UNIFORM ADVANCE DIRECTIVES FORM FOR A NURSING HOME RESIDENT
(*Complies with R.I. Gen. Laws § § 23-4.13-1 et seq.-Rights of the Terminally Ill Act -Living Will***)**

INTRODUCTION

Adults have the right to control decisions relating to their health care, including the decisions to have life sustaining procedures withheld or withdrawn in instances of a terminal condition. You may express your wishes for medical treatment in written documents which can speak for you when you are not able to participate actively in health care decision making. No special form must be used.

Rhode Island law permits two types of documents to be used to express your wishes for end of life medical treatment.

One, the Durable Power of Attorney for Health Care, let's you name someone to make health care decision for you when you cannot actively participate in health care decision making. The Durable Power of Attorney for Health Care provides greater flexibility for medical decision making than the other document, a Living Will. Some people prefer a Durable Power of Attorney for Health Care to a Living Will as the way to express end of life health care wishes.

The second document, the Living Will, let you express end of life health care wishes. If you have an incurable and irreversible condition which will cause death and you cannot actively participate in health care decision-making, you may provide a written statement telling the attending physician to withhold or withdraw procedures that prolong dying and that will not relieve discomfort and pain. **THE UNIFORM ADVANCE DIRECTIVES FOR A NURSING HOME RESIDENT IS A LIVING WILL**. Remember: you may revoke your Living Will at any time.

INSTRUCTIONS FOR THE UNIFORM ADVANCE DIRECTIVES FORM

Only **Sections 1 and 6** must be completed. The other Sections are optional but will give health care providers information to help them respect your wishes for end of life medical treatment.

SECTION 1 (Required): **Fill-in your name.**

SECTION 2 (Optional): You may describe your present medical condition.

SECTION 3 (Optional): You may give specific instruction for certain treatments or procedures.

SECTION 4 (Optional): You may provide your preference for treatment facility.

SECTION 5 (Optional): You may provide request for religious or spiritual services.

SECTION 6 (Required): Your signature in the presence of two (2) witness not related by blood or marriage to you and the signatures of the two (2) witnesses.

SECTION 7 (Optional): List of who you gave copies of the UNIFORM ADVANCE DIRECTIVES FORM FOR NURSING HOME RESIDENT

SECTION 8 (Optional): Acknowledgment that the nursing home staff/physician discussed advance directives with you.

SECTION 9 (Optional): You may provide your preference for your body after death.

COMMONLY USED LIFE-SUPPORT MEASURES

Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

When used quickly in response to a sudden event like a heart attack or drowning, CPR can be life-saving. But the success rate is extremely low for people who are at the end of a terminal disease process. Critically ill patients who receive CPR have a small chance of recovering or leaving the hospital.

If you do not wish to receive CPR while in the hospital, your doctor must write a separate do-not-resuscitate (DNR) order on the chart. Your doctor should affix a copy of your Living Will to your medical file.

Rhode Islanders with a terminal condition who do not want rescue/ambulance service/emergency medical services personnel to perform CPR may join COMFORT ONE. Rescue/ambulance/emergency workers will provide comfort measures but will not perform CPR or any resuscitation. To join COMFORT ONE, speak to your physician. ONLY your physician can enroll you in the COMFORT ONE PROGRAM. Your physician writes a medical order directing rescue/ambulances service/emergency personnel not to start CPR.

Mechanical Ventilation

Mechanical ventilation is used to support or replace how the lungs work. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure happens due to injuries to the upper spinal cord or a progressive neurological disease.

Some people on long-term mechanical ventilation are able to enjoy themselves and live a quality of life that is important to them. For the dying patient, however, mechanical ventilation often merely prolongs the dying process until some other body system fails. It may supply oxygen, but it cannot improve the underlying condition.

When discussing end-of-life wishes, make clear to loved ones and your physician whether you would want mechanical ventilation if you would never regain the ability to breathe on your own or return to a quality of life acceptable to you.

Artificial nutrition and hydration

Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluid through a tube placed directly into the stomach, the upper intestine, or a vein. Artificial nutrition and hydration can save lives when used until the body heals. Long-term artificial nutrition and hydration may be given to people with serious intestinal disorders that impair their ability to digest food, thereby helping them to enjoy a quality of life that is important to them. But long-term use of the tube feeding frequently is given to people with irreversible and end-stage conditions. Often, the treatment will not reverse the course of the disease itself or improve the quality of life. Some health care facilities and physicians may not agree with stopping or withdrawing tube feeding. Therefore, explore this issue with your loved ones and physician and clearly state your wishes about artificial nutrition and hydration in your advance directive.

THINGS TO THINK ABOUT WHEN MAKING A LIVING WILL

WHAT DO YOU WANT FOR THE GOALS OF MEDICAL TREATMENT

General statements such as "no heroic measures," "die with dignity," or "do everything," can mean very different things to different people and should not be used. To arrive at the clear understanding, you need to have a conversation about your particular views, you might discuss some concrete situations. The following are some examples:

- If you suffered a massive stroke or had a head injury from which you were unlikely to regain consciousness, how aggressively would you want to be treated? What if you were conscious but made a poor recovery and were unable to recognize people or to move your body?

- How aggressively would you want medical treatment to prolong your life if you suffered from a progressive debilitating disease such as Alzheimer's disease, Parkinson's, or a similar disorder and could no longer make decision?

- If you were in any of these situations, would you want to receive nourishment and fluids artificially by tubes?

- If you were seriously ill and your heart stopped beating or you stopped breathing, would you want to go through resuscitation attempts or to receive long-term mechanical ventilation?

- If your underlying disease were terminal or irreversible, would you want to receive antibiotics for pneumonia or other infections that might occur?

- If you were very ill, would you never want treatments such as ventilation, artificial nutrition and hydration, or antibiotics? Would you want them on a trial basis? Would you want them regardless of the outcome?

- If you were seriously ill, would you want aggressive pain management even if it shortened your life?

- Would you want special attention paid to providing you with palliative care – care designed to keep you comfortable and not treat your disease?

- How do religious or spiritual beliefs affect your attitudes toward dying and death?

- Should financial concerns enter into decisions?

- Would you prefer to die at home if possible?

Although you cannot expect to cover every specific situation that might arise, some discussion of concrete situations helps your health care providers to understand how you think about the purpose and use of medical treatments at the end of life.