Mastering Advance Directives: What Every Hospital Practitioner Needs to Know

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Speaker

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Phone questions, no emails
Learning Objectives

1. Explain what is required of hospitals under the federal law called the Patient Self Determination Act.

2. Discuss the information on the hospital's advance directive policies that must be given to inpatients, ED, observation, and same day surgery patients.

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, DNR 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

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
- 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

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 tubes, surgery or respirators
- Doctor wrote a DNR order in her chart

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 Alzheimer'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
Know Who is a DNR and Who is Not

Nurse refuses to perform CPR despite 911 dispatcher's plea

Brain Dead Girl Moved From Ca Hospital

Lawyer: Brain dead girl moved from Calif. hospital

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.
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
Marise 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

$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

Texas case a reminder that living wills protect patients, providers
February 18th, 2013

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 Maria Echeverria, a 32-year-old pregnant woman who was declared brain-dead, on life support against her wishes and those of her family.

[More]
ABA Myths and Facts about AD

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.

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
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<tbody>
<tr>
<td>1. You must have a Living Will to stop treatment near the end of life.</td>
<td>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.</td>
</tr>
<tr>
<td>2. You have to use your state’s statutory form for your advance directive to be valid.</td>
<td>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 use.</td>
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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

Welcome to the Conversation Starter Kit

It's not easy to talk about how you want the end of your life to be. But it's one of the most important conversations you can have with your loved ones.

This Starter Kit will help you get your thoughts together and then have the conversation.

This isn’t about filling out Advance Directives or other medical forms. It’s about talking to your loved ones about what you or they want for end-of-life care.

Whether you’re getting ready to tell someone what

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)
Resources

- Physician assisted suicide website at www.willamette.edu/wucl/pas

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

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**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 website¹


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 SUPPLIER AGREEMENTS
The authority cited for part 489 continues to read as follows:
Authority: Secs. 1190.1850, 1864, 1866, 1867, and 1871 of the Social Security Act (42 U.S.C. 1395b(h), 1395cc, 1395dd, and 1395gg), and sec. 802 (j) of Pub. L. 94-580 (42 U.S.C. 1395ww note).

Subpart I — 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 hospice care, and 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 each individual concerning—

(A) An individual’s rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, 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

(B) The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitations if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider’s statement of limitations 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...
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 http://ecfr.gpoaccess.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

www.gpoaccess.gov/cfr/index.html
Psychiatric Advance Directives

State by State Information
State Specific Advance Directives

CMS HOSPITAL CONDITIONS OF PARTICIPATION (COPS)

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

- CMS hospital CoP effective in 1986 and amended February 14, 2014
  - 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

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<tr>
<th>App. No.</th>
<th>Description</th>
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<td>A</td>
<td>Hospitals</td>
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<tr>
<td>AA</td>
<td>Psychiatric Hospitals</td>
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CMS Hospital CoP Manual

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

Table of Contents
(Rev. 103, 02-14-14)

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
Nursing Home Survey Module
CMS Survey and Certification Website

CMS Policies & Memos to States

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Select From The Following Options:

- Show all items
- Show only (select one or more options):
  - Show only items whose
  - Show only items whose Fiscal Year is
  - Show only items containing the following word

There are 465 items in this list.

Click on policy & memos to states
Number of Deficiencies

- CMS issued its first deficiency report in March 22, 2013
- CMS plans to update quarterly
  - In March 2013 the number of patient rights deficiencies was **950**
    - Advance directive is in patient rights chapter
  - In November 2013 the number of patient rights deficiencies was **2303**
    - Reports lists the name and address of all hospitals receiving deficiencies

Access to Hospital Complaint Data
### Advanced Directive Deficiencies Nov 2013

<table>
<thead>
<tr>
<th>Section</th>
<th>Tag Number</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directives and Notice of Patient Rights</td>
<td>117 (and 116)</td>
<td>121</td>
</tr>
<tr>
<td>Advance Directive &amp; Care Planning</td>
<td>130</td>
<td>68</td>
</tr>
<tr>
<td>Advanced Directives, Consent, Decision Making</td>
<td>131 &amp; 132</td>
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<tr>
<td>Advance Directive &amp; Visitation</td>
<td>216</td>
<td>15</td>
</tr>
<tr>
<td>Advance Directive &amp; Transfer</td>
<td>837</td>
<td>37</td>
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<tr>
<td>Total</td>
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<td>428</td>
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### CMS Changes to Advance Directives

- CMS issues a 34 pages memo on September 7, 2011 and 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
Center for Medicare & Medicaid Services
5555 Teljeur Boulevard, Mail Stop 02-02-205
Baltimore, Maryland 21201-3220

Advance Directive Changes

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

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

Memorandum Summary

1. President’s Directive: On April 15, 2010, the President issued a memo concerning hospital visitation and designation of representatives.
2. 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 this applicable requirement.

Transmittal Dec 2, 2011

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

Effitctive Date: December 2, 2011

I. SUMMARY OF CHANGES: Classification is provided for existing hospital regulations 42 CFR 482.13(a) and 0.5, and new 42 CFR 482.130, concerning hospital patients’ rights, including advance directives and visitation rights. Classification is provided for existing CAH regulations at 42 CFR 485.608(a), concerning compliance with Federal law and regulations, including regulations governing advance directives and required patient disclosures. Guidance is provided for new 42 CFR 485.625(c), concerning CAH patients’ visitation rights.

