatients and outpatients have the same rights under §482.13(a)(1), §489.102(b)(1) requires that notice of the hospital's advance directive policy be provided at the time an individual is admitted as an inpatient. However, in view of the broader notice requirements at §482.13(a)(1), the hospital should also provide the advance directive notice to outpatients (or their representatives) who are in the emergency department, who are in an observation status, or who are undergoing same-day surgery. The notice should be presented at the time of registration. Notice is not required for other outpatients, given that they are unlikely to become incapacitated.

Patient Rights 0132

- Note rights as inpatient and outpatient AD requirements of TJC
- Be sure practitioners and staff provide care that is consistent with these directives with the patient is incapacitated
  - That why it is called an advance directive
  - Patient while competent decide in advance what they do and do not want done when they become unable to speak for themselves
- In your policy should have clear statement of any limitations such as conscience

Conscience Objectors 132

- CMS states that the provision allowing for conscience objection to implementing an advance directive is narrowly focused on the directive's content related to medical conditions or procedures
  - This would not allow a hospital or individual physician to refuse to honor those part of the advance directive that designate an individual as the patient's representative and/or support person
  - This is because this does not concern a medical condition or procedure
- Notice to the patient must be clear on basis of conscious objections

Advance Directives

- At a minimum, clarify any difference between facility wide conscience objections and those raised by individual doctors or other practitioners
- Identify the state legal authority permitting such objection
- Describe the medical conditions or procedures affected by the conscience objection
- You must provide written information to the patient on their rights under state law

Advance Directives

- Document in the MR whether or not they have one
- Not condition treatment on whether or not they have one
- Ensure compliance with state laws on AD
- Inform patients they may file complaints with state survey and certification agency
  - Like the department of health or the QIO for Medicare patients

Patient Rights Advance Directives 0132

- Provide for education of staff and on P&P on advance directives
- Provide community education and document
- Right to formulate advance directives includes right to make psychiatric AD (PAD) as allowed by state law
- PAD should be given respect and consideration as traditional AD
- PAD may apply if subject to involuntary commitment

Survey Procedure 132

- CMS has survey procedures which directs the surveyor what to ask and what documents to look at
- Surveyor is to review the advance directive notice given to the inpatients and applicable outpatients
  - Does this include the right of the patient to make an advance directive
  - Does it include that staff must comply with the advance directive in accordance with state law
- Surveyor is instructed to review the medical record for evidence of compliance with AD
  - Is there documentation in every inpatient and applicable outpatient record that the notice was given to the patient when they registered

Survey Procedure 132

- If patient reported they have an AD, has a copy been placed in the medical record?
- What process is in place to allow patients to make one if they want?
- What is the process to update their current advance directive?
- Surveyor is suppose to look at what education hospital has done on AD
- Surveyor is to interview staff to determine their knowledge of AD

Informing the Patient 216

- Must inform each patient of their visitation rights or support person when appropriate
- Patient can withdrawal consent for visitors at anytime
- If patient is incapacitated or unable to communicate then provide information to their advance directive designating a support person
  - Could be a visitation advance directive and can be different than the DPOA

Advance Directives 216

- If no AD designating a representative then individual who asserts is spouse, domestic partner, parent of a child, or other family friend or family, the hospital will accept this without requiring proof
  - Unless more than one person claims to be the support person then ask for documentation
- Need to have non-discriminatory resolution of disputes
- Refusal to honor request of person to be treated as the support person must be documented in the medical record along with basis for refusal

Incapacitated Patient with No AD

When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is no advance directive designating a representative on file, and no one has presented an advance directive designating himself or herself as the patient's representative, but an individual asserts that he or she, as the patient's spouse, domestic partner (including a same-sex domestic partner), parent or other family member, friend, or otherwise, is the patient's support person, the hospital is expected to accept this assertion, without demanding supporting documentation, provide the required notice of the patient's visitation rights, and allow the individual to exercise the patient's visitation rights on the patient's behalf. However, if more than one individual claims to be the patient's support person, it would not be inappropriate for the hospital to ask each individual for documentation supporting his/her claim to be the patient's support person.

- *Hospitals are expected to adopt policies and procedures that facilitate expeditious and non-discriminatory resolution of disputes about whether an individual is the patient's support person, given the critical role of the support person in exercising the patient's visitation rights.*

CMS Surgery Section Tag 751

- CMS has a standard in the surgery section, tag A-0951, that requires a policy on DNR status
- Staff should be aware of their facility policy on DNR in the OR and in the hospital setting
- Policy should consider position statement from professional organizations
- Policy should reflect state regulations and case law
  - For example in Ohio has a statute and rules on DNR
- Rules contain the substantive information on how personnel should proceed
- Know your state laws (statutes and case law)

Transfer or Referral 837

- This standard talks about what the hospital must do when it transfers a patient
- The hospital must send the necessary medical records along with the patient
- CMS requires that when the patient is transferred that a copy of the advance directives is sent with the patient
- Also make sure you use an interpreters if patient need and remember issue of low health literacy

CMS Critical Access Hospital (CAH) on Advance Directives

Amended June 7 2013 C-0151

Appendix W
Critical Access Hospital Interpretive Guidelines

C-0151

§485.608(a) Standard: Compliance With Federal Laws and Regulations

The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients.

Survey Procedures §485.608(a)

Each CAH must be in compliance with applicable Federal laws and regulations related to the health and safety of patients. This includes other Medicare regulations and Federal laws and regulations not specifically addressed in the CoPs. State Survey Agencies are expected to assess the CAH's compliance with the following Medicare provider agreement regulation provisions when surveying for compliance with §485.608(a):

Advance Directives

An advance directive is defined at 42 CFR 489.100 as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." In accordance with the provisions of 42 CFR 489.102(a), the advance directives regulations apply to CAHs. The CAH patient (inpatient or outpatient) has the right to formulate advance directives, and to have CAH staff implement and comply with the individual's advance directive. The regulation at 42 CFR 489.102 specifies the rights of a patient (as permitted by State law) to make medical care decisions, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option,

CAH Advance Directives 151

- CAH must in compliance with federal laws and regulations related to the health and safety of patients
- Inpatients and outpatients have the right to make advance directives
- Staff must comply with their advance directives
- Patients have the right to refuse treatment
- Make have a DPOA or another person such as a support person

CAH Advance Directives 151

- Must use advance directives to designate a support person for person of exercising the visitation rights
- If patient incapacitated and DPOA then must give this information to make informed decisions and consent for the patient
- CAH must also seek the consent of the patient's representative when informed consent is required for a care decision

CAH Advance Directives 151

- Must provide advance directive information to the competent patient when admitted
  - Must also give to the outpatient if in the ED, observation, or same day surgery patient
  - Must document you gave it in the medical record
- If incapacitated then to the family or surrogate
- Has conscience objector clause but must still allow DPOA or support person to make decision if incapacitated

Advance Directives 151

- Can not require one
- Must make sure staff is educated on the P&P
- This includes the right to make a psychiatric advance directive or mental health declaration
  - Should still give consideration even if not a state specific law
- Must provide community education

Joint Commission Tracer

Patient Rights includes addressing advance

Patient Rights Tracer Removed 2015

- Please note that patient rights tracer removed in 2013 but provided as reference since surveyor may still ask questions
- A list of these questions have been included for reference
- Note that rights of patients is mentioned under individual tracers
- Documents surveyor is suppose to see is information in the admission packet such as advance directives

Questions Asked About in Past

- Surveyor should assess patient and family understanding of the following:
- Rights including advance directives
- Make sure given rights prior to receiving care
- Process and right to register a complaint or grievance (CMS has grievance standards)
- Patient safety and privacy of health information

Patient Centered Communication Removed 2013

- During each individual tracer surveyor will interview staff about the following (still a standard in 2015):
  - What the hospital is doing to minimize risk
  - How the hospital is collecting race and ethnicity data
  - How are the staff asking patients about their communication needs
  - How staff identify if patients have oral or written communication needs and how these are address
  - Access to language interpreters and translated documents and involvement of interpreter on the care team

Patient Centered Communication

- During each individual tracer surveyor will interview staff about the following:
- Hospital support of patient's right of access to advocate or support person during hospitalization
- Will interview interpreters and translators about their training, experience, and qualifications
  - This includes employed staff, bilingual staff, and volunteers
- Remember the TJC five patient centered communication standards in 4 different chapters

TJC Advance Directive Standards

What Hospitals Should Know

TJC Standards Advance Directive is..

TJC Definition (not called JCAHO anymore):

- A document or documentation allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if the individual loses decision-making capacity
- Advance directives may include living wills, durable powers of attorney (DPOA), do-not-resuscitate (DNRs) orders, right to die, or similar documents listed in the Patient Self-Determination Act (PSDA) which express the patient's preferences

TJC Advance Directive RI.01.05.01

- Standard: The hospital addresses patient decisions about care and services received at end of life care
- There are 21 elements of performance
- Actually only 16 since 2, 3, 7, 14 and 18 do not apply to hospitals
- This standard does not have a rationale
- Standard especially important for patients to make end of life decisions

End of Life Decision

- The hospital should address the wishes of the patient relating to end-of-life decisions
- P&P address advance directives and are consistent with the federal and state law
- P&P provide the framework for foregoing or withdrawing life-sustaining resuscitation services
- Do you provide end of life education to staff?

TJC Advance Directive RI.01.05.01

- **EP1** Hospital has written P&P on advance directives
  - Need to include P&P on forgoing or withholding life sustaining treatment
  - And P&P on withholding resuscitation services
  - Must in accordance with laws
- **EP4** Need to specify whether hospital will honor AD in outpatient setting
  - Need written policy on this

TJC Advance Directive RI.01.05.01

- **EP5** Hospital must implement its AD policies
- **EP6** Hospital provides patients with written information about AD
  - This includes foregoing or withdrawing life sustaining treatment and withholding resuscitation services
- **EP8** Hospital must provide patient with information on admission is able or if unable or unwilling to comply with AD

TJC Advance Directive RI.01.05.01

- **EP9** Hospital must document if the patient has or does not have an AD
- **EP10** Hospital refers patient for assistance in drafting AD, upon request
- **EP11** Staff and LIPs involved in patient's care are aware of whether or not patient has AD
- **EP12** Hospital honors patient's right to review and revise their AD

TJC Advance Directive RI.01.05.01

- **EP13** Hospital needs to honor AD in accordance with law and regulation and the hospital's capabilities
- **EP15** Document patient wishes concerning organ donation when they make their wishes known to the hospital or as required by P&P or laws and regulations
- **EP16** Must honor the patient's wishes concerning organ donation within limits of hospital's capabilities and laws

TJC Advance Directive RI.01.05.01

- **EP17** Access to care is not determined by fact patient has an AD or doesn't have one
- **EP19** The hospital must communicate its policy upon request or when warranted by the care provided if their P&P on AD in the outpatient setting
- **EP20** Hospital refers patient to resources to help them draft an AD in the outpatient setting

TJC Advance Directive RI.01.05.01

- **EP21** The hospital defines how it obtains and documents permission to perform an autopsy
  - Will ask for copy of autopsy policy
- This standard is for hospitals that use the Joint Commission standard for deemed status (DS)
  - The VA is TJC accredited but they do not accept Medicare or Medicaid reimbursement at this time so they do not have to follow this standard
- This was added to the TJC standards because it is a CMS CoP

Record of Care RC.02.01.01 EP4

- TJC has a Record of Care chapter or RC
- It has one section regarding advance directives
- This standard says that the medical record must contain a copy of the advance directive
- Remember to follow up with patients and obtain a copy and place it on the chart

Recommendation for Compliance

- Place a **sticker** on the front of the chart that lists the types of advance directives and mark each one that the patient has or have a tab in the electronic record
- Comply with standard so that all staff are notified patient has an AD
- Have a **policy and procedure** that is includes these provisions
- Complete an advance directive form on every patient upon admission, get copies on the chart!
- Ask the patient and document if they want any **changes** to their advance directives

Recommendation for Compliance

- Document review by one of your staff to make sure the patient has not changed their mind
- Add this as a check off box on your advance directive form
- Advance directives reviewed with patient or family members
- Policy needs to address what will happen when patient goes to surgery
- May include information in packet for outpatients as to your policy

Organizations Position Statements

Position Statements

- American College of Surgeons on Advance Directives and DNR orders in the operating room[1]
- AORN has policy on perioperative care of patients with DNR orders, automatically suspending order during surgery undermines patient's right to self determination
- Need to discuss and document issues with patients whether to be continued in OR or not or partially suspended

[1] http://www.facs.org/fellows_info/statements/st-19.html or https://www.facs.org/about-acs/statements/19-advance-directives

ASA Position Statement

- American Society of Anesthesiologist “Ethical Guidelines for the anesthesia care of patients with do not resuscitate orders or other directives that limit treatment[1]
- Policies automatically suspending DNR orders may not address patient’s rights to self determination
- Administration of anesthesia might involve some practices seen as resuscitation in other settings

[1] www.asahq.org/publicationsAndServices/sgstoc.htm 2 http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

ASA DNR Orders

ETHICAL GUIDELINES FOR THE ANESTHESIA CARE OF PATIENTS WITH DO-NOT-RESUSCITATE ORDERS OR OTHER DIRECTIVES THAT LIMIT TREATMENT

Committee of Origin: Ethics

(Approved by the ASA House of Delegates on October 17, 2001, and last amended on October 16, 2013)

These guidelines apply both to patients with decision-making capacity and also to patients without decision-making capacity who have previously expressed their preferences.

I. Given the diversity of published opinions and cultures within our society, an essential element of preoperative preparation and perioperative care for patients with Do-Not-Resuscitate (DNR) orders or other directives that limit treatment is communication among involved parties. It is necessary to document relevant aspects of this communication.

II. Policies automatically suspending DNR orders or other directives that limit treatment prior to procedures involving anesthetic care may not sufficiently address a patient's rights to self-determination in a responsible and ethical manner. Such policies, if they exist, should be reviewed and revised, as necessary, to reflect the content of these guidelines.

III. The administration of anesthesia necessarily involves some practices and procedures that might be viewed as "resuscitation" in other settings. Prior to procedures requiring anesthetic care, any existing directives to limit the use of resuscitation procedures (that is, do-not-resuscitate orders and/or advance directives) should, when possible, be reviewed with the patient or designated surrogate. As a result of this review, the status of these directives should be clarified or modified based on the preferences of the patient. One of the three following alternatives may provide for a satisfactory outcome in many cases.

A. Full Attempt at Resuscitation: The patient or designated surrogate may request the full suspension of existing directives during the anesthetic and immediate postoperative period, thereby consenting to the use of any resuscitation procedures that may be appropriate to treat clinical events that occur during this time.

