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Webinar Series
Resident-Centered Care: Carrying Out Your Residents' End-of-Life Decisions
May 4, 2018

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Today's Speaker

Karen Goldsmith
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RESIDENT CENTERED CARE:  
CARRYING OUT YOUR RESIDENTS END-OF-LIFE DECISIONS

Presented By:  
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• All medical decisions are based on the patient giving informed consent.
• What is informed consent:
  1. The doctor should be involved
  2. The doctor should explain to the patient:
     • The procedure or treatment
     • The benefits
     • The risks
     • Options
Chapter 765 is the Florida statute on Advance Directives. It includes the following definition of informed consent for its purposes:

- Consent given by a person...
- after a sufficient explanation...
- and disclosure of the subject matter...
- to enable that person to have a general understanding of:
  - the treatment or procedure...
  - the medically acceptable alternatives...
  - including the substantial risks and hazards inherent in the proposed treatment or procedure...
  - and to make a knowing health care decision...
  - without coercion or undue influence.

Since we are talking about end of life let's look also at the definition of life-prolonging procedures:

Any medical procedure, treatment, or intervention, including artificially provided sustenance and hydration, which sustains, restores, or supplants a spontaneous vital function. The term does not include the administration of medication or performance of a medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.
• What does the last part of the last sentence mean?
  • What about antibiotics?

• Who makes the determination?
  • The doctor?
  • The legal representative?
  • The facility?

Let’s pause a minute and talk about who the legal representative is:
  • The resident who is competent to make medical decisions can always make their decisions
  • The resident has been determined incapable of making medical decisions by at least one doctor; two if the first doctor is not sure or the resident required this in their advance directive
  • The guardian if one has been appointed and has that authority
  • The surrogate, if no guardian and one has been named or
  • Someone named in a valid durable power of attorney
  • The proxy, if none of the above

• The authority of the guardian may be limited by the guardianship orders
• The authority of the surrogate may be limited by the resident in the declaration
• Some is true of the designation of the agent under a power of attorney
• Since a proxy is not named by the resident, their power would not be limited by the resident’s declaration but when it comes to life-prolonging decisions, proxy must show by clear and convincing evidence what the resident would want or what is in the resident’s best interest
• What resident would want should be paramount
• If unknown what would be in the resident’s best interest

• Timing of the authority to make decisions:
  ▪ When the physician has determined incapacity to make medical decisions
  ▪ Incapacity to make medical decisions does not mean that the person is not able to make other decisions
  ▪ A person may go in and out of capacity and when that occurs the substitute decisionmaker may go in and out of authority
  ▪ When a court changes the guardian’s authority
  ▪ If the substitution is voluntarily made by the resident when the resident revokes the authority

• Let’s talk about revocation:
  ▪ A competent resident can revoke an advance directive at any time
    ▪ Orally (may also amend)
    ▪ In writing (may also amend)
    ▪ By preparing a new one that is inconsistent with the old
    ▪ Destruction
    ▪ Dissolution or annulment of marriage (unless specifically set out in advance directive)
    ▪ Effective when communicated
• Powers of attorney:
  • Durable endures beyond when the person becomes incapacitated and ends at death
  • Regular takes effect when set out in document (if before October 1, 2011) or when signed (if October 1, 2011 or later) and ends when principal becomes incapacitated or dies

• Special issues with durable power of attorney:
  • October 1, 2011 powers of attorney must take effect when signed
  • Prior to that time many people wrote durable powers of attorney that went into effect when the person became incapable of making medical decisions
  • Now, technically, the agent can assume the power when it is signed

• What does that mean:
  • DPOA's prepared before that time are still valid
  • If a DPOA is signed after that time but restricts that the agent make medical decisions after the person is incapable of doing so, it may be a health care surrogate designation even if it is not enforceable as a power of attorney
  • If the person has named someone to be the agent for medical purposes after that date and the DPOA is legally enforceable, the person can still take the power away from the agent until they care not capable of doing so
October 11, 2011 changes to law require specificity in powers of attorney
• Helps health care providers understand when the power includes health care decisions

How to determine whether person is at a stage in life where life-prolonging decisions need to be made:
• Resident who is competent can always make their own decisions:
  • Needs adequate information to make decisions
  • Provider needs informed consent
  • Resident can make bad choices

When resident is making bad choices facility has responsibility:
• To assess resident to determine if a medical or mental condition is driving the decision
• If mental whether resident is still capable of making medical decisions
• Without using undue influence or coercion, work with the resident to ensure the decision is being consciously made
• Care plan
  • Revisit the issue regularly
  • Keep physician informed

Needs adequate information to make decisions
Provider needs informed consent
Resident can make bad choices
For incapacitated residents life-prolonging procedures can be withheld or withdrawn when the resident is:

1. In a terminal condition which means a condition caused by injury disease or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

2. In an end-stage condition which is an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

3. In a persistent vegetative state which is:
   - a permanent and irreversible condition of unconsciousness in which there is...
   - the absence of voluntary action or cognitive behavior or any kind; and
   - an inability to communicate or interact purposefully with the environment.

