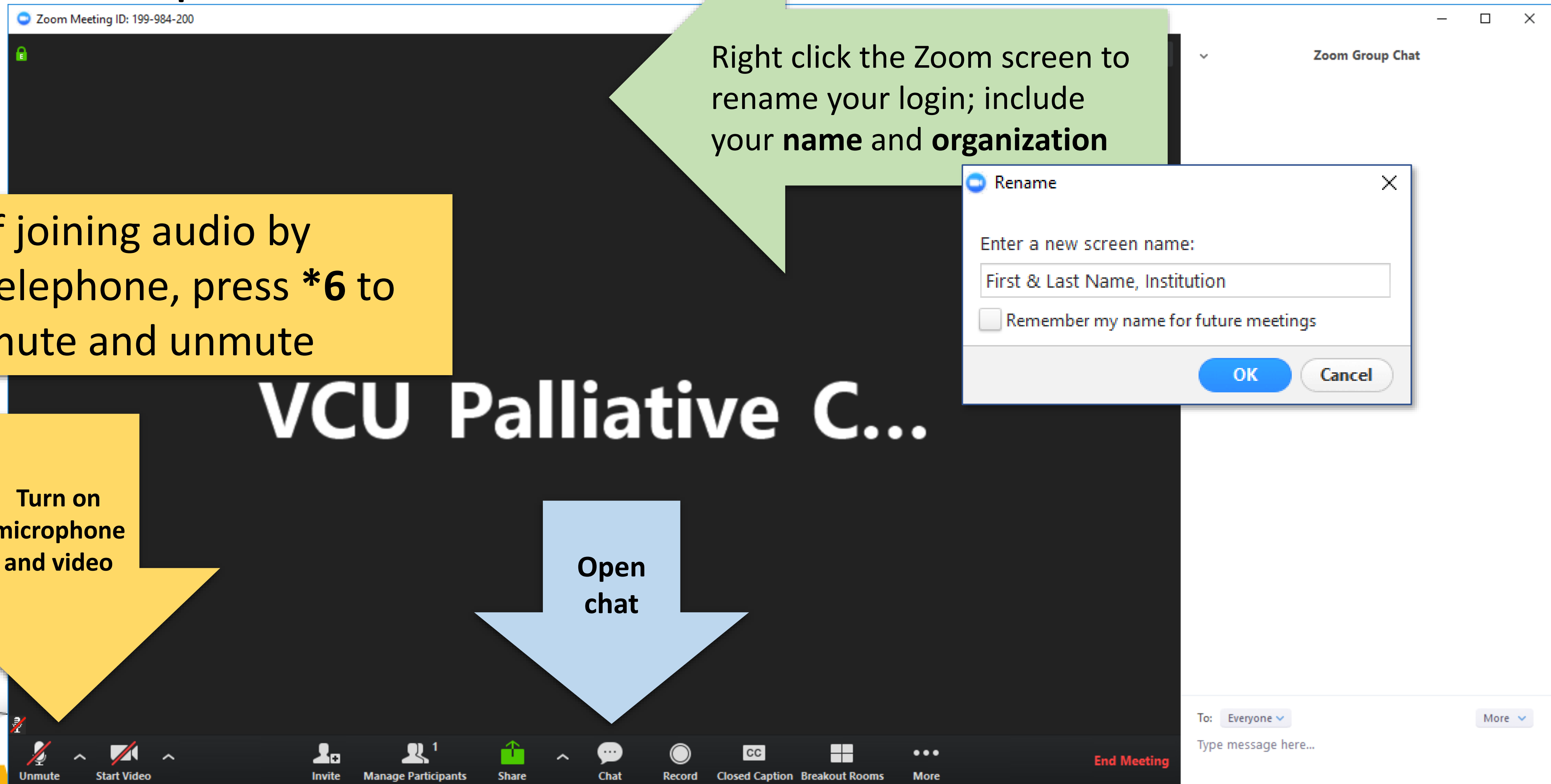
VCUHealth™

Documentation Review *and horror stories*

Candace Blades, JD, RN
Palliative Care Project ECHO

Setup



JA Accreditation & Credit Designation Statements – LIVE Activities

VCU Health Continuing Education

In support of improving patient care, VCU Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

VCU Health designates this live activity for a maximum of **1.00 AMA PRA Category 1 Credits™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

1.00 ANCC contact hours

1.00 CE credits will be awarded for psychologists attending the entire program. Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibly for the content of the programs.

