

ADVOCATING FOR ADVANCE DIRECTIVES:
GUIDELINES FOR HEALTH CARE PROFESSIONALS

by

Rebecca Cowell Murphy

A professional project submitted in partial fulfillment
of the requirements for the degree

of

Master

of

Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

April 2009

©COPYRIGHT

by

Rebecca C. Murphy

2009

All Rights Reserved

APPROVAL

of a professional paper submitted by

Rebecca Cowell Murphy

This professional paper has been read by each member of the professional project committee and has been found to be satisfactory regarding content, English usage, format, citation, bibliographic style, and consistency, and is ready for submission to the Division of Graduate Education.

Elizabeth Kinion, EdD, MSN, APN-BC, FAAN

Approved for the Department of Nursing

Elizabeth Nichols, DNS, RN, FAAN

Approved for the Division of Graduate Education

Dr. Carl A. Fox

STATEMENT OF PERMISSION TO USE

In presenting this professional paper in partial fulfillment of the requirements for a master's degree at Montana State University, I agree that the Library shall make it available to borrowers under rules of the Library.

If I have indicated my intention to copyright this thesis by including a copyright notice page, copying is allowable only for scholarly purposes, consistent with "fair use" as prescribed in the U.S. Copyright Law. Requests for permission for extended quotation from or reproduction of this thesis in whole or in parts may be granted only by the copyright holder.

Rebecca Cowell Murphy

April 2009

TABLE OF CONTENTS

1. INTRODUCTION	1
Purpose of the Project	1
Background and Significance of the Project.....	1
Types of Advance Directives.....	1
History of Advance Directives.....	2
Legal Support of Advance Directives.....	3
Professional Support of Advance Directives	5
Project Description.....	7
2. REVIEW OF THE LITERATURE	8
Value of Completing Advance Directives	8
Who Completes Advance Directives?	9
Barriers to Completing Advance Directives	11
Patient Barriers.....	11
Health Care Provider Barriers.....	12
System Barriers	13
Interventions to Increase the Utilization and Completion of Advance Directives	13
Patient Interventions	14
Health Care Provider Interventions	14
System Interventions.....	15
3. PROJECT DEVELOPMENT AND IMPLEMENTATION.....	17
Project Location	17
Advance Directive Committee and Goals.....	17
Assessment of the Local Community Hospital’s Current Use of Advance Directives	18
Advance Directive Policy and Procedure Update and Revision.....	19
Development of the Advance Directive Education Module	20
4. DISCUSSION	24
Assets and Challenges.....	25
Implications for Advanced Practice Nursing.....	26
REFERENCES CITED.....	28

TABLE OF CONTENTS- CONTINUED

APPENDICES35

 APPENDIX A: The Joint Commission Standards Addressing Advance Directives ...36

 APPENDIX B: Advance Directive Policy and Procedure.....39

 APPENDIX C: Advance Directive Education Module Course Content43

 APPENDIX D: Advance Directive Test Questions and Answers51

 APPENDIX E: Permission to Use Name.....54

ABSTRACT

An advance directive, such as a Living Will or Durable Power of Attorney for Health Care, allows a person to give their instructions about future medical care if he or she is unable to participate in decisions due to serious illness or incapacity. Despite the fact the Patient Self Determination Act requires health care facilities to provide patients with information about advance directives on admission, and the public and health care professionals support the use of advance directives, few people actually complete these documents.

This project was developed in support of a local community hospital's commitment to promote the creation and use of advance directives. Part one of the project involved working with the hospital's Advance Directive Committee to update and revise the Advance Directive Policy and Procedure to meet Joint Commission Standards. Part two of the project was the creation of an Advance Directive Education Module for health care professionals designed to be used as part of the employees' annual education review.

The new policy created a solid framework for health care professionals to follow when working with patients and their health care goals. The computer-based Advance Directive Education Module reviewed general information about advance directives, informed health care professionals of the new Advance Directive Policy and Procedure, and gave facility-specific actions to take when working with patients and their advance directives.

CHAPTER 1

INTRODUCTION

Purpose of the Project

This project was developed in support of a local community hospital's commitment to promote the creation and use of advance directives. Part one of the project involved working with the hospital's Advance Directive Committee to update and revise the Advance Directive Policy and Procedure to meet Joint Commission Standards. This policy created a solid framework for health care professionals to follow when working with patients and their health care goals. Part two of the project was the development of an Advance Directive Education Module for health care professionals designed to be used as part of the employees' annual education review.

Background and Significance of the Project

Types of Advance Directives

The living will and the durable power of attorney for health care are the two primary types of advance directives. A living will is a written legal document expressing an individual's future medical care and treatment choices if he or she is not able to express his or her wishes. It may contain specific instructions with regards to intubation and life support, CPR, and artificial nutrition and hydration (National Hospice and Palliative Care Organization [NHPCO], 2009; Sessanna & Jezewski, 2008). According to

the NHPCO, a living will may also be called a directive to physicians, a health care declaration, or a medical directive.

A durable power of attorney for health care (DPOAHC) is a written document allowing an individual to legally appoint someone to determine future medical care and treatment choices in the event the individual is not able to make health care decisions for him or herself (NHPCO, 2009). It may also be called a medical power of attorney; a healthcare proxy, representative or surrogate; or attorney in fact. The DPOAHC assumes patients have communicated their values, goals and wishes for end of life care to the chosen proxy so this decision-maker will know what treatments the patient would or would not want (Brown, 2003).

History of Advance Directives

At the beginning of the 20th century, the average American life span was 47 years. Most people died quickly due to infection, injury, sudden unexplained death, or shortly after diagnosis of untreatable conditions such as cancer, diabetes, or heart disease (Lynn, 2000). The average life span has increased by 70% to over 80 years and the end of life, once dependent on fate, is now more often shaped by deliberate choices in response to incurable, progressive, disabling and eventually fatal illness (Bunting & Benton, 2000; Kiernan, 2006; Lynn, 2000).

Prior to the late 1950s, there were few if any interventions that could alter the outcome of serious illness or cardiac arrest. Advances in medical technology and pharmaceuticals changed the trajectory of an illness (Brunnhuber, Nash, Meier, Weissman, & Woodcock, 2007) and the development of cardiopulmonary resuscitation

(CPR) revised the inevitability of sudden death. By 1960, the American Heart Association (American Heart Association, 2008) promoted CPR as the standard of care when a patient had no pulse or respiration.

By the mid 1960s, physicians realized CPR was not appropriate for every patient, and Do Not Resuscitate (DNR) orders were instituted as a way to limit CPR. Brown (2003) notes both CPR and DNR orders were initiated by physicians, often without input from the patient. An Illinois attorney developed the first Living Will in 1969 (Gillick, 2003) in an attempt to help individuals exercise control over their end-of-life decisions and to promote patient autonomy. By 1973, the American Hospital Association created the Patient's Bill of Rights, addressing the patient's right to be informed of treatment options and to refuse treatment if so desired. This was updated in 1993 to include the right to create advance directives and was replaced in 2003 with "The Patient Care Partnership" (American Hospital Association, 2003).

Legal Support of Advance Directives

Two highly publicized legal cases brought informed consent and the right to refuse treatment to the American public's attention (Brown, 2003; Gostin, 2005). In 1976 Karen Ann Quinlan was left in a persistent vegetative state after CPR. Her parents requested permission to remove the ventilator and after a lengthy court battle, the request was finally granted (Brown, 2003). Nancy Cruzan sustained injuries in 1983 that left her in a persistent vegetative state. When her parents requested the feeding tube be discontinued, it took eight years in the legal system before the judge allowed her feeding tube to be removed. According to Perkins (2007), these high-profile court cases involving

long-term treatments for patients in comas or vegetative states convinced many people to sign advance directives in an attempt to document their end of life wishes and avoid similar fates.

In response to concerns raised during these court cases, the United States Congress enacted the Patient Self Determination Act (PSDA) in 1991 as part of the Omnibus Reconciliation Act of 1990 (OBRA, 1990). Brown (2003) described rising health care costs, consumerism, and sophisticated technology that developed ahead of the ability to manage it, as driving forces behind the development of the PSDA. This important federal law formalized the right of each American to specify wishes at end of life or to appoint a spokesperson to make health care decisions when and if the patient was not able. The PSDA requires all health care facilities receiving Medicare or Medicaid reimbursement to:

1. Provide each adult patient with written information regarding individual patient's rights under state law to create advance directives and make medical treatment decisions.
2. Document in the medical record the presence or absence of an advance directive.
3. Avoid discrimination against any patient on the basis of whether an advance directive has been created.
4. Provide education for staff and community members concerning advance directives.

