Advance Directives and Self-Directed Care – Advance Directives and Patient Self-Management

SECTION: 12.01

Strength of Evidence Level: 3

PURPOSE:
To support the implementation of the Patient Self-Determination Act (PSDA) and ensure that all patients are informed of their rights to formulate advanced directives within state and federal law, and agency policy.

CONSIDERATIONS:
1. Check state laws and licensing regulations regarding advance directives which include:
   a. Living wills.
   b. Directives to physicians.
   c. Durable power of attorney for healthcare.
2. Terms patient should know:
   a. Advance Directives are also known as Living Wills or Instruction Directives. These are formal documents stating specific wishes about providing, withholding or withdrawing life-sustaining treatment, or you may state your general treatment philosophy. A Combined Directive includes both the above and allows a person to be named as healthcare representative.
   b. A durable power of attorney is also known as a health care proxy. This document allows the patient to designate a surrogate, a person who will make treatment decisions for the patient if the patient becomes too incapacitated to make such decisions.
   c. A directive to the physician is a written document that can be useful for terminally ill adults who have no other person to name as their agent for making health care decisions. The person directs the physician to be his or her decision-maker. The physician must also agree, in writing to accept this responsibility.
   d. A POLST- Practitioner Order for Life Sustaining Treatment can be obtained from a physician or health care provider. POLST promotes patient right to self determination with respect to goals of care, treatment preferences, and choices for life sustaining treatment. Following a discussion with the patient and physician, the physician completed the green POLST form including instructions and physician signature. This document is a physician order that must be followed across all health care settings. The POLST must be kept with the patient and may not be removed from their possession.
3. Patient/family understands that the home health agency does not require an advance directive in order to receive care.
4. Definitions:
   a. Adult: A person 18 years or older, or a person legally capable of consenting to his/her own medical treatment.
   c. Attending physician: The physician who is primarily responsible for the medical care of a patient receiving home health services.
   d. Do Not Resuscitate (DNR): A medical order to refrain from cardiopulmonary resuscitation if the patient suffers cardiac or respiratory arrest.
   e. Healthcare Proxy: A document delegating authority to make decisions.
   f. Healthcare Agent: An adult to whom authority to make healthcare decisions is delegated under a healthcare proxy.
   g. Patient Self-Determination Act: A federal statute enacted as part of the 1990 Omnibus Budget Reconciliation Act (OBRA) (PL 101-508) which requires, among other things, that healthcare facilities provide information regarding the right to formulate advance directives concerning healthcare decisions.
   h. POLST – Practitioner Order for Life Sustaining Treatment: A physician order which must be followed across all health care settings. Details goals of care, treatment preferences, and choices for life sustaining treatment.
5. The Patient Self-Determination Act of 1991 requires all healthcare institutions that receive Medicare or Medicaid funds to provide patients with written information about their rights under state law to execute advance directives, but it does not require states to adopt or change any substantive laws. The PSDA also requires facilities to document in each patient’s health record whether an advance directive has been executed, to educate staff and the public about the right to forgo treatment, and to ensure institutional compliance with state law. Violation of the act can lead to loss of federal funding.
6. Patients who speak with their healthcare providers and their families regarding end of life decision-making tend to be less anxious, understand, and feel more autonomous regarding decisions impacting their healthcare.
7. Patients who have progressive chronic conditions need to have an advance directive. Most patients eventually die from chronic conditions. These patients require the same kind of advance care planning as those suffering from predictably terminal conditions such as cancer.
8. An advance directive can be revised, changed and updated at any time.

EQUIPMENT:
The following Advance Directive forms should be available on the admission visit:
Living will
Durable power of attorney
Do not resuscitate/Do not intubate
Written information regarding Patient Self-Determination Act and Advance Directives

PROCEDURE:

1. Upon admission and prior to the treatment and/or services, the clinician will provide written and verbal information to the patient regarding a patient’s right to make decisions regarding healthcare. Included in the information should be the following:
   a. The right to accept or refuse medical or surgical treatment, even if that treatment is life-sustaining.
   b. The right to execute advance directives.
   c. Applicable agency policies.
2. The clinician will document in the health record that the information was provided and document all discussions concerning advance directives.
3. If the patient lacks decision-making capacity, the admitting clinician will provide information and direct inquiry about advance directives to the patient’s representative. The clinician will document that the patient representative received information. If patient subsequently becomes able to receive information, the office will provide information to the patient.
4. If conditions are such that it is not practical to provide information to the patient or his/her representative at the time of admission, such information will be provided as soon as feasible after admission.
5. During the admission, the admitting clinician will ask the patient or his/her representative whether or not he/she has appointed a health care proxy, completed an advance directive, living will, or DNR order. If an advance directive has been completed, the clinician will request a copy of the advance directive so it may be placed in the health record. The patient’s wishes will be communicated to the appropriate staff. If a copy is not immediately available, clinician will document how the advance directive can be accessed.
6. If the attending physician is not willing to honor a patient’s advance directive to limit treatment, the patient can choose to discuss with physician, select another physician or transfer to another healthcare provider that will carry out the patient’s wishes.
7. The patient is encouraged to participate in all aspects of decision-making regarding home healthcare and treatment. Statements by a competent patient regarding his/her desire to accept or refuse treatment will be documented in the patient’s health record.
8. The patient will be informed of any limitations the agency has in respecting the patient’s advance directive.
9. All clinicians providing care for the patient will:
   a. Review the advance directive and report any discrepancies between the directive and current treatment plan to the clinical manager and the patient.
   b. Utilize available educational materials to answer the patient’s questions about advance directives, healthcare proxies or living wills.
   c. Encourage the patient to discuss questions and concerns with appropriate individuals such as the physician, family/caregiver, and his/her selected advocate.
   d. Assist the patient who wants to develop an advance directive by obtaining a form and providing access to outside individuals as necessary to execute the directive.
   e. In absence of an appropriate “Do Not Resuscitate” order, all patients will be resuscitated if clinician is CPR certified. If not, emergency medical services will be contacted.
10. An advance directive will be implemented as follows:
   a. The durable Power of Attorney (POA) for an advance directive is effective only when the patient is unable to participate in his/her own medical treatment decisions.
   b. Once the POA is executed, the patient’s designated advocate can then make medical treatment choices based on the advance directive. The patient advocate may make a decision to withhold or withdraw treatment, which allows the patient to die only if the patient expressed in a clear and convincing manner, that the advocate is authorized to make such a decision and acknowledges that such a decision would or could allow the patient’s death. [Note: This type of decision cannot be made if the patient is pregnant.]
   c. Executing and implementing an advance directive is a process, not a one-time event. On an ongoing basis, the clinical staff will keep the patient, family/caregiver and patient’s representative up to date concerning the patient’s medical condition. They will discuss the patient’s preferred course of treatment as his/her condition changes. All discussions are documented in the health record.
11. Educational materials/information about advance directives and policies regarding advance directives will be provided to all clinical professional staff, home healthcare personnel and volunteers during orientation and on an annual basis.
12. If a patient’s healthcare decisions present a religious or moral conflict to the clinician or homecare staff, the staff will inform the clinical manager. The clinical manager in consultation with his/her manager will reassign staff.
13. The agency will participate in community forums, as appropriate, to educate the community and provide educational materials regarding advance directives.

14. The patient may file complaints regarding implementation of advance directives with the state survey and certification agency through the state hotline.

REFERENCES:


Patient Self-Determination Act, 42 USC 1395cc


Advance Directives and Self-Directed Care – Communication with Patients and Other Clinicians

SECTION: 12.02

Strength of Evidence Level: 3

PURPOSE:
The Situation-Background-Assessment-Recommendation (SBAR) technique provides a framework for communication between members of the healthcare team about a patient's condition. SBAR is an easy-to-remember, concrete mechanism useful for framing any conversation requiring a clinician's immediate attention and action. It allows for an easy and focused way to set expectations for what will be communicated between members of the team, which is essential for developing teamwork and fostering a culture of patient safety. It may also be taught to patients to improve the effectiveness of their communications with their professional caregivers.

CONSIDERATIONS:
1. Why is communication so important? Failures of communication were reported as the major cause (66%) of sentinel events between 1995-2004
2. SBAR was developed as a method of ensuring complete, accurate information transfer during shift changes on submarines. It has since been tested and demonstrated to be effective during care transitions in the healthcare environment and is now considered essential to the patient safety culture of healthcare organizations.
3. Staff training in the use of the technique is essential to effective use. (See Guidelines at the end of this procedure.)