As a Jointly Accredited Organization, VCU Health is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. VCU Health maintains responsibility for this course. **Social workers completing this course receive 1.00 continuing education credit**.

This activity was planned by and for the healthcare team, and learners will receive **1.00 Interprofessional Continuing Education (IPCE)** credit for learning and change.

Disclosures

In compliance with the Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support of CME, VCU Health Continuing Medical Education discloses all relevant relationships which program faculty and planners report having with "any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients." VCU Health Continuing Medical Education has procedures to resolve any apparent conflicts of interest.

The following Planning Committee and Presenting Faculty Members report having **no relevant financial relationships**:
Danielle Noreika, MD; Egidio Del Fabbro, MD; Diane Kane, LCSW; Tamara Orr, PhD, LCP, PMHNP-BC; Brian Cassel, PhD; Felicia Barner, RN; Candace Blades, JD, RN; Jason Callahan, MDiv

No commercial or in-kind support was provided for this activity

Claiming CE Credit May 18, 2020

If you **have not** participated in a VCU Health CE program in the past:

Go to:
vcu.cloud-cme.com

- Create an account
- Be sure to add your cell phone number
- Text your email address to (804) 625-4041

Submit Attendance

Text today's course code to

(804) 625-4041

The course code for this event is:

17208-17203

Complete Evaluation & Claim Credit

- Sign in to **vcu.cloud-cme.com**
- Click "My CE"
- Click "Evaluations and Certificates"
- Complete evaluation

Or…

- Open the **CloudCME app** on your device
- Click "My Evaluations"
- Click name of activity to complete evaluation

VCU Health

View recorded sessions at **vcuhealth.org/pcecho**

Introductions

Project ECHO® Virginia Commonwealth University

Our ECHO Team: Planning Committee

Clinical Leadership	**Egidio Del Fabbro, MD** VCU Palliative Care Chair and Program Director **Danielle Noreika, MD, FACP, FAAHPM** Medical Director/Fellowship Director VCU Palliative Care
Clinical Experts	Candace Blades, JD, RN – Advance Care Planning Coordinator Brian Cassel, PhD – Palliative Care Outcomes Research Jason Callahan, MDiv – Palliative Care Specialty Certified Felicia Hope Coley, RN – Nurse Navigator Diane Kane, LCSW – Palliative Care Specialty Certified Tamara Orr, PhD, LCP – Clinical Psychologist
Support Staff	
Program Managers	Teri Dulong-Rae & Bhakti Dave, MPH
Telemedicine Practice Administrator	David Collins, MHA
IT Support	Frank Green

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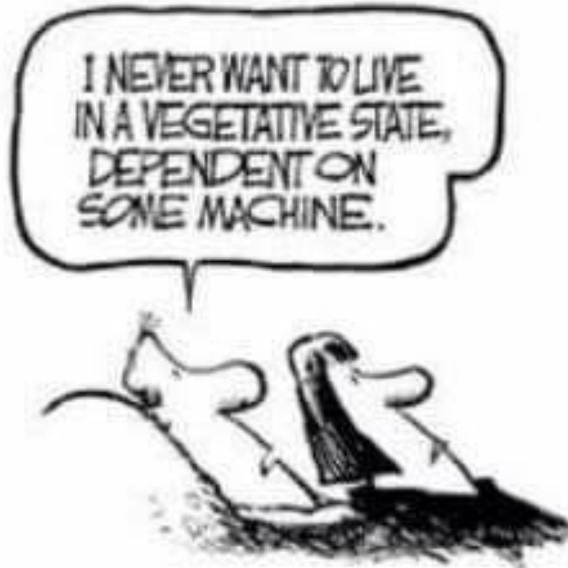
Candace Blades, JD, RN

JUST SO
YOU KNOW.


I NEVER WANT TO LIVE
IN A VEGETATIVE STATE,
DEPENDENT ON
SOME MACHINE.

IF THAT EVER
HAPPENS, JUST
UNPLUG ME, OK?
OK.

Hey!

... really?

3. Notwithstanding the provisions of this section, if I am determined to be medically and legally dead, as defined by Section 54.1-2972 of the Code of Virginia, as amended from time to time, the provisions of such statute shall apply and all life support systems and treatment shall be withheld or withdrawn.

