Implementation of Advance Directive
and Informed Consent in Long-Term Care:
Surveyor Learning Module

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the clinical project of KAREN SUE WENKHEIMER find it satisfactory and recommend that it be accepted.

[Signatures]

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In today’s long-term care (LTC) environment, elderly residents are frequently being asked to make end-of-life healthcare decisions, through the use of advance directives. Despite legal supports and general supports (e.g., pamphlets and staff to explain resident rights) for an individual’s right to self-determination, implementation of these directives are often complex and confusing. This article addresses the use of advance directives in LTC and provide information concerning: the evolution of an individual’s right to consent to or decline medical treatment; problems associated with the implementation of the various types of advance directives for healthcare; and methods that can be used to avoid these problems.

EVOLUTION OF THE ADVANCE DIRECTIVE FOR HEALTHCARE

For many centuries there was no such thing as a patient’s right to consent to healthcare treatments and therapies. According to Brazell (1997), the ancient Greeks provided an opportunity for the patient to discuss their condition with their physician. This was a time when the physician offered hope and comfort, while being as manipulative and deceitful as necessary to obtain compliance. The legal concept of a patient consenting to treatment began in England in the 18th century and has continued to grow in the United States in the 20th century (Brazell, 1997). Hassmiller (1991) indicates that until the 1950s, generally speaking, there was no practical reason to consider an individual’s right to withholding treatment. Prior to this time, when a person’s heart stopped or the person stopped breathing, the individual died. With the arrival of cardiopulmonary resuscitation and various forms of advanced technology, the options and areas for concern changed. Nationally renowned cases such as Cruzan and Quinlan helped introduce new questions and concerns relevant to self-determination and life sustaining treatment (Flarey, 1991).
Included in the concept of self-determination in healthcare is the need for informed consent (see Table I). In 1972, the American Hospital Association published the Patient’s Bill of Rights, which asserts that patients have the right to receive the information necessary to give informed consent before any medical procedure or treatment. In order to assure that an individual’s right to self-determination in healthcare decisions was both protected and communicated, the Patient Self-Determination Act was established by the federal government in the early 1990’s. Today, a common method of assuring this communication is through the use of an advance directive (see Table I). The most common forms of these directives are the advance directive for health care and a durable power of attorney (see Table I). The process of informed consent is also an important part of the process of signing these document.

(INsert Table I HERE)

PROBLEMS ASSOCIATED WITH IMPLEMENTATION OF ADVANCE DIRECTIVES IN LTC

Implementation of an advance directive for healthcare in LTC can be scary business. In addition to the positive outcomes from the use of these directives, Dubler (1993) states there are reasons for concern about the possible negative consequences of an individual signing an advance directive. This article will discuss problems that can occur with the use of these directives: relating to implementation of the LTC resident’s specific wishes; the inadequacies associated with the use of a generic advanced directive; confusion surrounding the application of a living will; a surrogate’s potential violation of a resident’s right to self-determination; problems surrounding the assessment of a resident’s ability to make informed consent; and finally, other factors that can interfere with a resident’s right to self-determination.
Advance Directive for Healthcare  As indicated in Table 1, an advance directive for healthcare is a document that allows competent residents the opportunity to make their wishes known concerning future treatment choices, should they become incompetent to make such choices. Included in these choices, is the right to refuse various treatments under stated circumstances. For example, residents can specify that they do not wish life sustaining measures for conditions such as coma or severe dementia and when they are terminal and/or death is imminent. Quality of life or a medical condition may be the driving force behind these decision. The directive also may include the various life sustaining measures they do or do not wish performed (e.g., tube feedings, hospitalization). These various options provide flexibility and participatory decision-making for the resident, but makes the process of honoring these wishes far more complex and difficult to implement.

Communication of the resident’s individual wishes also can become difficult with the use of a generic advance directive. This form of directive is generally inadequate in one respect or another (Sabatino, 1994). Its use requires a “one size fits all” mentality. Unfortunately, each individual’s circumstances is different. The specifics frequently cannot be determined with standardized questions, or communicated with a one page checklist.

The living will (see Table I) is one of the most common forms of an advance directive for healthcare. It is different from other directives for healthcare in that it specifically addresses the use of healthcare measures that prolong the dying process. According to Flarey (1991), the most essential requirement of this directive, which makes it effective and binding, is that the resident must be found to have a terminal condition and/or death must be imminent. However, this fact is frequently overlooked. Use of this directive for decisions made concerning treatment outside of these two situations would be in conflict with its’ intent. In some cases, the LTC staff
mistakenly believe that the “do-not-resuscitate” provision in the living will limits aggressive care for other than terminal conditions (Flarey, 1991). Long term care residents sign a living will to avoid being kept alive against their wishes when death is near. Sabatino (1994) cautions that it is a mistake to assume that the existence of this document means “do not treat” under other circumstances.

**Durable Power of Attorney for Healthcare** Through the use of this directive, the mentally competent resident may designate a surrogate who has legal authority to make healthcare decisions, if the resident becomes mentally incompetent. The expectation is that the surrogate’s decisions will be those that the resident would have made, if able. Generally, the designate, because of his or her closeness to the resident, has a legitimate interest in the care provided to the resident. This interest however may become misplaced when the surrogate wishes to make decisions for a competent resident or makes decisions based on his or her choosing versus those of the resident. Long term care staff may forget that, legally, the resident’s decisions over-ride those of the surrogate.

When the delegation of decision-making due to mental incompetence occurs, two additional questions arise: when is a resident considered incompetent and what rights do incompetent residents have for self-determination? Generally, each state has its own specific laws concerning the rights of an incompetent individual.

**Informed Consent for Healthcare** Prior to signing an advance directive, the ethical and legal precepts demand that individuals are informed to the fullest extent possible (Tymchuk, Ouslander, Rahbar, Fitten, 1988). This concept is referred to as informed consent. Through the use of this process, a resident’s decision to seek or deny healthcare is done in collaboration with
healthcare professionals. Before making a decision, the resident must be informed about the possible benefits and risks of his or her decision to accept or withhold treatments.

Unfortunately, the process of informed consent is affected by the aging process. There is a high level of mental impairment among elderly LTC residents. However, Wetle, Levkoff, Cwikel, and Rosen (1988) warn that care providers can fall into the trap of assuming that the residents, due to their age and fragile condition, are incapable of making decisions regarding their own care. A healthcare culture or family members that view age or illness as a reason to help relieve a resident of the “burden” of decision making, needs to be careful that this does not result in disempowerment of the resident (Jameton, 1988).

There are a multitude of other factors that can impair the ability of the LTC resident to participate fully in decision making. These include characteristics of the elderly persons themselves, the institutional environment, psychosocial conditions, and the manner in which the information is presented (Tymchuk, Ouslander, Rahbar, Fritten, 1988). In addition, some cultures require that certain individuals (e.g., Native American family and elders) are present to participate in the decision making process. In other culture’s, there may be additional rules and customs that affect the process of a resident signing an advance directive.

The problems listed above are just a few of the potential areas for concern when using the various types of advance directives in LTC. These directives provide the nurse with a much needed vehicle by which to make decisions concerning life-sustaining treatment. Flarey (1991), however, warns that having a signed advance directive may meet the minimum requirement but not satisfy the real objective of a patient’s right to self determination. Failure to take into account the difference between a signed document and the messy reality of understanding and implementing what the resident truly wishes can lead to catastrophic results for the resident.
According to Dubler (1993), bringing a resident’s preferences and rights, family concerns, legal rights, and ethical principles into harmony is a difficult task.

SOLUTIONS

There is a body of literature, policy, law, and regulation that provide a set of basic principles and recommendations for incorporating a resident’s healthcare decisions into practice (Solomon et al., 1993). If these principles are to be realized and practiced in LTC facilities, the LTC nurse needs to become educated in several areas.

Unfortunately, most of a nurse’s education, except for some ethic’s classes, focuses on the use of scientific knowledge. Dubler (1993), questions how we can expect staff to be comfortable with end-of-life decisions for which they have little training and which are fraught with moral, legal, and regulatory dangers. It is essential that LTC nurses become well versed in the legal principles and their own state’s statutes concerning the use of advance directive. Each state has its’ own form, procedures and policies concerning these directives. In addition, LTC facilities generally have policies that define their use. The process of learning these complex principles, regulations and policies can be both confusing and time consuming. A self paced learning module, including critical documents (e.g., state and facility policies and regulations) and their application to common scenarios in LTC, combined with guided discussions can facilitate the process.

In addition to a clear understanding of the legal issues and facility policies involved with the use of advance directives, the LTC nurse needs to develop a method of assuring an accurate understanding of the resident’s wishes concerning end-of-life decisions. This process requires continuing conversations among the parties involved. According to Love (1995), the nurse needs to encourage dialogue between the resident, family members, physician, and nursing staff to
assure that decisions are made thoughtfully, and examined in great detail. There are changing situations in elderly residents’ lives that can impact their healthcare decisions. Residents have the right to change their minds and it is the nurse's responsibility to remain current concerning these residents’ on-going wishes. As a minimum standard, the resident’s desires concerning medical treatment need to be addressed at the resident’s request as well as initiated by the nurse with each significant change in the resident’s condition. Hasmiller, (1991), indicated that time spent at the bedside gives the nurse insight into an individual’s wishes. The resident care conference is another excellent opportunity to discuss the resident’s wishes.

