



Indiana State Department of Health

2 North Meridian Street
Indianapolis, Indiana 46204

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ADVANCE DIRECTIVES

YOUR RIGHT TO DECIDE

The purpose of this brochure is to inform you of ways that you can direct your medical care and treatment in the event that you are unable to communicate for yourself. This brochure covers:

- What is an advance directive?
- Are advance directives required?
- What happens if you do not have an advance directive?
- What are the different types of advance directives?

THE IMPORTANCE OF ADVANCE DIRECTIVES

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as a “physician”) about your medical problems. Your physician makes a diagnosis and informs you about available medical treatment. You then decide what treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer’s disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

WHAT IS AN ADVANCE DIRECTIVE?

“Advance directive” is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf.

Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

ARE ADVANCE DIRECTIVES REQUIRED?

Advance directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

WHAT HAPPENS IF YOU DO NOT HAVE AN ADVANCE DIRECTIVE?

If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36 allows any member of your immediate family (meaning your spouse, parent, adult child, brother, or sister) or a person appointed by a court to make the choice for you. If you cannot communicate and do not have an advance directive, your physician will try to contact a member of your immediate family. Your health care choices will be made by the family member that your physician is able to contact.

WHAT TYPES OF ADVANCE DIRECTIVES ARE RECOGNIZED IN INDIANA?

- Talking directly to your physician and family
- Organ and tissue donation
- Health care representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Psychiatric advance directives
- Out of Hospital Do Not Resuscitate Declaration and Order
- Power of Attorney

TALKING TO YOUR PHYSICIAN AND FAMILY

One of the most important things to do is to talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing your wishes with your physician, your physician will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choices in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements.

If you have written advance directives, it is important that you give a copy to your physician. He or she will keep it in your medical chart. If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitation (CPR), your physician will need to write a “do not resuscitate” (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important to talk with your family about your wishes and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in an emergency. They are the best source of providing advance directives to a health care provider.

ORGAN AND TISSUE DONATION

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. This lets them know that you wish to be an organ donor. Organ donation is controlled by the Indiana Uniform Anatomical Gift Act found at Indiana Code § 29-2-16. A person that wants to donate organs may include their choice in their will, living will, on a card, or other document. If you do not have a written document for organ donation, someone else will make the choice for you. A common method used to show that you are an organ donor is making the choice on your driver’s license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

HEALTH CARE REPRESENTATIVE

A “health care representative” is a person you choose to receive health care information and make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative may agree to or refuse medical care and treatments when you are unable to do so. Your representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, your health care representative may decide if food, water, or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act, found at Indiana Code § 16-36-1. The advance directive naming a health care representative must be in writing, signed by you, and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana courts have made it clear that decisions made for you by your health care representative should be honored.

LIVING WILL

A “living will” is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you want or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator, and blood transfusions. The Indiana Living Will Act is found at Indiana Code § 16-36-4. This law allows you to write one of two kinds of advance directive.

Living Will Declaration: This document is used to tell your physician and family that life-prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make the decision for you.

Life-Prolonging Procedures Declaration: This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatments used to extend your life.

Both of these documents can be canceled orally, in writing, or by destroying the declaration yourself. The cancellation takes effect only when you tell your physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone that has permission to sign your name in your presence.

PSYCHIATRIC ADVANCE DIRECTIVE

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code § 16-36-1.7 provides the requirements for this type of advance directive.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

In a hospital or health facility setting, if you have a terminal condition and you do not want CPR, your physician will write a “do not resuscitate” order in your medical chart. If you are home when an emergency occurs, there is no medical chart or physician’s order. For situations outside of a hospital or health facility, the “Out of Hospital Do Not Resuscitate Declaration and Order” is used to state your wishes. The Out of Hospital Do Not Resuscitate Declaration and Order is found at Indiana Code § 16-36-5. The law allows a qualified person to say they do not want CPR given if the heart or lungs stop working in a location that is not a hospital or a health facility. This declaration may override other advance directives. The declaration may be canceled by you at any time by a signed and dated writing, by destroying or canceling the document, or by communicating to health care providers at the scene the desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order. You should contact your local EMS provider to find out their procedures.

