



1. Purpose

This Procedure outlines the process for the development and operation of Advance Directives by patients/consumers of the West Coast District Health Board (WCDHB).

2. Application

This Procedure is to be followed by all clinical staff throughout WCDHB.

3. Definitions

For the purposes of this Procedure:

Advance Directive is taken to mean a written or oral directive by which a patient/consumer makes a choice about possible future health care and treatment choices that is intended to be effective only when they are not competent to make their wishes known. This includes “*Not For Resuscitation*” orders.

Competent means that a patient/consumer understands his or her diagnosis, is able to make an informed decision as to what, if any, treatment he or she will consent to, and understands the consequences of that decision. Competence may be affected by permanent factors such as mental in-capacity, or temporary factors such as unconsciousness or the effects of pain or medications. Competence must be assessed at the time of the decision and must be commensurate with the gravity of the decision to be made. The more serious the decision, the greater competence is required.

Resuscitation is taken to mean emergency clinical measures, up to and including Cardiopulmonary Resuscitation (CPR) undertaken to prevent imminent death.

Not for Resuscitation Order is taken to mean a document that gives the instruction not to attempt CPR or other resuscitation procedures if the patient/consumer has a cardiac arrest (is unresponsive and pulseless) or a respiratory arrest (is unresponsive and stops breathing).

4. Responsibilities

For the purposes of this Procedure:

All WCDHB Clinical Staff Members are required to abide by the requirements of this Procedure

5. Resources Required

This Procedure requires no specific resources.

6. Process

1.00 Introduction

1.01 Right 7(5) of the Code of Health and Disability Services Consumers’ Rights states that “Every consumer may use an advance directive in accordance with common law”.



- 1.02 An Advance Directive only becomes active when the patient/consumer to whom it relates is deemed to be no longer competent to make decisions regarding their own welfare.

2.00 Criteria of a Valid Advance Directive:

- 2.01 An Advance Directive is only valid if the patient/consumer:
- a) was competent to make the Advance Directive when it was made;
 - b) made the Advance Directive free from any undue influence;
 - c) was sufficiently informed at the time they made the Advance Directive; and
 - d) intended the Advance Directive to apply in the current circumstances.
- 2.02 Where all the criteria of Section 2.01 are met, the relevant health professionals cannot ignore an Advance Directive, unless there are reasonable grounds to question one of the four criteria in Section 2.01 or the Advance Directive has expired. Failure to follow a valid Advance Directive may result in a patient/consumer making a complaint to the health and Disability Commissioner. In the event that the Advance Directive has not been followed, the reasons are to be documented in the patient/consumer's clinical notes.

3.00 Compulsory Treatment Orders

- 3.01 Compulsory Treatment Orders (CTO) made pursuant to the Mental Health (Compulsory Assessment and Treatment) Act 1992 relate to treatment of mental disorders only; not physical conditions. All patients/consumers are presumed to be competent, including those who are subject to a CTO. Unless one of the exceptions contained in Section 2.01 above applies, Advance Directives of those patients/consumers subject to a CTO should be followed.

4.00 Welfare Guardians and Powers Of Attorney

- 4.01 If a patient/consumer has appointed a Welfare Guardian or executed an Enduring Power of Attorney under the PPPR Act, the appointed person may have been given the ability to make choices about personal care and welfare should the patient/consumer lack the competence to do this. In this instance, consent for treatment will be sought from the Welfare Guardian or Enduring Attorney.

Note: A welfare guardian or person with enduring power of attorney is not able to consent to ECT or any treatment that would destroy brain tissue or brain function for the purpose of changing that person's behavior, or to consent to that person taking part in a medical experiment other than one conducted to save the person's life or prevent them from serious harm.

- 4.02 If a patient/consumer is deemed to be incompetent at the time they wish to make an Advance Directive, they are to be informed that they will be unable to make an Advance Directive until they have the required level of competence to do so.
- 4.03 Where a health professional, for ethical or personal reasons, cannot implement an Advance Directive, then they are required to explain this to the patient/consumer, and transfer the care of the patient/consumer to another health professional.



5.00 Refusal of treatment

- 5.01 In accordance with Right 7(7) of the Code of Health and Disability Services Consumers' Rights, and Section 11 of the New Zealand Bill of Rights, a patient/consumer has the right to use an Advance Directive to refuse medical treatment in the event they become incompetent (e.g. Not for Resuscitation Orders).
- 5.02 When an Advance Directive involves the refusal of treatment or care necessary to save the patient/consumer's life, health professionals need to carefully consider the Advance Directive against the criteria in Section 6.3 and also consult with those persons who could provide information about the patient/consumer's intentions and reasoning when they created the Advance Directive. Note that while next of kin have no legal right to consent to, or to refuse, treatment on behalf of the patients/consumers, they may be able to provide information about the patient's/consumer's reasoning and intentions when making the Advance Directive.
- 5.03 While the patient/consumer is not obliged to involve a clinician in the development of an Advance Directive, their involvement may increase the chances of a directive being judged as valid, and consequently followed. Specifically, clinical staff members can:
- i) witness the patient/consumer's competency to make the Advance Directive;
 - ii) provide protection from the possibility of undue influence;
 - iii) provide relevant information to assist the patient/consumer;
 - iv) clarify the situations in which the patient/consumer intends the Advance Directive to apply;
 - v) ensure that the Advance Directive contains sufficiently accurate instructions.
- 5.04 Clinical staff members need to be aware that by assisting a patient/consumer to develop an Advance Directive, they are in fact providing a health service, and therefore the requirements of the Code of Health and Disability Services Consumers' Rights need to be complied with.
- 5.05 Clinical staff members should also encourage the patient/consumer to involve their family/whanau/caregivers in the development of the Advance Directive. This involvement assists the patient's/consumer's significant others in understanding the Advance Directive process. It also lessens the risk to clinical staff of family disagreeing with treatment in accordance with the Advance Directive and promotes a more balanced discussion and helps to demonstrate that the patient's/consumer's choices have been made free of coercion.

6.00 Documentation

- 6.01 While the Code of Health and Disability Services Consumers' Rights allows for an Advance Directive to be made orally and in writing, it is advisable that the Advance Directive be developed in writing, using the WCDHB Resuscitation Status/Advance Directive Form, and that the patient/consumer, clinical staff member and family/whanau/caregiver sign and date the Form.



- 6.02 A copy of the WCDHB Resuscitation Status/Advance Directive Form (printed on bright yellow paper) is to be placed into the front of the patient/resident/consumer's clinical record.

7.00 Review of Advance Directives

- 7.01 The Advance Directive belongs to the patient/consumer, and as such it is their responsibility to review and update this as desired. However, in the spirit of collaboration, it is prudent for the clinician to encourage review of an Advance Directive s/he knows is likely to be outdated. Space for reconfirmation or revocation of the Advance Directive appears on the form, and may be used to maintain its currency.
- 7.02 In the case of medically initiated Advance Directives, these will be reviewed on any substantial change in the health status of the patient/resident/consumer, or when they are transferred from one care setting or care level to another, or are readmitted to a WCDHB Facility.
- 7.03 Reviews of Advance Directives are to include the patient/consumer/resident, and where appropriate, their family/whanau/caregivers.
- 7.04 When a consumer/patient/resident wishes to revoke their Advance Directive, an assessment is to be made of the consumer/patient/resident to ensure that all criteria in Section 2.01 are met.
- 7.05 Where the Section 2.01 criteria are met, the consumer/patient is to be asked if they wish to alter the Advance Directive, make a new one, or revoke the current Advance Directive.
- 7.06 Any alteration or revocation is to be documented on the WCDHB Advance Directive Form in the consumer/patient's clinical record.
- 7.07 It is the responsibility of the consumer/patient's responsible clinician/key worker to ensure that all health professionals providing care and treatment to the consumer/patient are aware of the Advance Directive.

8.00 Not for Resuscitation Orders

- 8.01 There are two pathways for effecting a Not for Resuscitation (NFR) order:
- An advance directive initiated by the patient/consumer; or
 - A medically initiated NFR order used when medical staff caring for the patient/consumer believe such limitation of care is appropriate because it is in the patient's/consumer's best interests. It does not require patient consent, but does require that staff attempt to explain the situation to the patient/consumer, and discuss it fully with family/whanau, and document these discussions clearly.
- 8.02 Where patients/consumers reside long term and have degenerative illness where death is anticipated, discussion should always commence early with patients and their families



regarding resuscitation, with time and privacy allowed for patients/consumers to discuss and communicate their views.

- 8.03 NFR orders will be recorded on the Resuscitation Status/Advance Directive form, printed on bright yellow paper, and included at the front of the clinical file.
- 8.04 In acute care the resuscitation status will be reviewed at least two weekly, and will be deemed to be deactivated if the review has lapsed. It will also be reviewed if there is significant change to the patient's condition, and prior to anesthesia or interventional procedure.
- 8.05 Information offered for discussion by the medical staff with the patient/consumer and their family/whanau will include:
- the patient's illness and prognosis
 - the effect and possible outcomes, both immediate and long term, of initiating further resuscitation procedures should the patient deteriorate
 - what resuscitation may involve
 - the effect and consequences of a NFR order on the patient's management.
- 8.06 Where the patient/consumer is not competent to make an Advance Directive or NFR order (for example may suffer dementia) every effort should be made to consult with an appropriate person who is entitled to make decisions on behalf of the patient/consumer (for example an Enduring Attorney or Welfare Guardian). Relatives cannot be assumed to have legal authority to make decisions and grant consent on a patient/consumer's behalf. If there is no other person legally entitled to make decisions on behalf of the patient, the clinical team must determine the best management for the patient/consumer in full consultation with the family (as above). The Consultant (SMO) is responsible for this, and a medically initiated NFR order may result.
- 8.07 Although a medically initiated NFR order can be legally effected without the patient/consumer's consent, this Procedure requires that the NFR order cannot be effected unless formal discussions have occurred with the patient and their family/whanau. If, after discussion, the family disagrees with the NFR order, the medical staff may still choose to continue with the NFR order. However careful consideration should be given, and it may be prudent to suspend the NFR order until further discussion can occur with the family/whanau at a later date. A second medical opinion may be beneficial for family/whanau to seek in this instance. All discussions with the family/whanau should be documented fully in the clinical notes, and any second medical opinions also fully documented. (See Guidelines Section at end of this document)
- 8.08 Cardiac Arrest procedures will be initiated on all patients/consumers who have an unanticipated death unless they have a NFR order in place or it would be obviously futile to attempt resuscitation given the patient's/consumer's characteristics.

7. Precautions And Considerations

- ➔ Every patient/consumer may use an advance directive in accordance with common law



Advance Directive Procedure

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- ➔ Patient/consumers have the right to use an advance directive to refuse medical treatment in the event they become incompetent.
- ➔ Clinical staff members can be involved in the development of an advance directive.
- ➔ A copy of the advance directive is to be placed into the patient/consumer's clinical record.

8. References

Code of Health and Disability Services Consumers' Rights

New Zealand Bill of Rights

Mental Health (Compulsory Assessment and Treatment) Act (1992) and Amendments.

9. Related Documents

WCDHB Clinical Documentation Procedure

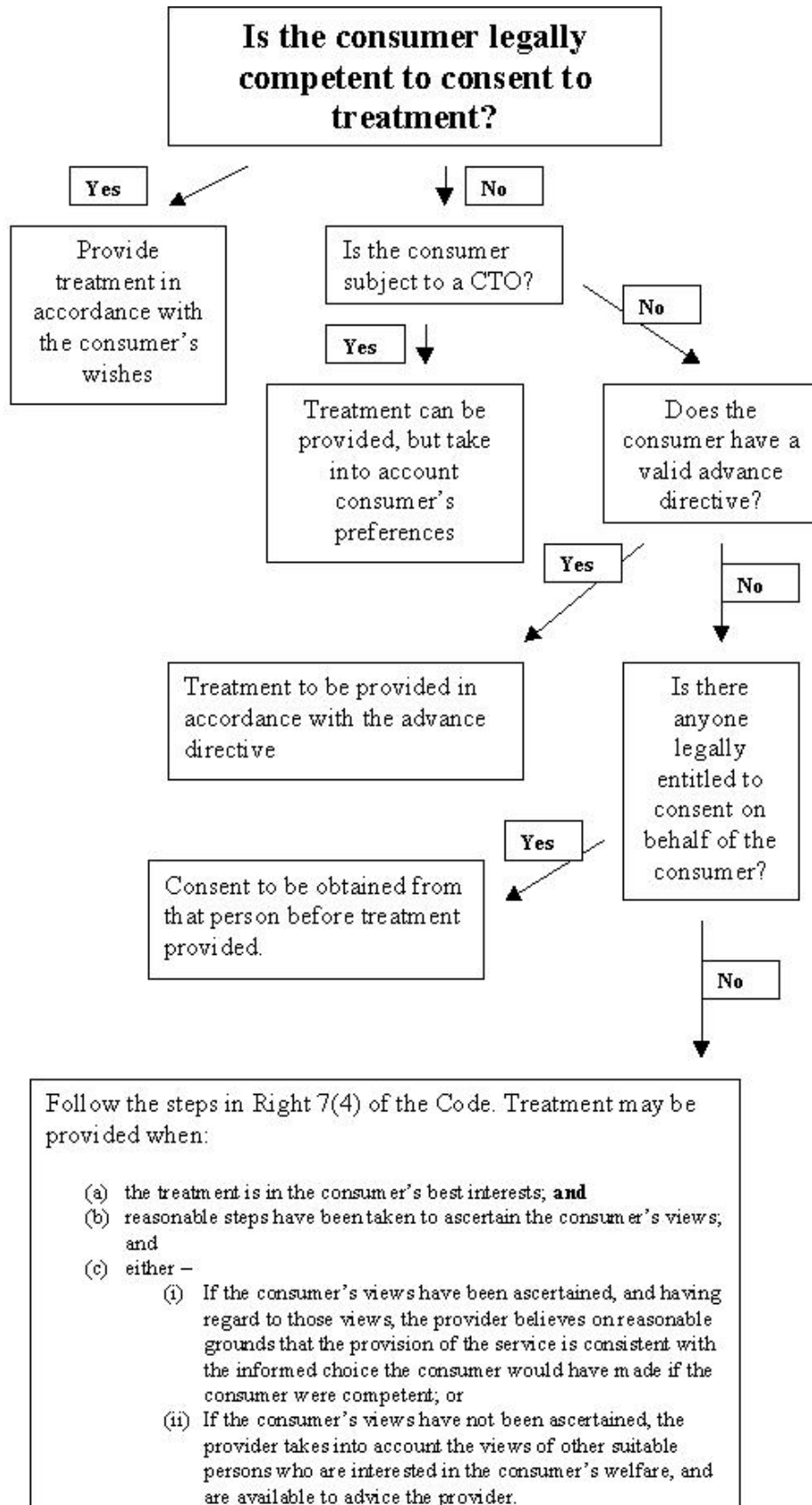
WCDHB Compliance with the Code of Health and Disability Services Consumer Rights Procedure

WCDHB Informed Consent Procedure

WCDHB Advance Directive Consumer/Patient Information Sheet



10. Guidelines





Strategies for Effective Communication with Family/Whanau Concerning Resuscitation Status

Preparing for a meeting about resuscitation decisions:

- Review previous knowledge of the patient and/or family/whanau and their attitudes and reactions
- Review your knowledge of the disease – prognosis and treatment options
- Acknowledge your own person feelings, attitudes, bias and grieving
- Discuss with the family/whanau in advance about who should and will be present
- Plan for a nurse directly caring for the patient to attend. Clarify if the patient or family/whanau accepts this, and if there are any other key individuals they want present
- Limit the number of staff present to only those with a genuine relationship with the patient and/or their family/whanau
- Plan the specifics of the location: a quiet, private, comfortable place
- Set up a meeting room, bearing in mind the potentially adverse impact of seating arrangements. Try to avoid placing staff and family/whanau in physically opposing seats.
- Plan for sufficient uninterrupted time. Arrange for pager or mobile calls to be taken by someone else.
- Provide an adequate supply of tissues and water.

During the family/whanau meeting

- Introduce yourself and everyone present
- If appropriate, set a non threatening tone (e.g. “this is a conversation we have with many families...”)
- Discuss the goals of the meeting
- Find out what the family/whanau understands. Ask them to narrate how the patient has come to this stage
- Review what has happened and is happening to the patient
- Discuss prognosis frankly, in a way that is meaningful to the family/whanau
- Acknowledge uncertainty in the prognosis if this exists
- Review the principle of substituted judgment: “what would the patient want if he or she was making decisions about care?”
- Do not discourage all hope; consider redirecting hope toward other things, such as a “good death”, adequate symptom relief and a strengthening of relationships
- Avoid the temptation to give too much medical detail
- Explain likely benefits, burdens and poor outcomes of CPR relative to this patient
- Make it clear that withholding life-sustaining treatment is not withholding care and sufficient pain relief will never be withheld
- Make explicit what care will be provided including symptom management, where care will be delivered and the family’s access to the patient
- Discuss what the patient’s death might be like, if this is imminent, and what practical steps follow next
- Use repetition to show that you understand what the patient or family/whanau is saying
- Be prepared for the possible strong expression of grief or anger
- Acknowledge strong emotions and use reflection to encourage family/whanau to talk about these emotions
- Tolerate silence
- Allow sufficient time for others to absorb information
- Invite participation in the discussion from the patient/family and form other members of the health care team where appropriate
- At completion ask for questions. Ensure basic follow up plan and that the family/whanau knows how to reach you with questions. Having a support person such as a nurse or social worker stay with the family/whanau after the meeting concludes may be helpful.

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