Advance Directive
and
Colorado Proxy Law Explained

Created 6/15/2010
You are **legally** and **ethically** responsible for ensuring your patient's Advance Directive wishes are complied with.
What are Advance Directives?

Instructions that guide health care decision making in accordance with a patient’s wishes, should that patient lose the ability to speak for himself.
Types of Advance Directives

- Living Will
- DNAR order (Do Not Attempt to Resuscitate”
- Medical Power of Attorney
- Surrogate decision maker or Medical Proxy
- MOST: (Medical Orders for Scope of Treatment)
  - Passed into Colorado Law May, 2010
  - Awaiting standardization paperwork
What is a Living Will?

- **Actual Document** *signed by the patient* stating what type of interventions he would want in the event of a critical or terminal illness.

- May include his thoughts on:
  - Artificial nutrition and hydration
  - Life support and intubation
  - Spokesperson who will make decisions on his behalf
Resuscitation: Order Differences

• Inpatient orders:
  – DNAR = Do not attempt resuscitation
  – DNI = Do not intubate
Resuscitation: Order Differences

• Outpatient orders:
  – Colorado CPR Directive = No CPR or machines if patient had cardio-pulmonary arrest at home
  – MOST (Medical Orders for Scope of Treatment)
    • Passed into Colorado Law this month!
PHYSICIAN DO NOT ATTEMPT RESUSCITATION ORDER (DNAR) FORM

Purpose
- To clarify this patient’s resuscitation status.
- Regardless of DNAR status, all measures to assure the patient’s comfort and dignity will be maintained.

Note: DNAR = no resuscitative measures if full cardiopulmonary arrest occurs
-Heart and Lungs stop

- 1. Do Not Attempt Resuscitation (DNAR)
If patient is a DNAR/DNI:

- RN must place purple DNAR wristband on patient.
- Resident must document conversation immediately.
- Attending must sign order within 24 hours.
2. Limited Resuscitation, as checked below:

(Pre-death scenarios)

- Do Not Intubate (DNI)
- Do Not Defibrillate
- NO CPR

Other Limits on life sustaining treatments:

- No Cardioversion
- No transfusions
- No Pressors
- No antibiotics
- No Bipap
- No artificial feedings
3. The Above was based on the following:

- **Discussion with patient**
  - Discussion with family/significant other / medical proxy
    - Name/relationship: ________________

- **Written Advance Directives:**
  - Durable Power of Attorney For Medical Affairs
  - Home DNAR orders / CPR directives
  - Living Will / Medical declaration
Housestaff Physician Note:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Housestaff Physician Signature ____________________________ GME # ____________

Housestaff Physician communication with the following attending:
________________________________________________________________________
Date: ____________ Time: ________________

Attending Confirmation / Note (Indications, basis of DNAR order): ________________________________________________________________________________________________

Attending Physician Name (print)
________________________________________________________________________
Signature: ____________________________ Date: ________________ Time: ____________

UPI # ____________
Overlooked Bullets at the bottom of the DNAR form

- If DNAR status, RN must place purple band on pt
- Attending must cosign DNAR orders within 24 hours
- Order must be reviewed regularly
- Must be reviewed prior and after surgery and interventional procedures
- May be rescinded by patient and/or his/her representative at will.
- “No CODE” or DNAR does not mean abandonment of active medical treatment.
- At discharge, continued DNAR orders should be transferred to “Colorado CPR Directive”.
Colorado CPR Directive

- State-wide Outpatient Form
- If DNAR inpatient, should complete for home
- Needed for transport home
- Accompanying jewelry
- Every unit should have a supply
Medical Power of Attorney

- Document signed by the patient naming someone to make medical decisions for the patient’s behalf if the patient is unable to make decisions for himself.
The Medical Power of Attorney (MPOA) must be:

• 18 years of age
• Mentally competent
• Willing to serve as the patient’s agent.
• Must have had a thorough discussion between patient and the person whom the patient has chosen.
Medical Power of Attorney

Medical power of attorney is obligated to make decisions in accordance with what the now incapacitated person would have wanted, not what the power of attorney thinks is best.
Colorado Proxy Law: What happens when…

• Patient unable to make decisions for himself…
  o A physician certifies in the patient’s records that the person is incapable of acting in their own behalf
  o The patient does not have a written document stating who the Medical Power of Attorney is??
Colorado Proxy Law continued

- Physician and healthcare team must make an attempt to contact all “interested parties”

  - These persons must meet and select a “surrogate decision maker” or “medical proxy”.

  - Family must have consensus on who this person is, otherwise, decision goes to “all interested parties”
Colorado Proxy Law continued

• When the selection is made and documented in the patient’s records, the medical provider can act on the proxy’s instructions.

• **NOTE:** In Colorado, there is NO hierarchy based on marriage or blood relations

• *If there is No consensus:* it goes to court appointment process
SCREENING ADVANCE DIRECTIVE WORKSHEET

Your right to make medical care decisions includes giving “advance directives”. These are written instructions concerning your wishes about your medical treatment. These instructions are used in the event you become unable to make health care decisions for yourself. It is very important to share your wishes with your doctor and the person that you have selected to make medical decisions for you if you are not able to.

Instructions:
Side One: Questions # 1 and # 2 must be completed on all patients.
Side Two: All questions must be completed if the patient has a completed advance directive.

All shaded areas: need follow up by a Registered Nurse /Healthcare Provider.

If the patient is incapacitated at the time of encounter, who is accompanying the patient at present?

Name __________________________ Phone __________________________ Relationship __________________________

☐ No one present with patient at time of encounter. Initial __________ Date ____________

☐ Healthcare decision maker identified (May be identified at a later time after present encounter or admission):
Date: ________________________
Name __________________________ Phone Number __________________________ Relationship __________________________

*If patient is unable to verbalize, refer to the Consent for Medical Care and Procedures UCH policy
The shaded gray box is completed IF the patient is incapacitated.

