POLICY # 4.5
OCTOBER 2012
Title: Advanced Directive Health Care Proxy and Power of Attorney

Purpose: The purpose of this policy is to ensure that there is a process regarding the use of Advanced Directives, Living Wills, Health Care Proxy and Power of Attorney. This process also ensures that the wishes of our patients are met and the staff and facility is directing care in a responsible manner.

Definitions:

Advanced Directive or Living Will is any written directions prepared in advance to say what kind of medical care one would want in the event they became unable to make decisions for themselves.

Health Care Proxy is a legal document in which an individual designates another person to make health-care decisions if he or she is rendered incapable of making their wishes known. The health-care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.

Durable Power of Attorney in this type of advance directive, an individual executes legal documents that provide the power of attorney to others in the case of an incapacitating medical condition. The durable power of attorney allows an individual to make bank transactions, sign social security checks, apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated.

Procedure: Patients will be asked on the pre-op call if they have any type of advanced directive in place and this information will be documented on the pre-op assessment. If a patient is found to have an advanced directive the pre-op call nurse will advise the patient to bring a copy of that advanced directive with them. On the day of the procedure the patient will be asked if they have any form of advanced directive. If a patient responds yes and only if they brought a copy with them a copy will be placed on the patient's chart.

In response to seriously ill patients who are medically frail with limited life expectancy, regardless of their age a Practitioner Order for Life-Sustaining Treatment (POLST) form will be utilized. The POLST form is a set of orders specified and signed by the MD/APN and by the patient/surrogate that gives these patients more control over their end-of-life care. The values in the POLST form should reflect the same values that are expressed in an advanced directive. If conflict exists then a conversation must be had with the patient/surrogate to determine the most current preferences as soon as possible.
The original POLST form printed on green paper must stay with the patient at all times even if transferred to another facility. A copy is placed on the patients chart and is part of the medical record. POLST forms can be modified or rescinded by a patient with decision making capacity verbally or in writing at any time. Changes may also be made by the legal surrogate if the patient authorized the surrogate. All changes should be made in collaboration with the MD or APN.

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Faxed copies and photo copies of POLST forms are valid. Green paper is preferred and should be used; however the form will be honored no matter what color as long as is contains the appropriate signatures.

In the case that a patient is in a state where they are unable to make decisions for themselves prior to admission to the facility the legally designated authority must sign all necessary documents and consents. A copy of paperwork that legally designates that person as the authority must be present and a copy will be kept in the chart.

If the POA does not arrive with the patient consent may be obtained via fax or via telephone. If telephone consent is obtained a second individual must speak with the POA over the phone to verify understanding of the consent. If the consent is of clinical nature i.e. operative consent that second individual must be a licensed professional.

Any patients that do not have advanced directives in place will be offered information regarding advanced directives when they arrive for their procedure.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, then contact physician/APN. This Medical Order Sheet is based on the current medical condition of the person referenced below and their wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

Person Name (last, first, middle) Date of Birth

A

GOALS OF CARE *(See reverse for instructions. This section does not constitute a medical order.)*

B

MEDICAL INTERVENTIONS: *Person is breathing and/or has a pulse*

- ❑ **Full Treatment.** Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status.
- ❑ **Limited Treatment.** Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ❑ Transfer to hospital for medical interventions.
  - ❑ Transfer to hospital only if comfort needs cannot be met in current location.
- ❑ **Symptom Treatment Only.** Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use Antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.

Additional Orders: _____

C

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:

Always offer food/fluids by mouth if feasible and desired.

- ❑ No artificial nutrition.
- ❑ Defined trial period of artificial nutrition.
- ❑ Long-term artificial nutrition.

D

CARDIOPULMONARY RESUSCITATION (CPR)

Person has no pulse and/or is not breathing

- ❑ Attempt resuscitation/CPR
- ❑ Do not attempt resuscitation/DNAR
  Allow Natural Death

AIRWAY MANAGEMENT

Person is in respiratory distress with a pulse

- ❑ Intubate/use artificial ventilation as needed
- ❑ Do not intubate - Use O2, manual treatment to relieve airway obstruction, medications for comfort.

E

If I lose my decision-making capacity, I authorize my surrogate decision maker, listed below, to modify or revoke the NJ POLST orders in consultation with my treating physician/APN. ❑ Yes ❑ No

_____

Print Name of Surrogate *(address on reverse)* Phone Number

F

SIGNATURES:

I have discussed this information with my physician/APN.

Signature_____

- ❑ Person Named Above
- ❑ Health Care Representative/Legal Guardian
- ❑ Spouse/Civil Union Partner
- ❑ Parent of Minor
- ❑ Other Surrogate_____

Has the person named above made an anatomical gift:
❑ Yes ❑ No ❑ Unknown

These orders are consistent with the person's medical condition, known preferences and best known information.

_____

PRINT - Physician/APN Name Phone Number

_____

Physician/APN Signature (Mandatory) Date/Time

10/8/12

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

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PRINT PERSON'S NAME (LAST, FIRST, MIDDLE) DATE OF BIRTH

PRINT PERSON'S ADDRESS

CONTACT INFORMATION

PRINT SURROGATE HEALTH CARE DECISION MAKER ADDRESS PHONE NUMBER

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

COMPLETING POLST

- Must be completed by a physician or advance practice nurse.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms may be used.
- Any incomplete section of POLST implies full treatment for that section.

REVIEWING POLST

POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

MODIFYING AND VOIDING POLST - *An individual with decision making capacity can always modify/void a POLST at any time.*

- A surrogate, if designated in Section E on the front of this form, may, at any time, void the POLST form, change his/her mind about the treatment preferences or execute a new POLST document based upon the person's known wishes or other documentation such as an advance directive.
- A surrogate decision maker may request to modify the orders based on the known desires of the person or, if unknown, the person's best interest.
- To void POLST, draw a line through all sections and write "VOID" in large letters. Sign and date this line.

SECTION A

What are the specific goals that we are trying to achieve by this treatment plan of care? This can be determined by asking the simple question: "What are your hopes for the future?" Examples include but not restricted to:

- Longevity, cure, remission
- Better quality of life
- Live long enough to attend a family event (wedding, birthday, graduation)
- Live without pain, nausea, shortness of breath
- Eating, driving, gardening, enjoying grandchildren

Medical providers are encouraged to share information regarding prognosis in order for the person to set realistic goals.

SECTION B

- When "limited treatment" is selected, also indicate if the person prefers or does not prefer to be transferred to a hospital for additional care.
- IV medication to enhance comfort may be appropriate for a person who has chosen "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), or bi-level positive airway pressure (BiPAP).
- Comfort measures will always be provided.

SECTION C

Oral fluids and nutrition should always be offered if medically feasible and if they meet the goals of care determined by the person or surrogate. The administration of nutrition and hydration whether orally or by invasive means shall be within the context of the person's wishes, religion and cultural beliefs.

SECTION D

Make a selection for the person's preferences regarding CPR and a separate selection regarding airway management.

SECTION E

This section is applicable in situations where the person has decision making capacity when the POLST form is completed. A surrogate may **ONLY** void or modify an existing POLST form, or execute a new one, if named in this section by the person.

SECTION F

POLST must be signed by a practitioner, meaning a physician or APN, to be valid. Verbal orders are acceptable with follow-up signature by physician/APN in accordance with facility/community policy. POLST orders should be signed by the person/surrogate. Indicate on the signature line if the person/surrogate is unable to sign, declined to sign, or a verbal consent is given.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED