Who Decides?
Surrogate Decision-Making in Assisted Living Communities

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Overview

- Basic Concepts
  - Informed Consent
  - Incapacity

- Hierarchy of Decision-Makers
  - Guardianship
  - DPOAs and Attorneys-in-Fact
  - Statutory “Proxies”

- End-of-Life Decisions
  - Advance Directives
  - POLSTs

DISCLAIMER: This presentation provides general information only and is not intended as legal advice applicable to any specific situation.
Informed Consent

The personal right to bodily integrity
"Every human being of adult years and sound mind has the right to determine what shall be done with his own body."

Justice Cardozo

_Schloendorff v. Society of New York Hosp._, 211 N.Y. 125 (1914)
Informed Consent Required

- Any health care decision must be made with INFORMED CONSENT
  - Including decisions regarding life sustaining treatment
  - Whether made by the resident himself/herself, or a legally-authorized substitute decision-maker on behalf of the resident
- Informed Consent should be documented in the resident’s medical record.
Informed Consent requires a substantial disclosure of:

- The nature and character of the contemplated treatment
- The risks and anticipated benefits involved
- The prospect for success
- The possibility for complications
- The alternatives available
- The likely result if the patient remains untreated
SNF Regulatory Requirements

- **WAC 388-97-0260**
  - Informed consent is a “process” that must be followed with the resident or the surrogate decision-maker
  - Comply with RCW 7.70 as part of comprehensive care plan
  - Provide information in neutral manner, in language resident or surrogate-decision maker can understand
  - Resident has right to change his or her mind
  - Resident has right to choose not to be informed
AL Regulatory Requirements

- No specific regulation on informed consent for assisted living facilities, BUT:

- WAC 388-78A-2350(7): When coordinating care or services, the AL facility must:
  - Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and
  - Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

- WAC 388-78A-2020: “Resident’s Representative” means:
  - The person or persons identified in RCW 7.70.065 and who may act on behalf of the resident pursuant to the scope of their legal authority . . . or,
  - If there is no legal representative, a person designated voluntarily by a competent resident in writing, to act in the resident's behalf. . . . The resident's representative . . . shall not have authority to act on behalf of the resident once the resident is no longer competent. The resident's competence shall be determined using the criteria in RCW 11.88.010 (1)(e).
  - NOTE: RCW Chapter 11.88 is no longer applicable after December 31, 2020.

- WAC 388-78A-2600: Policies on substitute decision-making
In the event of a recognized health care emergency, the patient’s consent will be implied.

- Life-or-death situations
- Patient is not competent to consent and nobody authorized to provide consent is readily available
- All “required treatment” will be provided

BUT: advance directive or POLST?
Incapacity

When is a surrogate decision-maker needed?
What is “capacity”?

- Ability to make decisions regarding one’s person and property
- A legal determination, not a strictly medical one
- A person may have capacity to make some decisions but not others
- Capacity may change or fluctuate over time
When is a person incapacitated?

For purposes of giving informed consent for healthcare, a person is incapacitated if incompetent by reason of:

- Senility
- Mental illness
- Developmental disability
- Habitual drunkenness
- Excessive use of drugs
Capacity for Medical Consent

- Can the patient give informed consent? Can the person understand:
  - The nature and character of the contemplated treatment?
  - The risks involved?
  - The prospects for success?
  - The possibility for complications?
  - The alternatives available?
  - The likely result if the condition remains untreated?

- A patient may be competent for some decisions but not others
Incapacity: the Person and the Estate

- Incapacity as to Person
  - Inability to adequately provide for nutrition, health, housing, or physical safety

- Incapacity as to Estate
  - Inability to adequately manage property or financial affairs
Financial Surrogate Decision-makers

- Legal Guardian
- Power of Attorney
- Representative Payee
- Trustee
Heirarchy of Surrogate Decision Makers
Who Can Give Informed Consent: RCW 7.70.065

Statutory hierarchy of possible decision-makers:

- Resident
- Court-Appointed Guardian
- Attorney-in-Fact or DPOA agent
- Spouse or Domestic Partner
- Adult Children
- Parents
- Adult Siblings
Who Can Give Informed Consent: RCW 7.70.065 (Effective July 2019)

- Adult grandchildren who are familiar with the patient
- Adult nieces and nephews who are familiar with the patient
- Adult aunts and uncles who are familiar with the patient
- An adult who:
  - (i) has exhibited special care and concern for the patient
  - (ii) is familiar with the patient’s personal values;
  - (iii) is reasonably available to make health care decisions
  - (iv) is NOT: A physician or employee of the physician; the owner, administrator, or employee of a health care facility, nursing home, or long-term care facility where the patient resides or receives care; or a person who receives compensation to provide care to the patient
The unrelated adult has to provide a declaration under penalty of perjury that:
- they know the patient
- are willing to be involved in health care decisions
- that no higher priority class is willing and able to provide informed consent on behalf of patient

Declaration is valid for 6 months

Health care provider has choice on whether to accept the declaration, but is immune from any liability based on reliance on such declaration

A person who knowingly provides false declaration is subject to criminal penalties
Health Care Provider’s Role:  
RCW 7.70.065

- If health care provider makes reasonable efforts to locate and secure the proper person and finds no such person available, then can move on to the next person on the list.
- Cannot seek informed consent where a person of higher priority has refused such authorization
- Two more people in the same class – unanimous decision making
Decision-Making Standards
Decision-Making Standards: Informed Consent

- **Substituted Judgment**
  - Preferred standard
  - What choice would this particular individual make if he/she were competent?
  - Based on the resident’s preferences and eccentricities; may not be what most people would choose
  - What the resident now says he/she wants is relevant, but not necessarily the final answer

- **Best Interest**
  - Applies when substituted judgment is not possible
  - What is objectively best for the person?
The authorized person(s) must first determine in good faith that if the resident were competent, they would consent to the proposed health care.

If the decision that the resident would have made if competent cannot be determined, then the authorized person(s) must determine that the proposed health care is in the resident’s best interests.

RCW 7.70.065(1)(c)

_In re Guardianship of Ingraham_ (1984)

_Raven v. DSHS_ (2013)
“...in matters of consent, though a ward may choose a course of action that would strike many as unreasonable, if the guardian can determine that the ward would choose such an action if competent, the guardian is bound to advocate for that position. . .“

The goal is not to do what most people would do, or what the court believes is the wise thing to do, but rather what this particular individual would do if she were competent and understood all the circumstances, including her present and future competency.”
Guardianship

Involuntary loss of personal autonomy
History of Guardianship

- English common law – the King as “parent” had the power to care for helpless subjects
- In American colonies, evolved into equitable court proceedings
- Initially focused on preserving wealthy estates
- Increasingly focused on personal decisions
- Evolving constitutional norms of Due Process
Types of Guardians

- Guardian of the Estate
  - Decisions related to finances and property.

- Guardian of the Person
  - Decisions related to medical care, residence, etc.

- Full Guardian
  - Guardian with all powers that a guardian may have as to person, estate, or both.

- Limited guardianship
  - Guardian with only certain enumerated powers.

- Co-guardian
  - Generally, each co-guardian has independent authority—but not always
Types of Non-Guardians

- Standby guardian:
  - No decision making authority unless the primary guardian is unavailable (usually when emergency health care decisions must be made).

- Resident Agent:
  - Washington resident chosen to receive service of process on guardianship matters for a guardian who lives out of state. No decision making authority.
Types of Non-Guardians

- **Guardian ad Litem (Title 11)**
  - Appointed by court to investigate need for a guardian for an adult. Has emergency (life-threatening) medical decision authority, and may be given additional authority by the court.

- **Guardian ad Litem (Title 26)**
  - Appointed by court to represent the interests of a minor or dependent child in a family law proceeding (i.e. divorce).

- **Litigation GAL**
  - Appointed by court to represent the interests of an incapacitated person in a lawsuit.
Loss of Rights

- The guardian’s decision-making is the legal substitute for the incapacitated ward’s own decisions.
  - Informed consent
  - Contracts/financial obligations
- The guardian’s decisions override the decisions of the incapacitated person.
  - Incapacitated person retains certain fundamental rights
  - Guardian cannot force provider to take certain actions
A PETITION TO HAVE A GUARDIAN APPOINTED FOR YOU HAS BEEN FILED IN THE ____ COUNTY SUPERIOR COURT BY ____. IF A GUARDIAN IS APPOINTED, YOU COULD LOSE ONE OR MORE OF THE FOLLOWING RIGHTS:

(1) TO MARRY, DIVORCE, OR ENTER INTO OR END A STATE REGISTERED DOMESTIC PARTNERSHIP;

(2) TO VOTE OR HOLD AN ELECTED OFFICE;

(3) TO ENTER INTO A CONTRACT OR MAKE OR REVOKE A WILL;

(4) TO APPOINT SOMEONE TO ACT ON YOUR BEHALF;

(5) TO SUE AND BE SUED OTHER THAN THROUGH A GUARDIAN;

(6) TO POSSESS A LICENSE TO DRIVE;

(7) TO BUY, SELL, OWN, MORTGAGE, OR LEASE PROPERTY;

(8) TO CONSENT TO OR REFUSE MEDICAL TREATMENT;

(9) TO DECIDE WHO SHALL PROVIDE CARE AND ASSISTANCE;

(10) TO MAKE DECISIONS REGARDING SOCIAL ASPECTS OF YOUR LIFE.
Who needs a guardianship?

- Is the person competent to handle their basic affairs?
- Is access to medical care a problem?
- Are the person’s informal supports making poor decisions on their behalf?
- Is there a family member or friend willing to be guardian; or does the person have resources to pay a CPG?
- Are there alternatives to guardianship?
  - Arrangements made while competent?
  - Family decision-makers?
Petition Process

- Petition filed
  - By whom?

- Guardian ad Litem (GAL) appointed
  - Meet with alleged incapacitated person
    - Right to attorney
  - Medical report & other investigation
  - Meet with proposed guardian

- GAL reports back to court (45 days)
  - Proposed guardian
  - Scope of guardianship

- Hearing or trial (60 days)
  - Right to jury trial
Scope of Guardianship

- Person and/or Estate
- Full or Limited
  - What decisions is the resident unable to make?
  - Do the resident’s abilities or existing supports allow him/her to retain some areas of decision-making?
- Modification: scope can change over time
Letters of Guardianship

- Issued by court
- Describe the guardian’s authority
  - Questions? See court order.
- Expiration date?
  - Letters now expire after 5 years
  - Older orders do not include expiration
  - Does not mean the guardianship has terminated
- Reasonable reliance
Limits to Guardian Authority

- The guardian only has authority as provided in the order appointing guardian
- The guardian can only make decisions their ward had the power to make in the first place
- Some decisions require a court order
Limits to Guardian Authority

- Convulsion therapy, psychosurgery, sterilization . . .
- Involuntary commitment to mental health facility
- Violation of legal rules or provider policies
  - Guardian may advocate, but cannot compel
  - All placements are voluntary
    - Guardian may choose to move the incapacitated person to a different home with policies they prefer
Limits to Guardian Authority: Gray Areas

- **Freedom of expression**
  - Lifestyle choices, recreation, leisure, religious activities

- **Freedom of association**
  - Friendships, social visits, phone/internet, romance

- **Freedom of movement**
  - Community access, mobility, community involvement

- **Individual preferences**
  - Clothes, food, drink, use of possessions
Guardian has a duty to “provide timely, informed consent for health care of the incapacitated person, except in the case of a limited guardian where such power is not expressly provided.”

Standby limited guardian may provide informed consent if guardian cannot be located within four hours.

No informed consent for involuntary commitment to mental health facility.
RCW 11.92.195: Incapacitated people have the right to communicate and associate with people of their choosing.

- Guardians may not restrict an incapacitated person’s right to associate with someone of his/her choosing unless . . .
Limited Exceptions to Incapacitated Person’s Right to Associate

Specifically authorized by guardianship court in an order

Pursuant to a protection order issued under VAPA, or other law, that limits contact between incapacitated person and other persons

Or...
Limited Exceptions to Incapacitated Person’s Right to Associate

“. . . the guardian or limited has good cause to believe there is an immediate need to restrict an incapacitated person’s right to communicate, visit, interact or otherwise associate in order to protect the incapacitated person from abuse, neglect, abandonment or financial exploitation . . . or to protect the incapacitated person from activities that unnecessarily impose significant distress on the incapacitated person; . . .”

