

# END OF LIFE CARE

Estimated Time: 60 minutes • Debriefing Time: 60 minutes



Scan to Begin



Patient Name: Laura C. Anderson

## SCENARIO OVERVIEW

Laura is a 35-year-old female with end stage lung cancer who was transported to the ER via ambulance. Laura's mother, Jane Beckman, has been caring for her at home. Yesterday the mom returned to Laura's home after being out of town for two days and was alarmed by her daughter's decreased level of consciousness and respiratory difficulty and called 911. Laura requested hospice services one week ago, but her mom still wants "everything possible done for her." The doctor has not yet seen Laura so students must do a full assessment focused on common end of life concerns including pain, dyspnea, GI symptoms, skin breakdown, and advance directives. When they assess the patient's sacral area, they will find a QR code to scan showing a Stage 1 pressure ulcer. Students should also demonstrate therapeutic communication regarding end of life issues with the patient and the mother while performing their assessments. Advance Directives should be further addressed with the patient using the form and patient education video provided. In State 2, orders are received from the hospitalist.

## LEARNING OBJECTIVES

(Based on AACN End-of-Life Nursing Education Consortium: Recommended Competencies and Curricular Guidelines for End-of-Life Nursing Care)

1. Communicate effectively and compassionately with the patient, family, and health care team members about end-of-life issues
2. Recognize one's own attitudes, feelings, values, and expectations about death and the individual, cultural, and spiritual diversity existing in these beliefs and customs
3. Demonstrate respect for the patient's views and wishes during end-of-life care
4. Assess symptoms (e.g., pain, dyspnea, constipation, anxiety, fatigue, nausea/vomiting, skin breakdown and altered cognition) commonly experienced by patients at the end of life and intervene appropriately according to evidence based palliative care practices
5. Apply legal and ethical principles in end-of-life care, recognizing the influence of personal values, professional codes, and patient preferences
6. Address spiritual health during end-of-life care

## CURRICULUM MAPPING

### WTCS NURSING PROGRAM OUTCOMES

- Implement one's role as a nurse in ways that reflect integrity, responsibility, ethical practices, and an evolving professional identity as a nurse committed to evidence-based practice, caring, advocacy and quality care
- Demonstrate appropriate written, verbal, and nonverbal communication in a variety of clinical contexts
- Integrate social, mathematical, and physical sciences, pharmacology, and pathophysiology in clinical decision making
- Provide patient centered care by utilizing the nursing process across diverse populations and health care settings
- Minimize risk of harm to patients, members of the healthcare team and self through safe individual performance and participation in system effectiveness
- Lead the multidisciplinary health care team to provide effective patient care throughout the lifespan

- Use information and technology to communicate, manage data, mitigate error, and support decision-making

## NURSING FUNDAMENTALS

- Maintain a safe, effective care environment for adults of all ages.
- Use appropriate communication techniques
- Differentiate scopes of practice within the nursing profession
- Use the nursing process
- Provide nursing care for patients with comfort alterations
- Provide nursing care for patients with nutritional, fluid, and electrolytes disturbances
- Provide nursing care for patients with commonly occurring alterations in elimination patterns
- Provide nursing care for patients and families experiencing grief and loss
- Provide nursing care for patients with alterations in oxygenation
- Provide nursing care for patients with sleep/rest/mobility alterations
- Adapt nursing practice to meet the needs of diverse patients in a variety of settings
- Provide nursing care for patients with integumentary disorders

## SIMULATION LEARNING ENVIRONMENT & SET-UP

### ENVIRONMENT

Inside room: Patient is lying in bed, hospital exam room setting

Inside or outside room: Hand sanitizer or sink, phone to “call provider”

Outside room: A printed copy of the Advance Directive form located in Appendix A

### PATIENT PROFILE

Name: Laura C. Anderson

Spiritual Practice: Catholic

DOB: 04/16/19XX

Ethnicity: Caucasian

Age: 35

Primary Language: English

MR#: 0912

Admitting Diagnosis: Chronic Pain, neoplasm related (G89.3)

Gender: Female

Chronic Medical Diagnoses: Metastatic Lung Cancer (C34.0)

Height: 152.4 cm (65 inches)

Weight: 47.62 kg (105 lbs)

Current Medications: None

Code Status: Full resuscitation

Allergies: NKDA

### EQUIPMENT/SUPPLIES/SETTINGS

#### Patient

- Wearing hospital gown
- Moulage to appear gray, thin and emaciated
- Bandana/turban on head (no hair)
- ID band with QR code
- Bible and rosary by bed
- Nasal cannula in place and set to O2 1L/min
- Bowel sounds: very hypoactive
- Lung sounds: crackles

- Heart sounds: normal S1S2

### **Monitor Settings**

- No monitor
- Vitals: BP= 154/74 T= 38.1 C HR= 130 RR= 25 O2= 89% on O2 1L (can increase O2 sat as student increase O2 flow rate but keep in low 90s)

### **Family Member**

- Mom is present during this scenario.
- Options:
  - Mom played by actor
  - Mom role-played by a student
  - Mannequin sitting in chair with “Mom” QR code attached
  - Mom “just left the room” after students watch the video of the mother’s concerns.

### **Supplies**

- General
  - Equipment to obtain vitals including oxygen saturation
  - Phone
  - Wound assessment tool(s)

## QR CODES

<p>START</p> 	<p>PATIENT</p> 	<p>PATIENT ID</p> 	<p>REPORT</p> 
<p>MOM REPORT</p> 	<p>SACRAL</p> 		

# TEACHING PLAN

## PREBRIEF

The facilitator should lead this portion of the simulation. The following steps will guide you through Prebrief.

