

# Advance Directive Policy and Procedure

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New York

## ADVANCE DIRECTIVE POLICY AND PROCEDURE

### POLICY

It is the policy of the facility to establish, implement and maintain written policies and procedures for advance directive. The resident has the right and the facility will assist the resident to formulate an advance directive at their option. The facility will inform and provide resident with a written description of the facility's policy to implement advance directives. Resident has the right to accept, request, refuse and/or discontinue medical or surgical treatment and to participate in or refuse to participate in experimental research.

### Centers for Medicaid and Medicare Services (CMS)

#### Definitions

**“Advance care planning”** is a process used to identify and update the resident's preferences regarding care and treatment at a future time including a situation in which the resident subsequently lacks the capacity to do so; for example, when a situation arises in which life-sustaining treatments are a potential option for care and the resident is unable to make his or her choices known.<sup>1</sup>

**“Advance directive”** means, according to 42 C.F.R. §489.100, a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Some States also recognize a documented oral instruction.

**“Cardiopulmonary resuscitation (CPR)”** refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased.

**“Durable Power of Attorney for Health Care” (a.k.a. “Medical Power of Attorney”)** is a document delegating to an agent the authority to make health care decisions in case the individual delegating that authority subsequently becomes incapable of doing so.

**“Health care decision-making”** refers to consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual's physical or mental condition.

**“Health care decision-making capacity”** refers to possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choices.

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<sup>1</sup> Adapted from: Emanuel, L.L., Danis, M., Pearlman, R.A., Singer, P.A. (1995). Advance care planning as a process: structuring the discussions in practice. *Journal of the American Geriatric Society*, 43, 440–6.



**“Life-sustaining treatment”** is treatment that, based on reasonable medical judgment, sustains an individual’s life and without which the individual will die. The term includes both life-sustaining medications and interventions such as mechanical ventilation, kidney dialysis, and artificial hydration and nutrition. The term does not include the administration of pain medication or other pain management interventions, the performance of a medical procedure related to enhancing comfort, or any other medical care provided to alleviate a resident’s pain.

**“Legal representative” (e.g., “Agent,” “Attorney in fact,” “Proxy,” “Substitute decision-maker,” “Surrogate decision-maker”)** is a person designated and authorized by an advance directive or by State law to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions.

**“Treatment”** refers to interventions provided for purposes of maintaining/restoring health and well-being, improving functional level, or relieving symptoms.

## **OBJECTIVE OF ADVANCE DIRECTIVE POLICY AND PROCEDURE**

The objective for this requirement is to establish a policy and procedure for the facility to educate and inform the resident of their rights, promoting the resident their right to accept or refuse medical or surgical treatment, refuse to participate in experimental research, and to formulate an advance directive in assisting the resident to exercise his/her rights. Resident choices will be incorporated into treatment, care and services.

## **PROCEDURE**

- A. Upon admission, identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advance directive. A resident has the option to execute an advance directive but will not be required to do so. The facility will not discriminate against a resident based on whether he or she has executed an advance directive.
- B. Examples include a Living will, a directive to the attending physician, a durable power of attorney for health care, a medical power of attorney, a pre-existing medical order for “do not resuscitate (DNR)”, or other document directing the resident’s health care. (Other State order forms such as a MOLST or POLST would also be included in this section).
- C. Facility staff will provide the resident and/or resident representative with written description of the facility’s policies to implement an advance directive. (Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements are met). The facility will identify the primary decision-maker (e.g. assess the resident’s decision-making capacity and identify

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or arrange for an appropriate legal representative for the resident assessed as unable to make relevant health care decisions).

- i. If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility will give advance directive information to the individual's resident representative in accordance with State law.
- ii. In the event that the resident condition changes, based on regular comprehensive assessment or change in resident status review, and the resident is able to receive such information, the resident will be provided with written description of the facility's policies to implement an advance directive.

**D. Determining a surrogate in New York State based on the Health Care Decisions Act:** In cases when patients cannot make their own decisions and do not have a legal guardian or health care proxy, the Family Health Care Decisions Act (FHCDA) specifies, using a prioritized surrogate list, who has legal authority to make health care decisions.

- i. Under the surrogate list, the spouse (if not legally separated from the patient) or the domestic partner is legally authorized to make decisions. If there is no spouse or domestic partner, an adult child may make health care decisions. Next on the list is a parent, then an adult sibling, and finally a close friend. The terms "domestic partner" and "close friend" are defined in the law. For persons with a Mental Hygiene Law Article 81 guardian authorized to decide about health care, that guardian is at the top of the surrogate list.
- ii. Surrogates can make any type of health care decision, including a decision to withhold or withdraw life-sustaining treatment. Decisions must always be made based on the patient's wishes, or based on the patient's best interests if the patient's wishes are not known. The FHCDA specifies the clinical criteria under which decisions to withhold or withdraw life sustaining treatment may be made.
- iii. In the event that no one on the surrogate list is available, the FHCDA allows (but does not mandate) physicians at facilities to make any type of health care decision without going to court. The law sets forth required procedures and clinical criteria, which vary depending on whether the treatment is routine medical treatment, major medical treatment, or a decision to withhold or withdraw life-sustaining treatment.

E. Families and/or health care surrogates are provided with a copy of the publication "Deciding about health care – A guide for patients and families" as required by NYS Department of Health to assist in making informed health care decisions.

F. If advance directives are formulated, all advance directive document copies will be obtained and located (identify the same section of the resident's medical record that would be readily retrievable by any facility staff.)