The nurse also will need to assure that the resident has a clear understanding of concepts such as, his or her present health status, and what healthcare options are available. The elderly LTC resident fatigues easily and takes more time to process information. Therefore, it is important to plan more than one discussion session to assure that the resident is not too tired to participate or understand their options (Alt-White, 1995). When addressing critical medical issues, the LTC nurse must take advantage of those opportune times when the resident shows an ability to make good decisions. Even with dementia, residents may still have the capacity to understand and recall information sufficiently to decide whether an intervention would be beneficial or burdensome for them. The process will require a high degree of time and patience on the part of the LTC nursing staff.

It is also the nurse's responsibility to protect the resident from outside influences. The decisions made can not be those of the family or physician versus the resident. An example of such a situation would be when the family and doctor choose a new treatment and the resident agrees it’s probably for the best. It is important to listen closely to what the resident is saying and not always accept his or her choice at face value. Also, the nurse needs to question a surrogate’s
decision that is in conflict with what the resident has indicated as his or her wishes. Long term care nurses, as the people who are with the resident daily, need to function as a resident advocate when self-determination is in question.

Once the resident’s wishes are accurately determined and documented, it becomes important that the staff who provide bedside care are aware of these wishes. These individuals play an active role in assuring the resident’s wishes are implemented. According to Hassmiller (1991), a study showed that out of 175 nursing home residents with an advance directive, both the physician and the nurse contradicted the directive instructions in at least 25 percent of the cases. In fact, the majority of the time, compliance with the directive’s instructions was merely coincidental. The effective communication of an advance directive is frequently met with mixed success. The management of the LTC facility and the nursing staff need to assess how well their institution is communicating the resident’s wishes to the bedside caregiver and develop mechanisms to assure accurate information to these staff members.

SUMMARY

Decisions that affect end-of-life healthcare choices are important to LTC residents’ autonomy and continued quality of life. Balancing life and death is a difficult task and should always be approached with caution and respect (Dubler, 1993). Long term care residents seek self-determination for end-of-life decisions through the use of advance directives. Despite the use of these documents, research suggests that there are obstacles that interfere with a resident’s right to decide. These barriers often result in failure on the part of the nurse to identify, understand and implement the individual’s wishes.

Some resident issues are very simple with little or no risk to the resident, while others are very complex with considerable risk to the resident. If an individual dies who wished to live or
lives who wished to die because of confusion on the part of the LTC nurse, then a serious problem exists. The perfect outcome may not always be possible. However, making the best of this difficult situation is not too much to expect, considering the consequences to the resident.
### Table I

**Definition of Terms Relative to Advanced Directive in Health Care**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Advance Directive in Healthcare</strong></td>
<td>A document that allows a competent individual the opportunity to make decisions regarding a variety of treatment choices such as refusal or withdrawal of life-sustaining treatment, while still competent to do so (Flarey, 1991).</td>
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<tr>
<td><strong>Durable Power of Attorney for Healthcare</strong></td>
<td>A legally binding written instrument in which an individual (principal) gives decision-making authority to another person (surrogate). This instrument becomes effective when and if the principal becomes incompetent and unable to express his or her wishes (Flarey, 1991).</td>
</tr>
<tr>
<td><strong>Informed Consent</strong></td>
<td>A process that requires a physician to disclose information about treatment to the resident and obtain consent prior to treatment. The information includes the resident’s diagnosis, the nature and purpose of the treatment, the risk and benefit of the treatment, and the probability that the treatment will be successful (Love, 1995). Generally, the informed consent process consists of three essential conditions that must be fulfilled: 1. the resident must be free to choose; 2. the information must be provided in a clear, usable, and understandable form for the individual resident; 3. the resident must be mentally competent to understand factual information and alternatives and to think rationally about care decisions (Alt-White, 1995).</td>
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<tr>
<td><strong>Living Will</strong></td>
<td>A legally executed advance directive for healthcare that indicates an individual’s wishes not to receive “life-sustaining medical treatment” in the event the individual becomes incompetent to make treatment decisions on his or her behalf and the individual has a terminal condition and/or death is eminent. Form, process, and procedure can vary according to state statutes (Flarey, 1991)</td>
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REFERENCES


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III. Pretest: with and without answers (green inserts)

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V. Regulations (ivory inserts)

VI. Posttest: with and without answers (green inserts)

VII. Evaluation form
PURPOSE: As a nursing home surveyor for the State of Washington, you are responsible to assure compliance with the state and federal regulations protecting resident rights.

According to the state of Washington (RCW 70.122.010) "adult persons have the fundamental right to control the decisions relating to rendering of their health care, including the decision to have life-sustaining treatment withheld in instances of a terminal condition or permanent unconscious condition." Federal regulation (CFR 483.10) addresses similar issues.

Unfortunately, it has recently been shown that identification & implementation of resident's wishes concerning health care and life-sustaining treatment can be confusing for nursing home (NH) staff. Considering the potential impact to the resident, it is important that surveyors understand the proper interpretation of these concepts, in order to assure compliance.

The enclosed learning module has been designed to assist you in understanding the concept of advance directives (AD) and informed consent (IC).
LEARNING MODULE

TOPIC: Implementation of Advance Directive and Informed Consent in Long-Term Care

DIRECTIONS:

1. Complete pretest and review answer sheet (orientation part 1/week one)
2. Review learning module (orientation part 1/week one)
3. Complete posttest and review answer sheet. (orientation part 1/week 2)
4. Review concepts identified in module with instructor (orientation part 1/week 2)
5. Complete posttest (orientation part 3)

OBJECTIVE: The student will:

1. Identify those state regulations that control the use of advance directives and informed consent in long-term care (LTC).
2. Identify appropriate application in LTC of state regulations: RCW 70.122.; RCW 7.70.060-065; WAC 388-97-060-065.

LEARNING ACTIVITIES:

READ the following regulations available in this learning module:
RCW 70.122, RCW 7.70.060-065
WAC 388-97-055-070

ALTERNATE READING (optional):
INFORMED CONSENT AND ADVANCE DIRECTIVES

Pre test (please include rationale with your answers):

1. What is the difference between an advance directive (AD) and informed consent (IC)?

2. Mr. Jones is admitted with early stage Alzheimer’s. He is oriented to time, place and person. He has no problems in communicating with others. The resident’s son has durable power of attorney (DPOA) for healthcare. The resident’s AD, signed by the son, indicates a “full code”. During your interview, the resident states he wants to be a “no code”. Should the resident’s code status be “full code” or “no code”? 
3. Mrs. Smith has end stage Alzheimer’s, has severe dementia, and has recently been identified to have a urinary tract infection (UTI). Her son indicates he does not wish treatment of the UTI. During a family interview, Mrs. Smith’s spouse indicates he wishes his wife to receive treatment of the UTI. There is no DPOA. Who has the authority to decide medical treatment for this resident?

4. The complaint nurse (CN) receives a complaint that a resident is being denied food at Acme NH. Review of the resident’s record shows that the resident’s diagnosis includes a cardiovascular accident with left side paralysis. The resident also has a severe swallowing disorder and there is an order for “no oral intake”. The minimum data set (MDS) indicates the resident is moderately impaired in her ability to make decisions. The husband does not want a tube feeding and has signed an AD that states “no tube feedings”. When the CN interviews the resident, the resident indicates she would like to eat. What would be the appropriate course of action by the facility?
5. The resident has signed a “no code” status. However, the physician refuses to sign an order for a “no code”. Can the facility follow the resident’s directive?

6. Mrs. James is a comatose resident admitted to a NH from the hospital. The family is not available to explain the resident’s wishes concerning the AD. There is however a “no code” on the orders used at the hospital. Can the facility use this document until the family can be contacted?

7. Mrs. Hart is mentally retarded and has a “no code” status signed by her sister. During an interview, the resident indicates that she does not want to die and “yes” she wants CPR. Do you follow the wishes of the resident or the sister?
8. Mr. Peterson has a simple AD in his record. The form asks whether the resident wishes to be a “full code” or a “no code”. No other details are found on the form. The resident signs the directive indicating a “no code”. What additional information would you expect the facility to ask and document concerning this resident’s AD?

9. Ms. West has dementia and difficulty remembering to feed herself. Otherwise, she is in relatively good health. The nursing assistant is helping the resident with her lunch when Ms. West aspirates a bite of meat and stops breathing. The resident has signed an AD indicating “no code”. Should the facility attempt to recover this resident?
10. Miss Snyder is 53 years old, mentally retarded, has middle stage Alzheimer's and not capable of decision making. The facility indicates that she is not interviewable and during your attempt to talk with the resident she rambles, making no attempt to address your questions in a logical manner. It has recently been identified that the resident has severe difficulty with swallowing. There is an AD, signed by the resident, that indicates she does not wish tube feedings. The family indicates the resident has no quality of life, and does not want the resident to be fed with a tube. They support that the resident has indicated, through her AD, that she would not wish to be fed by a tube at this time. Is it appropriate for the AD to be used during this decision making process?

11. Mr. Jackson is 94 years old with end stage COPD. The resident is severely demented. His son has DPOA for healthcare. The resident does not have an AD. Since the resident does not have a directive but the son has DPOA, how will the facility determine the resident's code status?
INFORMED CONSENT AND ADVANCE DIRECTIVES

Pre test:

1. What is the difference between an advance directive (AD) and informed consent (IC)?

   (Answer = ******) An AD for healthcare, is the written instructions an individual gives to his/her family and doctors that explain medical treatments he/she does or does not want, if unable to make the decision. This directive instructs the individual’s physician as to his/her preference to be resuscitated (“full code”) or not (“no code”) if his/her heart stops or he/she stops breathing.