II. CHANGES IN MANUAL INSTRUCTIONS: (NA if no change or not updated.)

- New or Revised: N – NEW, D – DELETED – (Only One Per Row)

The revision date and transmittal number apply to the red indicated 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.

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4/8/2014
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 censes 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

- 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

§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’s 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 or 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 interpreter if the patient needs one and remember the issue of low health literacy.
Joint Commission Tracer

Patient Rights includes addressing advance directives

Patient Rights Tracer Removed

- 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 right 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 2014):
  - 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**
- **This standard was new in 2009 and amended in 2010 and continues**
**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

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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

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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

- In 2009, there was a new documentation chapter
- It is called Record of Care 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 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](http://www.facs.org/fellows_info/statements/st-19.html)
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”
- 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

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 in 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 ever, 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
  - 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
PACU Care ASPAN

- Nurse should follow standards of post anesthesia nursing practice
- Position statements are available
- 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 periAnesthesia 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 35% 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. Palliative treatment or comfort care or emergency events might require anesthesia and surgery. Those 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.3,4,5
3. Endotracheal intubation, mechanical ventilation, cardiovascular medications, cardiopulmonary resuscitation, and defibrillation/cardioversion are often specifically restricted in an advance directive.5,6,7 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 autonomy and right to participate in informed decision making.

Position
The American Society of PeriAnesthesia Nurses (ASAPN) 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 clarify 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 vote of the ASAPN Board of Directors on April 20, 1996 in Phoenix, Arizona. ASAPN 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 Batavia, Illinois.
Position Statements

- ACEP 'Do Not Attempt Resuscitation' (DNAR) in the Out-of-Hospital Setting on website¹

- American College of Surgeons on Advance Directives and DNR orders in the operating room on website²

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. 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, exclusion of minors, futility, portability, utilization of healthcare resources, and responsibility for prognostic death.

As of 2002, 42 states had statewide out-of-hospital DNR protocols. Of these, 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 DNR 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. 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. 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 reference 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 Care, CPR directive, Arizona's prehospital advanced directive statute, 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. Despite public and professional agreement regarding the low likelihood of success in such situations, the medical/ethic compact to attempt resuscitation, in the absence of a valid DNR decision, continues to be sanctioned by society and supported by EMS providers as the standard of care.
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. 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. 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 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 canceling such orders do not sufficiently support a patient's right to self-determination. 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 decision making.

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 emotional or professional conflict with the patient's advance directive instructions.

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

References

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/

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AORN DNR 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. 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. 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. 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. Professional organizations support developing policies to address do-not-resuscitate or allow-natural-death orders in the operating or procedure room.

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.
- 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.
- Clear identification methods (e.g., standardized wrist bands) for the patient who has do-not-resuscitate or allow-natural-death orders may decrease the risk for miscommunication.  

Source: http://www.aorn.org/PracticeResources/AORNPositionStatements/Position_DoNotResuscitate/
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 physician orders for life-sustaining treatment
- 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 website¹
- Can see forms for New York, Oregon, Washington, West Virginia, and Wisconsin

¹ www.polst.org
Sample Policies and Protocols

Policies and Standards

Hospital Policies:
1. Hospital CPR Orders in Communities that have a POLST Paradigm Program (PDF)
3. PacHealth POLST Policy (PDF)
4. Mountain View Hospital POLST Policy (PDF)
5. Mobile 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. Fill in 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.

A Check Box

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 Box

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

   *Additional Orders:*

**SUMMARY OF MEDICAL CONDITION AND SIGNATURES**

- Discussed with:
  - Patient
  - Primary Care Provider
  - Health Care Representative
  - Court-Appointed Guardian
  - Other

- Print Physician/ Nurse Practitioner’s Name
- MD/DO/NP Phone Number
- Office Use Only

- Physician/NP Signature (mandatory)
- Date

**SEND FORM WITH PERSON WHenever TRANSFERRED OR DISCHARGED**

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**SEND FORM WITH PATIENT/RESIDENT WhEnever TRANSFERRED OR DISCHARGED**

**MOLST**

**Medical Orders for Life-Sustaining Treatment**

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

**“Supplemental” Documentation Form for MINORS**

- Do-Not-Renuscitate (DNR)

This form is used only for patient/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 form. If there is a question about the capacity of such an individual, contact legal counsel.

**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???

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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
CAH Advance Directives

- CAH must be 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

Ambulatory Surgery Centers (ASC)

Conditions for Coverage (CfC)
ASC Interpretive Guidelines

- CMS rewritten May 15, 2009 and revised many times since then
- Revised the CfCs and changed the interpretive guidelines
- Added survey procedures
- Renumbered the tag numbers and 167 pages which include infection control surveyor worksheet (Q tag numbers 001-267)
- Available on CMS website

Conditions for Coverage (CfC)

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

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
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.shtml
Assess to All 50 States AD Forms

4. The states listed below are linked to websites 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 website.

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia - Living Will
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming
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.

Thank you for attending!

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