B. Limited Attempt at Resuscitation Defined With Regard to Specific Procedures: The

ASA End Of Life Care

STATEMENT ON QUALITY OF END-OF-LIFE CARE

Committee of Origin: Pain Medicine

(Approved by the ASA House of Delegates on October 21, 1998, last amended on October 22, 2008, and reaffirmed on October 16, 2013)

Patients developing incurable diseases frequently experience more pain and distressing symptoms than necessary near the end of life. This circumstance is distressing because adequate pain and symptom management in most cases is not dependent upon future medical discoveries, but can be achieved with contemporary management methodologies. Quality end-of-life patient care requires that palliative (or comfort) treatment concepts be integrated into the care of these patients.

The American Society of Anesthesiologists believes that opportunities exist to improve our patients' end-of-life care. Education and training of patients, families, health care workers and physicians should be undertaken to promote available, compassionate, comprehensive and interdisciplinary end-of-life care.

Further, the American Society of Anesthesiologists believes that the improvements in palliative care should be based on values-based advanced care planning. This advanced care planning should attempt to minimize the sense of abandonment often described by patients near the end of life and the loss of control many patients feel.

Finally, the American Society of Anesthesiologists declares opposition to physician-assisted suicide and agrees in principle with the American Medical Association that provision of assisted suicide is not compatible with the role of a physician. Anesthesiologists should always strive to relieve suffering, address the psychological and spiritual needs of patients at the end of life, add value to a patient's remaining life and allow patients to die with dignity.

ASA Standard and Guidelines

Position

- Full attempt at resuscitation which includes the immediate post-op period
- Limited attempts such as chest compressions or defib or tracheal intubation
  - Patient is informed 1) essential to the success of the anesthesia and the proposed procedure, and 2) which procedures are not essential and may be refused
- Limited attempt with regard to patient goals and values
  - Anesthesiologists uses clinical judgment in which ones to use in light of patient's goals

Council on Surgical & Perioperative Safety

- One website to access DNR position statements of many organizations[1]
- This includes:
  - ASPAN for the PACU staff
  - ACS DNR in the OR for the surgeons
  - AORN for the OR nurses on Perioperative Care of the Patient with a DNR Order
  - AST DNR article for the surgical techs

[1] www.cspsteam.org/resuscitationplan/resuscitationplan.html

Council on Surgical & Perioperative Safety

CSPS COUNCIL ON SURGICAL & PERIOPERATIVE SAFETY

One Team. One Goal. Surgical Patient Safety.

Home | About Us | Safe Surgery Resources | Resources | News & Press Releases | Member Link | Contact Us

http://www.facs.org/fellows_info/statements/st-19.html

CSPS Safe Surgery Resources

EMAIL SHARE

Resuscitation Plan

#15

Patients who are not candidates for resuscitation may nonetheless require perioperative care. Such care should respect the patients' wishes and directives and their effect on the perioperative plan. These issues should be addressed by the surgeon and anesthesia provider with the patient or surrogate decision maker in advance of the procedure whenever possible. The plan of care should be shared with all members of the perioperative team.(Adopted 6.29.09)

- ASPAN: Position Statement on the Perianesthesia Patient with a Do-Not-Resuscitate Advance Directive
- ACS: Statement on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room
- AORN: Position Statement on Perioperative Care of Patients with Do-Not-Resuscitate or Allow-Natural-Death Orders
- AST: Do Not Resuscitate Article (pdf)

>>Back to Safe Surgery Resources

PACU Care ASPAN

- Nurse should follow standards of post anesthesia nursing practice
- Position statements are available[1]
- Also has position statement on Perianesthesia patient with DNR Advance Directive
- Three pages long and notes 15% of patients have a DNR order

[1] http://www.aspan.org/Portals/6/docs/ClinicalPractice/PositionStatement/2-DNR.pdf

POSITION STATEMENT 2

American Society of PeriAnesthesia Nurses

A Position Statement on the Perianesthesia Patient with a Do-Not-Resuscitate Advance Directive

Synopsis

Ethical care during the perianesthesia period requires that the nurse act in accordance with ethical principles and with a patient's predetermined end-of-life wishes. The perianesthesia nurse's ethical responsibilities encourage advocacy to assure a preanesthesia patient's consent is truly informed, autonomous and self-determined. The nurse also demonstrates respect by facilitating holistic concern for the perianesthesia patient's emotional, spiritual and educational well being while providing physical safety.

A patient whose advance directive specifies no life sustaining measures may be unaware that cardiac or respiratory arrest are always potential yet usually reversible outcomes associated with anesthesia. When the patient's desires for the perianesthesia period are not specifically identified, anesthetic-related changes in physiologic function present the perianesthesia nurse with ethical conflict and confusion about appropriate interventions.

Background

1. An estimated 15% of surgical patients have an active do-not-resuscitate or do-not-intubate clause that reflects the elderly or chronically ill patient's considered preference for a "dignified death" without artificial life support.[1,2]

2. Palliative treatment or comfort care or emergency events might require anesthesia and surgery. These interventions stress physiologic function, suppress consciousness and precipitate transient, reversible decreases in cardiac and respiratory function, but are not associated with natural evolutions toward the patient's death.[2,3,4,5]

3. Endotracheal intubation, mechanical ventilation, cardiovascular medications, cardiopulmonary resuscitation, and defibrillation/cardioversion are often specifically restricted in an advance directive.[1,2,6,7] The patient, family, and/or legal representative may not be aware that some of these interventions are routinely used to support vital organ functioning during the perianesthesia period.

4. Ethically, ignoring the issue, assuming the patient's wishes or applying a facility policy or medical decision that automatically suspends any patient's DNR/DNI directive during the perioperative period denies the patient's right to self-determination and to autonomous, informed choices.[2,4,7,8]

5. The perianesthesia nurse is intimately involved in determining patient readiness for procedures, often is the "first-responder" who witnesses, then collaborates with physicians to intervene and evaluate the outcomes of respiratory and/or cardiac arrest. [3,4,6,11] Unclear communications and ambiguous or nonexistent facility policies about a patient's DNR/DNI status during the perianesthesia period do not direct and support a nurse's decisions and actions. Ethically, this nurse must choose between not responding, thereby doing harm (maleficence), and a professional and legal obligation to preserve life without harm (beneficence). These choices may conflict with the patient's stated end-of-life choices.[9,10,12]

Position

The American Society of PeriAnesthesia Nurses (ASPAN) recommends that at the time of surgery and prior to receiving any anesthetic medication, a patient with an active do-not-resuscitate advance directive and/or patient representative will be asked to reclarify wishes about resuscitation during the perianesthesia period.

To limit potential for ethical dilemmas, the patient's informed consent will include discussion of the advance directive, living will or physician order that specifies Do-Not-Resuscitate (DNR) or Do-Not-Intubate (DNI) during a candid and well-documented conversation with physicians and appropriate significant other(s).

Each facility establishes and communicates a policy that identifies resources and procedures that detail the management of a patient's DNR/DNI status during the perianesthesia period.

Approval of Statement

This statement was approved by a vote of the ASPAN Board of Directors on April 20, 1996 in Phoenix, Arizona. ASPAN joins other professional colleagues, specifically the American Nurses Association (ANA), the Association of periOperative Registered Nurses (AORN) and the American Society of Anesthesiologists (ASA), in considering the ethical implications of the advance directive.

This position statement was reviewed at the October 2007 meeting of the Standards and Guidelines Committee in Batesville, Indiana.

Position Statements

- ACEP 'Do Not Attempt Resuscitation' (DNAR) in the Out-of-Hospital Setting on website[1]
- American College of Surgeons on Advance Directives and DNR orders in the operating room on website[2]

[1] http://www.acep.org/webportal/PracticeResources/PolicyStatements

[2] http://www.facs.org/fellows_info/statements/st-19.html

'Do Not Attempt Resuscitation' Orders in the Out-of-Hospital Setting

This Policy Resource and Education Paper is an explication of the Policy Statement 'Do Not Attempt Resuscitation' (DNAR) in the Out-of-Hospital Setting.

Overview

Emergency medical providers often care for patients in cardiac arrest, and numerous ethical dilemmas may be encountered, including conflicting family opinions, unreasonable requests by bystanders, lack of availability of advance directives, and others.[1,2] Protocols regarding the withholding of resuscitative efforts vary widely among states and EMS jurisdictions within states. Such protocols should address many issues including justification, specificity, patient participation, inclusion of minors, futility, portability, utilization of healthcare resources, and responsibility for pronouncing death.[3]

As of 2002, 42 states had statewide out-of-hospital DNR protocols.[4] Of those, 34 were specifically authorized by statute, usually supplemented by regulation or guidelines. Eight states had implemented protocols solely through regulations or guidelines without a change in their legal code. Eight states and the District of Columbia had no statewide protocol in place. Of the 42 protocols, 39 are physician orders requiring physician signature (7 states require only a physician signature, while in 32 states both physician signature and patient endorsement of the DNAR order are required). Three protocols are patient-initiated advance directives and are valid with a witnessed patient signature, no physician involvement required.

The significance of advance directives and their role in health care at the end of life has been previously demonstrated.[5,6,7,8,9] Unfortunately, despite efforts to increase public awareness of advance directives, including public education, education within the medical community, and legal mandates, (such as, the 1991 Federal Patient Self-Determination Act), only a minority of patients have completed advance directives.[10,11,12,13] When available, advance directives can be valuable in ascertaining and following patient wishes for end of life care. Yet, completing standard advance directives do no address resuscitation issues arising in the out-of-hospital setting.

In deference to basic ethical principles, some states and some organizations' suggested statutes have focused on providing comfort care while forgoing ***only*** resuscitative interventions. Such documents, (e.g., Comfort Care DNR Order, 'Physician Orders for Life-Sustaining Treatment [POLST], Comfort One®, CPR directive, Arizona's prehospital advance directive statute,[14] and others) emphasize the need for comfort and caring during the dying process.

In both out-of-hospital and hospital settings, current resuscitation techniques generally fail in patients with comorbid illness, terminal cancer, and other irreversible disease states, when they suffer a cardiopulmonary arrest. Public opinion polls echo awareness of these findings, claiming the majority of Americans oppose life support in scenarios of terminal illness or permanent unconsciousness.[15] Despite public and professional agreement regarding the low likelihood of success in such situations, the medicolegal compact to attempt resuscitation, in the absence of a valid DNAR decision, continues to be sanctioned by society and supported by EMS providers as the standard of care.

The Out-of-hospital DNAR policy should:

1. Note the established fact that current basic and advanced life support interventions may not be appropriate or beneficial in certain clinical settings;
    - Develop a means to educate the public about the appropriate use of 911 following *expected* deaths.
    - Establish the fact that comfort care and palliative care are affirmative actions for patients with DNAR orders. These appropriate interventions, (e.g., hospice or respite care) DO NOT require EMS activation, and often can be arranged by calling the patient's physician in anticipation of death.
    - Develop a means to educate healthcare workers on topics of Advance Directives, including information on local out-of-hospital DNAR, community hospice alternatives, and bereavement services.
2. Establish consensus on the ideal identification device for DNAR directive to assure continuity of care across settings;
3. Reiterate that initial resuscitative attempts are usually indicated when the patient's wishes are not known;
4. Define the conditions under which an out-of-hospital DNAR order can be considered; including its use in long term care settings and in the emergency department.
5. Define which patients have the decisional capacity to agree to a DNAR order and whether surrogates can sign such orders.
6. Establish a mechanism for determining the precedence of various directives (e.g., Living Will, Durable Power of Attorney for Healthcare, Out-of-Hospital Advance Directive (DNAR).
7. Develop a statutory prioritized list of surrogates to use when there are no advance directives and the patient's decisional capacity is impaired.
8. Consider language acknowledging the growing home hospice movement as concern children and incorporate provisions for document use in minors.
9. Establish that the decision not to attempt resuscitation must be an informed decision made by the patient or surrogate;
10. Identify the information that should be contained in the DNAR order and the authority that will be responsible for developing such a mechanism;
11. Identify the clinical procedures that are to be provided and those withheld in the adherence with the DNAR order, or specify which authority will verify adherence.
12. Define the exact manner in which the DNAR order is to be followed, including the role of on-line medical direction. Each system should ensure that a communication path to access on-line medical direction is immediately available, when necessary.
13. Establish legal immunity provisions for those who implement DNAR orders in good faith.
14. Establish data collection and protocol evaluation to perform periodic operational assessments;
15. Identify permissible exceptions to compliance with DNAR out-of-hospital directives. For example:
    - The patient is able to revoke a written directive at any time.
    - The EMS personnel can cancel the out-of-hospital DNAR order if there are doubts about the document's

American College of Surgeons

- Policies that lead either to the automatic enforcement of all DNR orders and requests or to disregarding or automatic cancellation of such orders and requests during the operation and recovery period may not sufficiently address a patient's right to self-determination
- An institutional policy of automatic cancellation of the DNR status in cases where a surgical procedure is to be carried out removes the patient from appropriate participation in decision making.
- Automatic enforcement without discussion and clarification may lead to inappropriate perioperative and anesthetic management.

[ST-19] Statement on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room

[by the American College of Surgeons]

The Board of Regents of the American College of Surgeons approved a revised [ST-19] Statement on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room, at the Board's meeting in October 2013. The revised statement was developed and submitted by the Committee on Ethics. The original statement was published in the September 1994 Bulletin.

It is generally expected that the surgeon will assume primary responsibility for advising patients regarding risks, benefits, and alternatives when discussing a potential operation.[1] This policy focuses on patients who accept a surgeon's recommendation to have surgery and who already have in place an advance directive, specifically, a "Do Not Resuscitate" (DNR) order. The best approach for these patients is a policy of "required reconsideration" of the existing DNR orders.[2] Required reconsideration means that the patient or designated surrogate and the physicians who will be responsible for the patient's care should, when possible, discuss the new intraoperative and perioperative risks associated with the surgical procedure, the patient's treatment goals, and an approach for potentially life-threatening problems consistent with the patient's values and preferences.

Some patients with DNR status become candidates for surgical procedures that may provide them with significant benefit, even though the procedure may not change the natural history of the underlying disease. Examples include procedures to treat intestinal obstruction in individuals with advanced malignancy and surgical procedures such as amputation to alleviate pain or prevent progression of underlying illness.

When such patients who have DNR orders in place undergo surgical procedures and the accompanying sedation or anesthesia, they are subjected to new and potentially correctable risks of cardiopulmonary arrest. Furthermore, many of the therapeutic actions employed in resuscitation (for example, intubation, mechanical ventilation, and administration of vasoactive drugs) are also an integral part of routine anesthesia management, and it is appropriate that the patient be so informed.

Policies that lead either to the automatic enforcement of all DNR orders or to disregarding or automatically cancelling such orders do not sufficiently support a patient's right to self-determination.[3-5] An institutional policy of automatic cancellation of DNR status in cases where a surgical procedure is to be carried out removes the patient or the patient's duly authorized representative from

Policies that lead either to the automatic enforcement of all DNR orders or to disregarding or automatically cancelling such orders do not sufficiently support a patient's right to self-determination.[3-5] An institutional policy of automatic cancellation of DNR status in cases where a surgical procedure is to be carried out removes the patient or the patient's duly authorized representative from appropriate participation in decision making. Automatic enforcement of DNR orders without discussion and clarification may not adequately inform patients or their authorized representatives about the new risks associated with surgery and anesthesia and may lead to inappropriate perioperative and anesthetic management.

The required reconsideration discussion should occur as early as practical after a decision is made to have surgery. This discussion may result in the patient agreeing to suspend the DNR order during surgery and the perioperative period, retaining the original DNR order, or modifying the DNR order. Required reconsideration works best when the patient has decision-making capacity and when time is available for a conversation. However, even in urgent situations or when the patient lacks decision-making capacity, the surgeon can usually discuss the situation with the patient's designated surrogate. In emergency situations, it may be impossible or impractical for the surgeon to speak with the patient or the patient's duly authorized representative prior to the patient's approaching demise, when irreversible damage occurs, or similar circumstances. In such situations, the surgeon must use his or her best judgment as to what the patient would wish.

Once a decision is reached on the patient's DNR status as a result of the required reconsideration conversation, the surgeon must continue his or her leadership role in the following areas: (1) documenting and conveying the patient's advance directive and DNR status to the members of the operating room team; (2) helping the operating room team members understand and interpret the patient's advance directive; and (3) if necessary, finding an alternate team member to replace an individual who has an ethical or professional conflict with the patient's advance directive instructions.[6]

State law and institutional policies may also impact DNR orders and must be taken into account in determining the appropriate course of action.

References

1. Joint Commission on Accreditation of Healthcare Organizations. *Manual of the Joint Commission on Accreditation of Health Care Organizations*. Patient Rights Chapter. Chicago, IL: JCAHO; 1994.
2. Cohen CB, Cohen PJ. Required reconsideration of "Do-Not-Resuscitate" orders in the operating room and certain other treatment settings. *Law Med Health Care*. 1992;20(4):354-363.
3. AORN position statement: Perioperative care of patients with Do-Not-Resuscitate or Allow-Natural-Death Orders. 2009. Available at: www.aorn.org/WorkArea/DownloadAsset.aspx?id=21917. Accessed September 11, 2013.
4. American Society of Anesthesiologists. Ethical guidelines for the anesthesia care of patients with Do-Not-Resuscitate orders or other directives that limit treatment. 2008. Available at: www.asahq.org/For-Healthcare-Professionals/~/media/For%20Members/documents/Standards%20Guidelines%20Stmts/Ethical%20Guidelines%20for%20the%20Anesthesia%20Care%20of%20Patients.ashx. Accessed November 18, 2013.
5. American College of Surgeons. Statement of the American College of Surgeons on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room. *Bull Am Coll of Surg*. 1994;79(9):29.
6. Demme RA, Singer EA, Greenlaw J, Quill TE. Ethical issues in palliative care. *Anesthesiol Clin*. 2006;24(1):129-144.

Governance

Presidential Address

ACS and the Seal

College Guidelines

Statements of the College

ACS Foundation

Archives and History

Careers at ACS

Newsroom

Association Management Services

Statement on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room

Online January 3, 2014

The Board of Regents of the American College of Surgeons approved a revised [ST-19] Statement on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room, at the Board's meeting in October 2013. The revised statement was developed and submitted by the Committee on Ethics. The original statement was published in the September 1994 Bulletin.

It is generally expected that the surgeon will assume primary responsibility for advising patients regarding risks, benefits, and alternatives when discussing a potential operation.[1] This policy focuses on patients who accept a surgeon's recommendation to have surgery and who already have in place an advance directive, specifically, a "Do Not Resuscitate" (DNR) order. The best approach for these patients is a policy of "required reconsideration" of the existing DNR orders.[2] Required reconsideration means that the patient or designated surrogate and the physicians who will be responsible for the patient's care should, when possible, discuss the new intraoperative and perioperative risks associated with the surgical procedure, the patient's treatment goals, and an approach for potentially life-threatening problems consistent with the patient's values and preferences.

Some patients with DNR status become candidates for surgical procedures that may provide them with significant benefit, even though the procedure may not change the natural history of the underlying disease. Examples include procedures to treat intestinal obstruction in individuals with advanced malignancy and surgical procedures such as amputation to alleviate pain or prevent progression of underlying illness.

When such patients who have DNR orders in place undergo surgical procedures and the accompanying sedation or anesthesia, they are subjected to new and potentially correctable risks of cardiopulmonary arrest. Furthermore, many of the therapeutic actions employed in resuscitation (for example, intubation, mechanical ventilation, and administration of vasoactive drugs) are also an integral part of routine anesthesia management, and it is appropriate that the patient be so informed.

Policies that lead either to the automatic enforcement of all DNR orders or to disregarding or automatically cancelling such orders do not sufficiently support a patient's right to self-determination.[3-5] An institutional policy of automatic cancellation of DNR status in cases where a surgical procedure is to be carried out

Once a decision is reached on the patient's DNR status as a result of the required reconsideration conversation, the surgeon must continue his or her leadership role in the following areas: (1) documenting and conveying the patient's advance directive and DNR status to the members of the operating room team; (2) helping the operating room team members understand and interpret the patient's advance directive; and (3) if necessary, finding an alternate team member to replace an individual who has an ethical or professional conflict with the patient's advance directive instructions.[6]

State law and institutional policies may also impact DNR orders and must be taken into account in determining the appropriate course of action.

References

1. Joint Commission on Accreditation of Healthcare Organizations. *Manual of the Joint Commission on Accreditation of Health Care Organizations*. Patient Rights Chapter. Chicago, IL: JCAHO; 1994.
2. Cohen CB, Cohen PJ. Required reconsideration of "Do-Not-Resuscitate" orders in the operating room and certain other treatment settings. *Law Med Health Care*. 1992;20(4):354-363.
3. AORN position statement: Perioperative care of patients with Do-Not-Resuscitate or Allow-Natural-Death Orders. 2009. Available at: www.aorn.org/WorkArea/DownloadAsset.aspx?id=21917. Accessed September 11, 2013.
4. American Society of Anesthesiologists. Ethical guidelines for the anesthesia care of patients with Do-Not-Resuscitate orders or other directives that limit treatment. 2008. Available at: www.asahq.org/For-Healthcare-Professionals/~/media/For%20Members/documents/Standards%20Guidelines%20Stmts/Ethical%20Guidelines%20for%20the%20Anesthesia%20Care%20of%20Patients.ashx. Accessed November 18, 2013.
5. American College of Surgeons. Statement of the American College of Surgeons on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room. *Bull Am Coll of Surg*. 1994;79(9):29.
6. Demme RA, Singer EA, Greenlaw J, Quill TE. Ethical issues in palliative care. *Anesthesiol Clin*. 2006;24(1):129-144.