- Scan the “**Scan to Begin**” QR Code while students are in Prebrief
- “Meet Your Patient” and “Meet the Family” (on iPad) and explain how the iPad works in the simulated learning environment including:
  - Explain how to use the iPad scanner and QR codes. Remind students that there are multiple QR codes in the simulation, but they should only scan them if they think it will provide data necessary for their assessment and evaluation of the patient.
  - For some scenarios, it may be helpful to tell students where the QR Code are located. For others, you may want students to “find” the QR Codes during their assessments. This is your choice.
  - As the facilitator, you should be aware that throughout the simulation some QR codes are necessary to the programming of the iPad content. Directions for which QR codes are required (to be scanned) in each state are listed under each state of the documentation below. The QR codes are also in **BOLD** type.
  - MAR Hyperlinks – On the MAR all medications are underlined and hyperlinked to DailyMed, which is a medication reference housed by the National Library of Medicine. Students can click on these links during the simulation for up-to-date medication content, labels, and package insert information.
  - Level Up tab – This tab “tells” the content in the iPad to change to what is needed for the next state of a simulation. It also helps students know where they are at in a scenario and it may give “clues” as to how to progress.
- Discuss the simulation “Learning Objective(s)” (on iPad) as well as any other Prebrief materials
- Get “Report” (on iPad)
  - Possible Facilitator Question
    - What are your priorities of care after listening to the nurse report?

- Play the “Mom” video (on iPad)
  - Possible Facilitator Questions
    - What important information did you discover from the conversation with the mother that will assist with continuity of care and should be documented?
    - Has the conversation with the mother changed your priorities for care? If yes, how?
    - How will you address the mother’s comment that “we don’t need any directives?”
- Play the “Patient” video (on iPad)
  - Possible Facilitator Question
    - Based the patient’s statements and current status, what are your priorities of care?
- Advance to the “Patient Profile” screen (on iPad). This will act as a simulated patient chart.
- Students can view the tabbed content on the iPad (see below) prior to entering the patient’s room and throughout the simulation as needed.
  - You should give the student(s) some time (5 minutes) to review this content prior to entering the patient’s room. It may be helpful to tap the Health Care Directives to and view the Patient Education video and Advanced Directives form before entering the room.
  - Possible Facilitator questions
    - “What does DNR mean?”
    - “What is the difference between a ‘Living Will’ and a ‘Power of Attorney for Health Care’?”
    - Note: The blank Advanced Directive form may be printed for students to take into the patient room. It is located in Appendix A.



**H&P**

Not available

**ORDERS**

Not available

**MAR**

Not available

**DAILY RECORD**

Not available

**VITALS**

When this tab is tapped, the iPad reads, “You must verify the patient before vitals can be taken.”

- Student must scan **QR Code: Patient ID** before entering vitals.
- Simulator vitals are set to: BP= 154/74, T= 38.1 C, HR= 130, RR= 25, O2= 89% on O2 at 1L/min

**PROGRESS NOTES**

Not available

**LAB-DIAGNOSTICS**

Not available

**IMAGING**

Not available

## HEALTH CARE DIRECTIVES

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The iPad shows 2 separate “buttons” students can click on. Those “buttons” are:

- Patient Education Video
- Advance Directive Form
  - A copy of this form is located in Appendix A.

## SCANNER

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Use this to scan scenario QR Codes.

## EXIT

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When this tab is tapped, the iPad reads, “Are you sure you want to exit? All data will be lost.”

- If “No” is selected, the iPad will return to the tabbed content.
- If “Yes” is selected, the iPad will let the student(s) exit and prompt them to complete an embedded 3-5 minute survey.

## STATE 1

# PATIENT ASSESSMENT

- Patient Overview
  - Patient is drowsy and is in severe pain that is not being managed by current medication. She desires hospice and states “just want to stop hurting,” but her mom still wants everything done. No advance directives are in place and patient is full code. End of life concerns include: pain, shortness of breath, anxiety/fear/depression, nausea, constipation, no appetite/weight loss, fever. Patient also has Stage 1 pressure ulcer on gluteus that has not yet been noticed.
- Expected Student Behaviors
  - Introduce themselves
  - Verify the patient (Scan **QR Code: Patient ID**)
  - Obtain vital signs
  - Students must enter vitals on the iPad, but the accuracy of those vitals are not tied to iPad programming
  - Assess chief complaint: pain
  - Assess respiratory status and relate to patient condition
  - Titrate oxygen therapy
  - Perform a thorough skin assessment (Scan **QR Code: Sacral**)
  - Recognize Stage 1 pressure ulcer on gluteus and implement appropriate interventions for an end of life patient
  - Assess GI status: hypoactive bowel sounds, nausea, lack of appetite
  - Communicate therapeutically with mom and patient about end of life issues such as hospice and pain control; DNR; and advance directives
  - May watch patient education video about advance directives with the patient and/or mom
  - May assist patient to complete the advance directive form located in Appendix A
  - Call provider to advocate for pain medications
  - May address spiritual health and call a chaplain or pastor
- Technician Prompts

- Patient is drowsy with flat, withdrawn affect.
- Patient responses can include:
  - “Just let me sleep.”
  - “It hurts so bad, nothing helps.”
  - “I just want to stop hurting.”
- If student(s) assist the patient to complete the advanced directive form, use the completed copy (Appendix B) as prompts for answering the questions.
- If an actor is used for the mother, responses can include:
  - “She still has a lot of life to live. I want everything done for her.”
  - “I found her lying on the floor this morning. She barely recognized me.”
  - “I am the emergency contact for Laura.”
  - “My husband passed away. It’s just Laura and me now.”
  - “She uses a Fentanyl patch and oxycodone for pain.”
  - “We don’t need advanced directives. Do everything you can!”
- Possible Facilitator Questions
  - What are your concerns based on your pain assessment findings?
  - What risk factors does Laura have for skin breakdown? How would you describe the skin changes on her gluteus? What interventions should be implemented?
  - What are some possible causes for Laura’s constipation?
  - What are some possible causes for Laura’s nausea and lack of appetite?
  - What stage of grief do you think the Laura is experiencing today?
  - What stage of grief do you think Jane (her mom) is experiencing today?
  - What is hospice care? How would it benefit Laura and Jane?
  - What are “comfort cares?”
  - What are advance directives? How would they benefit Laura?
  - How can spirituality be addressed with Laura and Jane?
  - What is Laura’s fluid and nutritional status? Are any interventions are required at this time?

- **Tabbed iPad Prompts & Content Changes**
  - The scenario automatically advances to Level 2 after the student(s):
  - Scans **QR Code: Patient ID**
  - Enters vitals on the enterable vitals screen under the Vitals tab
  - Scans **QR Code: Sacral**
  - At that time, the student(s) see a message on the iPad that reads, “New orders have been received.”

## STATE 2

# NEW ORDERS FROM THE HOSPITALIST

- Patient Overview
  - The student receives a message on the iPad that reads, “New orders have been received.” The student(s) should review and implement the new admission orders.
- Expected Student Behaviors
  - Prioritize implementation of new orders
  - Call RT for consult
  - Call palliative care for consult
  - Titrate oxygen PRN
  - Call “lab” for lab work
  - Determine what medications should be administered at this time
- Technician Prompts
  - The patient continues to be drowsy and in pain. The patient wants to stop treatment for cancer and go home to die peacefully. The mother continues to want everything done for Laura.
  - Patient responses can include:
    - “How is hydromorphone going to help me?”
    - “How is hydromorphone different from the oxycodone and Fentanyl that I’m already on?”
    - “Are there any side effects from the hydromorphone?”
    - “How will the Dexamethasone help me?”
    - “I just want to stop hurting.”
    - The patient refuses lab work and ABGs stating, “I don’t want anyone else poking me.”
    - “I feel queasy.”
    - “I feel bloated.”
    - “I haven’t been able to go to the bathroom.”

- “When will the hospice nurse get here? I want to talk to her.”
- “I just want to go home, but my mom still wants everything done for me. What should I do?”
- “I want to die at home, not here in the hospital.”
- “I want to be DNR, but don’t tell my mother. It will upset her.”
- If an actor is used for the mother, possible responses can include:
  - “Will the hydromorphone take away all her pain?”
  - “Why hasn’t any lab work been done?”
  - “We don’t want to see the hospice nurse. We’re not giving up on her!”
  - “Laura doesn’t need to complete the advanced directives. I still want everything possible done for her.”
- Possible Facilitator Questions
  - Does Laura need oxygen administration? Why or why not?
  - Explain the difference between hydromorphone IV, oxycodone ER and Fentanyl patch?
  - How will the dexamethasone help Laura?
    - Answer: It will help reduce ICP, nausea and bone pain.
  - What medications should be administered at this time? Why?
  - How will you manage Laura’s constipation?
  - How will you manage Laura’s nausea?
  - Who should make the decisions about hospice care and advanced directives?
  - What should you do when family member’s wishes contradict patient wishes?
- Tabbed iPad Prompts and Content Changes:

**H&P**

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**Name:** Laura C. Anderson

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MR#: 0912

DOB: 04/16/19XX

**Date:** Today**Time:** Now

**CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS:** This is a 35-year-old female brought to the ER with decrease in level of consciousness and respiratory difficulty. She has end stage lung cancer. Biopsy of right lower lobe 9 months ago revealed carcinoma that has now metastasized to the bone and brain. The patient has received eight monthly cycles of chemotherapy but requested hospice services one week ago according to her oncologist, Dr. Benton. She is accompanied by her mother who states she wants “everything possible done for her daughter.” No advance directives are in place.

**PAST MEDICAL HISTORY:** Lung Cancer with metastasis to brain and bone

**MEDICATIONS:**

- Fentanyl patch 25 mcg every 72 hours for pain
- Oxycodone ER 80 mg PO every 12 hours PRN for pain
- Docusate sodium 100 mg PO BID for constipation
- Compazine 10mg PO every 4-6 hours for nausea PRN

**ALLERGIES:** NNDA**SOCIAL HISTORY:** Single; No children; Lives alone. No advance directive.**REVIEW OF SYSTEMS:** Abbreviated due to end of life condition.

**HEENT:** Mother reports change in level of consciousness. Denies headaches or change in vision.

**Respiratory:** Complains of productive cough of white, blood streaked sputum and worsening shortness of breath. Complains of chest pain worse on inspiration.

**Cardiovascular:** Denies palpitations.

**Peripheral Vascular:** Denies claudication, leg cramps, paresthesias or edema.

**Gastrointestinal:** Mother reports “no appetite” and “has been losing a lot of weight.” Patient complains of nausea and vomiting relieved with Compazine. Patient complains of constipation that she treats with docusate sodium.



**Genitourinal:** Patient reports dark, concentrated urine but no dysuria or hematuria.

**PHYSICAL EXAM:**

**General Appearance:** 35-year-old female who appears emaciated and withdrawn. Alert but drowsy. Avoided eye contact and stated, “Just let me die.”

**Vital signs from paramedics:** BP= 154/74 T= 38.1 C HR= 130 RR= 25 O2= 85% on RA  
Height= 162.5 cm (65 inches) Weight= 47.62 kg (105 lbs)

**HEENT:** unremarkable, PERRLA

**Neurological:** Eyes open to speech, oriented x3. Visibly fatigued. Flat affect. GCS 14.

**Cardiovascular:** Normal heart sounds. No murmurs.

**Respiratory:** Course crackles throughout with occasional wheeze.

**Abdomen:** Hypoactive, non-distended.

**Vascular/Extremities:** Strength 2/5. Sensation and reflexes intact. Skin dry.

**Rectal:** Deferred.

**LABORATORY AND DIAGNOSTIC STUDIES:** ABGs STAT, CBC, Chem 7


**ASSESSMENT/PLAN:** End stage cancer; end of life.

- Admit to medical floor for pain management.
- Initiate home medications.
- Hydromorphone IV 0.5mg STAT and every 2 hours PRN for severe pain.
- Dexamethasone 20 mg PO.
- Bedrest.
- Diet as tolerated.
- Oxygen therapy to maintain O2 sat >90%.
- Consult for respiratory therapy.
- Palliative care consult.

I discussed with patient and mother her current end-stage lung cancer status and recommended hospice care, initiation of advance directives and DNR status. No decision was made so will order follow-up with palliative care consult.