See RCW 11.92.195(2)(c)(i).

NOTE: RCW Chapter 11.92 will no longer be applicable effective December 31, 2020.
Guardian can file a petition with the Court under VAPA on behalf of the vulnerable adult to seek protection from abuse and neglect.

RCW 74.34.120(3)
Additional Duties of Guardians

- To care for and maintain the incapacitated person in the setting least restrictive to the incapacitated person’s freedom – RCW 11.92.043(1)(e).

- “The court must modify or terminate a guardianship when a less restrictive alternative, such as a power of attorney or a trust, will adequately provide for the needs of the incapacitated person.” RCW 11.88.120(1)(b).
Additional New Duties of Guardians: RCW 11.92.043(1)(d)

Must inform persons entitled to special notice and any other person designated by the incapacitated person “as soon as possible” and within no more than five days, of:

- Change in residence expected to last more than 14 days
- Admission to medical facility for life-threatening injury or inpatient care
- Treatment in an emergency room or admission to hospital for observation that exceeds 24 hours
- Death (Notice of death must be in person, by phone or by certified mail)
Uniform Guardianship Act

Coming January 1, 2021
DPOAs and Agents

Voluntary assignment of decision-making
What is a Power of Attorney?

• A power of attorney (“POA”) is a document that appoints someone other than the person signing the document to make financial and/or health care decisions on behalf of the person executing the document.

• Very powerful – gives someone else power to do almost everything a person could do for himself or herself.
Two Types of Power of Attorney

- Health Care Power of Attorney
- Financial Power of Attorney
To continue authority beyond principal’s incapacity, POA must expressly provide:

- “This power of attorney shall not be affected by the disability of the principal. . . or similar words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding the principal’s incapacity.”

If POA does not expressly provide that effectiveness continues beyond principal’s incapacity, then the agent’s authority under the POA lapses with the principal’s incapacity.
Powers with Respect to Health Care Decisions

• Absent an express grant of authority in the POA, the agent cannot make health care decisions on behalf of the principal.

• A general grant of health care authority is deemed to include a HIPAA waiver.
Powers with Respect to Health Care Decisions (cont.)

• An agent must cooperate with the principal’s health care decision maker.

• Agent may exercise principal’s rights under Washington’s Natural Death Act (i.e., decline life sustaining treatment). See RCW 70.122.010.
• Agent may not exercise principal’s rights under Washington’s Death with Dignity Act (Chapter 70.245 RCW).

• Absent court authority, agent may not involuntarily commit principal, consent to convulsive therapy, psychotherapy, or procedures that restrict principal’s freedom of movement.
Who *cannot* be an agent under a health care POA?

- Agent may not exercise principal’s rights under Washington’s Death with Dignity Act (Chapter 70.245 RCW).

- Absent court authority, agent may not involuntarily commit principal, consent to convulsive therapy, psychotherapy, or procedures that restrict principal’s freedom of movement.

  Unless the person to be appointed is the principal’s spouse, registered domestic partner, parent, adult child or sibling of the principal, none of the following can serve as agent for health care decision-making:

  - Any of the principal’s physicians or employees of physician; or the owners, administrators, or employees of health care or long term care facility where the principal resides or receives care.
What About Coagents?

- Coagents must act jointly unless the POA provides that each agent may act independently.
- A coagent may delegate his or her authority to the other coagent.
  - “Old” statute was silent on coagents.
  - Requiring coagents to act jointly reduces risk of contradictory instructions to third parties (banks, care providers).
  - Requiring coagents to act jointly can act as a check/balance system.
  - Requiring coagents to act jointly can create paralysis due to conflict or unavailability in an urgent situation.
Termination of POA

- Death of principal
- Incapacity of principal (unless durability is specifically provided for in POA)
- Revocation by principal
- Happening of certain event specified in POA
Termination of POA

- Purpose of POA is accomplished
- Principal revokes agent’s authority or the agent dies, becomes incapacitated or resigns, and the POA does not provide for a successor agent.
- Existing POA is not automatically revoked or terminated upon execution of a new POA.
  - Note: Potential risks of concurrent authority.
Termination of Agent’s Power Under POA

• Revocation by principal.
• Agent dies, becomes incapacitated, or resigns.
• In the case of an agent who is the principal’s spouse, an action is filed for dissolution or annulment of marriage or domestic partnership, or for legal separation (but POA reinstated if action is withdrawn).
  • Note: Difference from “old” statute.
How Does a Guardianship Affect a POA?

- If a court appoints a guardian of the principal’s estate (or other fiduciary) charged with management of all of the principal’s property, then the POA is terminated, unless the court provides otherwise. UPAA is not clear about impact on healthcare POA.
Impact of Limited Guardianship on POA

If, however, guardianship is “limited,” then POA will not be terminated or modified, except to the extent ordered by the court.
Third party obligations upon presentation of POA

Third party may, within 7 business days of receipt of an acknowledged POA, request an agent’s certification (see RCW 11.125.430), and must accept the acknowledged POA within 5 business days of receipt of the certification unless:

- Third party believes in good faith that the POA is not valid;
- Third party believes in good faith that the agent is acting outside of his or her authority; or
- Third party makes or has actual knowledge that another person has made a good faith report that the principal may be subject to physical or financial abuse by the agent.
Third party may not:

- Insist on a certain POA form.
- Refuse to accept an acknowledged POA because third party believes POA is "too old."
If third party wrongfully refuses to accept an acknowledged POA, the agent can seek a court order requiring acceptance of the POA and payment of the agent's attorney’s fees.
Third party is not liable for reasonably relying on an *acknowledged* POA in good faith without actual knowledge that it is void, invalid, or terminated or being misused by the agent.
Advance Directives

End-of-Life Decisions:
The Washington Natural Death Act and "Living Wills"
Natural Death Act – RCW 70.122

- Do not resuscitate/No-code
- Withdrawal of life support
- Also known as Living Wills
- Competence to sign?
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 Natural Death Act – RCW 11.122.010

Legislative Findings
Modern medical technology has made possible the artificial prolongation of human life beyond natural limits.
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.

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**The Natural Death Act – RCW 11.122.010**

**Legislative Findings**
Advance Directives

- Any adult person with “capacity to make health care decisions” may execute a directive directing the withholding or withdrawal of life-sustaining treatment in the event of:
  - A terminal condition; or
  - A permanent unconscious condition

RCW 70.122.030
Conditions Activating Directive

“Terminal Condition”

- 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.

“Permanent Unconscious Condition”

- An incurable and irreversible condition in which the resident is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an **irreversible coma or persistent vegetative state**.
Life Sustaining Treatment Defined

- Includes artificially provided nutrition and hydration:
  
  “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 resident, would serve only to prolong the process of dying.”

- **Does not** include comfort care:
  
  - Administration of medication
  
  - Performance of any medical or surgical intervention deemed necessary solely to alleviate pain
Form of Directive

- Statutory model form
  - Use of the form is not mandatory
- Document used must clearly specify the person’s instructions
Form of Directive

- Notarized or signed in the presence of 2 witnesses

- Witnesses must:
  - Personally know the resident
  - Believe the resident is capable of making healthcare decisions at the time of execution

- Witnesses cannot be:
  - Entitled to any portion of the estate
  - The attending physician
  - An employee of the physician
  - An employee of the health facility where declarer resides or is a patient
Hospital Visitation Authorization
(Advance Directive Addendum)

This form enables people not traditionally recognized as family members to gain priority visitation rights. Once completed and signed, it should be kept with the advance directive.

I, ____________________________________________,
residing at ____________________________________________
County, state of ____________________________________________, do hereby give notice and authorization that if I should become ill or incapacitated through any cause that necessitates my hospitalization, treatment or long-term care in a medical facility, it is my wish that the following person(s),

be given first preference in visiting me in such medical or treatment facility, whether or not they are parties related to me by blood or law, unless or until I freely give contrary instructions to medical personnel on the premises involved.

Executed this _______________ day of _____________ (month), _______________ (year)
at (location of signing) ____________________________________________

by: _____________________________________________________________

_________________________________________________________________

WITNESS SIGNATURES:

WITNESS 1

Signature

Address

Date

WITNESS 2

Signature

Address

Date

* Doctors may see whether the therapy quickly reverses my condition. If it does not, I want it discontinued.
A directive, or a copy, must be made a part of the resident’s medical record kept by his or her attending physician.

The custodian of the records shall forward a copy of the directive to the resident’s nursing facility when a decision pertaining to life-sustaining treatment is being considered.
Certification of Resident Condition

- **Terminal Condition:**
  - One physician must certify
  - Physician must be the attending physician, who has personally examined the resident

- **Permanent Unconscious Condition:**
  - Two physicians must certify
  - Attending physician and one other physician, both of whom have personally examined the resident
Certification of Resident Condition

- Must be entered in the resident’s medical record, in the physician’s progress notes
- PRIOR TO the withholding or withdrawal of life-sustaining treatment
Health Care Provider Duties

- Physician’s Duty:
  - Prior to withholding or withdrawal of life-sustaining treatment
  - Physician shall make reasonable effort to determine that the directive complies with the statutory requirements
  - If the resident is capable of making health care decisions, physician shall make reasonable effort to determine that the directive and proposed treatment are currently in accord with the desires of the patient
  - An advance directive/living will cannot be required as a condition of providing care.
Health Care Facility or Personnel May Refuse to Participate

- No nurse, physician or other health care practitioner may be required to participate in the withholding or withdrawal of life-sustaining treatment.

- No person may be discriminated against in employment or professional privileges based on either: (i) participation or (ii) refusal to participate.
Effect of Incapacity

- A valid Advance Directive remains in effect while the person is comatose or otherwise unable to communicate with the physician
  - Until such time as his/her condition allows communication
- Even an incapacitated person may revoke an Advance Directive
Reciprocity & Retroactivity

- **Reciprocity:**
  - A directive executed in another jurisdiction or state
  - Valid to the extent allowed by Washington law and federal constitutional law.

- **Retroactivity:**
  - A directive is effective even if executed prior to June 11, 1992, if it generally complies with the Washington Natural Death Act.
Revocation of Directive

A directive may be revoked at any time by the resident, **without regard to the resident’s mental state or competency**, by any of the following methods:

- By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the resident or another in the resident’s presence and at the resident’s direction.

- By a **written, signed and dated expression** of intent to revoke. A written revocation is effective only upon communication to the attending physician, who shall record in the medical record the time and date when the physician received notice of the revocation.

- By a **verbal expression** by the resident of his or her intent to revoke the directive. A verbal revocation is effective only upon communication to the attending physician.

Separate method for revoking directive stored in the online registry.
Revocation of Directive

- Mental capacity not required for revocation
  - The resident may revoke at any time
  - Regardless of the resident’s mental state or competency
- Consult legal counsel if there is any concern about revocation of an advance directive by a mentally incapacitated or incompetent resident.
Revocation of Directive

- Revocation must be part of medical record
- If the revocation is written:
  - Physician records time and date when the physician received such notification
- If the revocation is oral:
  - Physician records time and date when the physician received such notification
  - Physician records time and date when the revocation was made if different from when/where the physician received it
Failure to Act Upon Revocation

- No criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to the statute
  - So long as the provider acts in good faith and without negligence
  - UNLESS the person has actual or constructive knowledge of the revocation

RCW 70.122.040
May a Proxy Authorize Withholding or Withdrawal of Life Sustaining Treatment?

- Natural Death Act specifies:
  - A person’s right to control his or her health care may be exercised by an authorized DPOA

- What about other substitute decision-makers?
  - Guardian?
  - Spouse/DP, adult child, parent, or adult sibling?
“If the incompetent patient’s immediate family, after consultation with the treating physician and the prognosis committee, all agree with the conclusion that the patient’s best interests would be advanced by withdrawal of life sustaining treatment, the family may assert the personal right of the incompetent to refuse life sustaining treatment without seeking prior appointment of a guardian.”

_In re Guardianship of Hamlin_, Washington Supreme Court (1984)
May a Proxy Authorize Withholding or Withdrawal of Life Sustaining Treatment?

Life sustaining treatment may be withdrawn, if:

(i) A three physician “prognosis committee” that includes the treating physician makes certain medical determinations of terminal or permanent unconscious condition; AND,

(ii) The legal guardian, or (if no guardian has been appointed) all members of the immediate family determine that either the resident if competent would choose to refuse life sustaining treatment or, if such determination cannot be made, that the withholding of life sustaining treatment would be in the best interests of the resident; AND,

(iii) No member of the immediate family, the treating physician or the health care facility objects.

*In re Colyer*, Washington Supreme Court (1983)


*In re Grant*, Washington Supreme Court (1987)
May a Proxy Authorize Withholding or Withdrawal of Life Sustaining Treatment?

If a guardian, spouse, state registered domestic partner, adult child or sibling wants to authorize withholding or withdrawal of life sustaining treatment in the absence of an advance directive/living will

or wants to make a decision that would be contrary to the resident’s advance directive/living will,

or,

If there is any disagreement amongst immediate family members or between the family and the physicians. . .

You should consult legal counsel.
Death with Dignity Act
An adult who is competent, is a resident of Washington state, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication that the patient may self-administer to end his or her life in a humane and dignified manner in accordance with this chapter.

No surrogate decision makers for Death with Dignity
Mental Health Advance Directive
Mental health advance directive: RCW 71.32.260

- Allows for consent to mental health treatment during periods when the person has capacity
  - Including up to 14 days of inpatient treatment, not considered “involuntary”

- Two options, non-exclusive:
  - May be similar to DPOA, appointing an agent
  - May specify person’s consent to certain treatments
Mental health advance directive: RCW 71.32.260

- Addresses situation where capacity fluctuates
- Not common in LTC, but potentially a useful tool
POLST

End-of-Life Decisions:
Physician Order for Life Sustaining Treatment
Philosophy of POLST

- Individuals have the right to make their own health care decisions

- These rights include:
  - Making decisions about life sustaining treatment
  - Having a mechanism for describing their desires for life sustaining treatment to health care providers
  - Having health care providers who understand how to provide comfort care while honoring the individual’s desires for life sustaining treatment
POLST Form

- Short summary of treatment preferences
- Physician’s order
- Portable:
  - Describes patient’s code directions
  - Resuscitation, medical interventions, antibiotics, artificially administered fluids, nutrition
  - Transfers among care settings with single uniform document
POLST Form

- Includes decisions about life sustaining treatment
- Includes description for life sustaining treatment to health care providers
  - Provides for comfort care
  - Honors life sustaining treatment
  - Promotes discussions
    ▶ Plans end of life care wishes
    ▶ Assists physicians, nurses, health care facilities, emergency personnel honor wishes for life-sustaining treatment
Why is the POLST Important?

- POLST summarizes and translates an Advance Directive into physician’s orders
  - NOT an Advance Directive
  - DOES NOT replace an Advance Directive

- Emergency Medical Services (EMS) personnel work under the authority and guidance of a physician.
  - In order to honor an individual’s request related to end of life decisions, EMS must have a physician’s order.
How Advance Directive and POLST Work Together

- **Advance Directive** is a legal statement, like a will
  - Allows withholding or withdrawal of life-sustaining treatment

- **POLST** is a doctor’s order
  - Allows EMS to honor the resident’s wishes in an emergency

- Talk to residents with an Advance Directive about whether a POLST would also be appropriate

- What if the POLST and Advance Directive do not match?
  - The law will follow the Advance Directive
  - EMS may err on the side of intervention
  - Consult legal counsel
How Advance Directive and POLST Work Together

1. Age 18
   - Complete an Advance Directive
2. Update Advance Directive Periodically
3. Diagnosed with Advanced Illness or Frailty (at any age)
   - Complete a POLST Form
4. Change in health status
   - May Complete a new POLST Form
5. Treatment Wishes Honored

Adapted from California POLST Education Program
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Other Uses for the POLST

The form can also be used by an admitting facility for information about a patient or resident’s advance directive choices before the facility/home has a chance to get more specific information through the assessment process.
POLST Form

- Any adult 18 years or older can complete it
- In a LTC setting it should be the first document in the clinical record
- In the home, should be made visible to emergency health care workers
**Washinton State POLST Form**

- Meant to assist staff in honoring the person’s wishes
- Emphasizes voluntary nature of the form
- Clarifies difference between emergency and non-emergency directives
POLST Form

- If an area on the form is not completed, it means that all medical needs for that section are complete

- Signature Block is mandatory

- Periodic Form Change Review
  - Patient transfers
  - Substantial health status change
  - Review (Part F)
  - Record (Part G)
  - Draw line and "VOID" (initial or sign)
    - (Physician Orders)
    - May complete new form
    - (No new form means full treatment and resuscitation)
POLST vs EMS Form

- EMS form no longer distributed by state
- Both are physician orders and recognized by the WA DOH and EMS (911)
- Both allow for a DNR choice if the patient/resident has no pulse or respirations
- **Only POLST** includes orders for medical interventions when patient/resident has pulse and/or is breathing
Other DNR Orders

- EMS will generally honor other Do Not Resuscitate orders
- Even if not on POLST form
  - Including individual health care facility forms
- If any doubt about validity, EMS will begin CPR
Comfort Care Measures Should Continue

- Basic Comfort care
- Controlling bleeding
- Responding to emergencies (falls, choking, unresponsiveness, etc)
- Providing pain medications pertinent to the level of certification/licensure
- Providing emotional support
- Providing emotional support to the family

- Contact patient's physician or on-line medical control if directed by local protocols or if questions or problems arise
Transfer

- Original bright lime green form
  - Must be transferred with individual to be valid
  - Goes with resident if they transfer out of facility

- Health Care Institutions
  - Keep duplicate copy in permanent medical record upon discharge
  - Also make copy prior to inter-facility transports
Form Location

- In the home
  - Front of refrigerator
  - Back of bedroom door
  - Bedside table
  - On medicine cabinet

- Health care setting
  - Kept with patient between care settings
  - Hospital and LTC facility: Kept in Medical Chart
POLST Form – Part A

- CPR:
  - Patient has no pulse and is not breathing
- Resuscitate, or Do Not Resuscitate
- Comfort measures will always be provided
POLST Form – Part B

- **Medical Interventions**
  - Patient has pulse and is breathing

- **Options**
  - Comfort only
  - Limited interventions:
    - No intubation
    - No mechanical ventilation, but may include CPAP etc.
  - Full Treatment
POLST Form – Part C

- **Signatures**
  - Physician
  - Patient or legal surrogate

- **Attaching other documents**
  - Advance directive/living will
  - DPOA
POLST Form – Part D

- Non-Emergency Treatment
- Options
  - Antibiotics?
  - Nutrition by tube?
  - Additional orders?
    - Dialysis, blood transfusions, pacemakers, etc.
Policies and Procedures

- Facilities need to have policies and procedures related to advance directives.
- Should include what staff can do with and about a POLST form.
(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:
   (a) Maintain or enhance the quality of life for residents including resident decision-making rights;
   (b) When there is reason to believe a resident is not capable of making necessary decisions and no substitute decision maker is available;
   (c) When a substitute decision maker is no longer appropriate;
   (d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;
   (e) When a resident does not have a personal physician or health care provider;
   (f) In response to medical emergencies;
   (g) When there are urgent situations in the assisted living facility requiring additional staff support;
(3) The nursing home must:

- (a) Document in the clinical record whether or not the resident has an advance directive;

- (b) Not request or 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 and words 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, including the right to change his or her mind regarding previous decisions;
  - (ii) Nursing home policies and procedures concerning implementation of advance directives; and

- (d) Review and update as needed the 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.

(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 must:

- (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; and

- (d) Determine, in light of the conflicting practice or policy, whether the resident chooses to remain at the nursing home.
Who Should Implement the POLST?

- Unless you are a licensed medical or nursing professional you likely do not have the scope of practice to evaluate the situation or to implement the individual’s advance directive.
- In that case you must call 911.
Resources

- Washington Natural Death Act

- POLST Form

- More POLST info:
  - http://www.wsma.org/wcm/Patients/POLST.aspx

- RCW 70.129.140 – LTC resident rights, quality of care and competency
Thank you