POWER OF ATTORNEY

A “power of attorney” (also referred to as a “durable power of attorney”) is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority, or both. By giving this power to another person, you give this person your power of attorney. The legal term for the person you choose is “attorney in fact.” Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

1. Name the person you want as your attorney in fact;
2. List the situations which give the attorney in fact the power to act;
3. List the powers you want to give; and
4. List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative. Health care powers are granted in the power of attorney document by naming your attorney in fact as your health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

1. Make choices about your health care;
2. Sign health care contracts for you;
3. Admit or release you from hospitals or other health facilities;
4. Look at or get copies of your medical records; and
5. Do a number of other things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code § 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

WHICH ADVANCE DIRECTIVE OR DIRECTIVES SHOULD BE USED?

The choice of advance directives depends on what you are trying to do. The advance directives listed above may be used alone or together. Although an attorney is not required, you may want to talk with one before you sign an advance directive. The laws are complex and it is always wise to talk to an attorney about questions and your legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one

state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney, and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician and tell him or her your exact wishes.

ARE THERE FORMS TO HELP IN WRITING THESE DOCUMENTS?

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities, or senior citizen groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed above.

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?

Make sure that your health care representative, immediate family members, physician, attorney, and other health care providers know that you have an advance directive. Be sure to tell them where it is located. You should ask your physician and other health care providers to make your advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to your attorney in fact. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located, and who to contact for your attorney in fact or health care representative, if you have named one.

FINAL THOUGHTS ABOUT ADVANCE DIRECTIVES

- You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.
- Even if you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.
- No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.
- This information was prepared by the Indiana State Department of Health as an overview of advance directives. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204
<http://www.in.gov/isdh>

LIVING WILL DECLARATION
PURSUANT TO INDIANA CODE 16-36-4

Declaration made this _____ day of _____,
20_____, I, _____, being at least eighteen
(18) years of age and of sound mind, willfully and voluntarily make known my
desires that my dying shall not be artificially prolonged under the circumstances
set forth below, and I declare:

If at any time my attending physician certifies in writing that:

- (1) I have an incurable injury, disease or illness;
- (2) My death will occur within a short time;
- (3) The use of life prolonging procedures would serve only to artificially
prolong the dying process,

I direct that such procedures be withheld or withdrawn, and that I be permitted
to die naturally, with only the provision of any medical procedure or medication
necessary to provide me with comfort, care, or to alleviate pain, and if I have so
indicated below, the provision of artificially supplied nutrition and hydration.

(Indicate your choice by initialing or making your mark before signing this declaration.)

_____ I wish to receive artificially supplied nutrition and hydration, even if the
effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the
effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition
and hydration, leaving the decision to my health care representative
appointed under I.C. 16-36-1-7 or my attorney-in-fact with health care
powers under I.C. 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Name

City, County, and State of Residence

The declarant has been personally known to me, and I believe _____ to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness

Date: _____

Witness

Date: _____

STATE OF INDIANA
LIFE PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

Other Instructions:

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed _____

City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____



**STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER**

State Form 49559 (12-99)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:

My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital or a health facility, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration

Signature of declarant

Printed name of declarant

City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness

Printed name

Date

Signature of witness

Printed name

Date

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I, _____, the attending physician of _____, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician

Date

Printed name of attending physician

Medical license number

INDIANA APPOINTMENT OF A HEALTH CARE REPRESENTATIVE

I, _____, of
(Name)

(Address)

hereby voluntarily appoint _____, of
(Name of Health Care Representative)

(Address & Telephone Number)

as my health care representative.

In the event that the person I appoint above as health care representative is unable, unwilling or unavailable to serve, I hereby appoint _____
(Name of Successor Health Care Representative)

of _____
(Address & Telephone Number)

as my substitute representative hereunder.

I authorize my health care representative to make decisions in my best interest concerning my health care including the consent to health care, as well as the withdrawal or withholding of health care. I understand health care to include medical care, treatment, service, or procedure to maintain, diagnose, treat or provide for my physical or mental well-being. Pursuant to the Indiana Health Care Consent Act, I authorize my health care representative to make decisions to withhold or withdraw artificial nutrition and hydration to the extent it is in my best interest to do so. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, my health care representative may express my will that such health care be withheld or withdrawn and consent on my behalf that any and all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent that they are available.