Other Entertaining Write-Ins:

- (from what appeared to be a physician AD): "If two ICU attendings agree then box me"
- In end of life wishes:
  "I want a six pack of beer, a box of Marlboro's (red), and tell Bubba to kiss my a**"
- Visitation instructions:
  "No Donald Trump"

SECTION V: ANATOMICAL GIFTS

(YOU MAY USE THIS DOCUMENT TO RECORD YOUR DECISION TO DONATE YOUR ORGANS, EYES AND TISSUES OR YOUR WHOLE BODY AFTER YOUR DEATH. IF YOU DO NOT MAKE THIS DECISION HERE OR IN ANY OTHER DOCUMENT, YOUR AGENT CAN MAKE THE DECISION FOR YOU UNLESS YOU SPECIFICALLY PROHIBIT HIM/HER FROM DOING SO, WHICH YOU MAY DO IN THIS OR SOME OTHER DOCUMENT. CHECK ONE OF THE BOXES BELOW IF YOU WISH TO USE THIS SECTION TO MAKE YOUR DONATION DECISION.)

- ○ I donate my organs, eyes and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes or tissues for donation. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, www.DonateLifeVirginia.org, and that I may use the donor registry to amend or revoke my directions; OR
- ○ I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

DO NOT DONATE. EVERYTHING IS WORN OUT ANYWAY.

What is Advance Care Planning? (ACP)

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ACP is a process of planning for future medical decisions. To be effective this process includes….

- **Understanding** possible future situations and decisions
- **Reflection** on goals, values, and beliefs (including cultural, religious, spiritual, and personal)
- **Discussion** of these reflections and decisions with those who might need to carry out the plan.

ACP is about thoughtful *conversation* that yields a quality ACP document such as an Advance Directive.

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Advance Care Planning Documents

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Virginia Commonwealth University

ACP involves communication of important healthcare wishes to family, loved ones and healthcare providers. Advance Care Planning Documents are the legal documents that express those wishes

Living Will/Advance Directive

Healthcare Power of Attorney

DNR and DDNR

POST

Living Wills/Advance Directives and Healthcare Powers of Attorney:

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- Can be created by any adult ≥18 years of age or emancipated minors and must be signed by the individual and two witnesses.
- Must be created by an individual with sufficient mental capacity, Decisional capacity includes the ability to understand the relevant information, the choices and the ability to state a decision. Capacity is task specific. Individuals with mild dementia may understand the issues related to ACP even if they no longer have the ability to live independently, for example. Capacity is presumed but where there are concerns about lack of capacity, a provider should make a determination.
- May be cancelled, revoked, or modified at any time, but only by the individual who created the advance directive. A *Healthcare Agent and/or family cannot create, revoke or override a patient's AD.*

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The standard Virginia Advance Directive:

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, ______________________________, willingly and voluntarily make known
Printed Name of Individual Making This Advance Directive for Health Care (Declarant)

my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND III BELOW.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent

I hereby appoint ______________________________
Name of Primary Agent | E-mail Address

____
Home Address | Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

____
Name of Successor Agent | E-mail Address

____
Home Address | Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

B. Powers of My Agent

(IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.
5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.

Healthcare Power of Attorney

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A Healthcare Power of Attorney (HPOA) appoints an Agent to make healthcare decisions for an individual when that individual loses the capacity to make decisions.

Who decides if no agent is appointed?

1. Legally appointed guardian
2. Patient's spouse (except where divorce action has been filed)
3. Adult children
4. Parents of patient
5. Adult siblings
6. Any blood relative in descending order of relationship

Do Not Resuscitate DNR/DDNR

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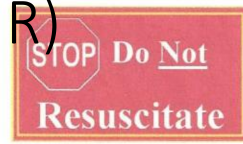
- **Inpatient**: A provider must enter an electronic DNR order. The presence of an inpatient DNR is indicated by "DNR" on the right side of the patient's banner bar in Cerner.
- **Outpatient:** Inpatient, electronic DNR orders do **<u>not</u>** follow a patient upon discharge. If the patient or surrogate decision maker wishes to continue the patient's DNR status upon discharge, a provider must complete a paper Durable DNR (DDNR) form. A copy should be scanned into the patient’s record and the original provided to the patient.

Virginia Durable Do Not Resuscitate (DDNR)

MUST include:
Patient's name, date, and a check on box #1 **or** #2

If box #2 is checked, **MUST** select A, B, **or** C below

MUST be signed by:
1. Provider **AND**
2. Patient if #1 is selected **or**
3. Legal Healthcare Decision Marker if #2 is selected



Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name ______________________ **Date** __________

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

Physician's Printed Name ____ Physician's Signature ____ Emergency Phone Number ____

Patient's Signature ____ Signature of Person Authorized to Consent on the Patient's Behalf ____

Copy 2 – To be kept in patient's permanent medical record

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POST (Physician Orders for Scope of Treatment)

- POST is a medical order set for patients with life-limiting illness or patients who are frail and elderly
- POST has a DNR section *plus* orders for other medical interventions to apply or withhold <u>in pre arrest situations</u> depending on the wishes of the patient.
- POST is portable like the DDNR
- POST does not replace an Advance Directive. It builds upon and complements the patient's Advance Directive.

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HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

Virginia Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the patient's current medical condition and wishes. Any section not completed creates no presumption about the patient's preferences for treatment.

Name Last / First / M.I.

Address

City / State / Zip

Date of Birth | Last 4 Digits of SSN

A ✓ one only

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ **Attempt Resuscitation** ☐ **Do Not Attempt Resuscitation (DDNR/DNR/No CPR)**

Y / N This form replaces a previous POST form that was signed by the patient indicating Do Not Attempt Resuscitation. Only the patient can consent to reversing this DDNR order.

If "Do Not Attempt Resuscitation" is checked, this is a DDNR order. See page 2 for instructions for use.

When not in cardiopulmonary arrest, follow orders in B and C.

B ✓ one only

If "Attempt Resuscitation" is checked in Section A, Virginia EMS protocol includes intubation when needed

MEDICAL INTERVENTIONS: Patient has pulse and / or is breathing.

☐ Comfort Measures: Treat with dignity and respect. Keep warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location. Also see "Other Orders" if indicated below.

☐ Limited Additional Interventions: Include comfort measures described above. Do not use intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP or BiPAP). Use additional medical treatment, antibiotics, and cardiac monitoring as indicated. Hospital transfer if indicated. Avoid intensive care unit if possible. Also see "Other Orders" if indicated below.

☐ Full Interventions: In addition to Comfort Measures above, use intubation, mechanical ventilation, cardioversion as indicated. Transfer to hospital if indicated. Include intensive care unit. Also see "Other Orders" below.

Other Orders: ______

C ✓ one only

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluids by mouth if medically feasible.

☐ NO feeding tube (not consistent with patient's goals given current medical condition)
☐ Feeding tube for a defined trial period (specific goal to be determined in consultation with treating physician)
☐ Feeding tube long-term if indicated

Other Orders: ______

D

Must be signed by a physician, nurse practitioner or physician assistant

PROVIDER SIGNATURE: *My signature below indicates that I have discussed the decisions documented herein with the patient or the person legally authorized to consent on the patient's behalf and have considered the patient's goals for treatment, to the best of my knowledge.*

DISCUSSED WITH (Required):

☐ Patient ☐ Agent named on Advance Directive ☐ Other person legally authorized ☐ Court-appointed guardian

Signature (Required) ______ Date (Required) ______

Provider Name (Required) ______ Phone ______

SIGNATURE OF PATIENT OR AUTHORIZED PERSON (REQUIRED)

Signature ______ Date ______

If the patient signs and Do Not Attempt Resuscitation is checked in Section A, only the patient can revoke consent for the Do Not Resuscitate order

Print Name ______

If patient lacks capacity, describe authority to consent on the patient's behalf: ______

If the patient has no advance directive, the following persons may consent for the patient in this order: guardian, spouse, adult children, parents, adult siblings, other relative in descending order of blood relationship (§54.1-2986)

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

©2017, Virginia POST Collaborative
Unauthorized alteration of this form is prohibited

patient label

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Documentation

We can't honor your wishes if we don't know what they are.

ACP documents must be reliable, visible and accessible

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“…several notes from one of our providers had an odd heading. This particular provider dictates his notes and apparently it picked up some side conversation or it was recording when he wasn't aware. I don't remember what the added words were--thankfully they were innocuous--but they clearly were not intended to be included in the note. Fortunately that doesn't seem to happen too frequently but we've definitely seen it a few times.”

--Melissa Bingham-Wolford, LCSW, ACHP-SW
Bon Secours Mercy Health St. Francis

Document Review

Adobe Acrobat Document

LIVING WILL

ICE HEALTH CARE DIRECTIVE
(Virginia - Â§Â§541-2981 To 541-2993)

In the event that the time comes and I am incapacitated to the point that I am no longer able to actively take part in decisions for my own life, and I am unable to direct my healthcare physician as to my own medical care, I hereby authorize this Living Will as my Advance Health Care Directive to stand as a testament of my wishes.

I, [redacted], residing at [redacted] in the State of Virginia in the zip code [redacted] and whose telephone number is [redacted], being of sound mind, and acting willingly and without duress, fraud or undue influence, herein direct that the instructions provided herein are to be recognized as a formal statement of my desires with regards to my health care, custody and medical treatment, and as such I hereby voluntarily declare and make this designation with regards to my Living Will (aka Advance Health Care Directive and/or Health Care Proxy). These instructions and directives shall be binding upon all involved to the fullest extent allowable by law.

DESIGNATION OF HEALTH CARE ADVOCATE

I herein designate [redacted], residing at [redacted] Washington, District Of Columbia [redacted] and whose telephone number is [redacted], as my advocate and agent to make any and all health care decisions on my behalf should I ever be diagnosed with a terminal illness, disease, injury, or should I become incapacitated or permanently unconscious (in a coma or persistent vegetative condition) where I would remain permanently unable to make decisions.

ADVOCATE'S AUTHORITY COMMENCEMENT

My advocate's or agent's authority shall become effective upon my primary or attending physician's determination that I lack the capacity to make my own health care decisions, unless otherwise stipulated below to commence when I am not able to think for myself.

ADVOCATE'S GENERAL POWERS

My health care advocate or agent shall have the power to make health care, custody and medical treatment decisions on my behalf if my attending and/or primary physician makes the determination that I am unable to make said decisions.

I have specific directives regarding the delivery of medical care in certain health care conditions. Therefore, I wish to direct my medical treatment by way of the following conditions:

- In the event I should fall into a permanently unconscious state (coma or persistent vegetative condition), I wish to not receive life-sustaining medical treatment in an attempt to prolong my life.

LIFE-SUSTAINING MEDICAL TREATMENT

Should any of the aforementioned events occur, I wish to leave the following directives regarding the treatment and procedures which may be used, withheld or withdrawn:

- I wish to receive cardiac resuscitation (CPR) in an attempt to try and prolong my life.
- I wish to receive life-support (e.g., respirators, ventilators) used in an effort to replace or support my natural breathing.
- I wish to not receive tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).
- I wish to receive blood or blood products.
- I wish to receive any form of surgery or invasive diagnostic tests.
- I wish to receive kidney dialysis.
- I wish to receive antibiotics or medication in an attempt to try and prolong my life.

I understand that if I do not specifically indicate my preferences above regarding any of the forms of treatment, I may be subjected to that form of treatment.

COMFORT AND PAIN RELIEF

With regards to the aforementioned medical situations outlined above, I herein provide the following directives pertaining to the comfort care and pain relief:

- I wish to receive maximum pain relief medication.
- I wish to receive maximum pain relief medication if it may unintentionally hasten my death.
- I wish to receive maximum pain relief medication if it may result in temporary addiction should I survive, recover or rebound from my current conditions and/or extended hospital stay.

ADVOCATE'S OBLIGATION

My appointed advocate or agent shall make health care decisions on my behalf in accordance with my other wishes known to my advocate and/or agent. To the extent that my wishes are not known to my advocate or agent, my advocate or agent shall make the necessary health care decisions for me in accordance to what my advocate deems to be in my best interest. In determining those best interests, my advocate shall take into consideration my personal values to the extent known to the advocate.

GUARDIAN NOMINATION

In the event that a guardian needs to be appointed to act in my best interests, I nominate the advocate or agent already named herein in the order designated to act as my guardian.

END OF LIFE DECISIONS

I direct my health care advocate, health care provider and others who may be involved in my health care, to withhold or withdraw treatment in accordance with the choice I have indicated below:

Choice Not To Prolong Life

It is my choice for my life not to be prolonged if:

- have an incurable and irreversible condition that will result in my death within a relatively short amount of time;

- I become unconscious and, to a reasonable degree of medical certainty, remain in a permanent vegetative state; or

- The like risks and burdens outweigh the expected benefits.

PREGNANCY STIPULATIONS

Under some state laws, advance directive instructions to refuse treatment may not be honored while a woman is pregnant. If you wish your advance directives to apply during pregnancy, you will improve your chances of having this wish honored, although not ensure it, by stating the wish clearly.

In the event that I become pregnant and my primary or attending physician or advanced health care advocate are aware of my pregnancy, this document shall have no force or effect during the course of my pregnancy. However, if at any point it is determined that it is not possible that the fetus is viable or could develop to the point of live birth with continued application of life-sustaining efforts and/or procedures, it is my preference that this document be given full effect and force at that point. In the event that life-sustaining procedures could be physically harmful or unreasonably painful to me in a manner that cannot be alleviated by the of pain relieving medication, I request that my desire for personal physical comfort be given consideration in determining whether this document shall be effective if I am pregnant.

DECLARANT STATEMENT AND SIGNATURE

This instrument shall be governed by the laws of Virginia, and I respectfully request that it be honored in any state in which I may reside at the time that this Living Will shall take effect.

By signing below, I certify that I am fully aware and completely understand the contents of this document, and that I am of sound body and mind. Furthermore, I am of the legal age of consent and not under undue influence, fraud or duress.

WITNESSES

9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

____

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

____

____

____

SECTION II: MY HEALTH CARE INSTRUCTIONS

[YOU MAY USE ANY OR ALL OF PARTS 1, 2 OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE AN EYE, ORGAN OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES AND TISSUE FOR DONATION.]

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

[CHECK ONLY 1 BOX IN THIS PART 1.]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☐ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

☑ *[YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]:*

I want the following treatments to prolong my life as long as possible within limits of generally accepted healthcare standards: CPR; IV fluids; tube feeding; antibiotics. I do NOT want dialysis or ventilator.

____

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

[CHECK ONLY 1 BOX IN THIS PART 2.]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☐ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

☑ I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest 3 days as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☐ *[YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

____

____

____

____

PART 2: Make your own health care decisions

What is most important to you? Your wishes for care today may differ from your wishes at the end of life. **Put an X along the line below to show how you would feel if you are very ill and your doctors do not think treatment will help you recover.**

To live as long as possible, no matter what — *Equally important* — *To stay off of machines and allow a natural death*

It is important for your doctor and medical decision maker to know what care you do and do not want. Which of the following choices would you choose if your doctors do NOT think treatment will help you recover? **You can only choose one option.**

Remember, no matter what you choose, comfort care will always be provided.

✓ **Option 1:** If treatment would **not** help me recover, I would want **comfort care only** (instead of living longer with machines and medical treatment) in the situations that I have **checked** below.

- ✓ Not being able to think for myself.
- ✓ Not being able to live without being hooked up to machines. 1 mth.
- ☐ Not being able to know who I am or who I am with.
- ☐ Not being able to feed, bathe, or take care of myself.
- ☐ Not being able to live on my own.
- ☐ Having constant and severe pain or discomfort.
- ✓ Being in a permanent coma.
- ☐ Something else: ____________________

✓ **Option 2:** I would like to live through all of the things listed above but only for a time period of 3-6 mths to see if I get better. I understand that the exact time period will be decided by my medical decision maker with help from my doctor.

☐ **Option 3:** I would like to live through all of the things listed above if it means a chance to live longer.

Please review above to make sure you have chosen only Option 1, Option 2, OR Option 3. Choosing more than one option means your medical team will not clearly know what care you want.

You can add additional instructions here: Be by myself before Surgery - to Answer questions needed for best surgical outcome. - Unless ~~change~~ chose person to be with me

Where would you like to be if you are dying?

____ at home ✓ in the hospital ____ nursing home ____ it does not matter

Organ Donation

Some people decide to donate their organs or body parts. What is your choice?

You should only choose one:

- ☐ I want to donate my organs, tissue, or body parts. Which organ or body parts do you want to donate?
  - ☐ Any organ, tissue, or body part. ☐ Only ______________________
- ☐ I want to donate my whole body for research.
- ☐ I do not want to donate my organs, tissue, or body parts.

What else do you want the people taking care of you to know about how you would want to be cared for?

Want some decision making in my hospital care - Want privacy in answering medical employee's questions before some procedures.

PART 3: Sign the form in front of two witnesses

Sign your name and write the date.

Sign your name: ______________ Today's date: ______________

Print your first name: ______________ Print your last name: ______________

Date of birth: ______________

Address: ______________

City: ______________ State: VA ______________ Zip: ______________

Two witnesses will sign their names and write the date.

By signing I promise that ______________ (the person named above) signed this form while I watched. I promise that I am 18 years of age or older.

Witness #1

Sign your name: ______________ Today's date: ______________

Print your first name: ______________ Print your last name: ______________

Witness #2

Sign your name: ______________ Today's date: ______________

Print your first name: ______________ Print your last name: ______________

Organ Donation

Some people decide to donate their organs or body parts. What is your choice?

You should only choose one:

- [ ] I want to donate my organs, tissue, or body parts. Which organ or body parts do you want to donate?
  - [ ] Any organ, tissue, or body part.
  - [ ] Only ______
- [ ] I want to donate my whole body for research.
- [x] I do not want to donate my organs, tissue, or body parts.

Wh[There is a procedure for obtaining verbal consent; this is not it]e taking care of you to know about how you would want to be cared for?

______

______

PART 3: Sign the form in front of two witnesses

Sign your name and write the date. Signed on pt's behalf.

Sign your name: ______ Today's date: ______

Print your first name: ______ Print your last name: ______

Date of birth: ______

Address: ______

City: ______ State: VA Zip: ______

Two witnesses will sign their names and write the date.

By signing I promise that ______ (the person named above) signed this form while I watched. I promise that I am 18 years of age or older.

Witness #1

Sign your name: ______ Today's date: ______

Print your first name: ______ Print your last name: ______

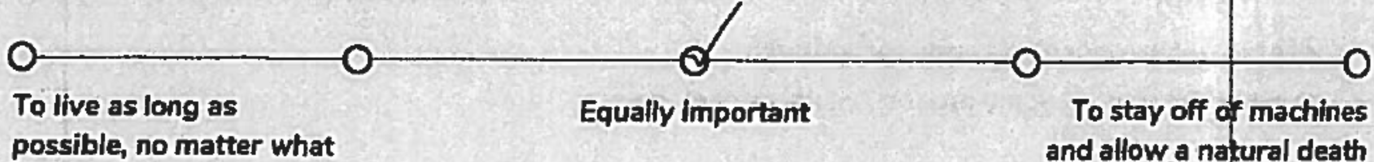
Witness #2

Sign your name: ______ Today's date: ______

Print your first name: ______ Print your last name: ______

PART 2: Make your own health care decisions

What is most important to you? Your wishes for care today may differ from your wishes at the end of life. **Put an X along the line below to show how you would feel if you are very ill and your doctors do not think treatment will help you recover.**



It is important for your doctor and medical decision maker to know what care you do and do not want. Which of the following choices would you choose if your doctors do **NOT** think treatment will help you recover? **You can only choose one option.**

Remember, no matter what you choose, ***comfort care*** *will always be provided.*

Option 1: If treatment would not help me recover, I would want **comfort care only** (instead of living longer with machines and medical treatment) in the situations that I have **checked** below.

- Not being able to think for myself.
- Not being able to live without being hooked up to machines.
- Not being able to know who I am or who I am with.
- Not being able to feed, bathe, or take care of myself.
- Not being able to live on my own.
- Having constant and severe pain or discomfort.
- Being in a permanent coma.
- Something else: ______________________

✓ **Option 2:** I would like to live through all of the things listed above but only for a time period of 1 month to see if I get better. I understand that the exact time period will be decided by my medical decision maker with help from my doctor.

Option 3: I would like to live through all of the things listed above if it means a chance to live longer.

Please review above to make sure you have chosen only Option 1, Option 2, OR Option 3. *Choosing more than one option means your medical team will not clearly know what care you want.*

You can add additional instructions here: No comfort care until I am actively dying.

Where would you like to be if you are dying?

___ at home ___ in the hospital ___ nursing home ✓ it does not matter

Organ Donation

Some people decide to donate their organs or body parts. What is your choice?

You should only choose one:

☐ I want to donate my organs, tissue, or body parts. Which organ or body parts do you want to donate?

☐ Any organ, tissue, or body part. ☐ Only ______________________________

☐ I want to donate my whole body for research.

☑ I do not want to donate my organs, tissue, or body parts.

What else do you want the people taking care of you to know about how you would want to be cared for?

No hospice; no cremation; I would like care ~~independent living~~ in the following order: ① home care; ② independent living; ③ Lucy Corr assisted living; ④ nursing facility. I prefer Mimms Funeral Home. Burial site: [redacted]

PART 3: Sign the form in front of two witnesses

Sign your name and write the date.

Sign your name: [redacted] Today's date: [redacted]

Print your first name: [redacted] Print your last name: [redacted]

Date of birth: [redacted]

Address: [redacted]

City: [redacted] State: VA Zip: [redacted]

Two witnesses will sign their names and write the date.

By signing I promise that [redacted] (the person named above) signed this form while I watched. I promise that I am 18 years of age or older.

Witness #1

Sign your name: [redacted] Today's date: [redacted]

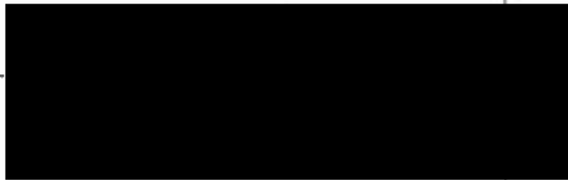
Print your first name: [redacted] Print your last name: [redacted]

Witness #2

Sign your name: [redacted] Today's date: [redacted]

Print your first name: [redacted] Print your last name: [redacted]

Name: ______________ Date: __________ DOB: ______



PART 2: Make your own health care decisions

What is most important to you? Your wishes for care today may differ from your wishes at the end of life. **Put an X along the line below to show how you would feel if you are very ill and your doctors do not think treatment will help you recover.**

To live as long as possible, no matter what — *Equally important* — *To stay off of machines and allow a natural death*

It is important for your doctor and medical decision maker to know what care you do and do not want. Which of the following choices would you choose if your doctors do **NOT** think treatment will help you recover? **You can only choose one option.**

Remember, no matter what you choose, **comfort care** will always be provided.

Option 1: If treatment would **not** help me recover, I would want **comfort care only** (instead of living longer with machines and medical treatment) in the situations that I have **checked** below.

- Not being able to think for myself.
- Not being able to live without being hooked up to machines.
- Not being able to know who I am or who I am with.
- Not being able to feed, bathe, or take care of myself.
- Not being able to live on my own.
- Having constant and severe pain or discomfort.
- Being in a permanent coma.
- Something else: ______________________

Option 2: I would like to live through all of the things listed above but only for a time period of ________ to see if I get better. I understand that the exact time period will be decided by my ~~medical decision maker with help from my doctor.~~

Option 3: I would like to live through all of the things listed above if it means a chance to live longer.

Please review above to make sure you have chosen only Option 1, Option 2, OR Option 3. *Choosing more than one option means your medical team will not clearly know what care you want.*

You can add additional instructions here: No CPR, no ventilator breathing machine, no shock treatment.

Where would you like to be if you are dying?

____ at home ✓ in the hospital ____ nursing home ____ it does not matter

9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

____

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

____

____

____

SECTION II: MY HEALTH CARE INSTRUCTIONS

[YOU MAY USE ANY OR ALL OF PARTS 1, 2 OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE AN EYE, ORGAN OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES AND TISSUE FOR DONATION.]

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

[CHECK ONLY 1 BOX IN THIS PART 1.]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

ok ☑ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

☐ *[YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

____

____

____

____

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

[CHECK ONLY 1 BOX IN THIS PART 2.]

☐ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

☐ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

☐ I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest ____________ as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will ~~receive treatment to relieve pain and make me comfortable. (OR)~~

ok ☑ *[YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

Try treatments as long as quality of life is good

____

____

What does quality of life mean to this individual?

Claiming CE Credit May 18, 2020

If you **have not** participated in a VCU Health CE program in the past:

Go to:
vcu.cloud-cme.com

- Create an account
- Be sure to add your cell phone number
- Text your email address to (804) 625-4041

Submit Attendance

Text today's course code to

(804) 625-4041

The course code for this event is:

17208-17203

Complete Evaluation & Claim Credit

- Sign in to **vcu.cloud-cme.com**
- Click "My CE"
- Click "Evaluations and Certificates"
- Complete evaluation

Or…

- Open the **CloudCME app** on your device
- Click "My Evaluations"
- Click name of activity to complete evaluation

VCUHealth

View recorded sessions at **vcuhealth.org/pcecho**

THANK YOU!

We hope to see you at our next ECHO