EQUIPMENT:
SBAR cue sheet (see attached)
Guidelines for use of SBAR (see attached)
Pocket guide for staff (optional)

PROCEDURE:
1. Whenever there is communication between healthcare clinicians, organizing the information according to the SBAR reporting method is essential to ensuring that all critical information is conveyed.
2. SBAR recognizes the importance of clinician reporting regarding treatment recommendations. This is not considered diagnosing and is appropriate for use between registered nurse and physician.
3. A small pocket guide may be provided with appropriate cues to remind staff of steps in using SBAR.
4. SBAR principles may also be shared with patients and their families in communicating with clinicians. Encouraging them to organize the information they wish to convey and to state what they anticipate to be the outcome of the conversation. Encouraging patients to organize the information they have prior to contacting clinician will create a more effective environment for communication.

AFTER CARE:
1. Document communications and their effectiveness in advancing the plan of care.

REFERENCES:

Guidelines for Communicating with Physicians Using the SBAR Process

1. Use the following modalities according to physician preference, if known. Wait no longer than five minutes between attempts.
   a. Direct page (if known)
   b. Physician’s Call Service
   c. During weekdays, the physician’s office directly
   d. On weekends and after hours during the week, physician’s home phone
   e. Cell phone

Before assuming that the physician you are attempting to reach is not responding, utilize all modalities. For emergent situations, use appropriate resident service as needed to ensure safe patient care.

2. Prior to calling the physician, follow these steps:
   a. Have I seen and assessed the patient myself before calling?
   b. Has the situation been discussed with resource nurse or preceptor?
   c. Review the chart for appropriate physician to call.
   d. Know the admitting diagnosis and date of admission.
   e. Have I read the most recent physician progress notes and notes from the nurse who worked the shift ahead of me?
   f. Have available the following when speaking with the physician:
      - Patient’s chart.
      - List of current medications, allergies, IV fluids and labs.
      - Most recent vital signs.
      - Reporting lab results: provide the date and time test was done and results of previous tests for comparison.
      - Code status.

3. When calling the physician, follow the SBAR process:
   (S) Situation: What is the situation you are calling about?
      - Identify self, unit, patient, room number.
      - Briefly state the problem, what is it, when it happened or started, and how severe.
   (B) Background: Pertinent background information related to the situation could include the following:
      - The admitting diagnosis and date of admission
      - List of current medications, allergies, IV fluids, and labs
      - Most recent vital signs
      - Lab results: provide the date and time test was done and results of previous tests for comparison
      - Other clinical information
      - Code status

   (A) Assessment: What is the nurse’s assessment of the situation?
   (R) Recommendation: What is the nurse’s recommendation or what does he/she want?

Examples:
   - Notification that patient has been admitted
   - Patient needs to be seen now
   - Order change

4. Document the change in the patient’s condition and physician notification.

SBAR report to physician about a critical situation

Example:
I am calling about <patient name and location>.
The patient’s code status is <code status>
The problem I am calling about is:

1. I am afraid the patient is going to arrest.

   I have just assessed the patient personally:
   Vital signs are: Blood pressure _____/_____, Pulse ______, Respiration______ and temperature ______

   I am concerned about the:
   2. Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual
   3. Pulse because it is over 140 or less than 50
   4. Respiration because it is less than 5 or over 40.
   5. Temperature because it is less than 96 or over 104.

Background
The patient’s mental status is:
1. Alert and oriented to person place and time.
2. Confused and cooperative or non-cooperative.
3. Agitated or combative.
4. Lethargic but conversant and able to swallow.
5. Stuporous and not talking clearly and possibly not able to swallow.

The skin is:
1. Warm and dry.
2. Pale.
3. Mottled.
4. Diaphoretic.
5. Extremities are cold.
6. Extremities are warm.

The patient is not or is on oxygen.
1. The patient has been on _______ (l/min) or (%) oxygen for ______ minutes (hours)
2. The oximeter is reading _______%
3. The oximeter does not detect a good pulse and is giving erratic readings.

**Assessment**

This is what I think the problem is: <say what you think is the problem>

The problem seems to be cardiac infection neurologic respiratory ______
I am not sure what the problem is but the patient is deteriorating.