This appointment becomes effective and remains effective if I am incapable of consenting to my health care.

I DO, DO NOT (circle one) authorize my health care representative hereby appointed to delegate decision making power to another.

APPOINTER SIGNATURE

I, _____, the Appointer, sign my name to this instrument this _____ day of _____, _____, and do hereby declare the undersigned
(day) (month) (year)

witness that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am eighteen (18) years of age or older, of sound mind, and under no constraint or undue influence.

(Signature)

(Date)

(Printed Name)

(Address)

(County)

(City/State/Zip)

WITNESS SIGNATURE

I declare that the Appointer who signed this document appears to be of sound mind and acting of his/her own free will. He/She signed (or asked another to sign for him/her) this document in my presence.

I further declare that I am an adult at least eighteen (18) years of age, and I am not the Representative or Successor Representative appointed in this document.

(Signature of Witness)

(Printed Name)

(Witness Address)

(City/State/Zip)

(Telephone Number)

Compliments of:

Hosparus Inc.

The Community Hospices of Louisville, Southern Indiana and Central Kentucky

DURABLE UNLIMITED POWER OF ATTORNEY

I, _____, of _____, City of _____,
(name of person granting power) (address of person granting power)
_____, State of _____, grant an
unlimited durable power of attorney to _____, of _____,
(name of person granted power)
_____, City of _____, State of _____,
(address of person granted power)
_____, to act as my attorney-in-fact.

I give my attorney-in-fact the maximum power under law to perform any acts on my behalf that I could do personally, including the power to make any health decisions on my behalf.

My attorney-in-fact accepts this appointment and agrees to act in my best interest as he or she considers advisable.

This power of attorney may be revoked by me at any time and is automatically revoked on my death. This power of attorney shall not be affected by my present or future disability or incapacity.

Dated: _____, _____

(signature of person granting power of attorney)

State of _____
County of _____

On _____, _____, _____ came before me
(Date) (Name)

personally and, under oath, stated that he/she is the person described in the above document and he/she signed the above document in my presence.

(Signature)

Notary Public, for the county of _____
State of _____
My commission expires: _____

I accept my appointment as attorney-in-fact.

(signature of person granted power of attorney)

HOSPARUS INC. Policies and Procedures	
Advance Directives	
Regulatory: 42 CFR 489.102; 42 CFR 418.52 (a) (2)	Section: Patient Care
Joint Commission: RI.01.05.01	Attachments: A, B, C, D, F, G, H, I, J, K, L, M
NHPCO: EBR 1.3; EBR 1.4; EBR 1.5	Effective: 9/95
Main Groups Affected: Admissions, Physicians, Social Workers, Nurses	Reviewed/Revised: 12/07; 5/08; 7/10

Policy Statement: Hosparus complies with all State and Federal laws regarding advance directives and informs and distributes written information to the patient on his or her right to formulate advance directives. The provision of hospice care is not conditioned upon whether or not the individual has executed an advance directive.

Definitions:

Power of Attorney (POA) – A document that authorizes someone to act in another’s behalf, only as long as the grantor still has capacity to make decisions for him/herself if necessary. The powers may not continue once the person becomes incapacitated or disabled. The document must specify particular powers granted, and/or any limits to such powers, particularly personal, healthcare and/or financial decision making.

Durable Power of Attorney (DPOA) – Power of Attorney that continues to be effective after a person becomes disabled or incapacitated. It should also specify the particular powers granted, and/or any limits to such power, especially powers pertaining to personal, healthcare and/or financial decision-making.

Full code by default – Patient is undecided or has not made a decision regarding resuscitation. When a patient is in an inpatient setting and stops breathing, if he/she or the family has not requested DNR status, he/she will be assumed to be full code. If the Call Center receives a call from a patient’s home that the patient has stopped breathing, staff will offer to make a visit or advise the individual present to call 911. If a staff member who is not CPR certified is present in the home and the patient stops breathing staff should call 911. CPR certified staff members should start CPR and have caregiver call 911. When a patient who resides in a nursing facility stops breathing, the facility will follow their protocol for responding to a person as “full code by default”.