The passage of the PSDA initiated a nation-wide campaign to promote advance directives, but left the specific requirements for advance directives up to individual states. Montana's Rights of the Terminally Ill Act (Montana Code Annotated, Section 50-9-103) went into effect in 1991. Montana continues to update and revise the laws regarding advance directives passing legislation for Comfort One in 2005, the End of Life Registry in 2006, and Provider's Order of Life Sustaining Treatments (POLST) in 2008 (Goetting & Bullock, 2009; Administrative Rules of Montana, 2008)

Despite the passage of advance directive legislation and the support of patient autonomy by the public and health care professionals, the lack of advance directives continues to draw public attention through legal cases. The long, drawn out 15 year litigation and political maneuvering involving the life and death of Theresa Shiavo in 2005 made what should have been a private and intimate decision to remove her feeding tube intensely public and polarizing (Gostin, 2005).

Professional Support of Advance Directives

The past 50 years has seen dramatic advancements in medical technology. Antibiotics, mechanical ventilation, and artificial nutrition and hydration make the lines between health, acute illness, chronic illness, and death less clear. Terminally ill patients and patients in vegetative states can be kept alive for extended periods of time. According to Bernal, Marco, Parkins, Buderer and Thun (2007) there has been increased acceptance of the view that patients capable of making decisions have the right to decline medical treatments, even if it hastens death. The assumption that physicians are obligated to provide, and patients are obligated to accept, every available means of technological

treatment, is no longer true (Bernal et al., 2007). The more recent concept of patient autonomy has replaced the medical paternalism of previous times.

Professional position and policy statements show health care professionals take patient self-determination, autonomy and decision-making seriously. The Code of Medical Ethics for the American Medical Association (AMA) states patients have the right to participate in decisions about their medical care. This fundamental principle of medical ethics holds true for all types of medical treatments. Patients can refuse treatments even when such refusal is likely to result in death (American Medical Association, 2005).

The American Nurses Association Code of Ethics (2001) clearly defines the nurse's obligation regarding patient choice and self determination. Provision One states the nurse 'practices with compassion for the inherent dignity, worth and uniqueness of every individual.' Interpretive Statements 1.3 and 1.4 explain that the respect for personal dignity requires nurses recognize the patient's right to self-determination, also known as autonomy. The Code is clear the nurse's role is to support a patient in his/her decision making and treatment choices, and assist with weighing the benefits, burdens and available options.

In addition to Federal and State law requirements the Joint Commission, an independent, not-for-profit organization that sets the standards by which health care quality is measured in the United States and around the world, has echoed the PSDA advance directives requirements by setting standards for the utilization of advance directives. To earn and maintain accreditation, health care organizations must have an

extensive on- site review by a team of Joint Commission professionals at least once every three years to review and evaluate the organization's performance in areas that affect care. Accreditation may then be awarded based on how well the organization meets the Joint Commission standards. Agencies or facilities seeking Joint Commission Accreditation must have advance directive policies and procedures in place showing the patient will be asked if they have an advance directive, will be given assistance if they would like to create an AD, and will be assured their care will not be influenced by the fact they do or do not have an advance directive (Joint Commission, 2008, p. RI-12).

Project Description

Part one of this project was the review and revision of the local community hospital's Advance Directive Policies and Procedures, as a member of the hospital Advance Directive Committee, in preparation for Joint Commission Accreditation survey in 2008. In addition to bringing the policy into compliance with The Joint Commission Standards and the PSDA, the Advance Directive Committee's objective was to improve patient-centered care by increasing the number of advance directives written by patients and making the advance directives more readily accessible to healthcare providers. Part two of the project was the development of an Advance Directive Education Module. Education for health care staff about advance directives is a requirement of the PSDA and Joint Commission standards. This education module provided health care providers with uniform information about the new Advance Directive Policy and Procedure.

CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of the literature review was to identify the value of advance directives, characteristics of patients completing advance directives, barriers preventing the creation of advance directives and interventions promoting the use, and the effectiveness of advance directives. Three databases were used: CINAHL, Medline and the Cochrane Database. Keywords included “advance directives”, “living will”, “end-of-life care” and “palliative care”. Articles published between 1990 and 2009 were considered as this covers the time period from the implementation of the PSDA and current day. Systematic review and primary research studies were chosen. Reference list reviews also yielded articles with more specific information.

Value of Completing Advance Directives

Advance directives were developed in an attempt to avoid unwanted patient suffering, and to prevent family members from being burdened and distressed when making difficult health care decisions for their loved ones (Gostin, 2005; Jezewski, Meeker & Schrader, 2003). Gillick (2003) noted advance directives are valued for two main reasons. First, personal health care choices can be communicated to family, friends, and health care providers should the patient be unable to express those wishes. Second, advance directives can help guide treatment at the end of life to match the patient’s personal preferences, goals, and values.

Patients as well as family and health care proxies find value in advance directives. Patient autonomy and patient satisfaction are valuable outcomes when advance directives are used to guide end of life care. Studies have shown increased patient satisfaction and decreased anxiety when providers and patients discuss advance directives (Kass-Bartelmes, Hughes, & Rutherford, 2003; Ditto et al. 2001). Patients who had completed advance directives and had talked with their families or providers about their preferences for end of life care were more likely to die at home (Raphael, Ahrens, & Fowler, 2001). They also believed the provider better understood the patient's wishes, and felt they were more able to direct and influence their medical care.

In addition to promoting patient autonomy and decreasing suffering, advance directives play a role in containing health care costs. Conversations about end of life wishes and the creation of advance directives are associated with fewer life-sustaining interventions and significantly lower medical costs in the last week of life (Kirmse, 1998; Zhang et al., 2009). According to Levinsky et al. (2001) one-third of Medicare expenditures in the last year of life occur during the final month. The observational study conducted by Zhang et al. (2009) showed cost savings of 35.7% in the last week of life for patients who had communicated their end-of-life wishes with the physician compared to those who had not.

Who Completes Advance Directives?

Despite the fact advance directives are supported by the public, physicians, ethicists, and legislators, surprisingly few Americans actually complete these documents

(Dexter et al, 1998; Ramsaroop, Reid, & Adleman, 2007). The overall prevalence of completed advance directives in the general population ranges widely from 4 to 30 percent (Schwartz et al., 2002; Collins, Parks, & Winter, 2006) with only 12% of those patients having input from their physician in the advance directive development (Kass-Bartelmes et al., 2003). In the general population, completed advance directives were more prevalent in well-educated persons over 50 years of age with a serious disease process or illness and a long-standing relationship with their primary care provider (AARP, 2008; Brown, 2003; Dexter et al., 1998; Sussanna & Jezewski, 2008).

On a national level, less than 50% of acutely ill patients have an advance directive in their medical record despite the relevance of advance directives to this population (Kass-Bartelmes et al., 2003; Kish, Martin, & Price, 2000). Advance directive completion rates in the ICU, where the most technologically advanced and aggressive interventions can be provided, remain low (Gross, 2006). Fifty five percent of patients with cancer have a documented living will, while only 14-50% of severely or terminally ill patients without cancer had an advance directive (Wilkinson, Wenger, & Shugarman, 2007).

In the last stages of life, 30% of Americans are cared for in multiple settings such as home, assisted living facilities, nursing homes and hospitals (Bradley, Peiris, & Werle, 1998; Trask, Teno, & Nash, 2006; Happ, Capezuti, & Strumpf, 2002). Nursing home residents are more likely than the general population or hospitalized patients to have completed an advance directive (Golden, Corvea, Dang, Llorente, & Silverman, 2009; McAuley & Travis, 2003; Lambert et al., 2005) with 20-70% of nursing home residents having some sort of advance directive in the medical record. In all settings, despite the

presence of advance directive in the medical record, there was often no evidence of discussion addressing different treatment options or communication of wishes between caregivers (Gillick, 2003; Jezewski et al., 2003).