- G. Resident wishes will be communicated to the staff via the care plan and (identify facility protocol for communication of advance directives either in written or oral format) and to the resident physician.
- H. The resident will be assessed periodically for decision-making ability capacity and for changes in resident preferences and choices.
- I. During the quarterly RAI process and with any significant changes of condition, facility staff will:
  - i. Identify, clarify and review the existing care instructions and whether the resident wishes to change or continue instructions from the advance directive
  - ii. Define and clarify medical issue, review the resident's condition and existing choices and present information regarding relevant health care issues to the resident or resident representative as appropriate to determine continuation or modification of choices of care
  - iii. Assess the resident for decision-making capacity and based on assessment, the resident is determined not to have decision-making capacity, facility staff will invoke the health care agent or legal representative (as described in the FHCDA).
  - iv. Identify situations where health care decision-making is needed, such as a significant decline or improvement in the resident's condition
  - v. Changes to the resident choices for advance directives will be documented, included in the resident plan of care; physician orders will be obtained to reflect new choices as applicable and all items will be communicated to staff providing resident care
  - vi. In the event that the facility and/or physician do not believe they can provide care in accordance with the resident's advance directives or other wishes on the basis of conscience, the facility should request a review by the facility ethics committee.

## **ADVANCE CARE PLANNING**

- A. In order for a resident to exercise his or her right to make informed choices about care and treatment in preparation for a time when the resident may not be able to make decisions, designated personnel and/or physician will assist with defining and clarifying medical issues and presenting the information regarding relevant health care issues to the resident or his/her legal representative, in a language that the resident can understand, as appropriate.



- B. The interdisciplinary team will identify, clarify, and review, as part of the comprehensive care planning process, the existing care instructions along with resident's goals wishes as the resident's medical condition changes.
- C. Encourage resident involvement and control in decision making as much as possible. One of the key elements identified at end of life the ability afforded to the dying person is control in decision making. This also allows the decision maker (whether it is the resident, resident representative) to be better informed about treatment alternatives.

#### **RIGHT TO REFUSE MEDICAL OR SURGICAL TREATMENT**

- A. If a resident (directly or through an advance directive) declines treatment (e.g., refuses artificial nutrition or IV hydration, despite having lost considerable weight), the resident may not be treated against his/her wishes.
- B. Facility staff will continue to offer alternative treatments and therapies.
- C. Staff will provide education and review risks/benefits on a regular basis with periodic documentation.
- D. If a resident is unable to make a health care decision, a decision by the resident's legal representative to forego treatment may, subject to requirements of the New York State FHCDA, be equally binding on the facility.
- E. The facility will not transfer or discharge a resident for refusing treatment unless the criteria for transfer or discharge are otherwise met.
- F. If a resident's refusal of treatment results in a significant change in condition, the facility will reassess the resident and modify the care plan as appropriate.
- G. The facility will assess the resident for decision-making capacity and invoke the health care agent or legal representative if the resident is determined not to have decision-making capacity. Once the decision-making capacity is assessed, the facility will determine and document what the resident is refusing, assess the reason(s) for the resident's refusal, advise the resident about the consequences of refusal, offer pertinent alternative treatments, and continue to provide all other appropriate services.
- H. The resident representative and physician/NP/Hospice will be notified of resident's refusal of treatment. Risks and benefits will be reviewed and documented in the resident record.

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## **CARDIOPULMONARY RESUSCITATION (CPR)**

### **POLICY**

It is the policy of this facility to provide basic life support, including CPR – Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advance directives.

- A. Nurses and other care staff are educated to initiate CPR, as recommended by the American Heart Association unless:
  - i. A valid Do Not Resuscitate order is in place.
  - ii. Resident presents with obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection or decomposition) are present.
  - iii. Initiating CPR could cause injury or peril to the rescuer.

CPR certified staff will be available at all times. Staff will maintain current CPR certification for healthcare providers including hands-on skills practice and in-person assessment and demonstration of skills.

## **RIGHT TO DECLINE TO PARTICIPATE IN EXPERIMENTAL RESEARCH**

### **POLICY**

It is the policy that if the facility participates in any experimental research that involves facility residents, that the Facility Institutional Review Board will review and approve any research program including a committee for oversight for adherence to 45 CFR Part 46, Protection of Human Subjects of Research.

- A. The resident has the right to refuse participation in experimental research.
- B. The resident who is being considered for experimental research must be fully informed (e.g. medication, treatment)
- C. The resident must give informed consent to participate.
- D. If the resident is incapable of giving informed consent but the legal representative gives proxy consent, it is the responsibility of the facility to properly obtain the proxy consent and measures taken to protect the individual from harm or mistreatment.

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- E. The legal representative also may refuse participation before and during the research activity.

## REFERENCES

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities  
10/04/16:

- <https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

CMS Memo Ref: S&C 17-07-NH: Advance Copy – Revisions to State Operations Manual (SOM),  
Appendix PP- Revised Regulations and Tags, 11/09/16:

- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf>

New York State Family Health Care Decisions Act (FHCA):

- [https://www.health.ny.gov/diseases/aids/providers/regulations/fhcda/ai\\_fact\\_sheet.htm](https://www.health.ny.gov/diseases/aids/providers/regulations/fhcda/ai_fact_sheet.htm)

Deciding about health care – A guide for patients and families: Handout required to be provided  
to families of residents in residential health care facilities in New York State:

- <https://www.health.ny.gov/publications/1503.pdf>

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