



ST. ANN'S COMMUNITY

Policy Name: Advance Directives

Policy No: RI-1

Responsible Dept: Medical, Social Work, Nursing

Original Date: 12/91;

Re-written: 11/7/03

Policy Statement

To ensure resident's/patient's advanced directives are honored.

Policy and Procedures

I. Definitions

1. New York Healthcare Proxy – A legal document that allows one to make decisions about their medical care including decisions about life support if they can no longer speak for themselves. The Healthcare Proxy form appoints someone to speak for them at any time they are unable to make their own medical decisions.
2. New York Living Will (New York State Advanced Directive) – Allows one to state their wishes about medical care in the event they develop an irreversible condition that prevents them from making their own medical decisions. The living will become effective if one becomes terminally ill, or permanently unconscious, or minimally conscious due to brain damage, or impaired cognition and does not regain the ability to make decisions.

NOTE: New York Healthcare Proxy Form and New York Living Will do not need to be notarized and a lawyer does not need to fill out these forms. These documents will be legally binding only if at the time of completion the person is a competent adult at least 18 years old, the signing of the documents are properly witnessed, and the documents are available when needed.

3. Surrogate – The person who has legal authority to consent to a DNR order for a resident/patient who lacks capacity and has not appointed a healthcare proxy. It is the person in the highest category on the following list who is reasonably available, willing, and competent to decide about CPR.
 - a. Resident's/Patient's designated healthcare proxy
 - b. A committee of the person or an Article 17:8 guardian – this is a person appointed by a court to manage the personal affairs of an adult who is incompetent, developmentally disabled or mentally retarded.
 - c. The spouse
 - d. A son or daughter 18 years of age or older
 - e. A parent
 - f. A brother or sister 18 years of age or older
 - g. A close friend – a close friend is any person who presents an affidavit (a sworn statement in writing) to an attending physician stating 1) that he or she is a close friend of the resident/patient and that he or she has maintained regular contact with the resident/patient so as to be familiar with the resident's/patient's activities, health and religious or moral beliefs and 2) the facts and circumstances that demonstrate such familiarity.

4. Non-Hospital DNR Order – Physician Order instructing emergency personnel not to perform CPR when the resident/patient is outside of the nursing home or hospital.
5. MOLST Form (Medical Orders for Life Sustaining Treatment) – A document which is a short summary of resident's/patient's treatment preferences and a physician's order for care that is easy to read in an emergency situation. It is not intended to replace an advanced directive document or other physician orders. Its intent is to centralize information, facilitate record keeping and ensure transfer of appropriate information among healthcare providers and healthcare settings.
6. Advanced Care Planning – Process of planning for future medical care in the event that one is unable to make health related decisions on their own behalf. Advanced Care Planning includes documents such as healthcare proxy, advanced directives/living will, etc.
7. Power of Attorney (POA) – An agent who is assigned by resident/patient to act on their behalf as it relates to financial matters, NOT healthcare matters.
8. Medically Futile – Under the law this means that CPR will be unsuccessful in restoring cardiac and respiratory function or that the resident/patient will experience repeated arrest in a short time period before death occurs.

II. Intake

- A. Intake will distribute information to residents/patients/families regarding advance directives, DNR/DNI orders and MOLST form prior to admission. This Advance Care Planning packet will include:
 1. Copy of frequently asked questions regarding MOLST form for patients and families.
 2. St. Ann's Community brochure on "DNR Orders in the Nursing Home".
 3. Letter from St. Ann's Medical Staff regarding St. Ann's approach to ensuring that resident's/patient's advance directives are honored.
 4. New York State "Planning in Advance for Your Medical Treatment".
- B. Every effort will be made to obtain copy of resident/patient New York Healthcare Proxy Form, New York Living Will or any other advanced care directives. These documents should be available and placed under "Advanced Directives" tab of chart in sleeve labeled "outside advance directives".
- C. Healthcare Proxy, New York Living Will, and other advance directive forms will only be legally binding and can only be honored if they are available.

III. New York Healthcare Proxy

- A. Social Work to review on admission.
 1. Resident/Patient with Capacity
 - a. If healthcare proxy form is present, place under "Advanced Directives" tab of chart in sleeve labeled "outside advance directives".
 - b. If resident/patient has healthcare proxy form filled out previously but no copy available on admission, social work will complete new form with resident/patient and place under "Advanced Directives" tab of chart in sleeve labeled "outside advance directives".
 - c. If resident/patient never filled out a healthcare proxy form, social work will complete new form with resident/patient and place under "Advanced Directives" tab of chart in sleeve labeled "outside advance directives".
 - d. Resident/Patient with capacity can change primary or secondary healthcare proxy at any time. Social Work to ensure that old healthcare proxy form is sent to medical records and new healthcare proxy form is appropriately filled out and place under "Advanced Directives" tab of chart in sleeve labeled "outside advance directives".

2. Resident/Patient without Capacity
 - a. Resident/patient has healthcare proxy and both healthcare proxy and healthcare proxy form are available on day of admission. Admitting MD to review.
 - b. Healthcare proxy/Healthcare proxy form/surrogate not present on admission
 - i. Place healthcare proxy form under “Advanced Directive” tab of chart in sleeve marked “Outside Advanced Directives” (if available).
 - ii. *Schedule meeting with healthcare proxy/surrogate and admitting physician.*
 - iii. If healthcare proxy form cannot be located, assumption is that resident/patient has no healthcare proxy, and social work will determine surrogate from hierarchy list and arrange for meeting with admitting physician.

Note: If healthcare proxy / surrogate not present on admission, and resident/patient was DNR/DNI before admission, this order shall be carried out pending meeting with healthcare proxy/surrogate. If no code status orders on admission, resident/patient will be full code pending meeting with healthcare proxy/surrogate.

IV. MOLST Form

- A. New Admission
 1. Admitting MD will *complete MOLST form.*
 2. With Capacity
 - a. Admitting MD will review sections A through E, sign and date where indicated, and obtain signature of witness and have resident/patient sign and date Section C and E
 - b. Check off CPR, intubation, and hospital status on index card, sign and date and place in pocket inside cover of chart
 - c. Place MOLST form under “Advanced Directives” tab of chart in sleeve marked “MOLST – Do Not Remove”.
 3. Without Capacity
 - a. Admitting MD must find to a “reasonable degree of medical certainty” that resident/patient lacks capacity and fill out MOLST “Supplemental Documentation Form for Adults”, Section I, steps 1 through 8 thus describing cause, nature, duration, and extent of lack of capacity.
 - b. If DNR/DNI order, admitting MD must find that one of the following conditions exist and make appropriate entry on same form (Section 1, Step No. 3).
 - i. Resident/patient has a terminal condition or
 - ii. Resident/patient is permanently unconscious or
 - iii. Resuscitation would be medically futile or
 - iv. Resuscitation would pose an extraordinary burden on the resident/patient in light of the resident’s/patient’s medical condition and the expected outcome of resuscitation of the resident/patient.
 - c. Second MD opinion
 - i. If admitting MD deems resident/patient to lack capacity, they will request second MD opinion. If second MD agrees with lack of capacity after personally examining resident/patient, they will sign MOLST “Supplemental Documentation Form for Adults”, Section 1, Step 9 and order will be written to “activate healthcare proxy” and notify social work.
 - ii. If second MD disagrees regarding lack of capacity, discussion will be held with admitting MD. If still no agreement, third MD opinion to reach consensus.

- d. MOLST Review with HCP/Surrogate
 - i. Admitting MD to obtain healthcare proxy/surrogate consent for DNR/DNI order and any other limitations on medical interventions designated on MOLST form by obtaining healthcare proxy /surrogate and witness signature Section I, step 5, MOLST “Supplemental Documentation Form for Adult”.
 - ii. Review MOLST Form Sections A thru E with healthcare proxy/surrogate, sign and date appropriate orders, have healthcare proxy/surrogate sign Sections D and E.
 - iii. Check off CPR, intubation and hospital status on index card, sign and date and place in pocket front of chart. Place MOLST form under “Advanced Directives” tab of chart in plastic sleeve labeled “MOLST – Do Not Remove”.
 - iv. If healthcare proxy and/or HCP form or surrogate not available on the day of admission, *meeting will be arranged between MD and healthcare proxy or surrogate* to review MOLST form and obtain appropriate signatures as described above.
- e. If resident/patient has no healthcare proxy and no surrogate, determination regarding medical futility of CPR will be made by attending MD and second MD. If CPR deemed medically futile, MD’s to sign MOLST “Supplemental Documentation Form for Adults”, Section 2B “Medical Futility Exception”. If CPR deemed not medically futile, consult legal counsel.
- f. *Once MOLST is completed/updated, HIM is notified to make copy.*

B. MOLST Form Review

- 1. Annual –
 - a. Social Work to review current MOLST form with resident/patient or HCP/surrogate to ensure orders still reflect wishes.
 - b. If any change requested, Social Work will notify attending physician *via medical rounds*.
 - c. Social Work to document status of review on “Social Work Annual Review of MOLST Form”, found under “Advanced Directives” tab of chart.
 - d. *If new MOLST is completed/updated, HIM is notified to make copy.*
- 2. Review if any of the following conditions apply:
 - a. Member of ICCP team feels resident/patient lacks capacity to make medical decision on their own behalf.
 - i. *Nursing* to notify attending physician to determine lack of capacity.
 - ii. Attending physician will personally examine resident/patient and if they agree on lack of capacity, will sign MOLST “Supplemental Documentation Form for Adults”, Section I, Steps 1 through 8.
 - iii. Attending physician to request second physician opinion.
 - iv. Second physician will personally examine resident/patient and if in agreement with lack of capacity will “Supplemental Documentation Form for Adults”, Section 1, Step 9.
 - v. If second physician not in agreement, two physicians will conference and request third physician opinion for consensus.
 - vi. Second physician to write order to “activate healthcare proxy” and to notify Social Work who in turn will arrange for meeting with attending physician.
 - b. Substantial change in resident/patient health status (either improvement or deterioration).
 - c. Resident/patient treatment preference changes.

3. DNR/DNI/Full Code orders reviewed and renewed every 60 days with date and attending physician name and signature Section F MOLST Form.
4. Documentation of Changes on MOLST Form/Section F
 - a. No change
 - b. If any changes
 - i. Check off “Form Voided, New Form Completed”
 - ii. Send voided form to medical records
 - iv. Review sections A through E with resident/patient/HCP/surrogate
 - v. *Witness to* sign along with attending physician appropriate Sections C, D and E.
 - vi. If new DNR, DNI - attending physician will fill out new index card indicating CPR, intubation and hospital status and sign non-hospital DNR order.
 - vii. If request that DNR, DNI order be withdrawn, attending physician will fill out new index card reflecting CPR, intubation and hospital status and void non-hospital DNR order. *Non-hospital DNR order will be sent to medical records.*
 - viii. All voided index cards to be sent to Medical Records
 - ix. If form is voided, and no new form completed
 - Check off “FORM VOIDED, NO NEW FORM”
 - Send voided form to medical records
 - Attending physician will complete new index card indicating new CPR, intubation and hospital status and void non-hospital DNR order and send to Medical Records.

NOTE: Index card must be filled out even if no MOLST form in chart

V. Non-Hospital DNR Order

- A. Resident/patient who is DNR/DNI – order will be issued on the standard DOH form for non-hospital DNR orders and signed and dated by attending physician.
- B. Attending physician will review the appropriateness of the non-hospital DNR order every 60 days.
 1. Unit Secretary to pull ALL Non-Hospital DNR orders every 60 days along with ALL MOLST forms. Fill in date and submit to attending physician for signatures.
- C. Non-hospital DNR order may be revoked at any time by the resident/patient, healthcare proxy or surrogate. The physician must note that the order has been revoked in the resident’s/patient’s medical record. Non-hospital DNR order which will be sent to medical records to be filed in the inactive chart. New MOLST form will need to be completed.
- D. Any time resident/patient status is changed from full code to DNR, a new MOLST and non-hospital DNR form will be completed.

VI. DNR/DNI Orders

- A. DNR order is “an order not to attempt CPR in the event a resident/patient suffers cardiac or respiratory arrest” (i.e., DNR = NO cardiopulmonary resuscitation, endotracheal intubation or mechanical ventilation if resident/patient has no pulse and/or no respirations.
 1. Section A MOLST form for residents/patients in cardiopulmonary arrest – 2 options
 - i. Do Not Resuscitate (DNR)
 - ii. Full cardiopulmonary resuscitation (CPR) – no limitations
- B. DNI Order is an order not to intubate if progressive or impending pulmonary failure without acute cardiopulmonary arrest.
 1. Section B MOLST form for resident/patient who has progressive or impending pulmonary failure without cardiac arrest – 3 options

- i. Do Not Intubate (DNI)
 - ii. A trial period of intubation and ventilation
 - iii. Intubation and mechanical ventilation if needed

- C. CPR means measures to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. The definition of CPR excludes “measures to improve ventilation and cardiac function in the absence of an arrest”. Therefore a resident/patient who experiences an arrhythmia or respiratory distress can be given cardiac or respiratory support even if there is a DNR order.