   The process of communication between the resident and the resident’s physician requires IC. The resident’s written preferences are expressed only after receiving information specifically relating to diagnosis, prognosis, risk and benefit, and alternatives relevant to the various options for treatment or non-treatment.

2. Mr. Jones is admitted with early stage Alzheimer’s. He is oriented to time, place and person. He has no problems in communicating with others. The resident’s son has durable power of attorney (DPOA) for healthcare. The resident’s AD, signed by the son, indicates a “full code”. During your interview, the resident states he wants to be a “no code”. Explain whether the resident’s code status should be “full code” or “no code” and why?

   ****** No code. (a.) The resident’s wish always takes precedence. (b.) The durable power of attorney for healthcare authorizes a proxy to make medical decisions if the person becomes unable to make them (RCW 11.94.010). This resident is competent. However, even with a DPOA for healthcare, the resident’s wish always takes precedence, even if the resident is not mentally competent (RCW 70.122.040). (c.) A family member may not sign the AD for the resident.
3. Mrs. Smith has end stage Alzheimer’s, severe dementia, and has recently been identified to have a urinary tract infection (UTI). Her son indicates he does not wish treatment of the UTI. During a family interview, Mrs. Smith’s spouse indicates he wishes his wife to receive treatment of the UTI. There is no DPOA. Who has the authority to decide medical treatment of this resident?

***** The husband. (a.) According to RCW 7.70.065, decisions can be made by an individual (surrogate) authorized to act on behalf of an incompetent individual. There is an order of priority for individuals who may serve as a surrogate. According to the RCW, the spouse takes priority over the children. (b.) The difference of opinion between the husband and children could be a red flag as to whether these decisions are being made according to wishes previously identified by the resident or the individual family member’s wishes. The surrogate is to make decisions that the resident would have made, if able.

4. The complaint nurse (CN) receives a complaint that a resident is being denied food at Acme NH. Review of the resident’s record shows that the resident’s diagnosis includes a cardiovascular accident with left side paralysis. The resident also has a severe swallowing disorder and there is an order for “no oral intake”. The minimum data set (MDS) indicates the resident is moderately impaired in her ability to make decisions. The husband does not want a tube feeding and has signed an AD that states “no tube feedings”. When the CN interviews the resident, the resident indicates she would like to eat. What would be the appropriate course of action by the facility?

***** The resident needs to make an informed decision. (a.) The resident’s wishes always take precedence. (b.) This resident is competent and the decision maker. The facility has the responsibility to discuss this situation with the resident, during a time when the resident is not
confused. The facility staff needs to explain the problem with swallowing, the potential problems with aspiration and the nutritional options available to her. Once the resident has a clear understanding of her options and the potential dangers involved, then the facility needs to follow the resident's wishes. (c.) The family may not sign the AD for the resident.

5. The resident has signed a "no code" status. However, the attending physician refuses to sign an order for a "no code". Can the facility follow the resident's directive?

*****Yes. (a.) Code status is not a physician order. According to RCW 70.122.060, the facility must notify the physician of the resident's wishes to have life sustaining treatment withheld. There are physician responsibilities concerning this resident's directive (see RCW), however, a signed order for a "no code" is NOT required.

6. Mrs. James is a comatose resident admitted to a NH from the hospital. The family is not available to explain the resident's wishes concerning the AD. There is however a "no code" on the orders used at the hospital. Can the facility use this document until the family can be contacted?

*****No. A code status is NOT transferable from the hospital to the nursing home (NH).

7. Mrs. Hart is mentally retarded and has a "no code" status signed by her sister. During an interview, the resident indicates that she does not want to die and "yes" she wants CPR. Do you follow the wishes of the resident or the sister?

*****The resident's wishes take priority regardless of the fact that she is mentally retarded (see question # 2).

8. Mr. Peterson has a simple AD in his record. The form asks whether the resident wishes to be a "full code" or a "no code". No other details are found on the form. The resident signs the
directive indicating a "no code". What additional information would you expect the facility to ask and document concerning this resident's AD?

*****Advance directives are intended to be part of an IC process. The facility needs to follow this IC process. For example:

- under what circumstances would the resident wish to have life-sustaining treatment withheld?
- does he understand the consequences of these actions?
- does he have a clear understanding of his present medical condition?

9. Ms. West has dementia and difficulty remembering to feed herself. Otherwise, she is in relatively good health. The nursing assistant is helping the resident with her lunch when Ms. West aspirates a bite of meat and stops breathing. The resident has signed an AD indicating "no code". Should the facility attempt to recover this resident?

*****Yes. For the "no code" directive to be initiated, the resident must be terminal (RCW 70.122.030). This resident is not terminal. Using an AD for other healthcare decisions is outside of the intended purpose of the directive.

10. Miss Snyder is 53 years old, mentally retarded, has middle stage Alzheimer's and not capable of decision making. The facility indicates that she is not interviewable and during your attempt to talk with the resident she rambles, making no attempt to address your questions in a logical manner. It has recently been identified that the resident has severe difficulty with swallowing. There is an AD, signed by the resident, that indicates she does not wish tube feedings. The family indicates the resident has no quality of life, and does not want the resident to be fed with a tube. They support that the resident has indicated, through her AD.
that she would not wish to be fed by a tube at this time. Is it appropriate for the AD to be used during this decision making process?

******No. The resident is not terminal at this time. The AD is intended to be used for end-of-life decisions, not other healthcare decision (see question # 8).

11. Mr. Jackson is 94 years old with end stage COPD. The resident is severely demented. His son has DPOA for healthcare. The resident does not have an AD. Since the resident does not have a directive but the son has DPOA, how will the facility determine the resident’s code status?

****** The family may not sign an AD. However, a surrogate decision maker may exercise the resident’s rights as long as the surrogate acts in accordance with state and federal law (See WAC 388-97-055 & 060). The surrogate must make decisions in accordance to what the resident would have wished and in the best interest of the resident. The same process is used for the surrogate as with the resident. These decisions are made as part of the IC process (see question #8 ) and need to be reviewed as the resident’s condition changes.
LEARNING MODULE

RCW 70.122 ....Natural Death Act (insert module #1) provides direction concerning decisions related to withholding or withdrawing life-sustaining treatment. The following relates to these legislative findings.

1. At the request of an adult person (declarer), life-sustaining treatment may be withdrawn in the event of a “terminal condition or permanent unconscious state”.
   1.a. Define “terminal condition”.
   1.b. As a surveyor, how would you determine the resident has been identified “terminal”?

2. A directive concerning life-sustaining treatments is applicable to “qualified patients”.
   2.a What is a “directive”?
   2.b. Define “qualified patients”.
   2.c. How is a person determined to be a “qualified patient”?

3. A resident may declare his/her wishes concerning life sustaining treatment.
   3.a. How does a resident declare his/her wishes concerning life sustaining treatments?
   3.b. As a surveyor, where in the resident’s record would you look for documentation of the resident’s wishes?

4. When an individual declares his/her wishes, it must be witnessed by 2 individuals. The RCW is specific concerning who can or cannot function as a witness.
   4.a. List 2 individual criteria for who may not witness the signing of the document.

5. A declarer may revoke his/her directive.
5.a. What are the criteria concerning the declarer's mental state that would allow this change?

5.b. List 2 methods of revoking the directive.

6. According to the RCW, there is one requirement that must be met before a written revocation of the directive is effective.

6.a. List the requirement.

6.b. How, as a surveyor, will you determine that the requirement is met?

7. The physician must be notified of a resident’s wishes concerning an advance directive (AD).

7.a. Describe the criteria concerning a physician's notification of a change in directive.

7.b. If a resident indicates he/she wishes to be a "no code" and the resident's physician refuses to sign a doctor's order indicating the resident is to be "no code", can the NH make the resident a "no code"?

RCW 7. 70. 065 (insert module #2) When a resident is no longer competent to sign an informed consent, authorization for consent may be obtained from another individual (surrogate decision maker).

1. Identify the order of authorized persons who can provide consent for an incompetent resident.

2. If a resident has signed a durable power of attorney (DPOA) for healthcare, does the resident or the DPOA have the right to make healthcare decisions?
3. Before a surrogate for the incompetent resident exercises that authorization, there are some requirements that must first be considered.

3.a Explain these requirements.

WAC 388-97-055 (insert module #3): Informed Consent is the process of communication between the resident and his/her physician, where the resident consents to or refuses care and services. The nursing home has the responsibility to inform the resident that he/she has the right to informed consent (IC).

1. In order to assure informed consent or refusal regarding a resident’s plan of care options, the nursing home must first complete several criteria concerning the process.

1.a List 5 of these criteria.

2. Is the NF required to follow the IC process with a surrogate decision maker? Explain your answer.

3. When a resident becomes incapacitated, a surrogate decision maker may be identified. This is a legal process versus a medical process.

3.a. List 2 legal documents used to document that a resident is incapacitated.

4. Prior to making a decision for a resident, the surrogate decision maker must meet certain responsibilities.

4.a List 3 requirements of the surrogate decision maker.
WAC 388-97-065 (insert module #3) An AD is a document used to indicate an individual’s choice concerning a specific service, treatment, medication or medical procedure option that may be implemented in the future.

1. Is the facility required to have evidence in the medical record of an AD for each resident?

2. Identify the procedure to be followed by the facility when a resident’s AD is in conflict with the facility’s practice and policies.