Barriers to Completing Advance Directives

Obstacles to completing or discussing advance directives found in this literature search have been divided into three categories: patient barriers, health care provider barriers, and system barriers. Although many of the barriers were present in more than one category, the lack of time to have discussions about advance directives was found to be a significant hindrance in all three categories (Ramsaroop et al., 2007; Sessanna & Jezewski, 2008; Tierney et al., 2001).

Patient Barriers.

While most people agree advance directives are important, the literature described numerous reasons patients do not complete advance directives including lack of knowledge about advance directives, (Golden, et al., 2009; Kirmse, 1998; Larson & Tobin, 2000, Wilkinson et al., 2007), procrastination (Sessanna & Jezewski, 2008), and difficulty discussing negative topics or death (Wilkinson et al., 2007). Often patients wait for medical providers to initiate discussions (Kirmse, 1998; Larson & Tobin, 2000). Many patients would rather have healthcare providers or family members make medical decisions for them (Anselm et al., 2005), or are uncertain an advance directive will make a difference in their care (Wilkinson et al., 2007).

Health Care Provider Barriers

According to Larson and Tobin (2000), and Wilkinson et al. (2007), reasons medical personnel avoid discussing advance directives include lack of education and formal training. A literature review by Wilkinson et al. (2007) confirmed the majority of providers felt unprepared to conduct end-of-life discussions such as breaking bad news and addressing patients' emotional concerns. Providers may be unfamiliar with suitable alternatives to aggressive treatment or may be unsure of the patient's medical condition and prognosis. Feeg and Elebiary (2005) found providers may be reluctant to engage in discussions if the patient is healthy. Providers may feel they do not have a relationship with the patient that would allow them to discuss sensitive subjects or they may want to avoid upsetting the patient or family by bringing up the topic of advance directives (Anselm et al., 2006; Ramsaroop et al., 2007; Tierney et al., 2001).

Studies of nurses and physicians revealed they did not feel knowledgeable about advance directive forms, paperwork and rules although they thought educational programs would be helpful (Gross, 2006; Larson & Tobin, 2000). In a study done by Badzek et al (2006), health care providers believed policies and procedures were not clear regarding their role and responsibility when helping patients with advance directives. Studies found providers may be uncomfortable with the emotion involved with discussions about advance directives or may disagree culturally, spiritually or morally with the patient's wishes (Anselm et al., 2006; Gross, 2006). According to Tierney et al. (2001) providers felt discussion about advance directives were time intensive and poorly reimbursed. These authors hypothesized that because of the current emphasis in health

care on productivity, health care providers may not want to initiate lengthy, in-depth conversations with patients or families.

System Barriers

System barriers were described by Anselm et al. (2005) as “institutional, professional, and societal factors perceived to limit communication regarding end-of-life care” (p. 217). Advance directive laws and forms lack consistency between states and may be considered narrow in scope and inflexible (Norton & Talerico, 2000; Wilkinson et al., 2007) or contain highly technical language making them difficult to interpret (Perkins, 2007). Health care staff complained it is often hard to find an advance directive in the medical record, or the advance directive is inaccessible, making communication between providers and disciplines difficult (Jezewski et al., 2003). Heavy patient assignments due to short staffing, inconsistent patient assignments and lack of privacy due to the poor physical layout of offices and hospital rooms are barriers that create difficulty in advance directive discussion (Anselm et al., 2005; Gross, 2006).

Interventions to Increase Utilization and Completion of Advance Directives

Interventions described in this literature review noted the increased use and effectiveness of advance directive were divided into three categories: patient directed interventions, health care provider interventions, and systems interventions. The interventions were primarily directed at patient and/or provider education (Brown, 2003), although there has been a recent increase in legal interventions and policy change as evidenced by the rise in the use of POLST.

Patient Interventions.

Simply asking whether someone has completed an advance directive had little or no effect on increasing advance directive completion (Lipson et al., 2004). A systematic review of 25 randomized controlled trials and observational studies by Ramsaroop et al. (2007) reported passive patient education interventions such as clinical mailings, brochures, videos, or information programs, did not increase advance directive completion rates. Slightly higher completion rates were documented in both primary and acute care settings when health care providers initiated discussion and provided personalized education for patients (Bravo, Dubois & Wagneur, 2008; Douglas & Brown, 2002). Several studies found moderate evidence that multi-component interventions, such as the combination of written materials and repeated interactive discussions between patients and physicians, nurses, social workers or counselors, lead to the most significant increase in advance directive completion (Brunnhuber et al., 2008; Lorenz et al., 2007; Patel, Sinuff, & Cook, 2004.)

Health Care Provider Interventions:

It is important for physicians and other primary care providers to learn to initiate conversations about advance directives. Tierney et al. (2001) found patients expect their primary care provider to start these discussions and they were more satisfied with their care when advance directives were discussed. In contrast, Brunnhuber et al. (2008) noted physicians often wait for patients to start conversations about advance directives. This may lead to confusion about expectations and treatments. Education interventions to improve health care provider knowledge, comfort, experience, and communication skills

when discussing advance directives show mixed results. Some interventions show little effect, while other interventions show improved attitude, communication skill, and self-confidence when discussing end of life care (Brunnhuber et al., 2007; Robinson et al., 2004). The most effective approach to increasing physician-initiated advance directive conversations and advance directive completion was a combination of health care provider education that included case examples and role playing, combined with reminders and performance feedback (Tierney et al., 2001; Dexter et al., 1998).

System Interventions

Although health care providers are thought to be the best catalyst to promote the completion of advance directives, according to Wilkinson (2007) clinicians do not routinely bring up the topic of advance directives. Health information technology systems such as electronic medical records have been promoted as a way to promote advance directive discussion and improve the communication of patient information between multiple providers and care settings. Dexter et al. (1998) tested the use of computer generated reminders to physicians in outpatient general medicine setting. Approximately 24% of patients had a discussion about advance directives when their physician received a computer reminder, compared to 4% of patients whose physician did not. Overall, 45% of advance directive discussions were associated with advance directive completion.

Broad community-wide education programs such as Last Acts, “Respecting Choices” and the National Health Care Decision Day as described by Wilkinson (2007) have shown minimal increase in advance directive completion rates. State legislation to standardize advance directive forms and make them more portable across patient care

settings has shown a promising improvement in advance directive use. Hickman, Tolle, Brummel-Smith, and Brooks (2004) found the use of POLST in Oregon decreased transfers from nursing homes to acute care facilities for ICU care and ventilator support. Use of POLST also showed medical care provided at end of life matched patient preferences.

Overall, research studies indicated that multi-component, longitudinal, educational interventions modestly increase advance directive completion rate and moderately increase medical record documentation (Wilkinson et al., 2007). However, more sophisticated techniques are needed to motivate medical providers and patients to initiate advance directive discussion and to induce patients to complete an advance directive.

CHAPTER 3

PROJECT DEVELOPMENT AND IMPLEMENTATION

Project Location

This project was a collaborative effort between a graduate nursing student and the local community hospital and health services. The hospital, outpatient clinics, and multispecialty physicians and health care professional offices are owned and operated by a local non-for-profit umbrella organization. The 86 bed hospital is a Joint Commission Certified, Level III trauma center, serving rural southwest Montana including Gallatin, Madison and Park Counties and is a major employer in the area.

Advance Directive Committee and Goals

The hospital's Advance Directive Committee was formed in 2007 as part of an Advocating for Clinical Excellence (ACE) Project led by a social worker who had completed ACE training and was employed in the Palliative Care Department. The ACE program is an educational initiative designed to improve the delivery of palliative care services through a leadership program sponsored by the National Cancer Institute and City of Hope Hospital (City of Hope, 2007). The program addressed deficits in the delivery of quality palliative care such as substandard pain and symptom management, poor access to care, and communication deficits across the continuum of care.

Committee members, including the author, were selected because they represented a wide variety of health care professionals and interested community members. Representatives from the hospital included inpatient medical unit, pre-surgery

and outpatient surgery departments, Hospice and Palliative Care, Spiritual Care, Medical Records, Information Technology Systems, and nursing administration. The owner of a privately owned case management company and an interested community member were also part of the committee.

The Advance Directive Committee discussed their vision of the “ideal” use of advance directives in the local health care community. The committee members proposed eight specific objectives to guide the committee work. This project addressed one of the Advance Directive Committee’s objectives: review and revise the hospital’s Advance Directive Policies and Procedures to insure advance directives are identified and made quickly available to health care providers.

DePalma (2002) describes policies as “purposeful plans of action directed toward an issue of concern” (p. 55). Six key factors should be considered in policy development including (a) a clear statement of the issue, (b) evidence of who is impacted by the problem, (c) views of all the stakeholders, (d) proposed action plan including timeline and educational needs, (e) objectives that lead to outcomes, and (f) feasibility of policy change. The Committee implemented the six principles when revising the policy.

Assessment of the Local Community Hospital’s Current Use of Advance Directives

Prior to revising the Advance Directive Policy and Procedure, the Advance Directive Committee gathered baseline data to evaluate the current use of advance directives within the hospital system. Data were gathered in two steps. During the first step department managers were asked to describe the advance directive process in their

department. The second step was a quality assurance audit of close medical records indicating the presence or absence of documentation of an advance directive. Reports from the department managers and the quality assurance audit were provided to the Advance Directive Committee.

Advance Directive Policy and Procedure Update and Revision

The Advance Directive Committee used information from the department managers, the quality assurance assessment, the PSDA guidelines, the hospital's previous Advance Directive Policy and Procedure and the Joint Commission Standards for Advance Directives (Appendix A) as a frame of reference when developing the new policy and procedure. Each member of the Advance Directive Committee participated in the policy revision. Additions and revisions to the policy took place during monthly meetings over the six month time period.

The Advance Directive Policy and Procedure addressed advance directives for inpatients, outpatients, and patients being treated in the Emergency Department. The policy defined the responsibility of the registered nurse or licensed practical nurse caring for inpatients. The policy and procedure specified nursing staff were to initiate advance directive discussions during the admission process. Additional guidelines addressed health care provider responsibilities when a patient requested a change in existing advance directive or wanted to create a new advance directive, as well as guidelines for obtaining advance directives from other departments. The policy emphasized the importance of departmental cooperation to assure the patient's advance directives were

present in the medical record, were readily accessible to health care providers and accompanied the patient between health care departments.

In an effort to promote uniform communication about advance directives the policy and procedure included a one page roster of definitions. See Appendix B, Advance Directive Policy and Procedure, for a copy of the completed policy.

The Advance Directive Policy and Procedure was reviewed by the Ethics Committee and the Chief Nursing Executive. Final approval was granted by Administration in March 2008. A copy of the policy was placed in the organization's Policy Notebook. The Joint Commission Accreditation Survey occurred in August 2008 and the Advance Directive Policy was found to be satisfactory and no corrections required.

Development of the Advance Directive Education Module

The committee determined the most effective way to provide advance directive information to the majority of health care providers employed by the hospital was to use the existing hospital computer-based education system. An on-line education module would impact the largest number of health care providers across the greatest diversity of disciplines. After consulting with the Education Department Manager the author developed an on-line education module that was integrated into the agency's yearly required courses.

The hospital computer based on-line learning system consisted of independent study modules for employees as part of their annual learning program. The required modules are based on the employee's position description and role. A variety of courses

are required. Two examples of required modules are infection control and fire safety.

The Advance Directive Learning Module was required for direct patient care providers. Health care providers who were considered direct care providers included physicians, nurse practitioners, physician assistants, registered nurses, licensed practical nurses, nursing assistants, medical assistants, managers and supervisors of clinical departments, chaplains, social workers, dieticians and clinical staff from the following ancillary care departments: Respiratory Therapy, Surgical and Peri-operative Care, Cardiology, Radiology, Laboratory Services, Pharmacy, Speech, Occupational Therapy, Physical Therapy, Radiation Oncology, and Wound Care.

The Advance Directive Committee determined that although a large portion of the staff included in the ascribed health care provider group may not be the individual who initiated conversations with patients about advance directives, as health care providers they must be able to (a) locate patients advance directives in the medical record, (b) be familiar with terms used when discussing advance directives, (c) assist patients with advance directives if asked, and (d) be able to effectively communicate patient's wishes to other health care providers. The education module was designed to address these issues.

The Education Department Manager indicated the criterion for on-line courses was approximately 30 power point slides of course content without pictures, background, or art. The included the stated purpose, course objectives, course content and six multiple choice questions to assess learning. New courses, such as this one, would be posted to the website in early 2009.

The Advance Directive Learning Module addressed the following topics: definitions, explanations of types of advance directives, the importance of asking patients about their advance directives, a summary of the Advance Directive Policy and Procedure, a review of resources available at the hospital to help patients with advance directives, and specific actions to take when helping patients with advance directives (see Appendix C Advance Directive Education Module Course Content and Appendix D Advance Directive Test Questions and Answers).

The Advance Directive course description, course objectives, and test items were developed using Bloom's Taxonomy. Objectives and test items were written reflecting the first three levels in the cognitive domain: knowledge, comprehension, and application (Oermann & Gaberson, 2006). The first two multiple choice questions measured knowledge and comprehension of advance directives types. Questions three through six were descriptions of clinical situations involving patients and advance directives. The answers demonstrated application of the concepts and principles contained in the Advance Directive Policy. All multiple choice questions were designed to have one correct answer, although all answers were plausible and the student was required to determine the single best answer.

During the development of the module, the author asked the Advance Directive Committee and the Education Manager to review the content and format. The module content and questions were pilot tested by three health care providers, a registered nurse working on the inpatient unit, a manager of an outpatient department, and a physical therapist. Data from the pilot test was used to refine the course and test questions.

The Advance Directive Education Module and multiple choice questions were loaded into the on-line learning shell by the education department staff in January 2009. This module was made available to 625 health care providers in March 2009. Health care providers completed the Advance Directive Education Module at their convenience during the 2009 calendar year. As with each of the required learning modules, data concerning course completion and test scores are maintained by the Education Department.

CHAPTER 4

DISCUSSION

The focus of this project was the revision of the Advance Directive Policy and Procedure and the creation of the Advance Directive Education Module for healthcare providers at a local community hospital. The new Advance Directive Policy met Joint Commission Standards during the 2008 Joint Commission site visit and created a clear standard of care for advance directives at the hospital.

Communicating the new policy information to direct patient care providers at the hospital was accomplished by the development and implementation of the Advance Directive Education Module. Although the literature does not demonstrate strong evidence that health care provider education alone will improve the understanding and use of advance directives, it does show that education a fundamental part of on-going multi-faceted interventions that do improve advance care planning and end-of-life conversations (Wilkinson et al., 2007). At the time this project was completed, the module had been on-line for less than one month.

A follow-up quality assurance review and on outcome assessment of the effectiveness of the Advance Directive Education Module will be determined at a later date. Unfortunately, a quality assurance review gives “process-as-outcome” data (Ingersoll, 2009, p. 694) measuring health care providers’ documentation , but it does not measure the effect advance directive discussions had on the patient’s care and whether it was congruous with the patient’s goals and wishes.

The Advance Directive Committee is continuing to address objectives that effect health care provider education and behaviors related to advance directives, community-wide education and social acceptance of advance directives need to be explored. Promotion of the state-wide policy changes regarding POLST is planned.

Assets and Challenges

A major asset in the development of this project was the commitment and dedication of the hospital's multidisciplinary Advance Directive Committee and support of the Education Department. The input from and discussion with the diverse members provided insight with multiple points of view that proved invaluable in the creations of an appropriate policy and procedure that met the organization and accrediting agency requirements. As with most group work there is ebb and flow and individuals and organizations may have differing timelines. Since this project was developed in concert with committee activities the author was challenged to complete her portion of the project in a timely manner.

Another asset was the invitation to include the Advance Directive Learning Module as part of the hospital on-line learning system. This allowed the advance directive information to be available to a large number of health care providers from a diverse group of disciplines over an extended period of time. The challenge was that although the on-line education module was designed to read a broad cross section of the health care staff, it limited the format and the type of education program that could be provided.

The effectiveness of the on-line, independent study, multiple choice question/answer formats would be enhanced with a face to face continuing education program offered periodically so that interactions, questions, and personal insights could be shared and serve as a means to improving discussion and understanding of this complex subject.

