Advance Directives

The Patient's Right To Decide

Covenant HEALTH

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Advance Directives

Your Right To Make Health Care Decisions Under The Law In Tennessee

Tennessee and federal law give every competent adult, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatment or you wish to name someone to make health care decisions for you, you have the right to make these desires known to your doctor, hospital or other health care providers, and in general, have these rights respected. You also have the right to be told about the nature of your illness in terms that you can understand the general nature of the proposed treatments, the risks of failing to undergo these treatments and any alternative treatments or procedures that may be available to you.

However, there may be times when you cannot make your wishes known to your doctor or other health care providers. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know what your specific wishes are about the medical care that you would want or do not want to receive.

Who will decide whether you should have CPR (cardiopulmonary resuscitation) if your heart should stop suddenly? Or what if you are 40 years old and are involved in a motor vehicle accident which leaves you permanently unconscious. Who will decide whether you are to be kept alive with tube feedings? Or what if you have Alzheimer's Disease and you develop a serious infection in a nursing home. Who will decide whether or not you will be hospitalized and treated with antibiotics?

To make these difficult issues easier to understand, the information is presented in the form of questions and answers.

Frequently Asked Questions About Advance Directives

1. What are "Advance Directives"?

Advance Directives are documents which state your choices about medical treatment or name someone to make decisions about your medical treatment, if you are unable to make these decisions or choices yourself. They are called "advance" directives, because they are signed in advance to let your doctor and other health care providers know your wishes concerning medical treatment. Through advance directives, you can make legally valid decisions about your future medical care.

2. When do Advance Directives go into effect?

It is important to remember that these directives only take effect when you can no longer make your own health care decisions. As long as you are able to give "informed consent", your health care providers will rely on **YOU** and **NOT** on your advance directives.

3. What is "Informed Consent"?

Informed consent means that you are able to understand the nature, extent and probable consequences of proposed medical treatments and you are able to make rational evaluations of

the risks and benefits of those treatments as compared with the risk and benefits of alternate procedures **AND** you are able to communicate that understanding in any way.

4. What is an Advance Care Plan (Living Will)?

A "Living Will" (officially called an "Advance Care Plan" in Tennessee) is a document that tells your doctor how you want to be treated if you are terminally ill, permanently unconscious, or in an end-stage condition. You can use an Advance Care Plan (Living Will) to tell your doctor you want to avoid life-prolonging interventions such as cardiopulmonary resuscitation (CPR), kidney dialysis or breathing machines. You can use this form to tell your doctor you just want to be pain free and comfortable at the end of life. You may also appoint a health care agent and alternate with this form (more about health care agent in #9). You may also add other special instructions or limitations in your form.

5. When does and Advance Care Plan (Living Will) go into effect?

A Tennessee Advance Care Plan (Living Will) goes into effect when: 1) your doctor has a copy of it and 2) your doctor has concluded that you are no longer able to make your own health care decisions, and 3) your doctor has determined that you are either terminally ill, permanently unconscious, or you are in an end-stage condition.

6. What is "terminally ill condition"?

Being terminally ill is defined as an incurable condition for which administering of medical treatment will only prolong the dying process and without administration of these treatments or procedures, death will likely occur in a relatively short period of time.

7. What is "permanently unconscious state"?

A permanently unconscious state means that a patient is in a permanent coma or state of unconsciousness caused by illness, injury, or disease. The patent is totally unaware of himself or herself, his or her surroundings and environment, and to a reasonable degree of medical certainty, there can be no recovery.

8. What is an "end-stage" condition?

An end-stage condition, is defined as an irreversible condition caused by injury, illness or disease which results in severe and permanent deterioration, incapacity, and physical dependence, and to a reasonable degree of medical certainty, medical treatment would not be effective.

9. What is an Appointment of Health Care Agent (Medical Power of Attorney)?

An Appointment of Health Care Agent (AHCA) is another type of advance directive that allows you to appoint another person (the "attorney-in-fact" or "agent" to make medical decisions for you if you if you should become temporarily or permanently unable to those decisions for yourself. The person you choose does not have to be a lawyer.