3. Are family members permitted to sign an AD?
INFORMED CONSENT AND ADVANCE DIRECTIVES

LEARNING MODULE

RCW 70.122...Natural Death Act (insert module #1) provides direction concerning decisions related to withholding or withdrawing life-sustaining treatment. The following relates to these legislative findings.

1. At the request of an adult person (declarer), life-sustaining treatment may be withdrawn in the event of a “terminal condition or permanent unconscious state”.
   1.a. Define “terminal condition”.

   *** (answer) RCW 70.122.010...page (P.) 2.

   1.b. As a surveyor, how would you determine the resident has been identified “terminal”?

   *** Minimum Data Set (MDS) # J-5 e, Physician progress notes.

2. A directive concerning life-sustaining treatments is applicable to “qualified patients”.
   2.a. Define “directive”.

   *** RCW 70.122.020 #3...P. 2

   2.b. Define “qualified patients”.

   *** RCW 70.122.020, #8...P. 2.

3. A resident may declare his/her wishes concerning life sustaining treatment.
   3.a. How does a resident declare his/her wishes concerning life sustaining treatments?

   *** RCW 70.122.030...P. 3.

   3.b. As a surveyor, where in the resident’s record would you look for documentation of the resident’s wishes?
4. When an individual declares his/her wishes, it must be witnessed by 2 individuals. The RCW is specific concerning who can or cannot function as a witness.

4.a. List 2 criteria for those who may not witness the signing of the an AD.

***RCW 70.122.030...P.3.

5. A declarer may revoke his/her directive.

5.a. What are the criteria concerning the declarer’s mental state that would allow this change?

*** RCW 70.122.040 (1)....P.4.

5.b. List 2 methods of revoking the directive.

***RCW 70.122.0 (1).....P.4-5).

6. According to the RCW, there is a requirement concerning the attending physician that must be met before a written revocation of the directive is effective.

6.a. List the requirement.

***RCW 70.122.040 (1.b.)....P.4.

7. The physician must be notified of a resident’s wishes concerning an AD.

7.a. Describe the criteria concerning a physician’s notification of a change in directive.

*****RCW70.122.040 (1.c)....P. 4-5.

7.b. If a resident indicates he/she wishes to be a “no code” and the resident’s physician refuses to sign a doctor’s order indicating the resident is to be “no code”, can the NH make the resident a “no code”?

****Code status does not require a physician order. However, the requirements defined in RCW 70.122.060 (2) need to be followed.
RCW 7.70.065...Informed Consent (insert module #2) When a resident is no longer competent to sign an informed consent, authorization for consent may be obtained from another individual (surrogate decision maker).

1. Identify the order of authorized persons who can provide consent for an incompetent resident.

*****RCW 7.70.065 (1&2)

2. If a resident has signed a durable power of attorney (DPOA) for healthcare, does the resident or the DPOA have the right to make healthcare decisions?

*****(See insert #4) RCW 11.94.010 (1)....P.91.)

3. Before a surrogate for the incompetent resident exercises that authorization, there are some requirements that must first be considered.

3.a Explain these requirements.

***RCW 7.70.065 (3)....P. 2-3.

WAC 388-97-055.....Resident Rights (insert module #3): Informed Consent is the process of communication between the resident and his/her physician, where the resident consents to or refuses care and services. The nursing home has the responsibility to inform the resident that he/she has the right to informed consent (IC).

1. In order to assure informed consent or refusal regarding a resident’s plan of care options,
the nursing home must first complete several criteria concerning this process.

1. a. List these criteria.

*** WAC 388-97-055 (1 & 2) .... P. 11.

2. Is the NF required to follow the IC process with a surrogate decision maker?

*** WAC 388-97-055 (3) .... P. 11.

3. When a resident becomes incapacitated, a surrogate decision maker may be identified. This is a legal process versus a medical process.

3. a. List 2 legal documents used to document that a resident is incapacitated.

*** WAC 388-97-055 (4) .... P. 12.

4. Prior to making a decision for a resident, the surrogate decision maker must meet certain responsibilities.

4. a. List 3 requirements of the surrogate decision maker.

*** WAC 388-97-055 (7) .... P. 12.

WAC 388-97-065 (insert module #3) An AD is a document used to indicate an individual’s choice concerning a specific service, treatment, medication or medical procedure option that may be implemented in the future.

1. Is the facility required to have evidence in the medical record of an AD for each resident?


2. Identify the procedure to be followed by the facility when a resident’s AD is in conflict with the facility’s practice and policies.

*** WAC 388-97-065 (4) .... P. 14.
3. Are family members permitted to sign an AD?

***NO. By definition, the advance directive is the resident’s choice.

4. When does the NH need to review the resident’s AD wishes.


**************************************************
CHAPTER 70.122 RCW
NATURAL DEATH ACT

Sections

70.122.010 Legislative findings.
70.122.020 Definitions.
70.122.030 Directive to withhold or withdraw life-sustaining treatment.
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70.122.051 Liability of health care provider or facility.
70.122.060 Procedures by physician--Health care facility or personnel may refuse to participate.
70.122.070 Effects of carrying out directive--Insurance.
70.122.080 Effects of carrying out directive on cause of death.
70.122.090 Criminal conduct--Penalties.
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70.122.900 Short title.
70.122.905 Severability--1979 c 112.
70.122.910 Construction.
70.122.915 Application--1992 c 98.
70.122.920 Severability--1992 c 98.

NOTES:

Futile treatment and emergency medical personnel: RCW 43.70.480.

RCW 70.122.010 Legislative findings. The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own health care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition.

The legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The legislature further finds that, in the interest of protecting individual autonomy, such prolongation of the process of dying for persons with a terminal condition or permanent unconscious condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient. The legislature further believes that physicians and nurses should not withhold or unreasonably diminish pain medication for patients in a terminal condition where the primary intent of providing such medication is to alleviate pain and maintain or increase the patient’s comfort.

The legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining treatment where the patient having the capacity to make health care decisions
has voluntarily evidenced a desire that such treatment be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition. The legislature also recognizes that a person's right to control his or her health care may be exercised by an authorized representative who validly holds the person's durable power of attorney for health care. [1992 c 98 § 1; 1979 c 112 § 2.]

RCW 70.122.020 Definitions. Unless the context clearly requires otherwise, the definitions contained in this section shall apply throughout this chapter.

(1) "Adult person" means a person who has attained the age of majority as defined in RCW 26.28.010 and 26.28.015, and who has the capacity to make health care decisions.

(2) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(3) "Directive" means a written document voluntarily executed by the declarer generally consistent with the guidelines of RCW 70.122.030.

(4) "Health facility" means a hospital as defined in RCW 70.41.020(2) or a nursing home as defined in RCW 18.51.010, a home health agency or hospice agency as defined in RCW 70.126.010, or a boarding home as defined in RCW 18.20.020.

(5) "Life-sustaining treatment" means any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which, when applied to a qualified patient, would serve only to prolong the process of dying. "Life-sustaining treatment" shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.

(6) "Permanent unconscious condition" means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(7) "Physician" means a person licensed under chapters 18.71 or 18.57 RCW.

(8) "Qualified patient" means an adult person who is a patient diagnosed in writing to have a terminal condition by the patient's attending physician, who has personally examined the patient, or a patient who is diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient.

(9) "Terminal condition" means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying. [1992 c 98 § 2; 1979 c 112 § 3.]
Directive to withhold or withdraw life-sustaining treatment. (1) Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition. The directive shall be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the declarer upon declarer’s decease under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon declarer’s decease at the time of the execution of the directive. The directive, or a copy thereof, shall be made part of the patient’s medical records retained by the attending physician, a copy of which shall be forwarded by the custodian of the records to the health facility when the withholding or withdrawal of life-support treatment is contemplated. The directive may be in the following form, but in addition may include other specific directions:

Health Care Directive

Directive made this . . . . day of . . . . . (month, year).
I . . . . . . . . having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.
(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):
   I DO want to have artificially provided nutrition and hydration.
   I DO NOT want to have artificially provided nutrition and hydration.

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(e) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(g) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

Signed ______________________________

City, County, and State of Residence

The declarer has been personally known to me and I believe him or her to be capable of making health care decisions.

Witness ______________________________

Witness ______________________________

(2) Prior to withholding or withdrawing life-sustaining treatment, the diagnosis of a terminal condition by the attending physician or the diagnosis of a permanent unconscious state by two physicians shall be entered in writing and made a permanent part of the patient’s medical records.

(3) A directive executed in another political jurisdiction is valid to the extent permitted by Washington state law and federal constitutional law. [1992 c 98 § 3; 1979 c 112 § 4.]

RCW 70.122.040 Revocation of directive. (1) A directive may be revoked at any time by the declarer, without regard to declarer’s mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in declarer’s presence and by declarer’s direction.

(b) By a written revocation of the declarer expressing declarer’s intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient’s medical record the time and date when said physician received notification of the written revocation.

(c) By a verbal expression by the declarer of declarer’s intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient’s medical record
the time, date, and place of the revocation and the time, date, and place, if different, of when said physician received notification of the revocation.

(2) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual or constructive knowledge of the revocation.

(3) If the declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarer’s condition renders declarer able to communicate with the attending physician. [1979 c 112 § 5.]

RCW 70.122.051 Liability of health care provider or facility. Any physician, health care provider acting under the direction of a physician, or health facility and its personnel who participate in good faith in the withholding or withdrawal of life-sustaining treatment from a qualified patient in accordance with the requirements of this chapter, shall be immune from legal liability, including civil, criminal, or professional conduct sanctions, unless otherwise negligent. [1992 c 98 § 5.]

RCW 70.122.060 Procedures by physician--Health care facility or personnel may refuse to participate. (1) Prior to the withholding or withdrawal of life-sustaining treatment from a qualified patient pursuant to the directive, the attending physician shall make a reasonable effort to determine that the directive complies with RCW 70.122.030 and, if the patient is capable of making health care decisions, that the directive and all steps proposed by the attending physician to be undertaken are currently in accord with the desires of the qualified patient.

(2) The attending physician or health facility shall inform a patient or patient’s authorized representative of the existence of any policy or practice that would preclude the honoring of the patient’s directive at the time the physician or facility becomes aware of the existence of such a directive. If the patient, after being informed of such policy or directive, chooses to retain the physician or facility, the physician or facility with the patient or the patient’s representative shall prepare a written plan to be filed with the patient’s directive that sets forth the physician’s or facilities’ intended actions should the patient’s medical status change so that the directive would become operative. The physician or facility under this subsection has no obligation to honor the patient’s directive if they have complied with the requirements of this subsection, including compliance with the written plan required under this subsection.

(3) The directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining treatment. No physician, health facility, or health personnel acting in good faith with the directive or in accordance with the written plan in subsection (2) of this section shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection.

(4) No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate
in the withholding or withdrawal of life-sustaining treatment if such person objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the withholding or withdrawal of life-sustaining treatment. [1992 c 98 § 6; 1979 c 112 § 7.]

RCW 70.122.070 Effects of carrying out directive--Insurance.
 (1) The withholding or withdrawal of life-sustaining treatment from a qualified patient pursuant to the patient's directive in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide or a homicide.
 (2) The making of a directive pursuant to RCW 70.122.030 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining treatment from an insured qualified patient, notwithstanding any term of the policy to the contrary.
 (3) No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving, health care services. [1992 c 98 § 7; 1979 c 112 § 8.]

RCW 70.122.080 Effects of carrying out directive on cause of death. The act of withholding or withdrawing life-sustaining treatment, when done pursuant to a directive described in RCW 70.122.030 and which results in the death of the declarer, shall not be construed to be an intervening force or to affect the chain of proximate cause between the conduct of anyone that placed the declarer in a terminal condition or a permanent unconscious condition and the death of the declarer. [1992 c 98 § 8; 1979 c 112 § 10.]

RCW 70.122.090 Criminal conduct--Penalties. Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarer's consent shall be guilty of a gross misdemeanor. Any person who falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in RCW 70.122.040 with the intent to cause a withholding or withdrawal of life-sustaining treatment contrary to the wishes of the declarer, and thereby, because of any such act, directly causes life-sustaining treatment to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for murder in the first degree as defined in RCW 9A.32.030. [1992 c 98 § 9; 1979 c 112 § 9.]

RCW 70.122.100 Mercy killing or physician-assisted suicide not authorized. Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or physician-assisted
suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying. [1992 c 98 § 10; 1979 c 112 § 11.]

RCW 70.122.110 Discharge so that patient may die at home. If a qualified patient capable of making health care decisions indicates that he or she wishes to die at home, the patient shall be discharged as soon as reasonably possible. The health care provider or facility has an obligation to explain the medical risks of an immediate discharge to the qualified patient. If the provider or facility complies with the obligation to explain the medical risks of an immediate discharge to a qualified patient, there shall be no civil or criminal liability for claims arising from such discharge. [1992 c 98 § 4.]

RCW 70.122.120 Directive's validity assumed. Any person or health facility may assume that a directive complies with this chapter and is valid. [1992 c 98 § 12.]

RCW 70.122.900 Short title. This act shall be known and may be cited as the "Natural Death Act". [1979 c 112 § 1.]

RCW 70.122.905 Severability--1979 c 112. If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application, and to this end the provisions of this act are severable. [1979 c 112 § 13.]

RCW 70.122.910 Construction. This chapter shall not be construed as providing the exclusive means by which individuals may make decisions regarding their health treatment, including but not limited to, the withholding or withdrawal of life-sustaining treatment, nor limiting the means provided by case law more expansive than chapter 98, Laws of 1992. [1992 c 98 § 11.]


RCW 70.122.920 Severability--1992 c 98. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected. [1992 c 98 § 17.]
RCW 7.70.050 Failure to secure informed consent--Necessary elements of proof--Emergency situations. (1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his representatives against a health care provider:

(a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;

(b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;

(c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;

(d) That the treatment in question proximately caused injury to the patient.

(2) Under the provisions of this section a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient or his representative would attach significance to it deciding whether or not to submit to the proposed treatment.

(3) Material facts under the provisions of this section which must be established by expert testimony shall be either:

(a) The nature and character of the treatment proposed and administered;

(b) The anticipated results of the treatment proposed and administered;

(c) The recognized possible alternative forms of treatment; or

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

(4) If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his consent to required treatment will be implied. [1975-'76 2nd ex.s. c 56 § 10.]

NOTES:

Severability--1975-'76 2nd ex.s. c 56: See note following RCW 4.16.350.

RCW 7.70.060 Consent form--Contents--Prima facie evidence--Failure to use. If a patient while legally competent, or his representative if he is not competent, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave his informed consent to the treatment administered and the patient has the burden of rebutting this by a preponderance of the evidence:

(1) A description, in language the patient could reasonably be expected to understand, of:

(a) The nature and character of the proposed treatment;

(b) The anticipated results of the proposed treatment;

(c) The recognized possible alternative forms of treatment; and
(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment;

(2) Or as an alternative, a statement that the patient elects not to be informed of the elements set forth in subsection (1) of this section.

Failure to use a form shall not be admissible as evidence of failure to obtain informed consent. [1975-'76 2nd ex.s. c 56 § 11.]

NOTES:

**Severability--1975-'76 2nd ex.s. c 56:** See note following RCW 4.16.350.

Minors
- access to personal records: RCW 42.48.020.
- alcohol and drug treatment: RCW 70.96A.095.
- mental health treatment: Chapter 71.34 RCW.
- sexually transmitted diseases: RCW 70.24.110.

Records, rights: RCW 70.02.130.

**RCW 7.70.065 Informed consent--Persons authorized to provide for patients who are not competent--Priority.** (1) Informed consent for health care for a patient who is not competent, as defined in *RCW 11.88.010(1)(b)*, to consent may be obtained from a person authorized to consent on behalf of such patient. Persons authorized to provide informed consent to health care on behalf of a patient who is not competent to consent shall be a member of one of the following classes of persons in the following order of priority:

(a) The appointed guardian of the patient, if any;
(b) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
(c) The patient’s spouse;
(d) Children of the patient who are at least eighteen years of age;
(e) Parents of the patient; and
(f) Adult brothers and sisters of the patient.

(2) If the physician seeking informed consent for proposed health care of the patient who is not competent to consent makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care:

(a) If a person of higher priority under this section has refused to give such authorization; or
(b) If there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.

(3) Before any person authorized to provide informed consent on behalf of a patient not competent to consent exercises that
authority, the person must first determine in good faith that that patient, if competent, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests. [1987 c 162 § 1.]

NOTES:

*Reviser's note: RCW 11.88.010 was amended by 1990 c 122 § 2, changing subsection (1)(b) to subsection (1)(e).
WAC sections 388-97-055, 388-97-060, and 388-97-065 implement the federal Patient Self-Determination Act and clarify requirements under chapter 11.94 RCW, Power of attorney; chapter 7.70 RCW, Actions for injuries resulting from health care; and chapter 70.122 RCW, Natural Death Act; chapter 11.88 RCW, Guardianship-appointment, qualification, removal of guardians and limited guardians; chapter 11.92 RCW, Guardianship-powers and duties of guardian or limited guardian.

WAC 388-97-055 Resident representative and decision making.

(1) At the time of admission, or not later than the completion of the initial comprehensive resident assessment, the nursing home shall determine:
   (a) Whether the resident has appointed another person to make health care, financial, or other decisions for the resident;
   (b) Whether the resident has created any advance directive or other legal documents that will establish a surrogate decision maker in the future; and
   (c) If a resident is not making the resident's own decisions, who has the authority for surrogate decision making, and the scope of the surrogate decision maker's authority.

(2) In fulfilling its duty to determine who, if anyone, is authorized to make decisions for the resident, the nursing home shall:
   (a) Seek copies of the legal documents that establish the surrogate decision maker's authority to act; and
   (b) Document in the resident's clinical record:
      (i) The name, address, and telephone number of the person who has legal authority for substitute decision making;
      (ii) The type of decision making authority such person has; and
   (iii) Where copies of the legal documents are located at the facility.

(3) In this chapter, the term "resident" includes the resident's surrogate decision maker in accordance with state law or at the request of the resident.
   (a) In the case of a capacitated resident, the surrogate decision maker is the person authorized by the resident to make decisions on the resident's behalf;
   (b) In the case of a resident adjudicated by a court of law to be incapacitated, the surrogate decision maker is the court appointed guardian; and
   (c) In the case of a resident who has been determined to be incapacitated, but is not adjudicated incapacitated, the surrogate decision maker is established through:
      (i) A legal document, such as a durable power of attorney for health care; or
      (ii) Authority for substitute decision making granted by state law, including RCW 7.70.065.
(4) Determination of a person's incapacity shall be a legal, not medical decision based on:
   (a) Demonstrated inability in decision making over time that creates a significant risk of personal harm;
   (b) A court order; or
   (c) The criteria contained in a legal document, such as durable power of attorney for health care.

(5) The nursing home shall:
   (a) Regularly review any determination of incapacity based on subsections (3)(b) and (c) of this section; and
   (b) If an incapacitated resident regains capacity, cease to rely upon the surrogate decision maker to exercise the resident's rights, unless so designated by the resident or by court order.

(6) The nursing home shall promote the resident's right to exercise decision making and self-determination to the fullest extent possible. Therefore, the nursing home shall presume that the resident is the resident's own decision maker unless:
   (a) A court has established a guardianship;
   (b) The resident has clearly and voluntarily appointed a surrogate decision maker;
   (c) A surrogate is established by a legal document; or
   (d) A resident has become legally incapacitated.

(7) The nursing home shall honor the exercise of the resident's rights by the surrogate decision maker as long as the surrogate acts in accordance with state and federal law which govern his or her appointment, and with this section.

(8) If a surrogate decision maker exercises a resident's rights, the nursing home shall:
   (a) Inform the resident that a surrogate decision maker has been consulted;
   (b) Provide the resident with the information and opportunity to participate in all decision making to the maximum extent possible; and
   (c) Recognize that involvement of a surrogate decision maker does not lessen the nursing home's duty to:
      (i) Protect the resident's rights; and
      (ii) Comply with state and federal laws.

Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-055, filed 9/15/94, effective 10/16/94.

WAC 388-97-060 Informed consent. (1) The nursing home as a health care provider as defined in chapter 7.70 RCW, Actions for injuries resulting from health care, shall follow the informed consent process as required in chapter 7.70 RCW in the development of the resident's comprehensive care plan. Refer to WAC 388-97-090, Comprehensive care planning.

(2) The nursing home shall follow this informed consent process with:
   (a) The resident to the maximum extent possible;
   (b) Any other person the resident has directed be consulted; and
   (c) The surrogate decision maker when the resident is determined to be incapacitated as established through the provision of a legal document such as durable power of attorney for health care, a court proceeding, or as authorized by state law, including RCW 7.70.065.
(3) To ensure informed consent or refusal by a resident regarding care plan options, the nursing home shall:
   (a) Provide the informed consent process to the resident in a neutral manner and in a language and manner the resident can understand;
   (b) Inform the resident of the right to consent to or refuse care and service options at the time of resident assessment and care plan development (see WAC 388-97-085 and 388-97-090) and as necessary to ensure the resident's wishes are known;
   (c) Inform the resident at the time of initial care plan decisions and periodically of the right to change his or her mind about an earlier consent or refusal decision;
   (d) Ensure that evidence of informed consent or refusal is consistent with WAC 388-97-085, Resident assessment and WAC 388-97-090, Comprehensive care planning; and
   (e) Where appropriate, include evidence of resident's choice not to be informed as required in subsections (1) and (3) of this section.

(4) The nursing home shall take into account that if a resident's rights are being exercised by a surrogate decision maker, the surrogate decision maker shall:
   (a) First determine if the resident would consent or refuse the proposed or alternative treatment;
   (b) Discuss determination of consent or refusal with the resident whenever possible; and
   (c) When a determination of the resident's consent or refusal of treatment cannot be made, make the decision in the best interest of the resident.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-060, filed 9/15/94, effective 10/16/94.]

WAC 388-97-065 Advance directives. (1) "Advance directive" as used in this chapter means any document indicating a resident's choice with regard to a specific service, treatment, medication or medical procedure option that may be implemented in the future such as power of attorney, health care directive, limited or restricted treatment order, code/no code order, and anatomical gifts.

(2) The nursing home shall carry out the provisions of this section in accordance with WAC 388-97-055, Resident representative and decision making, and WAC 388-97-060, Informed consent, and with state law.

(3) The nursing home shall:
   (a) Document in the clinical record whether or not the resident has an advance directive;
   (b) Not require the resident to have any advance directives and not condition the provision of care or otherwise discriminate against a resident on the basis of whether or not the resident has executed an advance directive;
   (c) In a language the resident understands, inform the resident in writing and orally at the time of admission, and thereafter as necessary to ensure the resident's right to make informed choices, about:
      (i) The right to make health care decisions;
      (ii) Nursing home policies and procedures concerning implementation of advance directives, including how the nursing home implements emergency responses; and

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(d) Review resident advance directive information:
   (i) At the resident’s request;
   (ii) When the resident’s condition warrants review; and
   (iii) When there is a significant change in the resident’s condition.

(e) If needed, based on the outcome of the review in subsection (3)(d) of this section, update advance directive information.

(4) When the nursing home becomes aware that a resident’s health care directive is in conflict with facility practices and policies which are consistent with state and federal law, the nursing home shall:
   (a) Inform the resident of the existence of any nursing home practice or policy which would preclude implementing the health care directive;
   (b) Provide the resident with written policies and procedures that explain under what circumstances a resident’s health care directive will or will not be implemented by the nursing home;
   (c) Meet with the resident to discuss the conflict;
   (d) Determine, in light of the conflicting practice or policy, whether the resident chooses to remain at the nursing home; and
   (e) Develop a plan in accordance with subsection (5) of this section; and
   (f) Attach the plan to the resident’s directive in the clinical record.

(5) If the resident chooses to remain in the nursing home, develop with the resident a plan in accordance with chapter 70.122 RCW to implement the resident’s wishes. The nursing home may need to actively participate in ensuring the execution of the plan, including moving the resident at the time of implementation to a care setting that will implement the resident’s wishes.

(6) If, after recognizing the conflict between the resident’s wishes and nursing home practice or policy as determined in subsection (4)(b) of this section, the resident chooses to seek other long-term care services, or another physician who will implement the directive, the nursing home shall assist the resident in locating other appropriate services.

(7) If a terminally ill resident, in accordance with state law, wishes to die at home, the nursing home shall:
   (a) Use the informed consent process as described in WAC 388-97-120, Informed consent, and explain to the resident the risks associated with discharge; and
   (b) Discharge the resident as soon as reasonably possible.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-065, filed 9/15/94, effective 10/16/94.]

WAC 388-97-070 Resident rights. (1) Medicaid-certified nursing facilities in compliance with federal requirements at 42 C.F.R. §483.10 will be deemed to meet subsections (2) through (18), except for (3)(c), (4)(g), (10)(a), (14), (15)(b) and (c), and (16)(b), (c), and (d).

(2) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the nursing home. A nursing home shall promote and protect the rights of each resident, including those with limited cognition or other barriers that limit the exercise of rights.

(3) Exercise of rights.
   (A) The resident has the right to exercise his or her rights as a resident of the nursing
HOME AND AS A CITIZEN OR RESIDENT OF THE UNITED STATES. REFER TO WAC 388-97-055, RESIDENT REPRESENTATIVE AND DECISION MAKING.

(b) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the nursing home in exercising his or her rights.

(c) The nursing home shall not require the resident to sign any contract or agreement that purports to waive any right of the resident.

(4) NOTICE OF RIGHTS AND SERVICES.

(a) The nursing home must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the nursing home. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;

(b) The resident or his or her surrogate decision maker has the right:

(i) Upon an oral or written request, to access all records pertaining to the resident including clinical records within twenty-four hours for skilled nursing facility and nursing facility, and according to chapter 70.02 RCW, health care information access and disclosure, for nursing homes; and

(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days advance notice to the nursing home.

(c) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including, but not limited to, his or her medical condition;

(d) The resident has the right to refuse treatment and to refuse to participate in experimental research; and

(e) The skilled nursing facility and nursing facility shall according to 42 C.F.R. § 488.10 (e)(18):

(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of:

(A) The items and services that are included in nursing facility services under the state plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each resident when changes are made to the items and services specified in paragraphs (e)(1)(B);

(f) The nursing home shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(g) Fee disclosure-deposits.

(i) Prior to admission, a nursing home that requires payment of an admission fee, deposit, or a minimum stay fee, by or on behalf of a person seeking admission to the facility, shall provide the resident:

(A) Full disclosure in writing of the nursing home's schedule of charges for items and services provided by the facility;

(B) The amount of any admission fees, deposits, or minimum stay fees; and

(C) Full disclosure in writing prior to admission of what portion of the deposits, admissions fees, or minimum stay fee will be refunded to the resident if the resident leaves the facility.

(ii) If a resident, during the first thirty days of residence, dies or is hospitalized and does not return to the facility, the nursing home shall refund any deposit already paid less the facility's per diem rate for the days the resident actually resided or reserved a bed in the facility, notwithstanding any minimum stay policy;

(iii) The nursing home shall refund any and all refunds due the resident within thirty days from the resident's date of discharge from the facility; and

(iv) Where the nursing home requires the execution of an admission contract by or on behalf of an individual seeking admission to the facility, the terms of the contract shall be consistent with the requirements of this section.

(h) The nursing home shall furnish a written description of legal rights which includes:

(i) A description of the manner of protecting personal funds, under paragraph (6) of this section:
(ii) In the case of a nursing facility only, a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under Section 1924(c) which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;

(iii) A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

(iv) A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility.

(i) The nursing home must inform each resident of the name, specialty and way of contacting the physician responsible for his or her care.

(j) The skilled nursing facility and nursing facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(5) Notification of changes.

(a) A nursing home must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's surrogate decision maker and when appropriate, with resident consent an interested family member when there is:

(i) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(ii) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychological status in either life-threatening conditions or clinical complications); refer to WAC 388-97-055, resident representative and decision making;

(iii) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(iv) A decision to transfer or discharge the resident from the facility.

(b) The nursing home must also promptly notify the resident and, if known, the resident's surrogate decision maker and when appropriate, with resident consent an interested family member when there is:

(i) A change in room or roommate assignment;

(ii) A change in resident rights under federal or state law or regulations as specified in paragraph (4)(a) of this section.

(c) The nursing home must record and periodically update the address and phone number of the resident's legal surrogate decision maker and interested family member.

(6) Protection of resident funds.

(a) The resident has the right to manage his or her financial affairs and the nursing home may not require residents to deposit their personal funds with the facility.

(b) Management of personal funds. Upon written authorization of a resident, the nursing home must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility.

(c) Accounting and records. The nursing home must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements on request to the resident or his or her legal representative.

(d) Notice of certain balances. The skilled nursing facility and nursing facility must notify each resident that receives Medicaid benefits:

(i) When the amount in the resident's account reaches two hundred dollars less than the SSI resource limit for one person; and

(ii) That if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(e) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the nursing home, the facility must convey within thirty days the resident's funds, and a final accounting of those funds, to the individual or jurisdiction administering the resident's estate.

(f) Assurance of financial security. The skilled nursing facility and nursing facility must purchase a surety bond, or otherwise provide assurance, to assure security of personal funds of residents deposited with the facility.

(g) Limitation on charges to personal funds. The skilled nursing facility and nursing facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare as described in 42 C.F.R. §483.10 (c)(3).

(h) The skilled nursing facility and nursing facility shall:

(i) Not charge a resident (or the resident's representative) for any item or service not requested by the resident.
(ii) NOT REQUIRE A RESIDENT (OR THE RESIDENT'S REPRESENTATIVE) TO REQUEST ANY ITEM OR SERVICE AS A CONDITION OF ADMISSION OR CONTINUED STAY; AND
(iii) INFORM THE RESIDENT (OR THE RESIDENT'S REPRESENTATIVE) REQUESTING AN ITEM OR SERVICES FOR WHICH A CHARGE WILL BE MADE THAT THERE WILL BE A CHARGE FOR THE ITEM OR SERVICE AND WHAT THE CHARGE WILL BE.

(7) FREE CHOICE. THE RESIDENT HAS THE RIGHT TO:
(a) CHOOSE A PERSONAL ATTENDING PHYSICIAN;
(b) BE FULLY INFORMED IN ADVANCE ABOUT CARE AND TREATMENT AND OF ANY CHANGES IN THAT CARE OR TREATMENT THAT MAY AFFECT THE RESIDENT'S WELL-BEING; AND
(c) UNLESS ADJUDGED INCOMPETENT OR OTHERWISE FOUND TO BE INCAPACITATED UNDER THE LAWS OF THE STATE, PARTICIPATE IN PLANNING CARE AND TREATMENT OR CHANGES IN CARE AND TREATMENT.

(8) PRIVACY AND CONFIDENTIALITY. THE RESIDENT HAS THE RIGHT TO PERSONAL PRIVACY AND CONFIDENTIALITY OF HIS OR HER PERSONAL AND CLINICAL RECORDS.
(a) PERSONAL PRIVACY INCLUDES ACCOMMODATIONS, MEDICAL TREATMENT, WRITTEN AND TELEPHONE COMMUNICATIONS, PERSONAL CARE, VISITS, AND MEETINGS OF FAMILY AND RESIDENT GROUPS, BUT THIS DOES NOT REQUIRE THE NURSING HOME TO PROVIDE A PRIVATE ROOM FOR EACH RESIDENT.

(b) EXCEPT AS PROVIDED IN PARAGRAPH (8)(c) OF THIS SECTION, THE RESIDENT MAY APPROVE OR REFUSE THE RELEASE OF PERSONAL AND CLINICAL RECORDS TO ANY INDIVIDUAL OUTSIDE THE NURSING HOME;
(c) THE RESIDENT'S RIGHT TO REFUSE RELEASE OF PERSONAL AND CLINICAL RECORDS DOES NOT APPLY WHEN:
(i) THE RESIDENT IS TRANSFERRED TO ANOTHER HEALTH CARE INSTITUTION; OR
(ii) RECORD RELEASE IS REQUIRED BY LAW.

(9) GRIEVANCES. A RESIDENT HAS THE RIGHT TO:
(a) VOICE GRIEVANCES WITHOUT DISCRIMINATION OR REPRISAL. SUCH GRIEVANCES INCLUDE THOSE WITH RESPECT TO TREATMENT WHICH HAS BEEN FURNISHED AS WELL AS THAT WHICH HAS NOT BEEN FURNISHED; AND
(b) PROMPT EFFORTS BY THE NURSING HOME TO RESOLVE GRIEVANCES THE RESIDENT MAY HAVE, INCLUDING THOSE WITH RESPECT TO THE BEHAVIOR OF OTHER RESIDENTS.

(10) EXAMINATION OF SURVEY RESULTS. A resident has the right to:
(a) Examine the results of the most recent survey or complaint investigation of the nursing home conducted by federal and state surveyors or inspectors and plans of correction in effect with respect to the facility. The nursing home shall:
(i) Publicly post a copy of the most recent survey and complaint investigation until the violation is corrected to the satisfaction of the department up to a maximum of one hundred twenty days;
(ii) Make a copy of the survey results available for examination in a place readily accessible to residents;
(iii) Post a notice that the results of the survey or investigation are available and the location of the surveys when not posted; and
(iv) Post surveys and notices in a place or places in plain view of the residents in the nursing home, persons visiting those residents, and persons who inquire about placement in the facility; and
(b) RECEIVE INFORMATION FROM AGENCIES ACTING AS CLIENT ADVOCATES, AND BE AFFORDED THE OPPORTUNITY TO CONTACT THESE AGENCIES.

(11) WORK. THE RESIDENT HAS THE RIGHT TO:
(a) REFUSE TO PERFORM SERVICES FOR THE NURSING HOME;
(b) PERFORM SERVICES FOR THE NURSING HOME, IF HE OR SHE Chooses, WHEN:
(i) THE FACILITY HAS DOCUMENTED THE NEED OR DESIRE FOR WORK IN THE PLAN OF CARE;
(ii) THE PLAN SPECIFIES THE NATURE OF THE SERVICES PERFORMED AND WHETHER THE SERVICES ARE VOLUNTARY OR PAID;
(iii) COMPENSATION FOR PAID SERVICES IS AT OR ABOVE PREVAILING RATES; AND
(iv) THE RESIDENT AGREES TO THE WORK ARRANGEMENT DESCRIBED IN THE PLAN OF CARE.

(12) MAIL. THE RESIDENT HAS THE RIGHT TO PRIVACY IN WRITTEN COMMUNICATIONS, INCLUDING THE RIGHT TO:
(a) SEND AND PROMPTLY RECEIVE MAIL THAT IS UNOPENED; AND
(b) HAVE ACCESS TO STATIONERY, POSTAGE AND WRITING IMPLEMENTS AT THE RESIDENT'S OWN EXPENSE.

(13) ACCESS AND VISITATION RIGHTS.
(a) THE RESIDENT HAS THE RIGHT AND THE NURSING HOME MUST PROVIDE IMMEDIATE ACCESS TO ANY RESIDENT BY THE FOLLOWING:
(i) ANY REPRESENTATIVE OF THE SECRETARY;
(ii) ANY REPRESENTATIVE OF THE STATE;
(iii) THE RESIDENT'S INDIVIDUAL PHYSICIAN;
(iv) ANY REPRESENTATIVE OF THE STATE LONG TERM CARE OMBUDSMAN (ESTABLISHED UNDER SECTION 307A(12) OF THE OLDER AMERICAN'S ACT OF 1965);
INFORMED CONSENT AND ADVANCE DIRECTIVES

Post test:

1. Mr. Williams is admitted with early stage Alzheimer’s. He is oriented to person and place.

The resident’s son has durable power of attorney (DPOA) for health care. The resident’s AD, signed by the son, indicates a “no code”. During your interview, the resident states he wants to be a “full code”. What should the resident’s code status be and why?

2. Mrs. Jones has end stage Alzheimer’s and a recent problem with pneumonia. Her sister indicates she does not wish treatment of the pneumonia. During a family interview, Mrs. Jones daughter states she wishes her mother to receive treatment. There is no DPOA. Should the facility follow the sister or daughter’s wishes and why?

3. During an interview with Ms. Byrd, the resident states she is being denied fluids. Review of the resident’s record shows that the resident’s diagnosis includes Parkinson’s disease. She is moderately impaired in her ability to make decisions and a swallowing evaluation indicates a severe swallowing disorder. The physician has ordered thickened liquids. The resident refuses thickened liquids and her husband does not want the resident to receive thin liquids. He has a DPOA for healthcare. What would be the appropriate course of action by the facility?
4. The resident has signed a “full code” status. However, the physician refuses to sign an order for a “full code”. Can the facility follow the resident’s directive?

5. Mr. Hines is a comatose resident being admitted to the NH from the hospital. The family is not available to explain the resident’s wishes concerning an AD. There is however a “no code” order on the orders used at the hospital. Should the facility make the resident a “no code” or “full code”?