Implications for Advanced Practice Nursing

The responsibility of providing advance directive planning falls naturally to primary care providers including Advanced Practice Nurses (APNs). Family Nurse Practitioners (FNPs) are in a unique position to facilitate these end-of-life discussions. Advanced practice nursing education emphasizes a holistic perspective, patient education and care, and effective communication with patients, families and other providers. These are key qualities that help patients with end-of-life decisions. Ingersoll (2009) found Advanced Practice Nurses spend more time with patients than physicians and communicate frequently and effectively with both patients and co-workers. APNs are well equipped to listen to patient values, wishes, and goals, to help patients define their end-of-life care, and to ensure those wishes are honored.

APNs are in a unique role that can effectively assist patients and families become knowledgeable about options for end-of-life care and advance care planning. APNs who are willing to be open and take the time to guide these discussion, thereby shifting the primary focus from completing an advance directive form to providing a more comprehensive approach to advance care planning. APNs can also advocate for the

development of systems and payments to allow providers and patients the opportunity to engage in these important discussions (Brunnhuber et al., 2007; Gillick, 2009; Perkins, 2007). Completing the advance directive form should not be a means to an end, but rather it should be an opportunity for ongoing discussions between health care providers and patients to clarify the patient values and goals as an integral part of patient-centered care throughout the life span.

REFERENCES CITED

- AARP Research Group. (2008). *AARP bulletin poll: Getting ready to go*. Retrieved February 8, 2009, from http://www.arp.org/research/endoflife/issues/getting_ready.html
- Administrative Rules of Montana. (2008). Section 37-10-101. Retrieved February 9, 2009 from <http://www.mtrules.org/gateway/ruleno.asp?RN=37.10.101>
- American Heart Association. (2008). *American Heart Association: Learn and live*. Retrieved February 17, 2009, from <http://www.americanheart.org/presenter.jhtml?identifier=3012990>
- American Hospital Association. (2003). *The patient care partnership*. Retrieved February 15, 2009 from <http://www.aha.org/aha/issues/Communicating-With-Patients/pt-care-partnership.html>
- American Medical Association. (2005). *AMA policy on provision of life sustaining medical treatment*. Retrieved February 9, 2009 from <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/about-ethics-group/ethics-resource-center/end-of-life-care/ama-policy-provision-life-sustaining-medical.shtml>
- American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements*. Washington, D.C.: American Nurses Publishing. Retrieved February 12, 2009 from www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/EthicsStandards/CodeofEthics/CodeofEthics.aspx
- Anselm, A. H., Palda, V., Guest, C. B., McLean, R. F., Vachon, M. L., Kelner, M., et al. (2005). Barriers to communication regarding end-of-life care: Perspectives of care providers. *Journal of Critical Care, 20*, 214-223.
- Association of Montana Health Care Providers. *Comfort One*. Retrieved February 14, 2009, from <http://www.mtha.org/comfort.htm>
- Badzek, L. A., Leslie, N., Schwertfeger, R., Deiriggi, P., Glover, J., & Friend, L. (2006). Advanced care planning: A study on home health nurses. *Applied Nursing Research, 19*, 56-62.
- Bernal, E. W., Marco, C. A., Parkins, A., Buderer, N., & Thum, D. (2007). End-of-life decisions: Family views on advance directives. *American Journal of Hospice and Palliative Medicine, 24*(4), 300-307.
- Bradley, E. H., Peiris, V., & Werle, T. (1998). Discussions about end-of -life care in nursing homes. *Journal of the American Geriatric Society, 46*(10), 1235-1241.

- Bravo, G., Dubois, M. F., & Wagneur, B. (2008). Assessing the effectiveness of interventions to promote advance directives among older adults: A systematic review and multilevel analysis. *Social Science and Medicine*, *67*, 1122-1131.
- Brown, B. (2003). The history of advance directives: A literature review. *Journal of Gerontological Nursing*, *29*(9), 4-14.
- Brunnhuber, K., Nash, S., Meier, D. E., Weissman, D. E., & Woodcock, J. (2008). *Putting evidence into practice: Palliative care*. BMJ Publishing Group Limited.
- Bunting, R. F., & Benton, J. (2000). *Advance directives: What every nurse should know*. The Journal of Nursing Risk Management 2000. Retrieved September 6, 2007 from Armed Forces Institute of Pathology Web Site:
<http://www.afip.org/departments/legalmed/jnrm2000/directives.htm>
- City Of Hope. *Advocating for clinical excellence: The ACE project*. Retrieved February 18, 2009, from <http://www.cityofhope.org/education/health-professional-education/nursing-education/ACE-project/Pages/default.aspx>
- Collins, L. G., Parks, S. M., & Winter, L. (2006). The state of advance care planning: One decade after SUPPORT. *American Journal of Hospice and Palliative Care*, *23*(5), 378-384.
- DePalma, J. A. (2002). Proposing an evidence-based policy process. *Nursing Administration Quarterly*, *26*(4), 55-61.
- Dexter, P. R., Wolinsky, F. D., Gramelspacher, G. P., Zhou, X. H., Eckert, G. S., Waisburd, M., et al. (1998). Effectiveness of computer generated reminders for increasing discussions about advance directives and completion of advance directive forms: A randomized controlled trial. *Annals of Internal Medicine*, *128*(4), 102-110.
- Ditto, P. H., Danks, J. H., Smucker, W D., Bookwala, J., Coppola, K. M., Dresser, R., et al. (2001). Advance directives as acts of communication: A randomized controlled trial. *Archives of Internal Medicine*, *161*, 421-430.
- Douglas, R., & Brown, H. N. (2002). Patient's attitudes toward advance directives. *Journal of Nursing Scholarship*, *34*(1), 61-65.
- Feeg, V. D., & Elebiary, H. (2005). Exploratory study on end-of-life issues: Barriers to palliative care and advance directives. *American Journal of Hospice and Palliative Care*, *22*(2), 119-124.

- Gillick, M. R. (2003). Adapting advance medical planning for the nursing home. *Innovations in End-of-Life Care*, 5(3), 1-7.
- Gillick, M. R. (2009). Decision making near life's end: A prescription for change. *Journal of Palliative Medicine*, 12(2), 121-125.
- Goetting, M., & Bullock, S. (2009). *Montana's End-of-Life Registry: A self-learning resource from MSU extension*. Retrieved February 15, 2009, from Montana State University Extension Web Site:
<http://msuextension.org/publications/FamilyFinancialManagement/MT200602HR.pdf>
- Golden, A. G., Corvea, M. H., Dang, S., Llorente, M., & Silverman, M. A. (2009). Assessing advance directives in the homebound elderly. *American Journal of Hospice and Palliative Medicine*, 26(1), 13-17.
- Gostin, L. O. (2005). Ethics, the Constitution, and the dying process: The case of Theresa Marie Schiavo. *JAMA*, 293, 2403-2407.
- Gross, A. G. (2006). End-of-life care obstacles and facilitators in the critical care units of community hospital. *Journal of Hospice and Palliative Nursing*, 8(2), 92-102.
- Happ, M. B., Capezuti, E., & Strumpf, N. E. (2002). Advance care planning and end-of-life care for hospitalized nursing home residents. *American Journal of the Geriatric Society*, 50(5), 829-835.
- Hickman, S. E., Tolle, S. W., Brummel-Smith, K., & Carley, M. M. (2004). Use of the Physician Order for Life Sustaining Treatment program in Oregon nursing facilities: Beyond resuscitation. *Journal of the American Geriatrics Society*, 52(9), 1430-1434.
- Ingersoll, G. (2009). Outcomes evaluation and performance improvement: An integrative review of research on advanced practice nursing. In A. Hamric, J. Spross, & C. Hanson (Eds.), *Advanced practice nursing: An integrative approach* (4th ed., pp. 681-732). St. Louis: Saunders Elsevier.
- Jezewski, M., Meeker, M., & Schrader, M. (2003). Voices of oncology nurses: What is needed to assist patients with advance directives. *Cancer Nursing*, 26(2), 105-112.
- Joint Commission (2008). *Comprehensive accreditation manual for hospitals: The official handbook* (p. RI.12-13). Chicago: Joint Commission Resources Publishing.

- Kass-Bartelmes, B. L., Hughes, R., & Rutherford, M. K. (2003). *Advance care planning: Preferences for care at the end of life*. Research in Action Issue #12, AHRQ Pub No. 03-0018. Rockville MD: Agency for Healthcare Research and Quality.
- Kiernan, S. (2006). *Last rites: Rescuing the end of life from the medical system*. New York: St. Martin's Press.
- Kirmse, J. M. (1998). Aggressive implementation of advance directives. *Critical Care Nursing Quarterly*, 83(7), 83-90.
- Kish, S. K., Martin, C. G., & Price, K. J. (2000). Advance directives in critically ill cancer patients. *Critical Care Nursing Clinics of North America*, 12(3), 373-383.
- Lambert, H. C., McColl, M. A., Gilbert, J., Wong, J., Murray, G., & Shortt, S. E. (2005). Factors affecting long-term-care-residents' decision-making processes as they formulate advance directives. *Gerontologist*, 45(5), 626-633.
- Larson, D. G., & Tobin, D. R. (2000). End-of-life conversations: Evolving practice and theory. *JAMA*, 284(12), 1573-1578.
- Levinsky, N. G., Yu, W., Ash, A., Moskowitz, M., Gazelle, G., Saynina, O., et al. (2001). Influence of age on Medicare expenditures and medical care in the last year of life. *JAMA*, 286(11), 1349-55.
- Lipson, A. R., Hausman, A. J., Higgins, P. A., & Burant, C. J. (2004). Knowledge, attitudes, and predictors of advance directive discussions of registered nurses. *Western Journal of Nursing Research*, 26(7), 784-796.
- Lorenz, K. A., Lynn, J., Dy, S. M., Shugarman, L., Wilkinson, A., Mularski, R. A., et al. (2007). Evidence for improving palliative care at the end of life: A systematic review. *Annals of Internal Medicine*, 148(2), 148-159.
- Lynn, J. (2000). Learning to care for people with chronic illness facing the end of life. *JAMA*, 284(19), 2508-2511.
- McAuley, W. J., & Travis, S. S. (2004). Advance care planning among long term residents in long-term care. *American Journal of Hospice and Palliative Care*, 20(5), 353-359.
- Montana Code Annotated. (2007). Rights of the Terminally Ill Act, 50-9-102. Retrieved February 9, 2009 from http://data.opi.state.mt.us/bills/mca_toc/50_9.htm

- National Hospice and Palliative Care Organization. *Caring Connections*. Retrieved February 28, 2009, from <http://www.caringinfo.org/PlanningAhead/AdvanceDirectives/WhatAreAdvanceDirectives.htm><http://>
- Norton, S. A., & Talerico, K. A. (2000). Facilitating end-of-life decision-making: Strategies for communicating and assessing. *Journal of Gerontological Nursing*, 26(9), 6-13.
- Oermann, M. H., & Gaberson, K. B. (2006). Evaluation, measurement, and the educational process. In *Evaluation and testing in nursing education* (2nd ed., pp. 1-21). New York: Springer.
- Omnibus Budget Reconciliation Act Of 1990 (in effect December 1991). Public Law 101-508 sec 4206-4207, 4751-4752. 42 U.S.C. sec 1395, 43 U.S.C. sec 1396a(a).
- Patel, R. V., Sinuff, T., & Cook, D. J. (2004). Influencing advance directive completion rates in non-terminally ill patients: A systematic review. *Journal of Critical Care*, 19(1), 1-9.
- Perkins, H. S. (2007). Controlling death: The false promise of advance directives. *Annals of Internal Medicine*, 147(1), 51-57.
- Ramsaroop, S. D., Reid, M. C., & Adelman, R. D. (2007). Completing an advance directive in the primary care setting: What do we need for success? *Journal of the American Geriatric Society*, 55(2), 277-283.
- Raphael, C., Ahrens, F., & Fowler, N. (2001). Financing end-of-life care in the USA. *Journal of the Royal Society of Medicine*, 94(9), 458-461.
- Robinson, K., Sutton, S., Von Gunten, C., Ferris, F. D., Molodyko, N., Martinez, J., et al. (2004). Assessment of the education of physicians on the End-of Life Care (EPEC) Project. *Journal of Palliative Medicine*, 7(5), 637-645.
- Schwartz, C. E., Wheeler, H. B., Hammes, B., Basque, N., Edmunds, J., Reed, G., et al. (2002). Early intervention in planning end-of-life care with ambulatory geriatric patients. *Archives of Internal Medicine*, 162, 1611-1618.
- Sessanna, L., & Jezewski, M. A. (2008). Advance directive decision making among independent community-dwelling older adults: A systematic review of health science literature. *Journal of Applied Gerontology*, 27(4), 486-510.
- Teno, J. M. (2004). Advance directives: Time to move on. *Annals of Internal Medicine*, 141(2), 159-160.

- Tierney, W. M., Dexter, P. R., Gramelspacher, G. P., Perkins, A. J., Zhou, X. H., & Wolinsky, F. D. (2001). The effect of discussions about advance directives on patients' satisfaction with primary care. *Journal of General Internal Medicine, 16*, 32-40.
- Trask, P. C., Teno, J. M., & Nash, J. (2006). Transitions of care and changes in distressing pain. *Journal of Pain and Symptom Management, 32*(2), 104-109.
- Wilkinison, A., Wenger, N., & Shugarman, L. R. (2007,). *Literature review on advance directives* (HHS-100-03-0023). United States Department of Health and Human Services. Retrieved February 9, 2009 from <http://aspe.hhs.gov/daltcp/reports/2007/advdirlr.htm>
- Zhang, B., Wright, A. A., Huskamp, H. A., Nilsson, M. E., Maciejewski, M. L., Earle, C. C., et al. (2009). Health care costs in the last week of life: Associations with end-of-life conversations. *Archives of Internal Medicine, 169*(5), 480-488.

APPENDICES

APPENDIX A

THE JOINT COMMISSION STANDARDS
ADDRESSING ADVANCE DIRECTIVES

THE JOINT COMMISSION STANDARDS
ADDRESSING ADVANCE DIRECTIVES

STANDARD RI.2.70

Patients have the right to refuse care, treatment, and services in accordance with law and regulation.

Elements of Performance for RI.2.70

1. Patients have the right to refuse care, treatment, and services in accordance with law and regulation.
2. When the patient is not legally responsible, the surrogate decision maker, as allowed by law, has the right to refuse care, treatment, and services on the patient's behalf.

STANDARD RI.2.80

The hospital addresses the wishes of the patient relating to end-of-life decisions.

Elements of Performance for RI.2.80

1. Policies, in accordance with law and regulation, address advance directives and the framework for forgoing or withdrawing life-sustaining treatment and withholding resuscitative services.
2. Adults are given written information about their right to accept or refuse medical or surgical treatment, including forgoing or withdrawing life-sustaining treatments or withholding resuscitative services.
3. The existence or lack of an advance directive does not determine an individual's access to care, treatment, and services
4. Documentation indicates whether or not the patient has signed an advance directive.
5. The patient has the option to review and revise advance directives.
6. Appropriate staff are aware of the advance directive if one exists
7. The hospital helps or refers the patients for assistance in formulating advance directives upon request.
8. The hospital has a mechanism for healthcare professionals and designated representatives to honor advance directives within the limits of the law and the hospital's capabilities.
9. The hospital documents and honors the patient's wishes concerning organ donation within the limits of the law or hospital capacity.
10. *For Outpatient Hospital Settings:* The hospital's policy address advance directive and specify whether the hospital will honor the directives.

11. *For Outpatient Hospital Settings:* The policies communicated to patients and families when asked about or as appropriate to the care, treatment, and services provided.
12. *For Outpatient Hospital Settings:* Upon request, the hospital helps patients formulate medical advance directives or refers them for assistance.
13. through 20. Not applicable.
21. The policies are consistently implemented.

Reference:

The Joint Commission (2008). *The Comprehensive Accreditation Manual for Hospitals: The Official Manual*. p. RI-12, RI-13. Chicago: Joint Commission Resources.

APPENDIX B

ADVANCE DIRECTIVE
POLICY AND PROCEDURE



POLICIES/PROCEDURES

TITLE: ADVANCE DIRECTIVES

SECTION: Administration (Organization-Wide)

JC STANDARD REFERENCE: RI 2.80

CURRENT DATE: 3/08

INITIATED BY:

REPLACES: 2/95, 5/99, 3/01

APPROVED BY: ETHICS COMMITTEE (ADVANCE DIRECTIVE COMMITTEE), CHIEF NURSING EXECUTIVE

REVIEWED:

POLICY: All Bozeman Deaconess Hospital (BDH) patients over 18 years of age will be offered the opportunity to complete an advance directive if one is not in their medical record.

PROCEDURE:

Principles:

- The advance directive provides information for health care providers regarding the types of treatment the patient wants to have in their current and future health care.
- It is a patient right to choose to complete an advance directive.
- Patients will not be discriminated against if they chose to have or choose to not have an advance directive in place.
- It is the role of BDH staff to honor the wishes of the patient set forth in their advance directive document to the best of their ability and to the extent possible and appropriate.
- If BDH is not able to comply with a patient's advance directive, the Ethics Committee will be consulted. At the patient's request, the staff may facilitate patient transfer to another facility.

BDH Inpatients:

1. RN/LPN will complete Admission, History and Assessment Data Base. This will include asking the patient or healthcare representative if there is an advance directive. Documentation of the outcome of this conversation will be in the Admission Data Base.
2. If the patient/family or healthcare representative states there is an advance directive:
 - a. Until the document is available, the RN/LPN is encouraged to ask the patient or healthcare representative to describe their understanding of the directions for care.

- b. The staff will attempt to locate the document in the medical records file. A green sticker on the outside of the permanent record will alert staff to the presence of an advance directive.
 - c. The staff will request a copy of the advance directive be sent from the physician office or sending facility if it is located there.
 - d. The family or healthcare representative will be asked to bring a copy of the advance directive to the hospital as soon as possible if it is not in the medical record.
 - e. A copy of the advance directive will be placed under the “Advance Directive” tab in the chart on the medical unit by the nurse or ward clerk.
 - f. The outside of the chart will be marked to alert healthcare providers there is an advance directive in place.
 - g. The presence of a patient’s advance directive will be entered in the computer in the patient’s administrative data screen.
3. If the patient does not have an advance directive and desires more information about advance directives, wishes to complete an advance directive, or change a previous advance directive; a referral is made to the Spiritual Care department by the nurse or ward clerk through the computer system.
 4. If the patient is also a Palliative Care patient, the Spiritual Care department will coordinate the referral with the Palliative Care team.
 5. A copy of the advance directive, Comfort One, or POLST will be placed with the discharge papers when the patient is transferred or discharged from BDH.

BDH Outpatient Surgical

1. During pre-surgery assessment, patient will be asked if they have an advance directive.
2. If an advance directive has been completed, patient will be asked to bring a copy with them to be placed in the medical record.
3. If patient wants more information about advance directives, wishes to complete an advance directive, or change a previous advance directive; assistance can be requested through the Spiritual Care or Palliative Care Departments.

Emergency Department

1. Sending facilities will be asked to send a copy of advance directives with patients when transported to the emergency department.
2. Patients being admitted to the hospital will be asked if there is an advance directive in place.
3. If there is an advance directive, emergency department staff will attempt to locate the document in medical records. As soon as the situation allows, staff will discuss the goals of care with the patient or healthcare representative.

Performance Improvement

1. Performance improvement will be done by the Spiritual Care department with the cooperation of other departments to monitor compliance with this policy.

Related Policies

Medical Records Advance Directive Policy
 Medical Staff Advance Directive Policy

References

Patient Self Determination Act (PSDA). Omnibus Budget Reconciliation Act (1990) Pub. L.No. 101-508,§ 4206,4751 of 1990.

DEFINITIONS

Advance Directive. A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity.

Comfort One. A DNR order that is recognized by emergency medical responders outside the hospital.

Do-Not-Resuscitate (DNR) order: A physician’s written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest.

Living will. A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at end of life and unable to communicate. May also be called a “directive to physicians”, “health care declaration”, or “medical directive.”

Medical power of attorney. A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive can be called a healthcare proxy, durable power of attorney for healthcare, or appointment of a healthcare agent. The person appointed may be called a healthcare agent, healthcare representative, surrogate, attorney-in-fact or proxy.

Montana End of Life Registry. A website maintained by the Montana Attorney General’s office for Montana citizens to securely store their advance directives online and to give authorized healthcare providers immediate access to them.

Physician Orders for Life Sustaining Treatment (POLST). A form that takes the previously expressed wishes of an individual and puts them into a portable set of physician orders for medical treatment that may be followed by healthcare providers in a variety of care settings. The POLST translates a person’s advance directives into a physician order.

APPENDIX C

ADVANCE DIRECTIVE

EDUCATION MODULE

COURSE CONTENT

2009 Guidelines for Advance Directives at Bozeman Deaconess

SLIDE #1

Course Description

- This course is designed for healthcare professionals at Bozeman Deaconess Hospital and Health Group.
- The basis of this course is the Bozeman Deaconess Hospital Advance Directives Policy and Procedure: Administrative (Organization-wide).

SLIDE #2

Your Learning Objectives

By the end of this course, you will be able to:

1. State the purpose for advance directives.
2. Differentiate between the use of living wills and wills.
3. Correctly recognize actions to take when assisting patients with different types of advance directives.

SLIDE #3

What is an advance directive?

DEFINITION: An advance directive is a general term describing two kinds of documents:

- LIVING WILL
- MEDICAL POWER OF ATTORNEY

SLIDE #4

What is an advance directive?

Living wills and durable power of attorney documents allow a person to give their instructions about future medical care if he or she is unable to participate in decisions due to serious illness or incapacity. A patient can change advance directives at any time.

SLIDE #5

What is a LIVING WILL?

A LIVING WILL is a type of advance directive document in which an individual states his or her wishes about medical treatment if he or she is at end of life and unable to communicate.

It may also be called a

- directive to physicians
- health care declaration
- medical directive

SLIDE #6***What is the difference between a “WILL” and a “LIVING WILL”?***

- A WILL (or “Last Will and Testament”) is a legal document with instructions for disposing of a person’s property and possessions after they die. It is often prepared by an attorney during estate planning.
- A LIVING WILL is a document listing a person’s preferences and wishes for medical care at the end-of-life. It is usually witnessed, but does not need to be written by an attorney.

SLIDE #7***What is a MEDICAL POWER OF ATTORNEY?***

A MEDICAL POWER OF ATTORNEY is a document an individual fills out to appoint someone to make healthcare decisions if he or she is unable to communicate. An attorney may assist with this document.

SLIDE #8***Are there other names for a Medical Power of Attorney?***

That person may be called a

- Healthcare representative or agent
- Healthcare surrogate
- Healthcare proxy
- Durable Power of Attorney for Health Care (DPOAHC)
- Attorney-in-fact

SLIDE #9***Why do we ask about advance directives?***

Honoring a patient’s treatment preferences during a life-threatening illness or at end- of-life is an important part of the commitment Bozeman Deaconess has made to quality, patient-centered care.

SLIDE #10***Why do we ask about advance directives?***

The Patient Self-Determination Act of 1990 (PSDA) requires all health care facilities paid by Medicare and Medicaid to tell patients they have the right to make choices about treatments they receive and to give them the opportunity to create advance directives.

The Joint Commission echoes this with standards addressing and honoring patients’ wishes at the end of life.

SLIDE #11

Bozeman Deaconess Patient Rights and Responsibilities

“Patients have the right to formulate an advance directive. This includes designating a person to make decisions for you in the event you become incapable of understanding a proposed treatment or are unable to communicate your wishes regarding care.”

SLIDE #12

Bozeman Deaconess Patient Rights and Responsibilities

“Hospital staff and practitioners shall comply with these directives.”

SLIDE #13

Bozeman Deaconess Policy Regarding Advance Directives

“All Bozeman Deaconess patients over the age of 18 years will be offered the opportunity to complete an advance directive if one is not in their medical record.”

SLIDE #14

Bozeman Deaconess Policy Regarding Advance Directives

“Bozeman Deaconess staff will honor the wishes of the patient to the best of their abilities.”

“Patients will not be discriminated against if they choose to have or choose to not have an advance directive in place.”

SLIDE#15

Why is it important to talk to patients about their advance directives?

In order to honor end-of-life wishes, the staff at Bozeman Deaconess need to understand the patient’s goals and wishes.

SLIDE #16

How do I ask a patient about their advance directives?

Patients are asked if they have or would like to have an advance directive, when they are seen in the *clinics, emergency department, or hospital*

SLIDE #17***How do I ask a patient about their advance directives?***

Staff can ask: (very important)

“Do you have an advance directive, such as a living will or a medical power of attorney?”