**Electronically signed** – Dr. Bennett, M.D.

## ORDERS



Orders

**Patient Name: Laura C. Anderson**  
**DOB:04/16/19XX Weight(kg):47.62**  
**MR#: 0912**  
**Provider: Dr. Bennett**  
**Allergies: NKDA**

Date	Time	Order
Today	Now	Admit to medical floor
		Bedrest
		Diet as tolerated
		Respiratory therapy consult
		Maintain O2 sat > 90%, start O2 via NC at 2 L and titrate prn
		ABGs STAT
		Palliative Care Consult
		Hydromorphone 0.5mg IV every 2 hours PRN for severe pain
		Fentanyl patch 25 mcg every 72 hours for pain
		Oxycodone ER 80 mg PO every 12 hours PRN for pain
		Docusate sodium 100 mg PO BID for constipation
		Compazine 10mg PO every 4-6 hours for nausea PRN
		Dexamethasone 4 mg PO daily
		Obtain advanced directives
		CBC, Chem 7
		-----Dr. Bennett, M.D.

[Continue >](#)

## MAR


MAR

**Patient Name: Laura C. Anderson**  
**DOB:04/16/19XX Weight(kg):47.62**  
**MR#: 0912**  
**Provider: Dr. Bennett**  
**Allergies: NKDA**

Order	Prev. Dose
<u>Fentanyl patch</u> 25 mcg every 72 hours for pain	
<u>Oxycodone ER</u> 80 mg PO every 12 hours PRN for pain	
<u>Docusate sodium</u> 100 mg PO BID for constipation	
<u>Compazine</u> 10mg PO every 4-6 hours for nausea PRN	
<u>Hydromorphone</u> 0.5mg IV every 2 hours prn for severe pain	
<u>Dexamethasone</u> 4 mg PO daily	

[Continue >](#)

## HEALTH CARE DIRECTIVES

The iPad shows a copy of the completed advance directive form. See Appendix B.

## EXIT

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When the Exit tab is tapped (students are not prompted to this), the iPad reads, “Scenario objectives have been met. Are you sure you want to exit the game?”

- If “No” is selected, the iPad automatically returns to the tabbed content area.
- If “Yes” is selected, the iPad will let the student(s) exit and prompt them to complete an embedded 3-5 minute survey.

## DEBRIEF

Nothing needed from the iPad.

## QUESTIONS

1. How did you feel this scenario went?
2. Review understanding of learning objective: Communicate effectively and compassionately with the patient, family, and health care team members about end-of-life issues.
  - a. What therapeutic techniques did you utilize today? Were they effective?
  - b. If you could “do over,” would you say anything differently to Laura or her mom?
3. Review understanding of learning objective: Recognize one's own attitudes, feelings, values, and expectations about death and the individual, cultural, and spiritual diversity existing in these beliefs and customs.
  - a. What did you learn about your own attitudes, feelings, values and expectation about death while participating in this scenario?
4. Review understanding of learning objective: Demonstrate respect for the patient's views and wishes during end-of-life care.
  - a. Whose decisions should be followed regarding Laura's care?
  - b. How did you advocate for Laura's wishes about her end of life care?
5. Review understanding of learning objective: Assess symptoms (e.g., pain, dyspnea, constipation, anxiety, fatigue, nausea/vomiting, skin breakdown and altered cognition) commonly experienced by patients at the end of life and intervene appropriately according to evidence based palliative care practices.
  - a. Pain
    - i. Explain how you performed a focused pain assessment on Laura
    - ii. Do you believe her pain is well managed? Why or why not?
    - iii. How will hydromorphone IV and dexamethasone PO improve Laura's pain management?
  - b. Respiratory status
    - i. What was Laura's respiratory status? How did you address it?
  - c. GI status

- i. How did you assess Laura's GI status?
        - ii. How does her GI status relate to her overall condition and treatments?
      - d. Anxiety/Fear/Depression/ Cognitive status
        - i. What was Laura's psychosocial status?
        - ii. What stages of grief are Laura and her mom demonstrating today?
        - iii. Do you think Laura is demonstrating any signs of depression? Delirium? Explain?
      - e. Skin integrity
        - i. What are Laura's risk factors for skin breakdown?
        - ii. What number do you calculate using the Braden scale and what level of risk does this indicate?
        - iii. Did you find any areas of skin breakdown? How would you describe her sacral area?
        - iv. What interventions could be implemented to prevent further skin breakdown?
6. Review understanding of learning objective: Apply legal and ethical principles in end-of-life care, recognizing the influence of personal values, professional codes, and patient preferences.
  - a. Compare palliative care/hospice services.
  - b. Compare what is contained in a "DNR," "Living Will" and "Power of Attorney for Health Care."
  - c. What are the goals for end of life care? Are these goals currently being met for Laura?
7. Review understanding of learning objective: Address spiritual health during end-of-life care
  - a. What spiritual cues did you notice when interacting with Laura and her mom?
  - b. How could spiritual wellness be incorporated into end of life care for Laura and Jane?
8. Tie the scenario back to the nursing process in a large group discussion. Concept mapping can be used to facilitate discussion.
  - a. Identify priority nursing problems you identified for Laura.

- b. Create a patient centered goal for each nursing problem you identified.
  - c. Discuss potential focused assessments for each nursing problem.
  - d. Discuss priority nursing interventions for each nursing diagnosis.
  - e. Re-evaluate the simulation in terms of the nursing process; what was actually accomplished? What could be improved in the future?
9. Summary/Take Away Points:
- a. “Today you cared for a patient with end stage lung cancer who arrived in the ED with poorly managed pain. You addressed several end of life issues such as pain; dyspnea; advance directives; and an ethical dilemma when the patient’s wishes are different from family’s wishes. What is one thing you learned from participating in this scenario that you will take with you into your nursing practice?” (Each student must share something different from what the others’ share.)

NOTE: Debriefing technique is based on INASCL Standards for Debriefing and NLN Theory-Based Debriefing by Dreifuerst.



## SURVEY

Print this page and provide to students.

Students, please complete a brief (2-3 minute) survey regarding your experience with this ARISE simulation. There are two options:

1. Use QR Code: Survey
  - a. Note: You will need to download a QR Code reader/scanner onto your own device (smartphone or tablet). There are multiple free scanner apps available for both Android and Apple devices from the app store.
  - b. This QR Code will not work in the ARIS app.



2. Copy and paste the following survey link into your browser.
  - a. [https://ircvtc.co1.qualtrics.com/SE/?SID=SV\\_6Mwfv98ShBfRnBX](https://ircvtc.co1.qualtrics.com/SE/?SID=SV_6Mwfv98ShBfRnBX)

## APPENDIX A



## Advance Directive including Power of Attorney for Health Care

### Overview

This is a legal document, developed to meet the legal requirements for Wisconsin. This document provides a way for a person to create a Power of Attorney for Health Care and other documentation that will meet the basic requirements for this state.

This advance directive allows you to appoint another person and alternate people to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **health care agent**. This document gives your health care agent authority to make your decisions *only when you have been determined incapable by your physicians to make them*. It does not give your health care agent any authority to make your financial or other business decisions. In addition, it does not give your health care agent authority to make certain decisions about your mental health treatment.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values, and this document with your health care agent.** If you do not closely involve your health care agent, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

If you want to document your views about future health care, but do not want to or cannot use this advance directive, ask your health organization or attorney for advice about alternatives.

This is an advance directive for:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

January, 2014 For additional copies visit: [www.honoringchoiceswi.org](http://www.honoringchoiceswi.org).

The name "Honoring Choices Wisconsin" is used under license from the Twin Cities Medical Society Foundation.

**NOTICE TO PERSON MAKING THIS DOCUMENT**

**YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.**

**BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.**

**IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.**

**THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS, AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE OR DOMESTIC PARTNER AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED OR THE DOMESTIC PARTNERSHIP IS TERMINATED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.**

**YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.**

**DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.**

**IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.**

## Part 1: My Health Care Agent

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my health care agent. This person will make my health care decisions when I am determined to be incapable of making health care decisions as provided under Wisconsin law. I understand that it is important for my health care agent and me to have ongoing discussions about my health and health care choices.

*When selecting someone to be your health care agent, choose someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person(s) you choose to be your health care agent(s).*

*Your health care agent must be at least 18 years old and may not be one of your health care providers, or an employee of your health care provider, unless he or she is a close relative. You may also designate an alternate and second alternate health care agent.*

### The person I choose as my health care agent is:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

If this health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:**

### Second choice (alternate health care agent):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

If this alternate health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:**

### Third choice (2nd alternate health care agent):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

Check here if you do not have an agent, and wish for your physician to follow the instructions below.

---

## Part 2: General Authority of the Health Care Agent

### I want my health care agent to be able to do the following:

Draw a line through (e.g., ~~Arrange for~~) anything listed below that you do **not** want your health care agent to do.

- Make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment already has been started, my health care agent can keep it going or have it stopped based on my stated instructions or my best interests.
- Interpret any instruction I have given in this form or given in other discussions according to my health care agent's understanding of my wishes and values.
- Review and release my medical records and personal files as needed for my medical care.
- Arrange for my medical care and treatment in Wisconsin or any other state, as my health care agent thinks is appropriate.
- Determine which health care professionals and organizations provide my medical treatment.
- Make decisions about organ and tissue donation (anatomical gifts) after my death according to my known wishes or values.

### Limitations on Mental Health Treatment

Pursuant to Wisconsin statutes my health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

To complete the next 3 sections:

Initial or check the box beside one statement in each section. If you do not mark any box in a section, your choice is "no" according to Wisconsin statute. This means if you do not indicate a choice, a court may make such a decision and not your health care agent.

### 1. Admission to a Nursing Home or Community-Based Residential Facility

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

Agent authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care:

**Yes**, my health care agent has authority, if necessary, to admit me to a nursing home or community-based residential facility for a long-term stay. This is subject to any limits I set in this document.

**No**, my health care agent does not have authority to admit me to a nursing home or community-based residential facility for a long-term stay.

**Unless I choose "yes," I can be admitted to a long-term care facility for a long-term stay only with a court order.**

### 2. Withholding or Withdrawal of Feeding Tube

**Yes**, my health care agent has authority to have a feeding tube withheld or withdrawn from me, unless my physician advises that, in his or her professional judgment, the withholding or withdrawing will cause me pain or discomfort. This is subject to any limits I set in this document.

**No**, my health care agent does not have authority to have a feeding tube withheld or withdrawn from me.

**Unless I choose "yes," a feeding tube can be withdrawn or withheld from me only with a court order.**

### 3. Health Care Decisions during Pregnancy

**Yes**, my health care agent has authority to make health care decisions for me if I am pregnant. This is subject to any limits I set in this document.

**No**, my health care agent does not have authority to make health care decisions for me if I am pregnant.

**Unless I choose "yes," health care decisions during pregnancy can be made for me only with a court order.**

**Does not apply.** I am either a male or no longer capable of becoming pregnant.

### Part 3: Statement of Desires, Special Provisions, or Limitations

**You are not required to provide any instructions or make any selections in this section.**

My health care agent shall make decisions consistent with my stated desires and values. He or she is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my health care agent and/or physician providing my medical care. If there are conflicts among my known values and goals, I want my health care agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this advance directive, or my health care agent cannot be contacted, I want the instructions to be followed based on my common law and constitutional right to direct my own health care.

If you choose **not** to provide any instructions, your health care agent will make decisions based on your oral instructions or what is considered your best interest. If you choose **not** to provide any instructions, it is recommended that you draw a line and write "no instructions" across the section.

#### Instructions Regarding Life-Prolonging Treatments

*Initial or check the box beside the statement or statements you agree with.*

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, who my family and friends are, or where I am, I want to be kept comfortable and clean, and I want my health care agent to:

- Stop or do not start medical treatments that might be used to prolong my life. Treatments I would not want if I were to reach this point include but are not limited to: feeding tubes including intravenous (IV) hydration, respirator/ventilator, and cardiopulmonary resuscitation (CPR). If I suffer this type of condition, in my view, the potential benefits of supportive medical treatments are outweighed by the burdens of those treatments.
- Continue or start feeding tubes including intravenous (IV) hydration if needed, but stop all other medical treatments including, but not limited to, a respirator/ventilator and cardiopulmonary resuscitation (CPR).
- I want my agent to be able to make decisions for me about life-sustaining treatment.
- Follow my instructions as provided below.

#### Pain and Comfort

*Initial or check the box beside this statement if you agree.*

- If I reach a point where efforts to prolong my life are stopped, I still want medical treatments and nursing care that will make me comfortable.