- D. DNR order will be reflected in Section A of the MOLST form.

- E. DNI order will be reflected in Section B of the MOSLT form.

- F. Physician DNR/DNI orders – 3 options
 1. DNR/DNI – Do Not Resuscitate and Do Not Intubate
 2. DNR – Do Not Resuscitate, but eligible for intubation if progressive and impending pulmonary failure.
 3. Full Code – Eligible for CPR and intubation
 4. Renewed and reviewed every 60 days.
 - a. Unit Secretary to pull ALL ORIGINAL MOLST forms every 60 days, fill in date, reviewers name, and location in Section F and submit to attending physician for signatures along with Non-Hospital DNR orders.
 5. Seek the resident’s oral or written consent
 - a. Verbal and written consent must be witnessed by two adults, one of whom is a physician.
 6. Section A through D of MOLST form will be completed which will act as DNR and/or DNI order or full code order.

- G. All resident/patient’s will have an index card in front pocket of chart with physician signature and date designating the following:
 1. CPR – check off yes or no.
 2. Intubation – check off yes or no.
 3. Hospitalization – check off yes or no.
 4. This card must be updated by physician whenever there are changes in MOLST form affecting CPR, intubation or hospital status.

- H. Resident/patient with capacity but would suffer “severe and immediate injury” from a discussion about CPR.
 1. Therapeutic Exception – If physician determines that a resident/patient would suffer “severe and immediate injury” from a discussion about CPR, then the physician does not have to obtain the resident’s/patient’s consent, but must then follow an alternative procedure for entering a DNR order.
 - a. Determine resident’s/patient’s wishes to the extent possible without subjecting resident/patient to “severe and immediate” injury.
 - b. Document and sign the reason resident/patient would suffer “severe and immediate injury” on MOLST “Supplemental” Documentation Form for Adults”, Section 2A and 2B.
 - c. Second Physician must personally exam resident/patient and sign as concurring physician on MOLST “Supplemental Documentation Form for Adults”, Section 2B.
 - d. Seek HCP/Surrogate consent if one exists, unless order is entered based on resident’s/patient’s previous consent.

- VII. Unit Secretary
 - A. Pull all non-hospital DNR orders, and all original MOLST forms, every 60 days for attending physician signature. **DO NOT PULL MOLST COPY**
 1. Write date on all non-hospital DNR orders.
 2. Write date and location of review in Section F of original MOLST form.
 3. Stamp attending physician’s name in Section F of original MOLST form in column entitled “Reviewer’s Name and Signature”.
 4. **THESE FORMS ARE TO BE PULLED, SIGNED, AND PLACED BACK IN RESIDENT/PATIENT CHART ON THE SAME DAY.**
 - B. Ensure that ALL advance directive forms are placed under “Advanced Directives” tab of chart in clear sleeves in the following order:
 1. Non-Hospital DNR order
 2. Original MOLST form marked “ORIGINAL MOLST/DO NOT REMOVE”
 3. Copy of MOLST form marked “MOLST COPY” for emergency transfer of resident/patient
 4. Original MOLST Supplemental Documentation Form for Adults marked “SUPPLEMENTAL MOLST – DO NOT REMOVE”
 5. “Outside Advanced Directives”
 - New York Health Care Proxy form.
 - New York Living Will form.
 - Any other advance directives.
 6. “Social Work Annual MOLST Review”

- VIII. Nursing
 - A. Whenever resident/patient is discharged to the emergency department or hospital, pink copy of MOLST form and Non-Hospital DNR order must always accompany them.
 - B. Whenever resident/patient leaves the facility for outside appointments or for social events, non-hospital DNR order must accompany them.

- IX. Recreation Therapy
 - A. Copy of non-hospital DNR order will accompany each resident/patient who is DNR/DNI and attends a recreation therapy activity out of house.

- X. HIM
 - A. Ensure pink copy of MOLST form is replaced in clear sleeve marked “MOLST COPY” under Advance Directive tab of chart whenever resident/patient is discharged to emergency room or hospital.
 - B. Conduct periodic audits of advance directives section of chart.

Regulatory Reference Sources						Revised Date:
X	42 CFR	483.15		OSHA		11/7/03
	JCAHO		X	DOH	415.5	1/11/05
	CMS			Other		
T:\Policies & Procedures\Resident Rights & Ethics (RI)\RI_01.doc						