Proper charting for advanced directives

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Before getting into the specifics of what should be charted regarding advanced directives an overview of the two types of Advanced Directives need to be addressed first in order to gain a proper understanding of the legal documents. **Understanding advanced directives:** An advanced directive is nothing more than a written document that puts into specifics how the patient wants medical decisions to be made for him if he can't make them himself. An advanced directive is not a requirement by law it is highly recommended for everyone aged 18 or older. A common misconception is advanced directives are only for elderly people who don't want heroic measures taken in the event of incapacitation or cardiac arrest, as a matter of fact nothing could be further from the truth. Young people are involved in far greater risk taking activities than their elders and subsequently end up in the emergency department with traumatic brain injuries quite often, I have seen the effects while working in the neurosurgical ICU and can tell you from experience the devastation of head injuries in young people and the decisions that families have to make about discontinuation of life support and organ donation. If half of the families had an advanced directive beforehand it would have made the process much smoother for the family and everyone involved in the care of their loved one. Advanced directives should be talked about in every family and should be reviewed each year to make sure one's wishes are still reflected. If the patient wishes to revise the document, the copy should be given to family, friends and lawyer. *There are actually two types of advanced directives, a living will and a durable power of attorney in health care.* **The Living Will:** Actually describes the types of medical treatments the patient does, and does not want to receive. Specific instructions about CPR, types of drugs given, blood products and transfusions, mechanical ventilation, tube feedings and dialysis are the usual measures that are listed a person may choose all or none or some of the measures I have listed. A person may also give different instructions for different situations, for example a person may want dialysis for acute renal failure but not for end stage renal disease from cancer. You must be aware that a living will lets the individual choose specific treatments; it can be difficult to anticipate different scenarios for real life situations and may come up vague even with the most clear of intentions. **The second Advanced Directive is the Durable power of Attorney:** Sometimes referred to as a proxy directive. For healthcare it is a document that designates another person to make medical decisions when the patient is unable to make the decision for them. The designee or agent is the decision maker and has the authority to accept or refuse treatment on behalf of the patient. Most patients choose a spouse, parent, child or close friend as their designee. The patient should have a lengthy discussion with the designee and go over various possible scenarios before signing the document in order to crystallize what treatments the patient wishes or refuses. **Living Will VS Advanced Directive**: The durable power of attorney for health care has an advantage over a living will in that it allows the designee to make decisions for the

patient even if the situation does not exactly meet the instructions the patient has given. Being that the designee yields this much powers it is imperative that the patient choose a person he can trust to follow out their instructions. The legal and ethical implications of advanced directives are enormous, here in the United States most if not all states have a right to die law; these laws are put into place by each individual state. These laws recognize the patients right to refuse any "heroic measures" when there is very little chance of recovery. The law also applies to the patients next of kin, so they can decide whether or not to discontinue life support; most hospitals honor the wishes of the family rather than relying on the court order such as the Terry Schiavo case. For example if a patient has their faculties and they refuse a type of treatment health care providers must honor the patients request to refuse ANY type of treatment. To treat someone against their wishes could be construed as battery to the patient and the patient can file a claim, this why it's important to honor the patient's wishes. It is also important to realize that the document will provide the best evidence of what treatment the patient would want and if you deviate from those wishes it can be used against you in court. **The PSDA Act:** Most people are unaware that when admitted to the hospital, an admitting clerk will ask you or your loved one if you have an advanced directive under the PSDA act. This is known as the Patient Self Determination Act, it requires that this question be asked of you upon the time of admission to the facility. The PSDA act also mandates that patients receive written information regarding the decisions of one's own medical care. **Proper Charting of Advanced Directives for Nurses:** If the Physician and family want to terminate life support then as a nurse and patient advocate you must determine your patient's wishes by checking the chart for advanced directives. **What if I can't find anything on the chart?** If you are unable to locate anything on the chart you should ask the physician if he/she has a copy or the family members. If you find the AD review it with your facilities risk manager to determine if the AD meets the state and facility standards. The risk manager and legal counsel will determine this. You should still check your facilities policy on life support termination and make sure all the proper consent forms are signed and in the medical record. If the patient's condition does not match the patient's wishes stated on the directive you must notify the risk manager. If the patient has no AD then you should notify the nurse administrator and risk manager. The risk manager will evaluate your states laws as well as the family consent. Depending on the circumstances, a court hearing may be required before life support is terminated. Your job, after a decision has been made on whether or not to terminate is to offer the family counseling through social workers and give the family alone time with the patient and ask if they would like to stay in the room as life support is discontinued. The patient's physician should be in attendance as life support is being withdrawn note: some facilities require this. **What the nurse should document:** At this point is the absence or presence of the AD on the patients chart? You should note that you have read the directive and had it reviewed by your risk manager and legal counsel. If you facility has a separate consent form for termination of life support then document that the form has been signed and placed in the medical record. You should also document the names of people you notified of the decision to terminate life support, notification times, and their responses. Record your conversations with family members and your offer of counseling via social workers at your facility. You should also document your physical care for the patient just before and after life support termination. Document the time of termination and the name of the person who turned off the life support equipment. Document the names of others present in the

room. Record the patient's vital signs and respiratory effort after extubation, and document the time the patient stopped breathing and was pronounced dead. Also, document the family's response, and describe your interventions for them and the patient after he/she has expired.

A quick note about DNR orders and charting: What to chart? First off make sure the patient's medical record contains ALL the necessary signatures, statements and forms and specifies the DNR order's renewal date. Document your conversations with patient and family about the DNR status. If you were present when the physician spoke with the family about withholding heroic measures then you need to document what each person said. According to your facilities policy write "DNR" on the front of the patient's medical record, in the nursing plan of care and in the MAR record. So the bottom line for a patient with a DNR order should include the following on the medical record: Prognosis and clinical condition, next of kin understands of the order and its implications, any specific treatments to be followed or discontinued, the name of the person who made the DNR decision if the patient did not make it themselves.

What the medical record should NOT include: A verbal or telephone DNR order-(unless it's part of your facilities policy) this can lead to many errors. An order for a "slow code," this entails walking slowly with the crash cart and calling the M.D. before initiating resuscitation. Understand that there is no such thing as a slow code, although I have seen many. Slow codes are unethical and can expose you to legal action for malpractice and failure to provide the acceptable standard of care.

In conclusion there is much we can do to plan in advance for not only our own care, but for our loved ones as well. Planning for end of life issues and care is not always the most pleasant of undertakings but is a must in order to avoid the common pitfalls and miscommunication that can occur during a stressful time such as end of life issues and care. With proper planning as outlined above, we can make our choices and wishes known to all family and caregivers. You can control who, what and where you want to be and who you want to be with. Financial planning, legal plans and advance directives need to be be made with the knowledge that some time down the line, you will have to rely on others to implement our wishes and live with the decision. From this understanding such plans should, when possible, allow for adjusting and trusting in the discretion of our representatives and advocates involved in our care.