Who is present with the patient (name, phone #, relationship)?

Who is the healthcare decision maker(s) for the patient (name, phone #, relationship?)

Instructions:

Side One: Questions # 1 and # 2 must be completed on all patients.

Side Two: All questions must be completed if the patient has a completed advance directive.

All shaded areas: need follow up by a Registered Nurse / Healthcare Provider.

If the patient is incapacitated at the time of encounter, who is accompanying the patient present?

Name __________________________ Phone Number ______________________ Relationship ________________

☐ No one present with patient at time of encounter. Initial __________ Date ______________

☐ Healthcare decision maker identified (May be identified at a later time after present encounter or admission):

Date: __________________________

Name __________________________ Phone Number ______________________ Relationship ________________

*If patient is unable to verbalize, refer to the Consent for Medical Care and Procedures UCH policy
AD Worksheet Question 1

1. Who would you like to make medical decisions for you during this hospitalization including anatomical gifts/organ donation (or be your Healthcare Decision Maker), if you are not able to make decisions for yourself?

Name _____________________________________________
Relationship to patient ______________________________________________
Phone number or other contact number ________________________________
Is this the same person who is indicated on your written advance directive?
☐ Yes  ☐ No  ☐ N/A

***If you would like to change your Healthcare Decision Maker at a later time, let your physician know and this form will be rescinded and a new Advance Directive worksheet will be completed.

Remember: Question 1 MUST be completed on ALL patients.
3. For patients that have a written advance directive:
   
   **My Advance Directive Type is:** (Check all that apply.)
   - Living Will
   - Medical Durable Power of Attorney
   - CPR Directive
   - Other (e.g. Five Wishes) ________________________

   □ My Advance Directive has changed since last admission. □ YES □ NO
   □ I would like to change my current Advance Directive. *(Primary physician to be alerted.)*
   □ I have a copy of my Advance Directive with me today. □ YES □ NO

4. Where is your Advance Directive located? _________________________

5. Who is your Primary Care Provider (PCP)? _________________________
   PCP Phone contact: _________________________

6. Because I do not have my written advance directive present today, the actions that are listed in my actual advance directive are:
   - □ I want to have life sustaining treatments.
   - □ There are limits to the amount of treatments that I want.
   - □ I want comfort care, but I do not want life sustaining treatment if there is no chance for meaningful recovery.
   - □ Specific actions are not listed in my advance directive other than who my medical proxy decision maker is.

I understand that this form DOES NOT REPLACE my written advance directive. I know that I must provide the most current copy of my advance directive in order to assure that my wishes are understood to the best of the hospital staff’s capacity.

**Patient's or authorized person's signature:** ________________________________

**Date:** _______________________

**Nurse / Healthcare Provider’s signature:** ________________________________

**Date:** ______________________
3. For patients that have a written advance directive:
   My Advance Directive Type is: (Check all that apply.)
   - [x] Living Will
   - [ ] Medical Durable Power of Attorney
   - [ ] CPR Directive
   - [ ] Other (e.g. Five Wishes) ________________________

☐ My Advance Directive has changed since last admission.  ☐ YES  x NO
☐ I would like to change my current Advance Directive.  (Primary physician to be alerted.)  ☐ YES  x NO

4. Where is your Advance Directive located?  _Lock box in master bedroom closet________________________________________

5. Who is your Primary Care Provider (PCP)?  _Dr John Davis_______________________
   PCP Phone contact: ____________________303- 590-3434_____

6. Because I do not have my written advance directive present today, the actions that are listed in my actual advance directive are:
   - [ ] I want to have life sustaining treatments.
   - [ ] There are limits to the amount of treatments that I want.
   - [x] I want comfort care, but I do not want life sustaining treatment if there is no chance for meaningful recovery.
   - [ ] Specific actions are not listed in my advance directive other than who my medical proxy decision maker is.

I understand that this form DOES NOT REPLACE my written advance directive.
I know that I must provide the most current copy of my advance directive in order to assure that my wishes are understood to the best of the hospital staff's capacity.

Patient's or authorized person's signature: __David Jackson____Date: 03/23/09____________________

Nurse / Healthcare Provider’s signature:  _Susie Jones, RN_ Date: 03/23/09
3. For patients that have a written advance directive:
   My Advance Directive Type is: (Check all that apply.)
   - Living Will
   - Medical Durable Power of Attorney
   - CPR Directive
   - Other (e.g. Five Wishes) ________

   - My Advance Directive has changed since last admission.  □ YES □ NO
   - I would like to change my current Advance Directive. (Primary physician
     to be alerted.)  □ YES □ NO
   - I have a copy of my Advance Directive with me today.  □ YES □ NO

Has the AD changed since the last admission?
Does the patient want to change their AD? If so, alert the PCP!
Does the patient have their AD with them?
6. Because I do not have my written advance directive present today, the actions that are listed in my actual advance directive are:

- I want to have life sustaining treatments.
- There are limits to the amount of treatments that I want.
- I want comfort care, but I do not want life sustaining treatment if there is no chance for meaningful recovery.
- Specific actions are not listed in my advance directive other than who my medical proxy decision maker is.

What are the patient wishes outlined in the AD? 

Are there limits to the treatment the patient wants? 

Does the patient want life sustaining treatment?
Accountability

- To locate
- To be familiar with what it says
- To document and communicate to others
Where do I find this information?

- First tab of the patient’s blue chart
- “Advance Directives” tab
- Yellow Advance Directives Worksheet
- Clinical Workstation (Patient Demographics, Legal Section)
- MedExplorer: Advance Directives section
- Document on back side of H&P