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Long-Term Care Survey Alert

Survey Management: 6 Mistakes You Never Want To Make With Advance Directives

These shortfalls offer advance warning of survey and legal woes

Advance directives help healthcare providers honor a resident's wishes - but they can also be the instruments of a facility's undoing with surveyors and plaintiff's attorneys.

And the handwriting is all over the wall for heightened scrutiny of advance directives, which the **Centers for Medicare & Medicaid Services** defines as "written instructions (such as a living will or durable power of attorney) recognized under state law relating to provision of healthcare when a person is incapacitated."

The revised F314 (pressure ulcer) survey guidance addresses advance directives in some detail, observes **Reta Underwood**, a survey consultant in Louisville, KY. The revised State Operations Manual Appendix PP also adds language requiring nursing facilities to notify residents/representatives in writing they have a legal right to complain to state survey agencies about noncompliance with advance directives.

Tip: Surveyors could review your admission documents to see if that language is included, warns **Marie Infante**, an attorney with **Mintz Levin** in Washington, DC.

Avoid These Minefields

Sidestep these six common problems with advance directives that can be a survey or medico-legal nightmare waiting to unfold:

Mistake No. 1: No standardized process for obtaining and maintaining advance directives that clearly reflect residents' wishes about treatment goals.

Solution: "Have the medical director help the facility develop a process to ensure staff have current information about what the resident, if mentally competent, and/or legal representative and family wants to do in terms of advance directives," advises **Dan Haimowitz, MD, CMD**, who practices in nursing homes in Levittown, PA.

For example, "if the resident or her [legal surrogate] or family wants her to be 'no code,' the physician must write an order to that effect and review it annually or when the person has a significant change in status," Haimowitz tells **Eli.**

Review and update the resident's advance directives at least annually and when the person has a change in competency or physical/mental condition, advises Boston attorney **Michael Kogut.**

Mistake No. 2: The resident or his empowered decision-maker doesn't really understand what services the person is agreeing to receive or forego.

For example, some facilities ask residents or their representatives to check off services on a list at admission that they don't want to receive under certain circumstances. But don't assume the resident/family and staff are defining those services in the same way - or understand the realities of saying yea or nay to certain procedures, cautions Haimowitz.

Examples: "The person may say he doesn't want cardiac resuscitation but will they tell you he wants a ventilator," Haimowitz notes. "Yet people usually suffer both a respiratory and cardiac arrest. Or the person may really want

antibiotics but check that he doesn't." He's also heard patients express confusion over the difference between a respirator and ventilator, which are interchangeable terms in advanced life support.

Proactive strategy: Communica- tion and education offer the keys to ensuring the resident or his representative, the physician and facility are on the same page. "Physicians also have to communicate the realities of the resident's prognosis to the resident and his family," says Haimowitz. "Never assume families understand a disease process or likely outcomes."

Mistake No. 3: Staff equates DNR orders or advance directives with no care at all.

Proactive strategy: Make sure staff understand that just because someone has specified they don't want CPR or a ventilator doesn't mean they don't want antibiotics, hospitalization or wound prevention and treatment, emphasizes Haimowitz.

Even a person on hospice may decide to receive more aggressive palliative care, including chemotherapy to reduce symptoms, whereas another person may decide to receive only comfort measures and pain medication.

Mistake No. 4: Staff isn't aware of the resident's advance directive when the resident becomes acutely ill or requires emergency care.

For example, Haimowitz encountered a situation recently where a nursing home patient developed an infiltrated IV and respiratory distress. The facility was ready to transfer the resident to the hospital when Haimowitz recalled that his partner had said the resident and her family didn't want her to be hospitalized.

"The facility did find that notation in the chart," Haimowitz relates. But if the facility had transferred the resident to the hospital, the hospital staff might have intubated her, restarted the IV and initiated a chain of care that the resident and family never intended, he cautions. (Noncompliance with advance directives can cause a big survey headache - see article later in this issue.)

Proactive strategy: Keep residents' advance directives in the same, designated place - for example, the front of the chart. Staff should be able to double check immediately that a resident is "no code" during an emergency.

Facilities use a variety of means of identifying resident's CPR status (DNR or not), notes attorney **Kendall Watkins** with **Davis, Brown, Koehn, Shors & Roberts, PC** in Des Moines, IA.

"For example, you can use color coded stickers on the binder of the chart and also on the resident's wristband and in his closet with his name on it," says Watkins. Prior to HIPAA, some facilities put DNR stickers on charts or on doors but that would probably be a privacy violation, Watkins cautions.

Tip: Don't forget to orient temporary nursing agency staff to the color-coding system.

What if you encounter a resident who has ceased breathing and don't know his code status? Err on the side of caution in such cases, advises Watkins. He'd rather see a facility provide CPR than incur the wrath of family members who claim staff didn't even attempt to revive the resident who had clearly requested the potentially life-saving procedure.

Mistake No. 5: The facility doesn't keep the communication channels open with the resident's decision maker and family about the advance directive.

Assess the family on a regular basis for their feelings about the advance directives, suggests Kogut. "Individual family members wax and wane on what they want for a cognitively impaired resident - or a new primary decision maker may emerge in the family," he notes. "And you don't want to find yourself in a situation where the family and resident have conflicting views about the advance directives."

A social worker or caregiver who has developed a close relationship with the family can often read the signs of family

dissent over the resident's care. "Sometimes it's only that the family may not be visiting as often," says Kogut. "But if you pay attention to those types of signals from the family, you can head off problems down the road with survey deficiencies and litigation - or a stalemate or dispute when the resident requires certain care measures or hospitalization," he advises.

Mistake No. 6: The facility has no formal process for reviewing situations involving disputed care decisions and ethical quandaries.

Some facilities have ethics committees that review cases where staff have questions about a resident's wishes, family conflict or some other uncertain situation, says Kogut.

For example, **Statesman Health and Rehabilitation Center** in Levittown, PA, has its ethics committee review such cases. The committee has become a vital resource on ethical end-of-life decision making for the facility and the organization's other nursing facilities in the area (for details, see the April 2005 Long-Term Care Survey Alert).