# Advance Directives

Mary Lanning
HEALTHCARE

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# Advance Directives

*Your right to make healthcare decisions*

## General Information

**What are Advance Directives?**
Advance Directives are legal documents stating choices about medical treatment or naming the people you want to make these decisions if you are unable to do so for yourself.

In Nebraska, the two most common types of Advance Directives are: The Power of Attorney for Health Care and the Rights of the Terminally Ill Declaration (sometimes called the Living Will). It is your right as an adult Nebraska citizen to sign either or both. Mary Lanning Healthcare also utilizes an Advance Care Planning document which is meant to be completed by an individual and their medical provider.

If recovery from severe illness seems unlikely, you and your family may need to make difficult decisions about whether to continue treatment. Your Advance Directive is one way of making sure your individual values and choices are respected when you are not able to make your own medical decisions. By completing an Advance Directive and talking to your doctor and family, you can guide the direction of your future care.

**How do I make Advance Directives?**
In Nebraska, you must be an adult — 19 years old or above.

Please read the instructions and forms in this booklet carefully. Discuss the forms and instructions with your family and your healthcare provider. Talk about treatment options and your feelings, beliefs and values. Then complete the forms according to the instructions.

Nebraska law does not require consultation with a lawyer but you may find it helpful to talk to a lawyer about the process.

When you have filled out your Advance Directives, you must sign and date them in front of a witness or notary public. This protects you. The witness or notary signature indicates no one forced you to sign the Advance Directives.

### What happens if I do not have Advance Directives?

It is entirely up to you to decide whether to complete Advance Directives. The presence or absence of one will not determine your access to treatment or care. If you are unable to make your own medical decisions and you do not have Advance Directives, your healthcare provider will usually ask family members or close friends about your treatment wishes. However, if there is a disagreement about what should be done, your healthcare provider may seek assistance from the Hospital Ethics Committee or ask the court to appoint a legal guardian to make decisions for you.

### What choices should I make in my Advance Directives?

You decide what you want to include in your Advance Directives. Your instructions should reflect your personal values, beliefs and faith. You should consider the circumstances in which you want life-prolonging medical treatment started, continued or stopped. Example situations include:

- A mechanical ventilator to help you breathe
- Kidney dialysis if your kidneys fail
- Cardiopulmonary resuscitation (CPR) if your heart or breathing stops
- Artificially administered nutrition fed through a tube or IV

### Will my Advance Directives be followed?

Yes, as long as they are in keeping with the laws of Nebraska. When you become a patient, your healthcare organization will ask for copies of your Advance Directives, which will become part of your medical record. If your healthcare provider cannot follow the instructions in your Advance Directives for any reason, he or she must arrange for your transfer to another provider or facility.

### Do I need to renew my Advance Directives?

No. Once you have signed and dated the Advance Directives and had them signed or notarized, they remain in effect indefinitely unless you cancel or change them. It is a good idea to review your Advance Directives periodically, especially if you have significant changes in your medical condition or family situation.

### What should I do with my Advance Directives?

When completed, keep the original documents in a safe and convenient place. Do not put them in a safe deposit box. Give copies to your attorney-in-fact, family members or close friends and your healthcare provider. Tell them where originals are kept. You also may want to give copies to your clergy person, lawyer and the primary hospital you plan to use.

## Power of Attorney and Living Will

### What is a Power of Attorney for Health Care (PAHC)?

In a PAHC document, you name a person to act as your "attorney-in-fact" or your "representative." You give this person authority to make medical decisions for you if you are temporarily or permanently unable to make decisions for yourself. Usually people choose their spouse, another family member or a close friend. Your attorney-in-fact must be an adult and should be someone who knows you well and respects your decisions about medical treatment. Discuss your decisions, wishes and beliefs with the person you choose to make sure he or she accepts the responsibility.

The person you designate has a duty to act consistently with your desires as stated in your PAHC. If your wishes are unknown, he or she must act in your best interests. The person you designate has the right to withdraw from this duty at any time.

You can also appoint a successor attorney-in-fact to be an alternative if your attorney-in-fact is unavailable.

**Does my Power of Attorney for Health Care cover my wishes regarding financial assets?**
No. The Power of Attorney for Health Care only addresses your medical wishes. If you wish to choose someone to take care of your finances or property, you will need to complete a Financial Power of Attorney document. We recommend that you talk with your banker or lawyer about Financial POA documents.

**What is a Living Will?**
A Living Will (known in Nebraska as the Rights of the Terminally Ill Declaration) is a legal document that takes effect if you have a terminal illness or are in a persistent vegetative state and cannot make your own medical decisions. This document tells your healthcare provider and facility that you do not want life-sustaining procedures and only wish to continue treatments given to make you comfortable and alleviate pain.