“If you became seriously ill or injured and could not speak for yourself, do you know what healthcare treatments you would or would not want?”

SLIDE #18***What if a patient tells me they have completed an advance directive, and a copy is not in their medical record?***

1. Ask the patient to summarize their wishes and document this conversation in the electronic medical record.
2. Request a copy of the advance directive be sent from the primary care provider’s office, the nursing home, or ask the patient or family to provide a copy for Bozeman Deaconess.
3. Check with the medical records department at Bozeman Deaconess. There may be a copy on file there.

SLIDE #19***Where do I document my conversation with a patient about their advance directives?*****If you work in a Clinic:**

- The NexGen Electronic Medical Record Social History includes a place for you to list the patient’s advance directives.
- A copy of the patient’s advance directive form can be scanned into the computer.

SLIDE #20***Where do I document my conversation with a patient about their advance directives?*****If you work in the Hospital:**

- The Meditech patient electronic medical record has multiple places for you to document
 - Admission Database I, Admission Database II
 - Administrative Data, process intervention screen
 - FOCUS note

SLIDE #21

The advance directives we have spoken of so far are created by the patient.....

Next, we will discuss physicians' orders reflecting patients' advance directives:

- Do Not Resuscitate (DNR)
- Comfort One
- Provider's Order for Life Sustaining Treatment (POLST)

SLIDE #22***Orders reflecting a patient's advance directives***

Do Not Resuscitate (DNR) is an order written by the patient's medical provider, after discussion with the patient or healthcare proxy, instructing healthcare providers not to attempt cardiopulmonary resuscitation in case of cardiac or respiratory arrest.

SLIDE #23***Orders reflecting a patient's Advance Directives***

Comfort One is a DNR order recognized by Emergency Medical Services (EMS) outside the hospital.

- When a patient has Comfort One order, instead of starting CPR, medical personnel outside the hospital provide comfort measures such as oxygen, suctioning, and pain medication for the patient.
- A patient can be transported to a healthcare facility where inpatient orders need to be written reflecting the patient's advance directives.

SLIDE #24***Orders reflecting a patient's advance directives***

Provider's Order for Life-Sustaining Treatment (POLST) is a form that takes a seriously ill patient's previously expressed wishes about cardiopulmonary resuscitation, medical interventions, intubation, transfer to the hospital, artificial fluids, nutrition, and comfort measures at the end-of-life, and translates them into a portable physician order.

SLIDE #25***Orders reflecting a patient's advance directives***

POLST orders are a result of discussion between the seriously ill patient and the healthcare provider. The form can be signed by both the patient and the provider.

POLST orders are recognized by healthcare staff in all healthcare settings including inpatient, outpatient, emergency medical services, long term care and at home.

SLIDE #26

Orders reflecting a patient's advance directives

Providers can download and print the Montana **POLST** form from Montana Board of Medical Examiners website:

http://mt.gov/dli/bsd/license/bsd_boards/med_board/licenses/med/pdf/polst

SLIDE #27

What resources do we have at BDH to help patients with advance directives?

- The patient's medical provider
- Spiritual Care staff
- Palliative Care team
- Five Wishes® booklets
- The nursing staff in collaboration with medical providers

SLIDE #28

Bozeman Deaconess has chosen the *Five Wishes™* booklet to be available to patients as a guide when creating their Advance Directives.

SLIDE #29

The *Five Wishes®* booklet is unique among Advance Directive and Living Will forms. It looks at more than just medical preferences at end-of-life. It also addresses personal, emotional, and spiritual wishes.

SLIDE #30

The Five Wishes booklet® asks the patient...

1. Which person would you want to make health care decisions for you when you can't make them for yourself?
2. What kind of medical treatments do you want? or not want?

SLIDE #31

The Five Wishes booklet® asks the patient...(cont.)

3. How you want people to treat you?
4. How comfortable do you want to be?
5. What it is you want your loved ones to know?

SLIDE #32

As a Bozeman Deaconess healthcare provider, what is my role regarding a patient's advance directives?

1. Know the patient's goals and wishes for end-of-life care by asking patients if they have advance directives.
2. Document conversations about advance directives.
3. Contact the patient's primary care provider, Spiritual Care or the Palliative Care team if the patient would like assistance with advance directives.

SLIDE #33

As a Bozeman Deaconess healthcare provider, what is my role regarding a patient's advance directives?

4. Know where to find a patient's advance directives in the electronic medical record.
5. Refer families as appropriate who have concerns or questions about treatments and advance directives.
6. Know where the Five Wishes Booklets and Patients Rights and Responsibility pamphlets are located.

SLIDE #34

Summary/Key Points

1. The Patient Self Determination Act of 1990 requires that healthcare providers tell patients they can make choices about treatments they receive and can create advance directives.
2. Knowing and honoring a patient's goals, wishes, and treatment preferences is part of quality patient-centered care at Bozeman Deaconess.

APPENDIX D

ADVANCE DIRECTIVE

TEST QUESTIONS AND ANSWERS

Advance Directive Test Questions and Answers

1. The primary advantage for a patient to have an advance directive is to:
 - a. Include family and friends in healthcare wishes.
 - b. Help patients state their healthcare wishes in writing.**
 - c. Allow patients to appoint someone to speak for them.
 - d. Guarantee a patient's goals and wishes will be followed.

2. The Bozeman Deaconess Advance Directive Policy gives patients the legal right to formulate an advance directive or appoint a medical power of attorney. The policy is based on:
 - a. National Medicare and Medicaid Rules.
 - b. Quality and Patient-Centered Care Legislation.
 - c. The Patient Self Determination Act of 1990 (PDSA).**
 - d. Durable Power of Attorney for Healthcare Act (DPOAHC).

3. When asked about having an advance directive, the 19-year old patient states "No." The next best step for the healthcare staff is to:
 - a. Refrain legally from asking a 19-year old patient about advance directives.
 - b. Request a Spiritual Care consultation to discuss advance directives with the patient.
 - c. Reschedule the surgery until the patient is able to fill out an advance directive.
 - d. Ask the patient if he/she would like more information about advance directives.**

4. When asked about advance directives, the patient states he gave a copy of his living will to his medical provider. The next step for the healthcare staff is:
 - a. Summarize in the electronic medical record what the patient tells you is in his living will.**
 - b. Check if a copy of the living will is in Bozeman Deaconess Medical Records Department.
 - c. Give the patient a copy of the Five Wishes Booklet to fill out.
 - d. Tell the patient to get a copy right away and give it to you.

5. When asked about having a living will or a durable power of attorney, the patient states,

"Yes, my will says to give all of my possessions to my children when I die." The healthcare staff's response should correctly include:

- a. "It is great you have done that. It must feel good to have all of your affairs in order and have your family informed."
 - b. "You need to make an appointment as soon as possible with your attorney to have a living will made."
 - c. **"May I help you with a living will for stating what medical treatments you want or don't want?"**
 - d. "That's all you need to do, because your will tells us about your possessions and healthcare wishes too."
6. A seriously ill patient has a signed Provider's Order for Life Sustaining Treatment (POLST) form in her medical record. The nurse reminds the provider to sign a Comfort One form before the patient is transported by ambulance to the nursing home. The nurse's action is:
- a. Correct. The patient needs a Comfort One signed before leaving the hospital.
 - b. Incorrect. The nurse should call discharge planning for the Comfort One form.
 - c. **Incorrect. The signed POLST form can be used by the ambulance staff.**
 - d. Correct. The patient really needs a "Do Not Resuscitate" order.

APPENDIX E

STATEMENT OF PERMISSION TO USE NAME



Bozeman Deaconess
HOSPITAL

3/18/09

Rebecca Murphy
48 Riverside Drive
Bozeman, Montana 59718

Dear Rebecca:

I understand that your graduate studies require a professional paper. I am excited that you selected "Advocating for Advance Directives: Recommendations for Health Care Professionals". It is an issue that is of utmost importance to our community.

You have permission to refer to Bozeman Deaconess as needed in your paper. Should you use information from your paper for a manuscript, please contact me for further permission.

I wish you the best in your continued studies and thank you for choosing Bozeman Deaconess for your project.

Very Truly Yours,

A handwritten signature in cursive script that reads "Liz Lewis".

Liz Lewis
Senior Vice President Operations/Legal