The AHCA only becomes effective when you are temporarily or permanently unable to make your own health care decisions and your agent consents to start making those decisions. Your agent will begin making decisions after your doctors have decided that you are no longer able to make them.

10. What happens if I regain the capacity to make my own decisions?

If your doctor determines that you have regained the capacity to make or to communicate health care decisions, then two things will happen: 1) Your agent's authority end; and 2) Your consent will be required for treatment. If your doctor later determines that you no longer have the capacity to make or communicate your health care decisions, then your agent's authority will be restored.

11. How is the Appointment of Health Care Agent different from the Advance Care Plan?

An Advance Care Plan only applies if you are terminally ill or permanently unconscious AND too sick to make decisions for yourself. An Advance Care Plan only tells your doctor what you do not want unless you write in other specific instructions. It is a written record of decisions that you have made yourself.

On the other hand, the Appointment of Health Care Agent allows you to appoint someone else to make health care decisions for you if you are too sick to make them for yourself. This person is called your Health Care Agent. Your Agent can make any health care decision that you could make if you were able. A Health Care Agent allows you to give specific instructions to your representative about the type of care you would want to receive.

The Appointment of Health Care Agent allows your decision maker to respond to medical situations that you might not have anticipated and to make decisions for you with knowledge of your values and wishes.

12. I am a young person in good health. Do I really need to create a formal Advance Directive?

Advance Directives are for all adults, including mature minors and emancipated minors. We never know when an accident or serious illness will leave us incapable of making our own health care decisions.

13. If I decide to appoint a Health Care Agent, how should I choose my Agent?

You can appoint almost any adult to be your agent. Choose someone who knows your values and wishes, and whom you trust to make decisions for you. Do the same for a successor agent. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

You can select a member of your family, such as your spouse, child, brother or sister, or a close friend. If you select your spouse and then become divorced, the appointment of your spouse as your agent is revoked.

The following people **CANNOT** be appointed as your agent in the AHCA:

1) Your treating health care provider

2) An employee of your treating health care provider, unless he or she is related to you by blood, marriage or adoption;

3) An operator of a treating health care institution;

4) An employee of an operator of a treating health care institution, unless he or she is related to you by blood, marriage or adoption; or

5) A Conservator, if one has been appointed by a court for you, except under conditions specific by Tennessee law.

14. What instructions should I give my agent concerning my health care?

You may give very general instructions and preferences, or be quite specific. It would be helpful to your agent to have directions from you about life-prolonging intervention, particularly medically administered food and water (tube feedings), cardiopulmonary resuscitation (CPR), the use of machines to help you breathe, and organ and tissue donation.

Many people choose to write their agents a letter stating their personal values and wishes, their feelings about life and death, and any specific instructions, and to attach a copy of this letter to their Appointment of Health Care Agent Form.

Talk with your agents about your choices and personal values and beliefs. Make sure they know what is important to you. This information will help them make the decisions that you would make if you were able.

15. Can any person create an Advance Directive?

Yes. Any adult (including a mature or emancipated minor) who has the capacity to make decisions for him or herself can create an Advance Directive.

16. Do I need a lawyer to create an Advance Directive?

A lawyer may be helpful and you might choose to discuss these matters with him or her, but there is no legal requirement in Tennessee to do so. You may use the forms that are provided in this packet to execute your advance directives.

17. Who should witness my signature on my Advance Directive?

You must sign (or have someone sign the document in your presence and at your direction, if you are unable to sign) and date the Advance Plan of Care or Appointment of Health Care Agent. Then it must be witnessed by 2 qualified people or notarized.

The following people **CANNOT** witness your signature of an Advance Plan of Care or Appointment of Health Care Agent:

1) Any person you may have appointed as your agent or alternate agent; or

2) Any person who is not yet 18 years of age.

In addition, at least one of the two witnesses must not be related to you by blood, marriage, or adoption, and not entitled to any portion of your estate upon your death.

18. How can I find a Notary Public if I choose to have my signature notarized?

Businesses such as banks, insurance agents, government offices, hospitals, doctors' offices, and automobile associations have or can direct you to a notary public.

19. What should I do with my Advance Directive after I sign it?

Keep the original document in a safe location where it can be easily found. Do **NOT** keep the original copies in your safe deposit box unless you are certain someone close to you has access to the safe deposit box if you become incapacitated. Give copies of these documents to as many for the following people as you are comfortable with: your spouse and other family members, your doctor; your lawyer; your clergyperson.

Make sure your agent knows where the original is so it can be shown to your doctor on request. However, a photocopy of your Advance Directive is legally valid.

20. What if my doctor or my family does not agree with my treatment choices or health care decisions?

You can prevent this from happening by talking with your family and health care providers about your decisions and personal values and beliefs. If others understand your choices and the reasons for them, there is less of a chance that they will challenge them later.

If you have made your wishes known in an Advance Directive and a disagreement does occur, your doctor and your agent must respect your wishes. You have a right to refuse or consent to health care. If your doctor cannot comply with your wishes, he or she must transfer your care to another doctor.

The consent or refusal of your Appointed Health Care Agent is as meaningful and valid as your own. The wishes of other family members will not override your own clearly expressed choices or those made by your agent on your behalf.

21. Do I have to sign an Advance Directive to receive health care treatment?

No. A doctor or other health care provider cannot require you to complete an Advance Directive as a condition for you to receive services.

22. Will another state honor my Advance Directive?

Laws on advance directives differ from state to state, but in general, a patient's expressed wished will be honored. No law or court has invalidated the concept of Advance Directives, and an increasing number of statutes and court decisions support it. However, if you plan to spend a great amount of time in another state, you should consider signing an advance directive that meets all the legal requirements of that state.

An advance directive executed in compliance with another state's laws will be valid in Tennessee to the extent permitted by Tennessee law.

ADVANCE CARE PLAN

(Tennessee)

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: _____ Relation: _____
Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation: Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation.

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

APPOINTMENT OF HEALTH CARE AGENT

(Tennessee)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place. My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (initial one): ____ I give my agent permission to make healthcare decisions for me at any time, even if I have capacity to make decisions myself. ____ I do not give such permission (this form applies only when I no longer have capacity).

Agent:

_____
Name Relationship

_____
Address

_____
City State Zip Code

(_____) _____
Area Code Phone Number

(_____) _____
Area Code Alternate Phone Number

Alternate:

_____
Name Relationship

_____
Address

_____
City State Zip Code

(_____) _____
Area Code Phone Number

(_____) _____
Area Code Alternate Phone Number

Organ donation: Upon my death, I wish to make the Following anatomical gift (initial one)
___Any organ/tissue ___My entire body
___Only the following organs/tissues: _____
___No organ/tissue donation

_____
Signature of patient (must be at least 18 or emancipated minor) Date

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

Block B Notarization

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____
Signature of Notary Public

Rev. 2011

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name

First Name/Middle Initial

Date of Birth

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)**

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

Section B *Check One Box Only*

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

☐ **Comfort Measures.** Treat with dignity and respect. Keep clean, 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. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

☐ **Limited Additional Interventions.** Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Full Treatment.** Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Include intensive care.**

Other Instructions: _____

Section C *Check One Box Only*

ANTIBIOTICS – Treatment for new medical conditions:

☐ **No Antibiotics**

☐ **Antibiotics** *Other Instructions:* _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically feasible.

☐ **No IV fluids** (provide other measures to assure comfort)	☐ **No feeding tube**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **IV fluids long-term if indicated**	☐ **Feeding tube long-term**

Other Instructions: _____

Section E *Must be Completed*

Discussed with:
- ☐ Patient/Resident
- ☐ Health care agent
- ☐ Court-appointed guardian
- ☐ Health care surrogate
- ☐ Parent of minor
- ☐ Other: _____ (Specify)

The Basis for These Orders Is: (Must be completed)
- ☐ Patient's preferences
- ☐ Patient's best interest (patient lacks capacity or preferences unknown)
- ☐ Medical indications
- ☐ (Other) _____

Physician Name (Print)	**Physician Signature** (Mandatory) Date	**Physician Phone Number**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)

Surrogate	Relationship	Phone Number

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.