ADVANCE DIRECTIVES

POLICY

High Peaks Hospice (HPH) will respect the rights of each adult patient to participate in health care decision making to the maximum extent of his or her ability. HPH will respect all rights consistent with New York State Law and Federal Patient Self-Determination Act of 1990. HPH will ensure that a patient’s health care decisions are followed.

DEFINITIONS:

Advance Directive: A type of written or oral instruction relating to the provision of health care when an adult becomes incapacitated, including but not limited to a health care proxy (HCP), a consent to the issuance of an order not to resuscitate (DNR) or other medical orders for life-sustaining treatment (MOLST) recorded in a patient’s medical record, and a living will.

Adult: Any person who is 18 years of age or older, or is the parent of a child, or has married.

Capacity to Make Health Care Decisions: A person is presumed to be capable of making health care decisions unless his or her attending physician determines that he or she does not understand or appreciate the nature and consequences of health care decisions, including the benefits and risks of alternatives to any proposed health care decision. If the decision to be made involves life-sustaining treatment, the attending physician’s determination of incapacity must be confirmed in writing by a second physician.

Capacity to Appoint a Health Care Agent: A person is presumed capable of appointing a health care agent under New York’s Health Care Proxy Law unless a judge determines that the person does not understand or appreciate that such an appointment authorizes someone else to make health care decisions for that person.

DNR (Do Not Resuscitate) Orders: An order signed by a physician that instructs medical professionals not to perform cardiopulmonary resuscitation (CPR) that is, emergency treatment to restart heart or lungs when heartbeats or breathing stops. (NYS Public Health Law, Article 29-B)
Health Care Proxy: A document created pursuant to Article 29-C of the State’s Public Health Law which delegates the authority to another adult known as a health care agent to make health care decisions on behalf of the adult when that adult is incapacitated.

Health Care Agent: An adult to whom authority to make health care decisions is delegated under a health care proxy.

Hospice: High Peaks Hospice (HPH)

Living Will: A document which contains specific instructions concerning an adult’s wishes about the type of health care choices and treatments that an adult does or does not want to receive, but which does not designate an agent to make health care decisions.

Medical Order for Life-Sustaining Treatment (MOLST): A medical order to provide for withholding or withdrawing life-sustaining treatment.

Primary Caregiver or Primary Care Person: The person who accepts home care responsibility for the patient while that patient is on hospice services.

Surrogate Decision Maker: A person selected pursuant to New York’s DNR Law to make decisions regarding resuscitation on behalf of a patient.

PROCEDURE:

A. Informational Visit:

1. The Patient Care Coordinator (PCC) or designee will give adults an information packet on advance directives during the informational visit. Individuals will be instructed to review the materials in order to be able to discuss them during the admission visit should they decide to come onto HPH services.

2. Each individual/family shall receive the following:
   a. HPH’s Patient Self-Determination Information
   b. New York State Office of the Attorney General: “Planning your Health Care in Advance”
   c. Each individual/family (or, if the individual is incapable of responding, the individual’s health care agent or primary caregiver) shall be asked if the individual has an advance directive. The response to this question will be documented on the individual’s “Referral/Informational For Hospice Care” form by the person making the informational visit.
B. Admission Visit:

1. The HPH representative will obtain a copy of the advance directive document(s) from the patient/family member. The copies will be added to the patient’s clinical record. The presence of any written directives will be documented in the patient’s clinical record.

2. If the patient does not have an advance directive, the HPH representative shall refer the patient to the information provided in the handouts. The HPH Registered Nurse (RN) Case Manager or Social Worker (SW) will review and discuss the various options with patient and family and encourage the execution of written directives.
   a. The HPH representative shall ask the patient (or, if the patient is incapable of signing, the patient’s agent or primary care person) to acknowledge the receipt of handouts as part of signing the HPH “Admission and Care Consent” form.
   b. This form, as well as copies of any advance directive HPH receives from the patient, will be kept in the patient’s Clinical Record.
   c. If a patient gives clear and convincing oral directives, HPH will strongly encourage the preparation of written advance directives, explaining the benefits of appointing a health care agent.
   d. If the patient chooses not to express his/her self in writing, the HPH RN Case Manager or SW will document the discussion and directives in the patient’s clinical record including the date, time and location it was received and those witnessing the discussion.

C. Verify the Validity of Advance Directive

1. For living wills and health care proxies, the HPH representative will ask the patient if he or she still intends the health care proxy or living will to be in effect and note the response in the patient’s medical record.

2. Specifically, the HPH representative will:
   a. Ask the patient if he or she was the person who signed the document;
   b. Verify that the document has at least two witnesses;
   c. For documents appointing health care agents, will ask the patient, a family member or primary caregiver if the agent’s address and phone number are correct. The correct information will be obtained; if it is lacking, the patient may be assisted in executing a new Health Care Proxy form to appoint a Health Care Agent.

3. Medical Order for Life-Sustaining Treatment (MOLST): Review for Physician’s signature

4. For Physician DNR Orders, the HPH representative will:
   a. For Home Care Orders:
1) Verify that the document is signed by the patient’s attending physician or HPH’s Medical Director
2) Verify that it is executed on the proper NYS Department of Health form. (Non-Hospital Order Not to Resuscitate - DOH Form 3474)
3) Verify that the patient still desires to maintain the DNR order in effect.
   b. For Inpatient Orders - If the document is a patient’s, agent’s, or surrogate’s consent to or request for a DNR Order:
      1) Ask the patient, agent or surrogate if he or she was the person who signed the document.
      2) Verify that the patient still desires to maintain the DNR order in effect.
   c. In all cases, the HPH representative will obtain a legally constituted DNR order from the attending physician, a copy of which shall be maintained in the patient’s clinical record.

5. Invalid advance directives: If the verification procedure reveals that an advance directive may be invalid, the HPH Representative will:
   a. encourage the execution of a valid advance directive
   b. notify the patient, the primary caregiver and the attending physician that the advance directive is invalid.

D. Determining the Point at which an Advance Directive Takes Effect

1. For DNR Orders:
   a. A DNR order takes effect as soon as the patient’s attending physician writes the order and it is placed in the patient’s medical record.
   b. The DNR should be updated/reviewed by the physician every 90 days.
   c. The DNR remains valid and must be followed even if it is not reviewed within the 90-day period (Per DOH-3474).

2. The health care proxy takes effect when the patient is no longer capable of making health care decisions. If there is any question as to capacity, the HPH staff or family shall request that the attending physician or medical director assess decision-making capacity. The physician’s determination shall be documented in the HPH patient’s clinical record.

3. HPH staff will notify the following persons in the case of a determination of incapacity
   a. the patient (if there is any indication that the patient could understand)
   b. the patient’s health care agent or surrogate, and
   c. the primary care person.

4. When an advance directive takes effect, HPH staff will comply with all statutes and regulations in the State of New York governing advance directives.
5. Health Care Agent Capacity: If HPH staff question the patient’s health care agent’s capacity to make health care decisions for the patient and/or believe that the patient’s health care agent is acting in bad faith, the personnel aware of this problem shall contact the Patient Care Coordinator.

E. Changes in Status of a Patient’s Advance Directives

1. HPH staff will notify the patient’s attending physician, primary caregiver, and, if there is one, the health care agent or surrogate who has been making decisions for the patient, of any changes in the status of a patient’s advance directive, including the execution, revocation, or any modification of the text of the advance directive.

2. A competent patient can change or revoke his or her advance directives at any time.

F. Staff and Community Education

1. Staff: Educational information about advance directives, HPH’s policies and procedures, and New York State law regarding advance directives shall be provided to all HPH staff through distribution of written materials and inservice education.

2. Community: HPH staff will provide presentations to the community in concert with other health care providers and/or in combination with other topics.

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