Procedures:

Admissions

1. During the admission interview, and prior to receiving care, the admissions staff or social worker provides written information and instruction on advance directives to the patient. If the patient is unable to understand this information it is given to the patient’s legal health

care representative or proxy. The written information given to the patient and or legal representative includes:

- a. Hosparus's policies on the implementation of the patient's advance directives including any limitations;
- b. A description of the patient's rights under State law, including the patient's right to formulate an advance directive and the right to accept or refuse medical or surgical treatment, including Do Not Resuscitate (DNR) orders.
- c. Documentation provided:
 - i. The Kentucky Advance Directives Packet (Attachment A) includes:
 1. Making Choices for End of Life Care in Kentucky
 2. Kentucky Living Will Directive (Attachment C)
 3. Durable Power of Attorney in Kentucky (Attachment F)
 4. Kentucky EMS Do Not Resuscitate Order and Instructions (Attachment I).
 - ii. The Indiana Advance Directives packet (Attachment B) includes:
 1. Making Choices for End of Life Care in Indiana
 2. Indiana Living Will Declaration (Attachment D)
 3. State of Indiana Life Prolonging Procedures Declaration (Attachment M)
 4. Indiana Durable Unlimited Power of Attorney (Attachment G)
 5. Indiana Appointment of a Health Care Representative or Surrogate form (Attachment H)
 6. Indiana Out of Hospital Do Not Resuscitate Declaration form (Attachment J)

The admitting staff (or other staff as circumstances necessitate) obtains current information about the patient's advance directives and enters specific information about advance directives or end of life wishes on the Advance Directives Form in the Electronic Documentation System (EDS), including an indication of whether or not the information was based on observing the actual documents or verbal wishes made known at the time. This is replicated immediately and available to the team for further follow-up, as needed.

2. Hosparus staff informs each patient, or his/her legal representative, of the right to:
 - withhold or withdraw life-prolonging treatment
 - withhold or withdraw artificially provided nutrition and hydration
 - accept or refuse cardiopulmonary resuscitation
 - donate organs or tissue
 - appoint a health care surrogate and/or durable power of attorney to make health care decisions when he/she is no longer able to make decisions.
3. If the opportunity to formulate an advance directive is declined at the time of admission, the patient may execute one at a later date by notifying a staff member who then notifies the

Social Worker. The Social Worker provides the patient with appropriate forms and ensures that they are properly completed.

4. If copies of a patient's advance directives forms are available, staff will document that on the Continuity of Care form and submit the forms to Medical Records to be scanned into the EDS, to be available for viewing in Suncoast Productions within 7 days, unless otherwise requested.
5. Family members or guardians are provided with information regarding advance directives when the patient is comatose or incapacitated and unable to receive the information. If an adult patient whose physician has determined that he or she does not have decisional capacity has not executed an advance directive, or the advance directive does not address a decision that must be made, the responsibilities are assumed by the party designated by law. (KRS 311.631 or Indiana Code 16-36-4-13, Attachment L) The party designated by law may not complete a Living Will Document or a Durable Power of Attorney document on behalf of an incapacitated person, but may complete an EMS or Out-of-Hospital DNR. If the patient regains capacity, the information is provided directly to the patient.
6. If a patient is capable of understanding and communicating verbally his/her advance directives but is unable to sign his/her name, he/she can direct another adult person to do so in front of two adult witnesses or a notary public.

Social Worker Responsibilities/Expectations

7. The Social Worker is the primary team member responsible for ensuring that advance directive information and assistance are provided as requested by patients and families. The Social Worker reviews existing advance directives with the patient and family to assure the patient's wishes are current and known. If the patient / family has declined the Social Worker, the nurse case manager assumes responsibility for ensuring that advance directive and assistance are provided. The team social worker provides consult to the nurse as needed.
8. If the patient has not completed advance directives, the Social Worker reviews the Hosparus Advance Directives packet, answers questions, and provides counseling as needed.
9. The Social Worker assists in completing any advance directives, as needed. The Social Worker reviews with the patient/family the importance of informing family members and other medical care providers of their wishes. Hosparus staff and volunteers do not serve as witnesses in the formulation of advance directives, but may serve as notaries.
10. The Social Worker will offer to contact the designated Health Care Surrogate and DPOA (if not present during the visit) to verify contact information and assure they are aware of the designation.

11. The Social Worker documents detailed information regarding the patients advance directives on the Advance Directives form in the EDS at the time of the Initial Psychosocial Assessment, or whenever such directives are completed. The Social Worker assures that Advance Directives information is consistent with the Family and Friends form (roles) in EDS. The Plan of Care will reflect any issue related to unresolved advance directives.

All Staff/Caregivers

12. Decisions will be reviewed when there is a change in the caregiver and/or there is a change in the expected course of the illness.
13. Registered nurses, licensed practical nurses and medical doctors employed by Hosparus Inc. and having patient contact are required to maintain current certification in Cardiopulmonary Resuscitation (CPR). If cardiac or respiratory arrest occurs in a patient with a full code status when any certified CPR employee is present, he/she will initiate CPR.
14. Staff for whom CPR certification is not required who witness a cardiac or respiratory arrest in a patient with a full code status contact 911 without initiating CPR.
15. Efforts are made to clarify resuscitation status prior to transfer to the Hosparus Inpatient Care Center (HICC). Patients admitted to the HICC with a full code status have a magnetic red heart placed on the doorframe of their room to aide in immediate recognition of this status. Patients and families are notified prior to admission to the HICC that immediate access to full resuscitative measures is not available at the HICC and transfer to an acute care facility could occur should the patient's condition decline. Requests for HICC admission for patients with a full code status are reviewed by the HICC Medical Director or acting Medical Director prior to placing the patient on the HICC waiting list if there is a significant risk of death within 48 hours of admission.
16. Persons under eighteen years of age do not have the legal authority to complete advance directives. Treatment decisions are the responsibility of the parents/legal guardians. Hosparus staff encourages families to involve children in decisions regarding their care to the extent feasible, given the child's developmental level, emotional and physical status, and desire to participate in discussions or decisions.
17. The Advance Directive for Mental Health Treatment form is available at Attachment K.

Staff Communication Expectations

18. IDT documents Advance Directive updates in EDS as it becomes available and communicates to IDT. Urgent updates must be communicated through voicemail and documented in EDS.

19. DNR orders are signed by the patient's physician with a copy placed in the patient's clinical record, documented in the EDS, and the original retained by the patient and in his or her possession at all times.

Education

20. Education is provided to hospice staff and the community regarding advance directives, advance care planning and patient rights regarding advance directives.

Policy Attachments:

Attachment A Kentucky Advance Directives Packet
Attachment B Indiana Advance Directives Packet
Attachment C Kentucky Living Will Directive
Attachment D Indiana Living Will Declaration
[Attachment E None at this time; was deleted 2008]
Attachment F Durable Power of Attorney Form
Attachment G Durable Unlimited Power of Attorney
Attachment H Indiana Appointment of a HealthCare Representative
Attachment I Kentucky DNR Order and Instructions
Attachment J Indiana Out of Hospital DNR
Attachment K Advance Directive for Mental Health Treatment
Attachment L Responsible Parties Authorized to Make Health Care Decisions
Attachment M State of Indiana Life Prolonging Procedures Declaration

Resources/Tools:

Bibliography: Joint Commission, CMS, Prior Hosparus Policy and Procedure and Attachments

History:

- Policy replaces 2008 Advance Directives Policy and Procedure.
- Names of Attachments of Attachment files have been renamed for consistency with titles of forms.
- The revised Attachment A KY Advance Directives compiles individual forms, saved as Attachments C, F, and I.
- The revised Attachment B IN Advance Directives compiles individual forms, saved as Attachments D, M, J, H and G.
- Attachment E was deleted in 2008. Renaming of Attachments alphabetically was not done, to ensure eliminate costs and potential inconsistencies of reprinting and distributing in Admission Packets.
- Attachments K and L are not part of the standard KY and IN Advance Directives packets, but are available as individual forms, as needed.

Approval Process	Person(s)	Date
Prepared by:	Amy Feusner	July 2, 2010
Reviewed and recommended by:	Policy & Procedure Committee	July 2, 2010
Approved by VP:	Terri Graham	August 1, 2010
Approved by AVP QualEd	Delanor Manson	August 13, 2010