6. Mrs. Lynn is severely demented and has an AD for a “no code” status, signed by her husband. During an interview, the resident indicates that she does not want to die and “yes” she wants CPR. Does the facility follow the wishes of the resident or the husband’s?

7. Mr. Roberts has a signed boilerplate AD in his record. The only question addressed on this form is whether an individual wishes to be a “full code” or a “no code”. No other details are found on the form. The resident signs the directive indicating a “no code”. What is missing with this AD and what does the facility need to do to correct the problem?
8. Ms. Winkler requires assistance with meals due to her moderate dementia. Otherwise her physical health is good. During dinner, the resident aspirates on a bite of chicken and stops breathing. The resident has signed an AD indicating “no code”. Should the facility attempt to recover this resident?

9. Miss Snyder is 53 years old, mentally retarded, middle stage Alzheimer’s and not capable of decision making. While talking with the resident you determine that the resident rambles but is not able to answer your questions. The resident has recently been identified to have severe difficulty with swallowing. There is an AD, signed by the resident, that indicates she does not wish tube feedings. The family indicates the resident has no quality of life, and do not want the resident to be fed by a tube. The family indicates they are following the resident’s wishes, listed on the AD. Is this an appropriate use of an AD?

10. Mr. Jackson is 94 years old with end stage Alzheimer’s. The resident is severely demented. His daughter is the DPOA for healthcare. The resident does not have an AD. Since the resident does not have an AD but the daughter has DPOA, how will the facility determine the resident’s code status.
INFORMED CONSENT AND ADVANCE DIRECTIVES

Post test:

1. Mr. Williams is admitted with early stage Alzheimer's. He is oriented to person and place.
   The resident's son has durable power of attorney (DPOA) for health care. The resident's AD, signed by
   the son, indicates a "no code". During your interview, the resident states he wants to be a "full code".
   What should the resident's code status be and why?

   Full code. (a.) The resident's wishes always take precedence. (b.) The DPOA for healthcare authorizes
   a proxy to make medical decisions if the person becomes unable to make them (RCW 11.94.010). This
   resident is competent. However, even with a DPOA for healthcare, the resident's wishes always
   takes precedence, even if the resident is not mentally competent (RCW 70.122.040). (c.) A family
   member may not sign the AD for the resident.

2. Mrs. Jones has end stage Alzheimer's and a recent problem with pneumonia. Her sister indicates
   she does not wish treatment of the pneumonia. During a family interview, Mrs. Jones daughter states
   she wishes her mother to receive treatment. There is no DPOA. Should the facility follow the sister or
   daughter's wishes and why?

   The daughter. (a.) According to RCW 7.70.065, decisions can be made by an individual (surrogate)
   authorized to act on behalf of an incompetent individual. There is an order of priority for individuals
   who may serve as a surrogate. According to the RCW, children of the resident take priority over
   the resident's sibling. (b.) The difference of opinion between the family members could be a red flag
   as to whether these decisions are being made according to wishes previously identified by the resident
   or the individual family members wishes. The surrogate is to make decisions that the principal would
   have made, if able.
3. During an interview with Ms. Byrd, the resident states she is being denied fluids. Review of the resident’s record shows that the resident’s diagnosis includes Parkinson’s disease. She is moderately impaired in her ability to make decisions and a swallowing evaluation indicates a severe swallowing disorder. The physician has ordered thickened liquids. The resident refuses thickened liquids and her husband does not want the resident to receive thin liquids. He has a DPOA for healthcare. What would be the appropriate course of action by the facility?

***** The resident is the decision maker and needs to be making an informed decision. (a.) The resident’s wishes always take precedence. (b.) The DPOA takes effect once the resident is incapacitated. And this resident is not incapacitated. This resident is competent and the decision maker. (c.) The facility has the responsibility to discuss this situation with the resident, during a time when she is not confused. The nursing home (NH) staff must explain the problem with swallowing, the potential problems with aspiration, and share with her the fluid options available to her. Once the resident has a clear understanding of her options and the potential dangers involved, then the facility needs to follow the resident’s wishes.

4. The resident has signed a “full code” status. However, the physician refuses to sign an order for a “full code”. Can the facility follow the resident’s directive?

***** Yes. According to RCW 70.122.060, the facility must notify the physician of the resident’s wishes for a full code. There are physician responsibilities concerning this resident’s directive (see RCW), however, a signed “code” order is NOT required.
5. Mr. Hines is a comatose resident being admitted to the NH from the hospital. The family is not available to explain the resident’s wishes concerning an AD. There is however a “no code” order on the orders used at the hospital. Should the facility make the resident a “no code” or “full code”?

*****The resident is a “full code” until there is clear direction from the surrogate. A code status is NOT transferable from the hospital to the facility.

6. Mrs. Lynn is severely demented and has an AD for a “no code” status, signed by her husband. During an interview, the resident indicates that she does not want to die and “yes” she wants CPR. Do you follow the wishes of the resident or the husband’s?

*****The resident’s. (a.) The resident’s wishes take priority regardless of the fact that she is severely demented. (b.) The resident is the only person who can sign her AD.

7. Mr. Roberts has a signed boilerplate AD in his record. The only question addressed on this form is whether an individual wishes to be a “full code” or a “no code”. No other details are found on the form. The resident signs the directive indicating a “no code”. What is missing with this AD and what does the facility need to do to correct the problem?

*****Advance directives are intended to be part of an IC process. The facility needs to follow the IC ....for example:

• under what circumstances would the resident wish to have life-sustaining treatment withheld?

• does he understand the consequences of these actions?

• does he have a clear understanding of his present medical condition and other factors that could influence this type of decision?
8. Ms. Winkler requires assistance with meals due to her moderate dementia. Otherwise her physical health is good. During dinner, the resident aspirates on a bite of chicken and stops breathing. The resident has signed an AD indicating “no code”. Should the facility attempt to recover this resident?

*****Yes. (1). For the AD to be initiated, the resident must be terminal (RCW 70.122.030). This resident is not terminal. Using an AD for other healthcare decisions is outside of the intended purpose of the directive.

9. Miss Snyder is 53 years old, mentally retarded, middle stage Alzheimer’s and not capable of decision making. The MDS indicates the resident is unable to make decisions. While talking with the resident you determine that the resident rambles but is not able to answer your questions. The resident has recently been identified to have severe difficulty with swallowing. There is an AD, signed by the resident, that indicates she does not wish tube feedings. The family indicates the resident has no quality of life, and do not want the resident to be fed by a tube. The family indicates they are following the resident’s wishes, listed on the AD. Is this an appropriate use of an AD?

******No. The resident is not terminal at this time. The AD is intended to be used for end-of-life decisions, not other healthcare decision (see question # 8).

10. Mr. Jackson is 94 years old with end stage Alzheimer’s. The resident is severely demented. His daughter is the DPOA for healthcare. The resident does not have an AD. Since the resident does not have a directive but the daughter has DPOA, how will the facility determine the resident’s code status.

*****A surrogate decision maker may exercise the resident’s rights as long as the surrogate acts in accordance with state and federal law (See WAC 388-97-055 & 060). The surrogate must
make decisions in accordance to what the resident would have wished and in the best interest of the resident. The same process is used for the surrogate as with the resident. These decisions are made as part of the IC (see question #7) and need to be reviewed as the resident's condition changes.
MODULE EVALUATION

Please assist in the evaluation of the attached module by completing the following information:

I found this packet to be: (1 = very, 2 = somewhat, 3 = not very, 4 = not at all)

- Material difficult to understand
  - [ ] 1
  - [ ] 2
  - [ ] 3
  - [x] 4

- Logically presented
  - [ ] 1
  - [ ] 2
  - [ ] 3
  - [x] 4

- Module helpful
  - [ ] 1
  - [ ] 2
  - [ ] 3
  - [x] 4

- Discussion with instructor helpful
  - [ ] 1
  - [ ] 2
  - [ ] 3
  - [x] 4

What suggestions do you have to improve the module:

- [ ] More application question
- [ ] Fewer questions
- [ ] Make instructions more clear
- [ ] Other

Approximate time required to complete module: ________________
IMPLEMENTATION OF LEARNING MODULE

PART I/ WEEK ONE OF ORIENTATION:

Step #1: At the beginning of the first week, the new surveyors will be given a pre-test (without the answers) before reviewing the learning module. This test is a series of application questions/situations, which relate to the enclosed regulations concerning informed consent and advance directives.

Step #2: After completion of the pre-test, the surveyor will be given the answers to the test and a learning module to review. Included inside the learning packet is a learning module containing regulations along with questions designed to direct the student's learning. An answer sheet with references to the exact location of the answer is included.

PART I/ WEEK 2 OR 3 OF ORIENTATION:

Step #3: A posttest will be given to determine learning and retention. This test will be similar to the pretest (including an answers sheet). An instructor will be present at this time to assist the learner with interpretation the regulations and answers questions. This process will facilitate learning through discussion between the learner and the instructor concerning informed consent, advance directives and their application for LTC residents.

PART III/ MONTH 6 ORIENTATION:

Step #4: The posttest will be given to assure retention.

The packet will be piloted during surveyor orientation beginning February 17, 1998. An evaluation form will be included. This input will be used to further refine the learning experience. The revised module will be given to the next group of new surveyors (orientation beginning April 6, 1998).

(Implementation of the module was denied by the legal department of Residential Care Services.)