# Advance Directive

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# OBJECTIVES

## Participants will:

- Review the Federal regulation at 483.10(c) (6) and 483.10(g)(12) and Guidance to Surveyors for F155 for Advance Directives
- Identify definitions from the Federal Requirements
- Describe the process for informing and assisting residents with their advance directives
- Recognize a system to re-evaluate resident for decision-making ability and how to include the resident representative
- Define requirements when research is being conducted on residents in the facility

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# **OVERVIEW** 483.10(c)(6)

- The Resident has:
  - The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive

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# **OVERVIEW** 483.10(g)(12)

- **§483.10(g)(12) – F155**
- The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
  - (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
  - (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.


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# **OVERVIEW** 483.10(g)(12)

- **§483.10(g)(12) –Continued**
- (iii)Facilities 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.


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# **OVERVIEW** 483.10(g)(12)

- **§483.10(g)(12) –Continued**

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.


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# **OVERVIEW** 483.10(g)(12)

- **§483.10(g)(12) –Continued**

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.


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# DEFINITIONS

- **"Advance care planning"** is a process used to identify and update the resident's preferences regarding care and treatment at a future time including a situation in which the resident subsequently lacks the capacity to do so; for example, when a situation arises in which life-sustaining treatments are a potential option for care and the resident is unable to make his or her choices known.1
- 1 Adapted from: Emanuel, L.L., Danis, M., Pearlman, R.A., Singer, P.A. (1995). Advance care planning as a process: structuring the discussions in practice. Journal of the American Geriatric Society, 43, 4406.

# DEFINITIONS

- **"Advance directive"** means, according to 42 C.F.R. §489.100, 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. Some States also recognize a documented oral instruction.

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# DEFINITIONS

- **"Cardiopulmonary resuscitation (CPR)"** refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased.
- **"Durable Power of Attorney for Health Care" (a.k.a. "Medical Power of Attorney")** is a document delegating to an agent the authority to make health care decisions in case the individual delegating that authority subsequently becomes incapable of doing so.

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# DEFINITIONS

- **"Health care decision-making"** refers to consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual' s physical or mental condition.
- **"Health care decision-making capacity"** refers to possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choices.

# DEFINITIONS

- **“Life-sustaining treatment”** is treatment that, based on reasonable medical judgment, sustains an individual’ s life and without which the individual will die. The term includes both life-sustaining medications and interventions such as mechanical ventilation, kidney dialysis, and artificial hydration and nutrition. The term does not include the administration of pain medication or other pain management interventions, the performance of a medical procedure related to enhancing comfort, or any other medical care provided to alleviate a resident’ s pain.

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# DEFINITIONS

- **"Legal representative" (e.g., "Agent," "Attorney in fact," "Proxy," "Substitute decision- maker," "Surrogate decision-maker")** is a person designated and authorized by an advance directive or by State law to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions.
- **"Treatment"** refers to interventions provided for purposes of maintaining/restoring health and well-being, improving functional level, or relieving symptoms.

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# Facility Policy

- It is the policy of the facility to establish, implement and maintain written policies and procedures for advance directives.
- The resident has the right and the facility will assist the resident to formulate an advance directive at their option.
- The facility will inform and provide resident with a written description of the facility's policy to implement advance directives and (describe items applicable by respective State law).
- Resident has the right to accept, request, refuse and/or discontinue medical or surgical treatment and to participate in or refuse to participate in experimental research

# Procedure

- When a resident is admitted, the facility will need to identify if the resident has an advance directive
- Examples can include:
  - Living Will
  - Medical Power of Attorney
  - DNR (Do Not Resuscitate) order
  - MOLST or POLST

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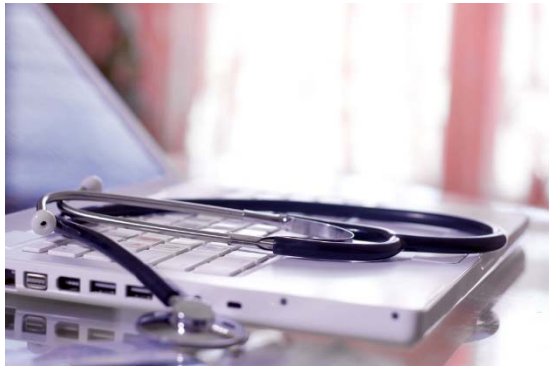
# Procedure

- The facility will need to provide the new resident with written description of the facility's policies to implement an advance directive
- The facility needs to identify if the resident is able to make decisions.  If not, identify the resident representative who will be responsible

# Procedure

- Advance Directive documents will need to be in the same section of the medical record in the facility for staff to be able to quickly and easily retrieve in the event of immediate need



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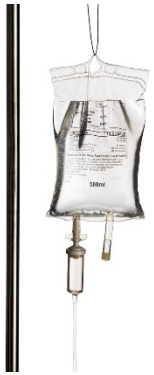
# Procedure

- Resident wishes identified in the Advance Directives will need to be in the Care Plan. Examples can include:
  - CPR
  - Tube Feeding
  - IV's or IV medications
  - Comfort Care directives
  - Etc.



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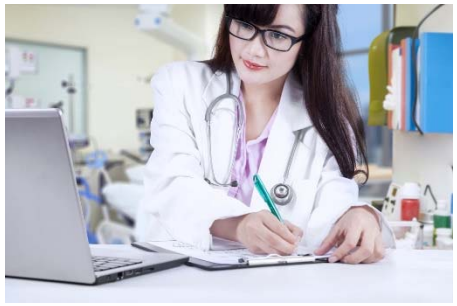
# Procedure

- When a resident has a change of condition, the facility Interdisciplinary Team should re-evaluate the Advance Directives with the resident or resident representative to ensure preferences are documented in light of the change.



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# Procedure

- There may be a time when a resident has a choice for care that the facility and physician do not believe they can accommodate in the facility, this will be addressed with the facility Medical Director, Administrator and QAA Committee for decision on placement.

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# Advance Care Planning

Advance Care Planning provides the resident the opportunity to make informed choices for their care IN ADVANCE, to be implemented at a time when the resident may not be able to make decisions—this is why it is called “Advance Care Planning”

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# Right to Refuse Medical or Surgical Treatment

- A resident has the right to refuse treatment and we cannot treat the resident against their wishes
- Facility staff can offer alternative treatments and therapies
- The nurse will need to provide and document education on the risks and benefits of refusal in order for the resident to make an informed choice

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# Right to Refuse Medical or Surgical Treatment

- The facility cannot transfer or discharge a resident for refusal of treatment unless other criteria for discharge or transfer are met

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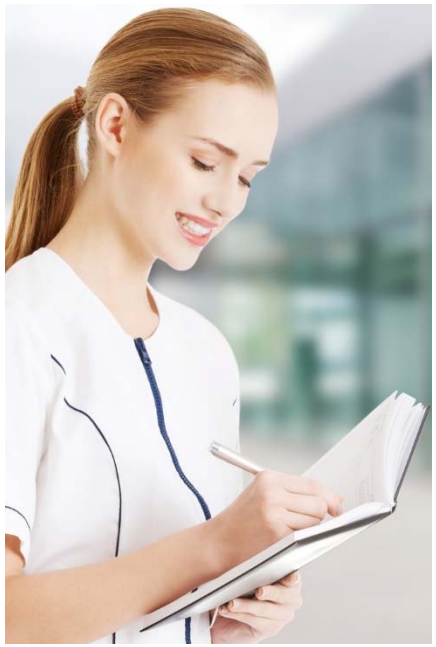
# Right to Refuse Medical or Surgical Treatment

- If the refusal of treatment results in a significant change in condition, the facility will need to reassess the resident and update the care plan.



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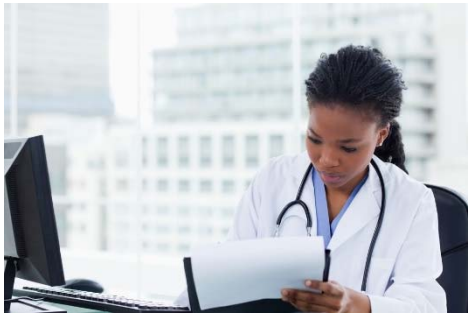
# Right to Refuse Medical or Surgical Treatment

- If the resident declines and is assessed that the resident is unable to make decisions, the facility will need to document the assessment and invoke the resident's health care agent or legal representative to make decisions



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# Right to Refuse Medical or Surgical Treatment

- The resident representative and physician will need to be notified of resident refusals

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# Cardiopulmonary Resuscitation - CPR

- The facility will provide basic life support, including CPR – Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advance directives.

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# Right to Decline to Participate in Experimental Research

- The resident has the right to refuse participation in experimental research.
- The resident who is being considered for experimental research must be fully informed (e.g. medication, treatment)
- The resident must give informed consent to participate

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# Right to Decline to Participate in Experimental Research

- If the resident is incapable of giving informed consent but the legal representative gives proxy consent, it is the responsibility of the facility to properly obtain the proxy consent and measures taken to protect the individual from harm or mistreatment.
- The legal representative also may refuse participation before and during the research activity

# Illinois Advance Directives

- Health Care Power of Attorney
- Living will
- Mental Health Treatment Preference Declaration
- Do-Not-Resuscitate (DNR)/Practitioner Orders For Life-Sustaining Treatment (POLST)

Illinois Department of Public Health

http://www.dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

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# Illinois Advance Directives

- The **health care power of attorney** lets you choose someone to make health care decisions for you in the future, if you are no longer able to make these decisions for yourself.




# Illinois Advance Directives

- A **living will** tells your health care professional whether you want death-delaying procedures used if you have a terminal condition and are unable to state your wishes. A living will, unlike a health care power of attorney, only applies if you have a terminal condition. A terminal condition means an incurable and irreversible condition such that death is imminent and the application of any death delaying procedures serves only to prolong the dying process.

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# Illinois Advance Directives

- A **mental health treatment preference declaration** lets you say if you want to receive electroconvulsive treatment (ECT) or psychotropic medicine when you have a mental illness and are unable to make these decisions for yourself. It also allows you to say whether you wish to be admitted to a mental health facility for up to 17 days of treatment.

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# Illinois Advance Directives

- A **DNR/POLST Order** is an advanced directive that says that cardiopulmonary resuscitation (CPR) cannot be used if your heart and/or breathing stops; it can also be used to record your desires for life-sustaining treatment.

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# Illinois Advance Directives

## What Happens If You Cannot Make Health Care Decisions For Yourself And You Don't Have an Advance Directive?

Health Care “Surrogate"

2 physicians must certify the need to appoint a surrogate

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# Illinois Advance Directives

- A health care surrogate can be one of the following persons (in order of priority):
  - Guardian of the person, spouse, any adult child(ren), either parent, any adult brother or sister, any adult grandchild(ren), a close friend, or guardian of the estate.

# Illinois Advance Directives

- A health care surrogate cannot tell your health care professional to withdraw or withhold life-sustaining treatment unless you have a "qualifying condition".
  - a “terminal condition”
  - “permanent unconsciousness”
  - “incurable or irreversible condition”

# Illinois Advance Directives

- A health care surrogate, other than a court-appointed guardian, cannot consent for you to have certain mental health treatments, including treatment by electroconvulsive therapy (ECT), psychotropic medication or admission to a mental health facility, although the health care surrogate can petition a court to allow these mental health services.

# Conclusion

- The resident has the right to be presented with written information on their rights, to formulate an advance directive if they don't have one—and the facility should offer assistance to the resident.
- The resident is not required to have an advance directive if they don't want one.

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# Conclusion

- Once resident has indicated preferences to either accept or refuse medical or surgical treatment or care, it needs to be on the care plan and communicated to care givers
- Residents can choose to change their mind at anytime
- The Interdisciplinary Team will need to periodically assess resident's decision-making ability

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# Conclusion

Potential areas surveyors can focus on:

- Resident resuscitated despite a DNR order in the resident record
- Resident hospitalized against documented wishes
- Resident had a complication from experimental research and there is no evidence of consent
- Treatment delivered to resident was based on consent from an individual that was not identified as the resident representative

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# Conclusion

Providing quality of care for our residents includes ensuring that the resident is able to direct his or her own medical care and treatment!

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# Questions?

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# REFERENCES

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# THANK YOU FOR PARTICIPATING IN THIS EDUCATION SESSION!

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