**The following are important to me for comfort** (If you don't write specific wishes, your physician and nurses will provide the best standard of care possible):

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**Cardiopulmonary Resuscitation (CPR)**

My CPR choice listed below may be reconsidered by my health care agent in light of my other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. **If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency personnel from attempting CPR in an emergency.**

*Initial or check the box beside the statement you agree with.*

- I want CPR attempted **unless** my physician determines any one of the following:
- I have an incurable illness or injury and am dying; OR
  - I have no reasonable chance of survival if my heart stops; OR
  - I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.
- I do not want CPR attempted if my heart stops. To the extent possible, I want to allow a natural death.

**Other instructions or limitations I want my health care agent to follow:**


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**When I am nearing my death and cannot communicate, I want my friends and family to know I have the following thoughts and feelings:**


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**If I am nearing my death, I want the following:**

*List the type of care, ceremonies, etc. that would make dying more meaningful for you.*

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**Person or people I want my health care agent to include when making health care decisions:**

I ask that my health care agent make a reasonable effort to include the following person or people in my health care decisions if there is time: \_\_\_\_\_



**Spirituality and/or Religious Affiliation**

I am of the \_\_\_\_\_ faith and am a member of the \_\_\_\_\_ congregation, parish, synagogue, or worship group in (city) \_\_\_\_\_.  
 The telephone number of the congregation, parish, synagogue, or worship group is: \_\_\_\_\_.  
 Please attempt to notify someone there if I am unable to give authorization to do so.

I am not religious or spiritually affiliated.

**Upon My Death**

After my death the following are my instructions. If my health care agent does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

- **Donation of my Organs or Tissue (Anatomical Gifts)**

*Examples of organs are kidney, liver, heart, and lungs. Examples of tissue are eyes, skin, bones, and heart valves. Initial or check the box beside the one statement you agree with.*

After I die, I wish to donate any parts of my body that may be helpful to others.  
 To make your wishes legally effective, register at [www.donorregistry.wisconsin.gov](http://www.donorregistry.wisconsin.gov)

After I die, I wish to donate **only** the following organs and tissue: \_\_\_\_\_  
 \_\_\_\_\_

I do not wish to donate any part of my body.

- **Autopsy**

*Initial or check the box beside one choice, or both A and B.*

A. I would accept an autopsy if it can help my blood relatives understand the cause of my death or affect their own health care choices.

B. I would accept an autopsy if it can help advance medicine or medical education.

C. I do not want an autopsy performed on me.

## Part 4: Making the Document Legal

This document must be signed and dated **in the presence of two witnesses** who meet the qualifications explained below.

### My Signature

**I am thinking clearly, I agree with everything that is written in this document, and I have completed this document willingly.**

My signature \_\_\_\_\_ Date \_\_\_\_\_

If I cannot sign my name, I ask the following person to sign for me \_\_\_\_\_

Signature of the person who I asked to sign this document for me \_\_\_\_\_

### Statement of Witnesses

By signing this document as a witness, I certify I am:

- At least 18 years old.
- Not related by blood, marriage, domestic partnership, or adoption to the person signing this document.
- Not a health care agent appointed by the person signing this document.
- Not directly financially responsible for this person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

I know this to be the person identified in the document. I believe him or her to be of sound mind and at least 18 years old. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

#### Witness Number One:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

#### Witness Number Two:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

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## Part 5: What to Do Next

Now that you have completed your advance directive, you also should take the following steps:

- Talk to the person you named as your health care agent, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future.
- Give your health care agent a copy of this document.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.
- Give a copy of this advance directive to your physician. Make sure your wishes are understood and will be followed.
- Keep a copy of this advance directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of this advance directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a physical exam or whenever any of the "Five D's" occur:
  - Decade* – when you start each new decade of your life.
  - Death* – whenever you experience the death of a loved one.
  - Divorce* – when your agent is your spouse or your domestic partner and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid. A new document must then be completed.
  - Diagnosis* – when you are diagnosed with a serious health condition.
  - Decline* – when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.
- If your wishes change, tell your health care agent, your family, your physician, and everyone who has copies of this advance directive. It would be necessary that you complete a new advance directive to reflect your current wishes.
- Cut out the card on the following page, fill it in, fold it and put it in your wallet.

**Copies of this document have been given to:**

**Primary (Main) Health Care Agent**

Name \_\_\_\_\_

**Alternate Health Care Agent**

Name \_\_\_\_\_

**2<sup>nd</sup> Alternate Health Care Agent**

Name \_\_\_\_\_

**Health Care Professional/Organization**


Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_

**Need Assistance?**

If you need assistance in completing this document, you may contact:

<b>I HAVE AN ADVANCE DIRECTIVE</b>	<b>Card holder information</b>
Name _____	Address _____
 <b>Honoring Choices</b> WISCONSIN AN INITIATIVE OF THE WISCONSIN MEDICAL SOCIETY <small>The name "Honoring Choices Wisconsin" is used under license from the Twin Cities Medical Society Foundation.</small>	City/state/ZIP _____
	Phone _____ Date of birth _____
	<b>My advance directive is filed at</b> _____
	Address _____
	City/state/ZIP _____
	Phone _____
	<b>My health care agent is</b> _____
	Address _____
	City/state/ZIP _____
	Phone _____

## APPENDIX B



## Advance Directive including Power of Attorney for Health Care

### Overview

This is a legal document, developed to meet the legal requirements for Wisconsin. This document provides a way for a person to create a Power of Attorney for Health Care and other documentation that will meet the basic requirements for this state.

This advance directive allows you to appoint another person and alternate people to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **health care agent**. This document gives your health care agent authority to make your decisions *only when you have been determined incapable by your physicians to make them*. It does not give your health care agent any authority to make your financial or other business decisions. In addition, it does not give your health care agent authority to make certain decisions about your mental health treatment.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values, and this document with your health care agent.** If you do not closely involve your health care agent, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

If you want to document your views about future health care, but do not want to or cannot use this advance directive, ask your health organization or attorney for advice about alternatives.

