INSTRUCTIONS AND FORM FOR LONG-TERM CARE OMBUDSMAN WITNESSING OF AN ADVANCE HEALTH CARE DIRECTIVE

Witnessing Advance Health Care Directives (AHCD) in a Skilled Nursing Facility (SNF)

1. Make sure that the requesting parties have a current AHCD form. If the resident's attorney has prepared the AHCD, determine if other powers of attorney are included in the document. If other powers of attorney are included in the document, the *Long-Term Care Ombudsman Witness Addendum to an Advance Health Care Directive* form (OSLTCO S102) will be required as an addendum to the AHCD.

2. Prior to witnessing the AHCD, make sure that the resident has read and completed the AHCD document or has had it read to him or her and the document has been completed by a family member, facility social services staff, clergy, etc. The Long-Term Care (LTC) Ombudsman only witnesses the document. The LTC Ombudsman does not complete the form for the resident,-read the document to the resident, explain or interpret at length the document for the resident or assist the resident with decision making regarding the AHCD.

3. Establish the identity of the resident. The identity of the resident can be established by the resident's wristband, photo identification or by asking the resident, his or her family member, friend, facility administrator or facility staff to identify the resident. Some facilities have binders with resident's name/photo or there may be a photo just outside the room.

4. Explain to the resident and other individuals present your special role as a LTC Ombudsman witness and that all information shared with you is confidential.

5. Conduct a private and confidential interview with the resident to determine the resident's capacity to execute an AHCD prior to witnessing the AHCD. It may be necessary to ask the facility staff to move the resident to another location, such as a visitor room. If the resident needs an interpreter, explain the interpreter's relationship to the resident in your documentation.

6. Reaffirm with the resident that all communication with him or her is confidential, and will not be revealed to anyone without obtaining his/her consent first.

7. Ask the resident questions 1 through 7 listed on page three of the *Witnessing/Intake Form* to establish that the resident has capacity to sign the AHCD and to <u>ensure that the resident is signing the AHCD willingly and voluntarily</u>.

8. This is a good opportunity to review any existing Physician Orders for Life-Sustaining Treatment (POLST) forms with the resident. Ask the resident whether he or she has completed a POLST form. If the resident says yes or is unsure, ask whether the resident would like to review his or her medical chart with you to see whether it contains a POLST that has been signed by both the resident and physician, and whether the POLST conflicts with the terms of the AHCD. If the POLST conflicts with the AHCD, discuss the discrepancy with the resident to determine if the resident wishes to revoke or revise the POLST to agree with the AHCD or revise the AHCD to agree with the POLST. If changes need to be made, assist the resident to discuss with appropriate facility staff.

9. If there is a question about the resident's ability to understand what he or she is signing, obtain written consent from the resident or his or her legal representative to examine the resident's medical record for any notations with regard to capacity. If the resident is the subject of a conservatorship, ask the facility for a copy of the record to determine if the conservator has authority regarding the residents' health care decisions. A conservatorship may apply to estate only, or of person only, or of both; and may or may not include the right of the conservator to make major medical decisions for the conservatee. If consent to review the medical record is refused, and you have doubts about the resident's capacity to execute the AHCD, DO NOT proceed with witnessing the AHCD. Indicate on the Witnessing/Intake Form the date, time, and reason the witnessing was not done.

10. If there is a question as to whether the resident would be signing willingly and voluntarily, DO NOT proceed with witnessing the AHCD. Indicate on the Witnessing/Intake Form the date, time, and reason the witnessing was not done.

11. In addition to the LTC Ombudsman, a second witness is required to sign to execute an AHCD. The second witness may be another capable resident, friend or family member of the resident or a notary. Facility staff cannot act as witnesses for an AHCD, including a notary employed by the facility. Document the name and relationship of the second witness on the *Witnessing/Intake Form*. Arrangements for the second witness should be made by the resident, the resident's family or facility social worker prior to the LTC Ombudsman's visit.

12. If persons other than the second witness, and if necessary, an interpreter are present with the resident when the AHCD is to be signed, ask the resident if he or she objects to their presence (e.g., roommates or family members). If the resident objects, communicate the resident's objection to the parties involved, if they refuse to leave, or cannot leave, have the resident taken to another location.

13. Ask facility staff to make at least three (3) copies of the AHCD document. Give the original and one copy of the signed AHCD document to the resident and if requested by the resident, give copies and or the original to the agent, attorney or family member present at the witnessing. Best practices indicate that the LTC Ombudsman give one copy of the AHCD to the facility to put in the resident's medical record. The LTC Ombudsman program does not keep copies of the AHCD, only the Witnessing Intake form.

Advance Health Care Directive Witnessing/Intake Form

Resident's Name:		
LTC Ombudsman's Name:		
LTC Ombudsman Certification #:		
Intake Date: / /	Action Date: / /	Date: / /
Facility Name:		Facility No:
Physician's Name (Optional):		

Preliminary Information

1. Individual requesting LTC Ombudsman to witness AHCD, if other than resident:

Name	Relationship	
Address		Phone ( ) -
City	State	Zip Code

2. Primary Agent's Name

Name	Relationship	
Address		Phone ( ) -
City	State	Zip Code

Meeting with the Resident

In witnessing an AHCD, a LTC Ombudsman must interview the resident. If there are any questions regarding the resident's ability to understand what he or she is signing, the LTC Ombudsman should obtain the resident's or legal representative's consent to briefly examine the resident's medical record to see if there is a notation regarding the resident's capacity. If consent to review the medical record is refused, and you have doubts about the resident's capacity to execute the AHCD, do not proceed with witnessing of the AHCD.

Chart Reviewed/Date: / / _____ By: _____
State Certified Ombudsman

Questions to Ask the Resident (Witnessing/Intake Interview)

1. What is your name? (Verify on wristband and one other means of identification.)
2. Have you read, or has someone read to you, this AHCD or the AHCD within this document?
3. Do you have any concerns about this document?
4. Are you naming _____ (name of primary agent) to make your health care decisions for you. Are you certain that this is the person you want to name to make your health care decisions for you? ☐ Yes ☐ No
5. Has any employee of this facility, a family member, or any other person tried to influence you against your own choice to name _____ as your primary agent to make health care decisions for you? ☐ Yes ☐ No (if you receive a "yes" response, do not witness the AHCD.)
6. Have you discussed the Advance Health Care Directive with the person you are naming as your primary agent to make health care decisions for you? ☐ Yes ☐ No (If the resident has not yet discussed with the person they are naming as their agent, suggest that they do this as soon as it is possible.)
7. Do you have a Physician Order for Life Sustaining Treatment or POLST? ☐ Yes ☐ No ☐ I don't know (If "yes" or "I don't know," ask whether the resident would like to review his or her medical chart with you.)

Ombudsman Witness Statement

1. I believe this resident is capable of signing the AHCD voluntarily, and with knowledge and understanding of what he/she is doing/signing. (Check the appropriate box below.)

☐ Yes
☐ Yes, but resident is unable to sign due to physical limitations. (Explain below.)
☐ No (Explain below.)

2. If the AHCD was not witnessed, please list below all of the dates and times of interview attempts and the reason(s) witnessing was not done.

DATE:	TIME:	REASON
/ /	:	
/ /	:	
/ /	:	
/ /	:	
/ /	:	

3. This resident has signed the AHCD document or acknowledged the signature on the document as his/her in my presence.
☐ Yes ☐ No

4. I signed the AHCD document and indicated that I was serving as a LTC Ombudsman witness.
☐ Yes ☐ No

5. Name of second witness _____ and their relationship to this resident:

6. Does the resident have a POLST?
☐ Yes ☐ No

7. Is the POLST in agreement with the provisions of the AHCD?
☐ Yes ☐ No (Explain below)

Complete if an AHCD Contains Other Powers of Attorney

8. I signed the *Long-Term Care Ombudsman Witness Addendum to an Advance Health Care Directive* (OSLTCO S102) and indicated that I was serving as an Ombudsman witness and that I only witnessed the portion of this document that relates to the AHCD. ☐ Yes ☐ No
9. This resident has initialed the AHCD addendum in my presence. ☐ Yes ☐ No

LTC Ombudsman Signature

/ /
Date

Printed Name of LTC Ombudsman Witnessing AHCD