The patient seems to be unstable and may get worse, we need to do something.

**Recommendation**

I suggest or request that you <say what you would like to see done>.

1. come to see the patient at this time.
2. Talk to the patient or family about code status.
3. Ask the on-call family practice resident to see the patient now.
4. Ask for a consultant to see the patient now.

**Are any tests needed:**

5. Do you need any tests like CXR, ABG, EKG, CBC, or BMP?

6. Others?

**If a change in treatment is ordered then ask:**

7. How often do you want vital signs?
8. How long do you expect this problem will last?
9. If the patient does not get better when would you want us to call again?

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PURPOSE:
To ensure meaningful access to agency services by persons with communication challenges.

EQUIPMENT:
None.

PROCEDURE:
1. The patient’s ability to communicate and particular communication challenges, if any, are assessed during the referral/intake process.
2. If a patient has a language or sensory impediment that hampers meaningful communication, efforts are made to ensure that the patient’s communication needs are met during the admission process, that the contents of all consents, waivers, and agreements are understood.
3. For patients with limited English proficiency (LEP):
   a. Reasonable interpreter services may include, but not be limited to:
      (1) Hiring or contracting with staff interpreters.
      (2) Using telephone interpreter lines.
      (3) Using staff or Agency volunteers proficient in the target language.
      (4) Family members or friends of the LEP/sensory impacted patient will not be used as interpreters unless requested by the individual and after an interpreter has been offered at no cost to patient. If the individual chooses to use family/friend issues of competency of interpreting confidentiality, privacy, and conflict of interest should be considered.
   b. Reasonable translation services may include, but not be limited to:
      (1) Determining which documents provided to patients/representatives are essential for translation and into which languages.
      (2) Obtaining professional and competent translation services and ensuring the translated documents are provided to LEP persons as needed and appropriate.
4. For visually impaired patients:
   a. The Agency nurse reads aloud all documents normally provided to the patient during admission and documents that the patient/caregiver has understood what was read.
5. For hearing impaired patients:
   a. The Agency nurse determines if writing, lip reading or signing is the most effective means of communication with the patient.
   b. If sign language is the most effective means of communication, the Agency contacts resources in the community that provide signing services.

REFERENCES:
Purpose:
Goal setting is essential to effective problem solving, a skill needed for patient self-management. Goals are desired outcomes to which effort is directed. It is important that goals be optimistic, yet realistic.

Considerations:
1. Clinical staff training in goal setting may be necessary.
2. Knowledge of motivational interviewing or coaching is helpful.
3. Goal setting is critical to patient self-management.
4. Goal setting is based on the psychological behavior change models: Health Belief Model, Self-Efficacy, Transtheoretical Model, and Health Promotion Model.

Equipment:
None

Procedure:
1. A recommended goal setting guide is the SMART principle: Specific, Measurable, Achievable, Realistic and Time limited
2. Assisting patient in setting goals requires helping them identify what changes they wish to see in their lives. This may include such things as returning to hobbies, resumption of roles such as babysitter, preparing meals for family. Helping patient/family begin to see beyond current level of health is key.
3. Helpful questions might include:
   a. Where would you like your health to be in 2 months?
   b. What are you currently unable to do that you would like to resume?
   c. What is a hobby you would like to do that you are currently unable to participate in?
4. Identify small, achievable steps needed to progress toward the goal. Include measurable steps to be taken to get to the goal. Each step should have a time limit placed on it to encourage evaluation and revision of the steps toward attaining the goal.
5. Goals should be written and shared with others vital to achievement of the goal such as clinicians, family members and significant others.

After Care:
1. Document goals and progress toward goals.

References:


PURPOSE:
Motivational interviewing techniques are used to activate the patient’s own motivation for change and to facilitate patient self-management. It is accomplished by identifying the patient’s values and beliefs and incorporating them into the plan of care.

EQUIPMENT:
None

PROCEDURE:

1. Clinicians working with patients will engage in the following approaches:
   a. Active listening.
   b. Working from the patient’s agenda.
   c. Identifying patient beliefs and values.
   d. Elicit change talk.
   e. Recognize patient’s change readiness.

2. Defining terms:
   a. Active listening is a structured form of listening that focuses on the patient. It does not focus on doing or teaching, but on listening to the patient to elicit information needed to support patient self-management. Active listening is the key to all of the other approaches listed. The amount of active listening engaged in by clinician may vary from visit to visit.
   b. Working from the patient’s agenda provides the clinician with insight into what motivates the patient to act. This may be accomplished through questions asked of the patient. The patient’s answers help to identify patient-centered goals. Example: What is the most important part of your recovery to you? Where would you like your health to be in 2 months?
   c. Identifying patient beliefs and values aids in understanding what is important to the patient and what will motivate his/her engagement in self-management. This is particularly important in medication reconciliation as patients may not openly share their reluctance to take a particular medication. The usual response is to tell the patient all of the reasons they need to take a medication, instead of finding out why they have reservations regarding taking the medication.
   d. Change talk provides cues regarding where the patient is in their readiness to change. The stages include: pre-contemplative, contemplative, active change, maintaining or relapsing.
   e. Recognize that patient’s readiness for change is accomplished by listening to a patient’s change talk. A tool used to measure change readiness is the “Importance of Change Ruler”.
   f. Engagement in active listening allows the clinician and patient to identify mutual goals valued by the patient and the clinician.
   g. Use of the “Importance of Change Ruler” (Miller & Rolnick, 2002) provides guidance to the clinician for evaluating change readiness. Ask the patient “On a scale from 0-10, with 0 being not at all important to 10 being extremely important: how important would you say it is for you to______________ (fill in patient identified goal).”

AFTER CARE:

1. Document patient goals in the record.

REFERENCES:


PURPOSE:
To provide patient/caregiver with written and verbal education and information to support and promote self directed care.

EQUIPMENT:
None

PROCEDURE:
1. Members of the interdisciplinary team assess the patient's/caregiver's education and training needs based on the care being provided to the patient.
2. As appropriate to each patient/caregiver, verbal or written information may be provided related to, but not limited to, the following:
   a. Effective pain management.
   b. The disease process and the relief of symptoms
   c. Signs and symptoms of change in condition.
   d. Safe and effective use of medications, including side effects, preparation and storage.
   e. Prevention and control of infection.
   f. Safe use of medical equipment.
   g. Nutritional needs.
   h. Community resources.
   i. Emergency preparedness.
   j. Appropriate and safe use of restraints.
   k. Basic home safety.

AFTER CARE:
1. All teaching provided to patients/caregivers, whether verbal or in the form of written materials, is documented in the patient's clinical record and includes the information provided and the patient's/caregiver's understanding and response.

REFERENCES:
Purpose:
1. To inform the patient/representative of his/her rights and responsibilities as a patient of the agency.
2. To ensure that the agency promotes and protects the patient’s rights.

Equipment:
- Written list of patient rights
- Written service agreement indicating projected service type and frequency

Policy:
1. The agency honors patient rights and informs patient/representative of his/her rights and responsibilities, both verbally and in writing, upon admission.
2. The agency’s “Patient Bill of Rights and Responsibilities” statement must contain the following:
   a. Rights regarding collection of Outcome and Assessment Information Set (OASIS) information and sharing of same with Centers for Medicare and Medicaid Services (CMS).
   b. Information will be kept confidential.
   c. The patient may refuse to answer any questions.
   d. The patient may rely on having their property treated with respect.
   e. The patient may voice grievances regarding treatment or care.
   f. The patient may participate in the planning of care.
3. The agency educates all staff about the policies and procedures regarding patient rights and responsibilities during orientation and on an ongoing basis, as necessary.

Procedure:
1. The admitting professional shall provide the patient/representative with the agency’s rights and responsibilities statement.
2. The admitting professional will review patient’s rights is listed in the statement.
3. The patient/representative indicates his/her receipt and understanding of the patient’s rights and responsibilities by signing an acknowledge of receipt form.
4. The patient/representative is given a copy of the signed form and patient rights and responsibilities statement. Original will be placed in the patient’s clinical record.
5. If the patient is unable to sign, the admitting professional documents the reason why on the form and the appropriate designee will sign for the patient. The admission narrative will indicate any limitations that the patient has consistent with the patient’s condition.
6. If the patient is unable to sign and there is no designee to sign on behalf of the patient, the agency cannot provide care and should document same.

References: