



OVERVIEW OF ADVANCE DIRECTIVES

Self-Study Guide

Objectives

The purpose of this self study is to inform PCH staff an overview of the rules and regulations surrounding Advance Directives. At the conclusion of this self study, staff will be able to:

1. Identify what a Living Will is.
2. Describe a Durable Power of Attorney for Healthcare.
3. Describe a DNR order.
4. Discuss Anatomical Gifts.
5. Be familiar with the Mental Health Declaration.
6. Have brief knowledge of MOLST.

Questions about this self study should be directed to Social Services, ext. 389 or your supervisor.

Introduction

Advance Directives is a broad term that includes several documents. Documents included under the umbrella of Advance Directives are: Living Will, DNR, Durable Power of Attorney for Healthcare, Anatomical Gift donation (organ and tissue donation) and Mental Health Declaration. This self study will discuss each of these documents and what these documents mean to healthcare providers.

Ohio Law

Each state has different rules regarding Advance Directives. In Ohio, the uniform rights act of the terminally ill patient (ORC 2133) allowed patients to make end of the life decisions and resulted in the use of living wills and durable power of attorney for healthcare. Further legislation, House Bill 354, amended this act and standardized procedures for physicians, emergency medical personnel and health care facilities. This resulted in the use of the state Do Not Resuscitate forms. Laws regarding Advance Directives are revised regularly. For example, Ohio Laws House Bill 392, effective September 2004, required changes to the Living Will and Durable Power of Attorney for Healthcare to allow designation of organ or tissue donation.

Advance Directives made in one state are not necessarily going to be recognized in another state. It is best to check with healthcare providers or other officials in states where it is questioned if your Advance Directive will be honored or not. There is proposed legislation in Ohio (HB 241) that is in committee at the time this inservice was written to try to make Ohio law more compatible with the Advance Directive legislation in other states.

Living Wills

Many patients confuse a Living Will with a Last Will and Testament. These are two separate and distinct documents. The Last Will and Testament describes how you want your property and assets distributed upon your death. A Living Will allows patients to designate the type of care they would like to receive if they are terminally ill or in a permanently unconscious state and can no longer make decisions for themselves. In other words, a Living Will tells healthcare workers and your family how the patient wants to live should the patient become terminally ill or permanently unconscious.

Living Wills have the following components:

- Allows patient to state if they would like no “life sustaining treatment” and authorizes the physician to “withdraw such treatment if it has been commenced.”
- Provides an additional opportunity for patients to authorize the attending physician to withhold or withdraw the provision of artificially supplied nutrition or hydration (feeding/IV tubes)
- Patient must be able to sign the form which must be notarized or witnessed by two individuals not related to the patient by blood, marriage or adoption.

Durable Power of Attorney for Healthcare

The Durable Power of Attorney for Healthcare (DPOA) is an advance directive in which the patient appointed another individual to make medical decisions for the patient should the patient is unable to do so. A patient may appoint anyone to be his or her DPOA except his or her attending physician or the nursing home administrator of the facility a patient resides. For example, a resident of Pleasant Hill Manor (PHM) who is a patient of Dr. Kessler may not appoint Dr. Kessler or the administrator at PHM to be his or her DPOA.

Once a patient is able to make his or her own medical decisions, the decision is the patient’s.

Please keep in mind that a DPOA is different from a Power of Attorney (POA). A Power of Attorney is the individual appointed by the patient to oversee the patient’s financial interests. As a general rule, a POA cannot make a patient’s medical decisions. The only exception is when the POA document has a specific healthcare clause giving the POA the power to make medical decisions. Along the same lines, a DPOA cannot oversee a patient’s financial interests. A DPOA is only involved in a patient’s medical care. The POA and the DPOA can be the same individual if the patient has appointed the same person to both roles.

It should also be noted that laws regarding Power of Attorneys and Durable Power of Attorneys for Healthcare vary from state to state in terms of time limitations and scope of powers available to the POA or DPOA.

A Durable Power of Attorney for Healthcare cannot stop a patient from making a “bad decision”. Consider the following example:

A patient is unable to ambulate and lives alone. The patient has no family support. The patient refuses home health or to go to the nursing home. Education is presented to the patient that this living arrangement is dangerous, but insists on returning home. The patient acknowledges and understands the risks of going home alone.

While we may not agree with the patient’s decision, it is the patient’s to make. In the above scenario, the DPOA could not be contacted to “overrule” the patient’s decision. This is different from a Power of Attorney.

Some of the components of a DPOA are:

- Allows the patient the same opportunity to make wishes known in regards to code status and artificial nutrition as a Living Will
- Also allows patient to appoint a person and two alternates to make health care decisions for the patient if the patient is unable to do so.
- Individual appointed to make medical decisions has the same power and authority as the patient to do so.
- The durable power of attorney does not cover finances.
- Patient must be able to sign the form which must be notarized or witnessed by two witnesses not related to the patient by blood, marriage or adoption.

At times a patient is unable to make medical decisions and has not named a DPOA. In such instances, medical decision-making is spelled out in the Ohio Revised Code. Those in line to make medical decisions are:

- Spouse (if you are separated and not divorced, your spouse is still the one to make medical decisions).
- Consensus of the adult children (if you have 17 children they would need to agree)
- Parents
- Consensus of the adult siblings
- Can extend further if needed

Think about who these individuals are in your own life. If they would not amok the decisions you would want, you may want to consider completing a DPOA yourself.

Anatomical Gift (Organ Donation)

The decision to donate an anatomical gift is also an Advance Directive. Every patient who has an Ohio driver's license or identification card and is 18-years-old or older has made this decision. Minors are able to become an organ donor on their identification card with parental permission. The patient's name is added to the appropriate registry, which is maintained by the Ohio Bureau of Motor Vehicles (BMV). A patient can change his or her mind regarding an anatomical gift by completing the donor registry enrollment form and mailing the form to the BMV.

Some patients are concerned that if they agree to be an organ donor, then their physician will not provide care to them. This is NOT true. The donor registry list is only accessed by appropriate personnel (outside the hospital) once a patient has passed away or is determined to have sustained "brain death". The patient is also screened by an outside agency (where PCH has to report all deaths at the hospital) to determine if the patient is even a candidate to donate. Only trained staff can approach a family regarding organ donation. Staff members who are able to do this are trained annually.

If a patient wants to be an organ donor or wants his or her name removed from the donation registry, please contact Social Services at extension 389.

To summarize an organ donation advance directive:

- Now required to be a part of any advance directive information distributed by a hospital.
- Allows option for the patient to donate specific or all body parts for any purpose authorized by law; transplantation, therapy, research or education
- Includes donor registry enrollment form that can be mailed to the Ohio Bureau of Motor Vehicles or completed at the renewal of a driver's license or state identification card.

The forms for Living Wills, DPOA and organ donation are available in the Social Services Department (ext. 389).

Do Not Resuscitate Orders

A Do Not Resuscitate (DNR-CC or DNR-CC Arrest) is the only Advance Directive that requires a physician's signature and not the patient's to be valid. There are two main types of DNR orders – DNR-CC and DNR-CC Arrest. Each has different rules regarding the care that can and cannot be given to a patient. The criteria for each are explained in Ohio Revised Code.

To understand DNR-CC and DNR-CC Arrest, it is important to have a working definition of the two. A DNR-CC tells providers what type of care a patient will receive. More is discussed regarding this later in this section, but in general a patient who has a signed DNR-CC order is to be kept comfortable. A DNR-CC Arrest means that providers will do

everything for a patient up to the point that the patient experiences a cardiac or respiratory arrest. In terms of patients, a patient with a DNR-CC order is typically a patient who is on Hospice or has had a lengthy disease process. Patients who have a DNR-CC Arrest cannot necessarily be classified as “terminal”.

A patient can revoke a DNR order at any time. If the patient’s DPOA or family signed the DNR order, then the same individual has the option to revoke the document.

DNR-CC

When a DNR-CC is signed, the protocol regarding care is immediately activated. By signing this document a physician has defined the course of treatment a patient will receive. Following the rules as defined in Ohio Revised Code for DNR-CC and DNR-CC Arrest is the only way providers are protected under the immunity that these documents afford healthcare workers.

Under the DNR-CC protocol, the following actions will be completed by healthcare workers:

Healthcare workers will:

- Suction the airway
- Administer oxygen
- Position for comfort
- Splint or immobilize
- Control Bleeding
- Provide Pain medication
- Provide emotional support
- Contact other healthcare providers such as hospice, home, health, physician

Healthcare workers will not do the following under DNR-CC protocol:

- Administer chest compressions
- Insert artificial airway
- Administer resuscitative drugs
- Defibrillate or cardiovert
- Provide respiratory assistance
- Initiate resuscitative IV
- Initiate cardiac monitoring

DNR-CC ARREST

When a patient has a signed DNR-CC Arrest, everything in the continuum of care will be done for this patient until the patient experiences an arrest. Once the patient experiences a cardiac or respiratory arrest, the DNR-CC protocol discussed above would be activated.

The protocol is not implemented unless the patient arrests. For example a patient is in our hospital and is a DNR-CC Arrest. Staff would treat the patient as any other full code patient. The patient experiences a respiratory arrest. At the time of the arrest the DNR-CC protocol would be implemented. So if a patient's code status is DNR-CC Arrest, staff should do everything medically necessary for the patient until the patient arrests.

Points to remember regarding DNR-CC and DNR-CC Arrest:

Knowing the difference between the two types of DNRs is only one piece of the puzzle. There are still other issues hospital staff needs to be aware of with these documents.

- A physician must sign the DNR form in order for the form to be valid. The patient's signature is optional. Either the DNR-CC or DNR-CC Arrest box must be marked.
- Patients must present the form to hospital personnel on each admission.
 - Nursing homes should send the form with the patient.
 - Form can be obtained from a previous medical record. Need to confirm that this is still the patient's wish.
 - Patients can wear an approved ID band or carry a wallet card.
- If a patient presents to the hospital a signed DNR-CC/DNR-CC Arrest form, nursing must call the physician to translate it into an order for either DNR-CC or DNRCC-Arrest (The form should have one or the other marked.).
- The physician is not required to use DNR-CC/DNR-CC Arrest language when writing an order, but doing so allows for the protection from liability.
 - Under Ohio Revised Code, healthcare workers have immunity from capital criminal prosecution, civil liability, and professional licensure disciplinary action if they follow the DNR-CC/DNR-CC Arrest protocol.
 - Deviations from the protocol such as placing a patient you know are a DNR-CC on telemetry takes away the immunity.
 - The immunity applies to physicians, nurse practitioners, EMS and employees who work for a health care facility
- At Pike Community Hospital, the physician's order is honored. So, we will accept "Do not resuscitate", "No code", "No code blue" or any variation the physician may write. However, if a physician writes the order this way, the immunity discussed above is lost. Therefore, clarifying the order to include DNR-CC or DNR-CC Arrest is important.

- If the physician writes specifically DNR-CC or DNR-CC Arrest, then
 - Implement the appropriate protocol/care.
 - If the patient does not have the form but the physician writes a “DNR-CC” or “DNR-CC Arrest” order a DNR form should be placed on the chart for physician’s signature. Once signed, the patient should receive the original form and a copy placed on the chart.
- If there is an order on the chart for a DNR-CC, DNR-CC Arrest or related order then a blue identification band should be placed on the patient and marked accordingly. A sticker should also be placed on the front of the chart.
- The blue ID band can also be used for patients who are made a “no code” or other variation by turning the insert over and writing the exact order from the physician and the patient & physician name.
- A physician can change a patient from a DNR-CC to a DNR-CC Arrest if treatment warrants such a change. For example, a DNR-CC patient comes in for chest pain and the physician wants the patient on telemetry. In this case, the patient’s code status should be changed to a DNR-CC Arrest so that the patient may have the telemetry. The physician can change the code status back if s/he elects to do so.
 - If a patient’s code status is changed in the above form, the physician should complete a new DNR form and check the appropriate box (DNR-CC or DNR-CC Arrest).
 - Copy of the new form should be given to the patient.
- Staff is not required to search a patient to determine if they have a signed DNR form prior to initiating treatment.

How does PCH Manage Advance Directives?

Every patient admitted at PCH is asked by the registrar if s/he has an advance directive. If the answer is yes, the patient is instructed to provide the Advance Directive to the nursing unit. Once the Advance Directive is provided, a copy is made for the patient’s chart. If the patient does not have an Advance Directive but is interested in completing one, social services should be contacted to facilitate.

Nursing also asks each patient on admission about Advance Directives. If presented with an Advance Directive, nursing copies the document, places the copy in the patient’s chart, and informs the physician. At discharge, the Advance Directive is filed in Medical Records.

If a patient has an Advance Directive but does not have it with them, nursing will document the content and request the patient to have a copy brought to the hospital

The physician reviews the advance directive and translates the advance directive into a physician's order as appropriate.

Patients (inpatients and outpatients) should be encouraged to carry a copy of their Advance Directives with them. This document will not provide the patient with the intended benefits unless staff members know that it exists.

Mental Health Declaration

This is an Advance Directive that is relatively new in Ohio. A Mental Health Declaration specifies who you would want to provide mental health services to you if needed and what type of services would you consent in addition to the care you do not consent to. Unlike other Advance Directives that do not expire until revoked by the patient, this Advance Directive expires after three (3) years. At the end of the three year period a new document needs to be completed.

MOLST Legislation

[HB 241](#) was introduced in June 2009 and would create a Medical Order for Life Sustaining Treatment (MOLST) form that would help provide standardized documentation of patients' wishes for treatment toward the end of their lives. The form incorporates do-not-resuscitate (DNR) wishes along with other treatment preferences such as comfort care, limited additional interventions or the use of antibiotics or artificially administered nutrition. The MOLST form would be standardized, brightly-colored and completed by a patient's physician, physician assistant or nurse practitioner after discussion with the patient or his or her representative. It also would be portable throughout the health care delivery system. Similar legislation has been adopted in other states. At the time of this inservice, this piece of legislation was still in review in the Health Committee of the Ohio legislature (Ohio Hospital Association).

To summarize, Ohio presently has five types of Advance Directives: Living Will, DPOA, Anatomical Gift Donation, DNR (DNR-CC/DNR-CC Arrest) and Mental Health Declaration. Each document provides different insight into the wishes a patient has about his or her healthcare. Efforts are also underway to make Ohio law more compatible with advance directive legislation in other states.

References

Calloway, Sue Dill (2006). *Advance Directive Update*. Training CD published by OHIC.

Dill, Sue (no date). *Do Not Resuscitate Summary*. OHIC.

Ohio Hospice and Palliative Care Organization (2005). *Choices: Living Well at the End of Life – 4th edition*.

Pike Community Hospital's Policy and Procedure manual regarding Advance Directives and DNR policies.