This is an advance directive for:

Name Laura C. Anderson Date of Birth 4/16/19xx  
 Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) 555-0123  
 Address 100 main street  
 City Any Town State/ZIP WI 55555

January, 2014 For additional copies visit: [www.honoringchoiceswi.org](http://www.honoringchoiceswi.org).

The name "Honoring Choices Wisconsin" is used under license from the Twin Cities Medical Society Foundation.

1

**NOTICE TO PERSON MAKING THIS DOCUMENT**

**YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.**

**BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.**

**IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.**

**THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS, AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE OR DOMESTIC PARTNER AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED OR THE DOMESTIC PARTNERSHIP IS TERMINATED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.**

**YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.**

**DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.**

**IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.**

2

## Part 1: My Health Care Agent

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my health care agent. This person will make my health care decisions when I am determined to be incapable of making health care decisions as provided under Wisconsin law. I understand that it is important for my health care agent and me to have ongoing discussions about my health and health care choices.

*When selecting someone to be your health care agent, choose someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person(s) you choose to be your health care agent(s).*

*Your health care agent must be at least 18 years old and may not be one of your health care providers, or an employee of your health care provider, unless he or she is a close relative. You may also designate an alternate and second alternate health care agent.*

### The person I choose as my health care agent is:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

If this health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:**

### Second choice (alternate health care agent):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

If this alternate health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:**

### Third choice (2nd alternate health care agent):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/ZIP \_\_\_\_\_

Check here if you do not have an agent, and wish for your physician to follow the instructions below.

---

## Part 2: General Authority of the Health Care Agent

### I want my health care agent to be able to do the following:

*Draw a line through (e.g., ~~Arrange for~~) anything listed below that you do **not** want your health care agent to do.*

- Make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment already has been started, my health care agent can keep it going or have it stopped based on my stated instructions or my best interests.
- Interpret any instruction I have given in this form or given in other discussions according to my health care agent's understanding of my wishes and values.
- Review and release my medical records and personal files as needed for my medical care.
- Arrange for my medical care and treatment in Wisconsin or any other state, as my health care agent thinks is appropriate.
- Determine which health care professionals and organizations provide my medical treatment.
- Make decisions about organ and tissue donation (anatomical gifts) after my death according to my known wishes or values.

### Limitations on Mental Health Treatment

Pursuant to Wisconsin statutes my health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.



To complete the next 3 sections:

Initial or check the box beside one statement in each section. If you do not mark any box in a section, your choice is "no" according to Wisconsin statute. This means if you do not indicate a choice, a court may make such a decision and not your health care agent.

### 1. Admission to a Nursing Home or Community-Based Residential Facility

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

Agent authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care:

**Yes**, my health care agent has authority, if necessary, to admit me to a nursing home or community-based residential facility for a long-term stay. This is subject to any limits I set in this document.

**No**, my health care agent does not have authority to admit me to a nursing home or community-based residential facility for a long-term stay.

**Unless I choose "yes," I can be admitted to a long-term care facility for a long-term stay only with a court order.**

### 2. Withholding or Withdrawal of Feeding Tube

**Yes**, my health care agent has authority to have a feeding tube withheld or withdrawn from me, unless my physician advises that, in his or her professional judgment, the withholding or withdrawing will cause me pain or discomfort. This is subject to any limits I set in this document.

**No**, my health care agent does not have authority to have a feeding tube withheld or withdrawn from me.

**Unless I choose "yes," a feeding tube can be withdrawn or withheld from me only with a court order.**

### 3. Health Care Decisions during Pregnancy

**Yes**, my health care agent has authority to make health care decisions for me if I am pregnant. This is subject to any limits I set in this document.

**No**, my health care agent does not have authority to make health care decisions for me if I am pregnant.

**Unless I choose "yes," health care decisions during pregnancy can be made for me only with a court order.**

**Does not apply.** I am either a male or no longer capable of becoming pregnant.

### Part 3: Statement of Desires, Special Provisions, or Limitations

**You are not required to provide any instructions or make any selections in this section.**

My health care agent shall make decisions consistent with my stated desires and values. He or she is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my health care agent and/or physician providing my medical care. If there are conflicts among my known values and goals, I want my health care agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this advance directive, or my health care agent cannot be contacted, I want the instructions to be followed based on my common law and constitutional right to direct my own health care.

If you choose **not** to provide any instructions, your health care agent will make decisions based on your oral instructions or what is considered your best interest. If you choose **not** to provide any instructions, it is recommended that you draw a line and write "no instructions" across the section.

#### Instructions Regarding Life-Prolonging Treatments

*Initial or check the box beside the statement or statements you agree with.*

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, who my family and friends are, or where I am, I want to be kept comfortable and clean, and I want my health care agent to:

- Stop or do not start medical treatments that might be used to prolong my life. Treatments I would not want if I were to reach this point include but are not limited to: feeding tubes including intravenous (IV) hydration, respirator/ventilator, and cardiopulmonary resuscitation (CPR). If I suffer this type of condition, in my view, the potential benefits of supportive medical treatments are outweighed by the burdens of those treatments.
- Continue or start feeding tubes including intravenous (IV) hydration if needed, but stop all other medical treatments including, but not limited to, a respirator/ventilator and cardiopulmonary resuscitation (CPR).
- I want my agent to be able to make decisions for me about life-sustaining treatment.
- Follow my instructions as provided below.

#### Pain and Comfort

*Initial or check the box beside this statement if you agree.*

- If I reach a point where efforts to prolong my life are stopped, I still want medical treatments and nursing care that will make me comfortable.

**The following are important to me for comfort** (If you don't write specific wishes, your physician and nurses will provide the best standard of care possible):

Medications for pain and nausea to keep  
me comfortable

**Cardiopulmonary Resuscitation (CPR)**

My CPR choice listed below may be reconsidered by my health care agent in light of my other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. **If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency personnel from attempting CPR in an emergency.**

*Initial or check the box beside the statement you agree with.*

- I want CPR attempted **unless** my physician determines any one of the following:
- I have an incurable illness or injury and am dying; OR
  - I have no reasonable chance of survival if my heart stops; OR
  - I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.
- I do not want CPR attempted if my heart stops. To the extent possible, I want to allow a natural death.