Reprinted from **Bulletin of the American College of Surgeons**
Vol. 99 No. 1, Pages 42-43, January 2014

Revised, previously posted September 1994.

Position Statements AORN

- **AORN** has policy on perioperative care of patients with DNR orders, **automatically suspending order** during surgery undermines patient's right to self determination
- Need to discuss and document issues with patients whether to be continued in OR or not or partially suspended

Source:
http://www.aorn.org/PracticeResources/AORNPositionStatements/Position_DoNotResuscitate/

AORN DNR Position Statement

AORN

POSITION STATEMENT

Perioperative Care of Patients with Do-Not-Resuscitate or Allow-Natural-Death Orders

PREAMBLE

Nurses have a responsibility to uphold the rights of patients.[1,2,3] It has been reported that approximately 15% of patients who have do-not-resuscitate or allow-natural-death orders undergo surgical procedures and anesthesia management.[4] These procedures often are for palliative care, to relieve pain or distress, to facilitate care, or to improve the patient's quality of life. Do-not-resuscitate or allow-natural-death orders should not mean that all treatment is stopped and the need for medical and nursing care is eliminated, but rather that the patient has made certain choices about end-of-life decisions.[5,6] A patient's rights do not stop at the entrance to the operating or procedure room. Automatically suspending a do-not-resuscitate or allow-natural-death order during surgery undermines a patient's right to self-determination.[7] Professional organizations support developing policies to address do-not-resuscitate or allow-natural-death orders in the operating or procedure room.[7,8,9,10,11]

POSITION STATEMENT

Patient autonomy must be respected and is the professional responsibility of the health care team. The perioperative registered nurse, as a patient advocate, has an ethical and moral responsibility to the patient. Therefore, AORN believes that:

- reconsideration of do-not-resuscitate or allow-natural-death orders is required and is an integral component of the care of patients undergoing surgery or other invasive procedures;[7,9,12,13]
- health care providers should have a discussion with the patient or patient's surrogate about the risks, benefits, implications, and potential outcomes of anesthesia and surgery in relation to the do-not-resuscitate or allow-natural-death orders before initiating anesthesia, surgery, or other invasive procedures;[9,12,14]
- clear identification methods (eg, standardized wrist bands) for the patient who has do-not-resuscitate or allow-natural-death orders may decrease the risk for miscommunication;[15] and

- clear identification methods (eg, standardized wrist bands) for the patient who has do-not-resuscitate or allow-natural-death orders may decrease the risk for miscommunication;[15] and
- use of acronyms and abbreviations (eg, DNR, DNAR, AND) should be discouraged to decrease the risk of miscommunication.[6,16,17]

AORN believes the following strategies should be followed during reconsideration of do-not-resuscitate or allow-natural-death decisions:

Communication with the patient and patient's family members

- The patient's physicians and anesthesia care providers are responsible for discussing and documenting issues with the patient and/or family members to determine whether the do-not-resuscitate or allow-natural-death orders are maintained or completely or partially suspended during anesthesia and surgery.[9,12]
- The discussion should include:
  - goals of the surgical treatment,

AORN

  - potential for resuscitative measures and a description of what these measures include (eg, whether withholding resuscitation compromises the patient's basic objectives for surgery); and
  - potential outcomes with and without resuscitation.[7,9,12]

Communication with the health care team

Position Statements

- ENA RESUSCITATIVE DECISIONS[1]
- AMA based on Universal out-of-hospital DNR systems, Opinion of the Council of Ethical and Judicial Affairs, DNR Order, amendment [2]
- AMA has model legislation on uniform DNR laws
- Some states have POLST or MOLST

[1] http://www.ena.org/about/position/

[2] http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_opinion_2_22.pdf

MOLST or POLST

- **POLST** stands for **p**hysician **o**rders for **l**ife-**s**ustaining **t**reatment
- National approach to end of life planning based on conversation with doctors and families
- Patient choose treatments they want when seriously ill
  - To read more about POLST or MOLST go to website[1]
- Can see forms for New York, Oregon, Washington, West Virginia, and Wisconsin

[1] www.polst.org

POLST

www.polst.org/

POLST®
physician orders for life-sustaining treatment paradigm®

Donate to POLST

About | News | For Patients and Families | Programs in Your State | Develop a Program | Resources

What is POLST?

The National POLST Paradigm is an approach to end-of-life planning based on conversations between patients, loved ones, and medical providers. The POLST Paradigm is designed to ensure that seriously ill patients can choose the treatments they want and that their wishes are honored by medical providers.

Recent News

Webinar: Utah's ePOLST Experience
on December 27, 2013

On January 28th, 2014, from 11am – 12 pm (Pacific Time) the National POLST Office will host a webinar on Utah's ePOLST Experience. Presenters Peter Taillac, Jeffrey Duncan, and Deepthi Rajeev will describe the development and initial pilot testing of Utah's new[...] Read more »

POLST

physician orders for life-sustaining treatment paradigm®

Donate to POLST

About | News | For Patients and Families | Programs in Your State | Develop a Program | Resources

Legal Resources | Sample Policies and Protocols | Quality/Research Tools | Resource Library | Videos | Research

Home » Resources » Sample Policies and Protocols

Sample Policies and Protocols

Policies and Standards

Hospital Policies:

1. Hospital CPR Orders in Communities that have a POLST Paradigm Program (PDF)
2. OHSU Policy: Do Not Resuscitate, Advance Directives, Physician Orders for Life-Sustaining Treatment, & End-of-Life Decision-Making Process (PDF)
3. PeaceHealth POLST Policy (PDF)
4. Mountain View Hospital POLST Policy (PDF)
5. Madras Medical Group (PDF)

EMS Policies:

1. Sample EMS Protocol (PDF)

Persons with Disabilities and/or Significant Mental Health Condition:

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

Physician Orders

for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP, or PA. This is a Physician Order Sheet based on the person's medical condition and wishes.
Any section not completed implies full treatment for that section.
Everyone shall be treated with dignity and respect.

Last Name
First Name/ Middle Initial
Date of Birth

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

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

When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

B *Check One*

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Do not transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ***Transfer*** *to hospital if indicated. Avoid intensive care.*

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C — Antibiotics

Check One

- ☐ No antibiotics. Use other measures to relieve symptoms.
- ☐ Determine use or limitation of antibiotics when infection occurs.
- ☐ Use antibiotics if life can be prolonged.

Additional Orders: _____

D — Artificially Administered Nutrition: **Always offer food by mouth if feasible.**

Check One

- ☐ No artificial nutrition by tube.
- ☐ Defined trial period of artificial nutrition by tube.
- ☐ Long-term artificial nutrition by tube.

Additional Orders: _____

E — Summary of Medical Condition and Signatures

Discussed with: ☐ Patient ☐ Parent of Minor ☐ Health Care Representative ☐ Court-Appointed Guardian ☐ Other: _____	**Summary of Medical Condition**	
Print Physician / Nurse Practitioner Name	MD/DO/NP Phone Number	Office Use Only
Physician / NP Signature (mandatory)	Date	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

© CENTER FOR ETHICS IN HEALTH CARE, Oregon Health & Science University, 3181 Sam Jackson Park Rd, UHN-86, Portland, OR 97239-3098 (503) 494-3965

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

MOLST

Medical Orders for Life-Sustaining Treatment

Do-Not-Resuscitate (DNR) and
other Life-Sustaining Treatments (LST)

"Supplemental" Documentation Form for MINORS

Do-Not-Resuscitate (DNR)

This form is used only for patients/residents who are under the age of 18, are not married, and are not parents. Patients/residents under 18 who are married or are parents are treated as adults for purposes of the DNR law. If there is a question about the capacity of such an individual, contact legal counsel.

Last Name of Patient/Resident

First Name/Middle Initial of Patient/Resident

Patient/Resident Date of Birth

NB: Actual orders should be placed on the MOLST form. The physician is responsible for completing both the MOLST and this documentation form, and for obtaining the additional consultations / signatures where indicated. These forms must be placed in the medical record.

Complete Steps 1-8 for "MINOR" patients/residents:

Step 1: Physician determination of lack of capacity:

I have examined the patient/resident and his/her medical record, and in consultation with his/her parents or legal guardian, have determined that the patient/resident:

___ a. does
___ b. does not

have the ability to understand and appreciate the nature and consequences of a DNR order, including benefits and burdens of such an order, and to reach an informed decision regarding the order.

The End

- Are you up to the challenge?
- Additional resources follow
- CAH revised advanced directives interpretive guidelines from CMS
- Information on informed consent and organ procurement organizations (OPO)
- Additional information on advance directives for freestanding ambulatory surgery centers.

The End! Questions???

Sue Dill Calloway RN, Esq.
CPHRM
AD, BA, BSN, MSN, JD
President Patient Safety and Healthcare Education

5447 Fawnbrook Lane
Dublin, Ohio 43017

614 791-1468 (Call with questions, No emails)
sdill1@columbus.rr.com

Patient Centered Communication

- During each individual tracer surveyor will interview staff about the following:
- Hospital support of patient's right of access to advocate or support person during hospitalization
- Will interview interpreters and translators about their training, experience, and qualifications
  - This includes employed staff, bilingual staff, and volunteers
- Remember the TJC five patient centered communication standards in 4 different chapters

Miscellaneous

CMS and TJC Informed Consent and Organ Donation Standards

Informed Consent

- Must include your state law in your informed consent process
- Must include TJC RI.01.03.01 standards on informed consent if you TJC accredited
- If you accept Medicare or Medicaid and you are a hospital you must comply with CMS CoP section on consent in patient rights, medical records (Tag 464) and Surgical Services (Tag 955)

Organ Donation

- You must also comply with the CMS CoP provisions on organ donation
- TJC has its organ donation standards in the chapter on transplant safety
- Need to be in compliance and ensure one call rule on all deaths

Ambulatory Surgery Centers (ASC)

Conditions for Coverage (CfC)

Federal Register

Tuesday,

November 18, 2008

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 416, and 419

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-37

DATE: May 15, 2009

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: State Operations Manual (SOM) Appendix L, Ambulatory Surgical Centers (ASC) Comprehensive Revision

Memorandum Summary

- New ASC Conditions for Coverage (CfCs) take effect on May 18, 2009.
- SOM Appendix L has been revised:
  - Part 1, Survey Protocol has been added.
  - The Interpretive Guidelines have been extensively updated to reflect the new and revised CfCs, as well as to provide more detailed guidance for existing CfCs. Feedback on this guidance is welcome; as needed, further refinements will be made in the future.
- ASPEN Tags for ASC surveys have been revised and renumbered. ASPEN surveyor kits with the new tags and regulatory text will be available shortly after May 18th.

On November 18, 2008 the Centers for Medicare & Medicaid Services (CMS) adopted the Hospital Outpatient Prospective Payment System final rule (73 FR 68502). The final rule included revisions to the ASC CfCs in 42 CFR 416.2 – 416.52 that take effect on May 18, 2009. Among the regulatory changes are the following:

Conditions for Coverage (CfC)

- All CMS manuals found at website[1]
- Appendix L in the State Operations Manual
- Section 1832 of SSA ASC must meet quality and safety standards

[1] http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf

Advance Directives 224

- Must provide the patient with information on P&Ps on advance directives (living wills, DPOA, DNR, mental health declaration, etc.)
- If requested, must provide a copy of the official state advance directive forms
- Must inform the patient of the right to make informed decisions and **educate** staff about P&P
- Must document in chart whether or not patient has an advance directive

Advance Directives

- Must provide information on advance directives in advance of the day of the procedure unless referral made on same day rule
- Provide patients with information on advance directives, description of state health and safety laws, if state form, for advance directives and their right to make informed decisions
- Include any limitations

AMERICAN BAR ASSOCIATION

Defending Liberty, Pursuing Justice

Search: Go Advanced Search Topics A-Z

Home | Membership | Member Resources | Public Resources | Legal Education | CLE | Calendar | Store | Publications | About the ABA

Print This | Page Feedback

- Division Home
- Practical Law
- Teachers & Students
- Lawyers & Judges
- Journalists
- Law Day
- Supreme Court Preview
- Featured Programs
- Awards
- Publications
- Products Catalog
- LRE Network
- Contact

DIVISION FOR PUBLIC EDUCATION

AMERICAN BAR ASSOCIATION

http://www.abanet.org/publiced/practical/directive_whatis.html

PRACTICAL LAW

Law for Older Americans

Health Care Advance Directives

What is a health care advance directive?

A **health care advance directive** is the primary legal tool for any health care decision made when you cannot speak for yourself. "Health care advance directive" is the general term for any written statement you make while competent concerning your future health care wishes. Formal advance directives include the **living will** and the **health care power of attorney**.

These legal tools evolved separately in the law, but today they are typically merged in a single, comprehensive advance directive. AARP, the ABA, and the AMA have collaborated on a sample comprehensive form. It is available on the ABA website at www.abanet.org/aging.

>>*What is a health care advance directive?*
>>How do you plan a health care advance directive?
>>Is a health care advance directive the same as a living will?
>>Why can't I just tell my doctor what I want?
>>Will doctors and hospitals recognize my advance directive?

Legal Issue: Guardianship Jurisdiction
Legal Issue: Guardianship Law and Practice
Legal Issue: Medicare
Legal Issue: Voting and Cognitive Impairments
Publications
State Law Charts and Updates
Contact Us
Useful Links

Consumer's Tool Kit for Health Care Advance Planning

INTRODUCTION

If you are looking at this tool kit, you are either thinking of making a health care advance directive (such as a living will or durable power of attorney for health care), or you may have already signed one. In either case, you should be aware that just having a written advance directive by itself does not ensure that your wishes will be understood and respected. Studies have shown that standard advance directive forms do little to influence end-of-life decisions without: 1) informed, thoughtful reflection about your wishes and values, and 2) personal communication between you and your likely decision-makers before a crisis occurs.

WHY A TOOL KIT?

Good advance planning for health care decisions is, in reality, a continuing conversation - about values, priorities, the meaning of one's life, and quality of life. To help you in this process, this tool kit contains a variety of self-help worksheets, suggestions, and resources. There are 10 tools in all, each clearly labeled and user-friendly. The tool kit does not create a formal advance directive for you. Instead, it helps you do the much harder job of discovering, clarifying, and communicating what is important to you in the face of serious illness.