This does not mean the person does not open their eyes, make sounds or otherwise appear to be conscious.

It is a complex medical decision made by the medical team.

- Because of the nature of PVS, the law has some explicit provisions relative to it:
  - Physician should apply current accepted medical standards
  - Physician may withhold life prolonging procedures if
    - Person has no advance directive
    - No surrogate or proxy
    - Guardian appointed to consent to medical treatment
• The guardian and the resident’s primary physician consult with the provider’s bioethics committee.
• Together they conclude that the condition is permanent and no medical probability of recovery.
• It is in the resident’s best interest to withhold or withdraw life-prolonging procedures.
• If facility has no bio-ethics committee must have an arrangement with another provider’s bioethics committee.
• The bioethics committee will review the case with the physician and guardian.

**F.S. 765.404**

• The presence of one of these conditions must be made by the resident’s primary physician and at least one other consulting physician who separately examine the patient. The findings of each such examinations must be documented in the patient’s medical record and signed by each examining physician before life-prolonging procedures may be withheld or withdrawn.

**COMFORT CARE AND PALLIATIVE**

• You cannot withhold comfort care.
  • What is it?
  • Something that may not be comforting for one resident may be for another.
  • Physicians should decide.
  • Families should be advised of this restriction.
What is Palliative Care:
- Comprehensive management of the physical, psychological, social, spiritual and existential needs of residents.
- Particularly suited to people with incurable, progressive disease
- Must include certain factors:
  - Opportunity for discussion and plan for end-of-life care
  - Assurance that physical and mental suffering will be attended to
  - Assurance that medical preferences will be honored
  - Assurance that personal goals of the dying resident will be addressed
  - Assurance of dignity
  - Assurance resident will not be abandoned
  - Assurance that burdens to family will be addressed
  - Assurance that advance directives will be honored regardless of location (think about the yellow form)
  - Assurance that organizational mechanisms are in place to evaluate the availability and quality of end-of-life, palliative, and hospice care services, including the evaluation of administrative and regulatory barriers
  - Assurance that necessary health care services will be provided and relevant reimbursement policies are available
  - Assurance that these will be accomplished in a culturally appropriate way

IN OTHER WORDS - PERSON-CENTERED CARE
THE YELLOW FORM AND DNRO
- Centers must advise residents about advance directives on admission and at intervals:
  - When condition changes
  - On regular basis – such as care plan time
  - When resident expresses desires
  - When someone tells you that the resident may wish a change
  - When else?

The yellow form is not a requirement:
- Typically called the uniform do not resuscitate order
- Designed originally for EMT's and is located in their statute and regulations
- Now applies across the continuum
- You must however give it to your residents as an option
- It is the only form the EMT’s will honor so if you do not offer it, you deprive residents of the opportunity to have a global form

It only deals with cardiopulmonary resuscitation as defined on the form:
- Artificial ventilation
- Cardiac compression
- Endotracheal intubation
- Defibrillation
• Form must be fully completed
• Must have doctor's signature
• Blankis cannot be signed in advance by doctor
• Must be on yellow paper
• Can be a copy if on yellow paper
• Some facilities experiencing timing problems because of electronic records

• If doctor gives legally valid order to not resuscitate in record it is valid but will not be honored by EMT's

• Some centers have both to ensure there is compliance

• We have seen a number of citations for advance directives;
  • Some for providing undesired care
  • Some for not doing so
  • Many are §’s because of the serious ramifications associated with failure
• What to do when all else fails:
  • There is judicial review available under the Probate Rules of Florida to permit a court to make a one-time treatment decision
  • If there is a guardian you can petition the court in the guardianship matter if you need guidance on how to proceed
  • When a resident is making a bad choice and you have shown them both sides of the decision and they understand the ramifications of their decision, make sure you have a good record to support what you have done.

• Document clearly and succinctly everything you do relative to life and death decisions so you may be called upon to support your decisions
  • You should always talk to others in your career or at your home office and get varying perspectives
  • If a person has made their wishes known and they violate your center’s ethical, moral or religious beliefs you can transfer the resident to a place where their wishes will be carried out. If you cannot and their wishes are legally valid you must follow them.

Questions

If we are unable to get to everyone’s questions this morning, we’ll compile a Q&A document that will be on FHCA’s Website.

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Thank you for attending today’s webinar.