**Other instructions or limitations I want my health care agent to follow:**

No feeding tube.  
No IVs

**When I am nearing my death and cannot communicate, I want my friends and family to know I have the following thoughts and feelings:**

I love them. It's time to let me go.

**If I am nearing my death, I want the following:**

*List the type of care, ceremonies, etc. that would make dying more meaningful for you.*

Last rites by my priest. Saying of rosary at my bedside.  
Read Bible verses to me.

**Person or people I want my health care agent to include when making health care decisions:**

I ask that my health care agent make a reasonable effort to include the following person or people in my health care decisions if there is time: none

**Spirituality and/or Religious Affiliation**

I am of the Catholic faith and am a member of the St. Patrick's congregation, parish, synagogue, or worship group in (city) Small Town.  
 The telephone number of the congregation, parish, synagogue, or worship group is: ?  
 Please attempt to notify someone there if I am unable to give authorization to do so.

I am not religious or spiritually affiliated.

**Upon My Death**

After my death the following are my instructions. If my health care agent does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

- **Donation of my Organs or Tissue (Anatomical Gifts)**

*Examples of organs are kidney, liver, heart, and lungs. Examples of tissue are eyes, skin, bones, and heart valves. Initial or check the box beside the one statement you agree with.*

After I die, I wish to donate any parts of my body that may be helpful to others.  
 To make your wishes legally effective, register at [www.donorregistry.wisconsin.gov](http://www.donorregistry.wisconsin.gov)

After I die, I wish to donate **only** the following organs and tissue: \_\_\_\_\_

I do not wish to donate any part of my body.

- **Autopsy**

*Initial or check the box beside one choice, or both A and B.*

A. I would accept an autopsy if it can help my blood relatives understand the cause of my death or affect their own health care choices.

B. I would accept an autopsy if it can help advance medicine or medical education.

C. I do not want an autopsy performed on me.

### Part 4: Making the Document Legal

This document must be signed and dated **in the presence of two witnesses** who meet the qualifications explained below.

#### My Signature

**I am thinking clearly, I agree with everything that is written in this document, and I have completed this document willingly.**

My signature Laura C. Anderson Date Today

If I cannot sign my name, I ask the following person to sign for me \_\_\_\_\_

Signature of the person who I asked to sign this document for me \_\_\_\_\_

#### Statement of Witnesses

By signing this document as a witness, I certify I am:

- At least 18 years old.
- Not related by blood, marriage, domestic partnership, or adoption to the person signing this document.
- Not a health care agent appointed by the person signing this document.
- Not directly financially responsible for this person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

I know this to be the person identified in the document. I believe him or her to be of sound mind and at least 18 years old. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

#### Witness Number One:

Signature Jane Smith Date Today

Print name Jane Smith

Address 100 Hospital Drive

City Any Town State/ZIP WI 55555

#### Witness Number Two:

Signature John Doe Date Today

Print name John Doe

Address 100 Hospital Drive

City Any Town State/ZIP WI 55555

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## Part 5: What to Do Next

Now that you have completed your advance directive, you also should take the following steps:

- Talk to the person you named as your health care agent, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future.
- Give your health care agent a copy of this document.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.
- Give a copy of this advance directive to your physician. Make sure your wishes are understood and will be followed.
- Keep a copy of this advance directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of this advance directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a physical exam or whenever any of the "Five D's" occur:

*Decade* – when you start each new decade of your life.

*Death* – whenever you experience the death of a loved one.

*Divorce* – when your agent is your spouse or your domestic partner and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid. A new document must then be completed.

*Diagnosis* – when you are diagnosed with a serious health condition.

*Decline* – when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

- If your wishes change, tell your health care agent, your family, your physician, and everyone who has copies of this advance directive. It would be necessary that you complete a new advance directive to reflect your current wishes.
- Cut out the card on the following page, fill it in, fold it and put it in your wallet.

**Copies of this document have been given to:**

**Primary (Main) Health Care Agent**

Name \_\_\_\_\_

**Alternate Health Care Agent**

Name \_\_\_\_\_

**2<sup>nd</sup> Alternate Health Care Agent**

Name \_\_\_\_\_

**Health Care Professional/Organization**

Name Hospital Central Telephone 555-555-0100


Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_

**Need Assistance?**

If you need assistance in completing this document, you may contact:

FOR SIMULATION PURPOSES ONLY

<b>I HAVE AN ADVANCE DIRECTIVE</b>	
Name <u>Laura C. Anderson</u>	<b>Card holder information</b> Address <u>100 Main Street</u> City/state/ZIP <u>Any Town, WI 55555</u> Phone <u>555-555-0100</u> Date of birth <u>9/16/1948</u>
 <p><b>Honoring Choices</b>                  WISCONSIN                  AN INITIATIVE OF THE WISCONSIN MEDICAL SOCIETY</p> <p><small>The name "Honoring Choices Wisconsin" is used under license from the Twin Cities Medical Society Foundation.</small></p>	My advance directive is filed at <u>Hospital Central</u> Address <u>100 Hospital Drive</u> City/state/ZIP <u>Any Town, WI 55555</u> Phone <u>555-555-0100</u> My health care agent is <u>none</u> Address _____ City/state/ZIP _____ Phone _____

## CREDITS

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Developed in collaboration with Carol Ness, APNP-BC, Palliative care specialty

Advanced directives document and “Honoring Choices” video available from the Wisconsin Medical Society, “Honoring Choices Wisconsin.” Retrieved from <https://www.wisconsinmedicalsociety.org/professional/hcw/>

End of Life learning objectives from: Peaceful Death: Recommended Competencies and Curricular Guidelines for End of Life Nursing Care, End of Life Nursing Education Consortium. Retrieved from: <http://www.aacn.nche.edu/el nec/publications/peaceful-death>

Image displayed is reprinted with permission of the copyright holder, Gordian Medical, Inc. dba American Medical Technologies. Buttocks, Stage 1, Close Up. Retrieved from: <http://www.npuap.org/online-store/product.php?productid=17557>

Medication information from National Library of Medicine: Daily Med at <http://dailymed.nlm.nih.gov/dailymed/>



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