List of "Tools" for Health Care Advance Planning

There Are 10 "Tools" in This Tool Kit:

Notice of Copyright and Notes to Second Edition

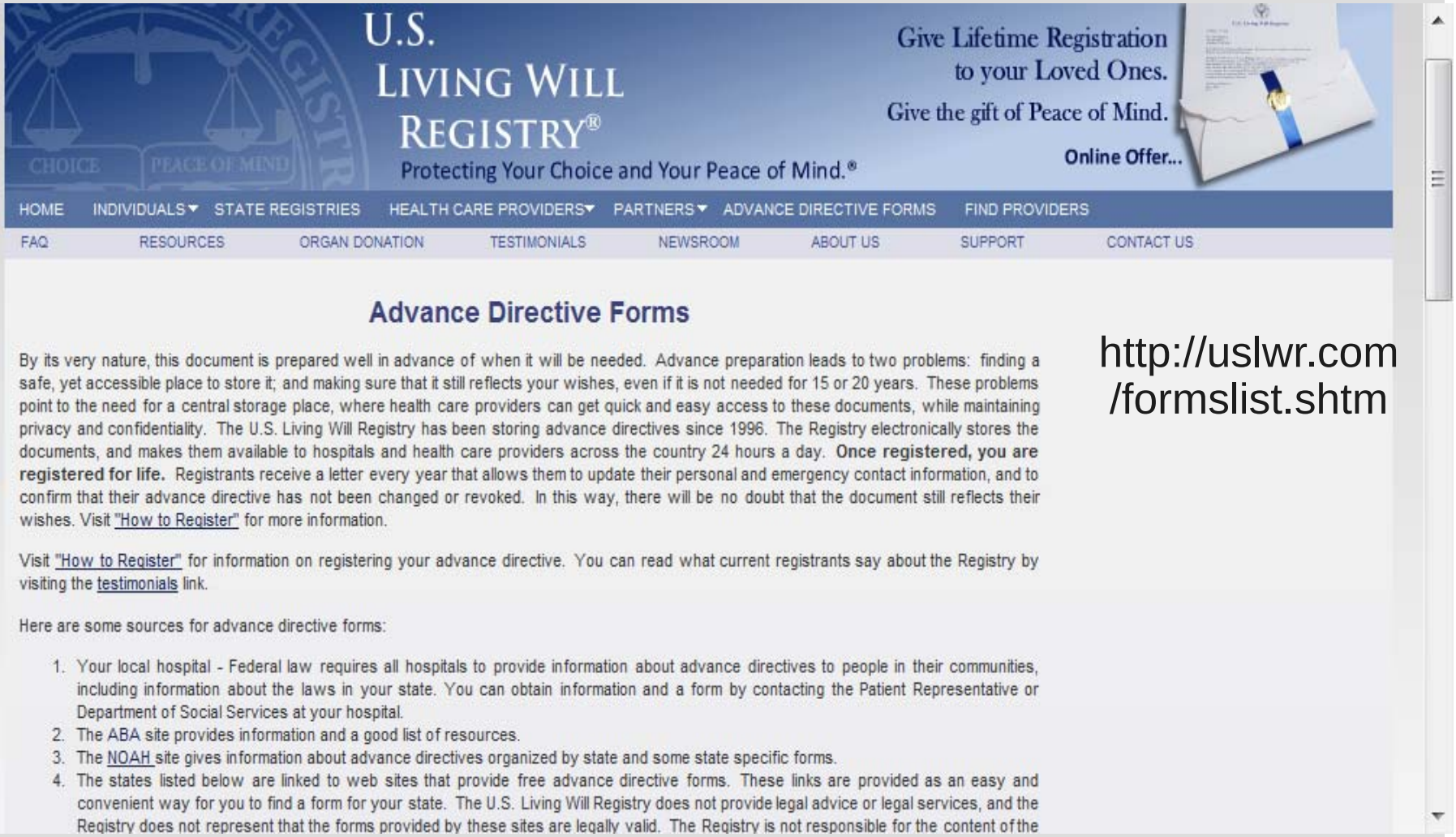
Tool #1	How to Select Your Health Care Agent or Proxy
Tool #2	Are Some Conditions Worse than Death?
Tool #3	HOW DO YOU WEIGH ODDS OF SURVIVAL?
Tool #4	PERSONAL PRIORITIES AND SPIRITUAL VALUES IMPORTANT TO YOUR MEDICAL DECISIONS
Tool #5	AFTER DEATH DECISIONS TO THINK ABOUT NOW
Tool #6	CONVERSATION SCRIPTS: GETTING PAST THE RESISTANCE
Tool #7	THE PROXY QUIZ FOR FAMILY & PHYSICIAN

http://www.abanet.org/aging/toolkit/home.html

Advance Directive Registries

- There are companies that will take a patient's advance directives and make it available when it is needed 24 hours a day
  - These companies charge a fee and usually fax a copy to the hospitals
  - Some are no longer in business when hospitals have tried to access the patient's advance directives
- Some hospitals have established their own advance directive registry
  - Free service and great for hospital to access these when a patient is admitted

All 50 States Forms



http://uslwr.com/formslist.shtm

Assess to All 50 States AD Forms

4. The states listed below are linked to web sites that provide free advance directive forms. These links are provided as an easy and convenient way for you to find a form for your state. The U.S. Living Will Registry does not provide legal advice or legal services, and the Registry does not represent that the forms provided by these sites are legally valid. The Registry is not responsible for the content of the forms on these sites. State laws sometimes change, making forms obsolete. You should check with an attorney to make sure that the advance directive you prepare complies with the law in your state. Click on your state to download an advance directive form. When you click on one of the links listed below you will be leaving the U.S. Living Will Registry's web site.

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia - Living Will
Hawaii
Idaho
Illinois
Indiana-Information
Indiana-Forms
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana

National Cancer Institute

U.S. National Institutes of Health | www.cancer.gov

In English | En español

SEARCH

NCI Home | Cancer Topics | Clinical Trials | Cancer Statistics | Research & Funding | News | About NCI

NATIONAL CANCER INSTITUTE FactSheet

http://www.cancer.gov/cancertopics/factsheet/support/advance-directives

Reviewed: 03/07/2000

Page Options

- Print This Page
- E-Mail This Document
- View/Print PDF
- Bookmark & Share

Search Fact Sheets by Keyword

GO

RSS Feed

View Fact Sheets by Topic

Cancer Type

Risk Factors and Possible

Advance Directives

More than ever before, people with cancer and their families are being asked to take part in decisions about end-of-life care. Yet, most people still do not discuss end-of-life care at all, even if they are seriously ill. This fact sheet provides patients with an outline for thinking about these issues and some guidelines for discussion with their doctors, families, and loved ones. This fact sheet is also designed to help patients understand the medical, legal, and personal choices they may face in the future.

1. **What rights do patients have regarding their medical treatment?**

   Patients are entitled to complete information about their illness and how it may affect their lives, and they have the right to share or withhold that information from others. People with cancer should also be informed about any procedures and treatments that are planned, the benefits and risks, and any alternatives that may be available. Patients may be asked to sign an "informed consent" form, which includes this information. Before signing such a form, patients should read it carefully and ask the doctor any questions they might have.

   Patients have the right to make decisions about their own treatment. These decisions may change over time. In the face of worsening disease, some patients may want to try every available

This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.

Thanks for Attending!

- Sue Dill Calloway RN, Esq. CPHRM
  - AD, BA, BSN, MSN, JD
  - President of Patient Safety and Education Consulting
  - Chief Learning Officer of the Emergency Medicine Patient Safety Foundation
  - 614 791-1468
  - sdill1@columbus.rr.com