**What is a terminal illness?**
A terminal illness is an incurable and irreversible condition that has no known medical cure and is expected to lead to death within a fairly short time, several weeks or months.

**What is a persistent vegetative state**
A persistent vegetative state is an irreversible unconsciousness or permanent coma in which the patient is completely unaware of self, loved ones, events or surroundings. Persistent means the condition cannot change and there is no known medical cure.

**When does a Living Will take effect in Nebraska?**
A Nebraska Living Will takes effect only when:

- You have been diagnosed by a physician as having an incurable and irreversible condition or are in a persistent vegetative state.
- You are not able to make your own medical decisions.

**Is a Living Will the same as a will or living trust?**
No. A Living Will is not the same as a will or living trust. Wills and living trusts assure distribution of financial assets but say nothing about medical wishes and decisions.

**Additional resources**
For more information or help with filling out a form, call the Mary Lanning Healthcare Social Services Department at **402-461-5198**. Hospital patients can dial ext. **5198**.

## Nebraska Power of Attorney for Health Care

I appoint _____,

whose address is _____,

and whose telephone number is (_____) _____, as my attorney-in-fact for health care.

I appoint _____,

whose address is _____,

and whose telephone number is (_____) _____, as my successor attorney-in-fact for health care.

I authorize my attorney-in-fact appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions. I have read the warnings stated in this document and understand the consequences of executing a Power of Attorney for Health Care.

**I direct that my attorney-in-fact comply with the following instructions or limitations:**

*I direct my attorney-in-fact to authorize the withholding or withdrawal of any mechanical procedure, treatment or intervention that uses mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function which would, when given to me, serve only to prolong my dying process or persistent vegetative state.*

**I direct that my attorney-in-fact comply with the following instructions on life-sustaining treatment:**

*If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without administration of life-sustaining treatment which could include, but is not limited to, artificially administered nutrition and hydration which will, in the opinion of my attending physician, serve only to prolong my dying process or persistent vegetative state, I direct my attorney-in-fact to authorize the withholding or withdrawal of life-sustaining treatment that is not necessary for my comfort or to alleviate pain.*

**I direct that my attorney-in-fact comply with the following instructions on artificially administered nutrition and hydration:**

*I direct my attorney-in-fact to authorize the withholding or withdrawal of artificially administered nutrition and hydration which would, when given to me, serve only to prolong my dying process or persistent vegetative state.*

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY-IN-FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

## Declarant Signature

Signed this _____ day of _____, _____ (year)

_____ _____

SIGNATURE PRINTED NAME

_____ _____

DATE OF BIRTH PRINTED ADDRESS

## Declaration of Witnesses

We declare that the principal known to us, that the principal signed or acknowledged his or her signature on this Power of Attorney for Health Care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney-in-fact by this document.

Witnessed By:

_____ _____

SIGNATURE OF WITNESS / DATE PRINTED NAME OF WITNESS

_____ _____

SIGNATURE OF WITNESS / DATE PRINTED NAME OF WITNESS

- or -

## Notary public

(You may sign this document before a notary public instead of having it witnessed above).

_____

NOTARY PUBLIC

_____

MY COMMISSION EXPIRES

County of _____

# RIGHTS OF THE TERMINALLY ILL DECLARATION

(Nebraska Living Will Declaration)

If I should lapse into a persistent vegetative state or have an incurable and irreversible condition, that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

**Declarant Signature**

Signed this _____ day of _____, _____ (year)

_____ _____

SIGNATURE PRINTED NAME

_____ _____

DATE OF BIRTH PRINTED ADDRESS

**Declaration of Witnesses**

We declare that the principal known to us, that the principal signed or acknowledged his or her signature on this Power of Attorney for Health Care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney-in-fact by this document.

Witnessed By:

_____ _____

SIGNATURE OF WITNESS / DATE PRINTED NAME OF WITNESS

_____ _____

SIGNATURE OF WITNESS / DATE PRINTED NAME OF WITNESS

- or -

**Notary public**

(You may sign this document before a notary public instead of having it witnessed above).

_____

NOTARY PUBLIC

_____

MY COMMISSION EXPIRES

County of _____

## Advance Care Planning at Mary Lanning Healthcare

Life-sustaining treatments can be a bridge to recovery, however sometimes these treatments do not lead to an acceptable quality of life. You can express your decisions about end-of-life treatments such as CPR, breathing machines, feeding tubes and other treatments in an Advance Care Planning discussion with your primary care provider.

Advance Care Planning is a service to help patients consider and prioritize their treatment goals. The Advance Care document is meant to be shared with and signed by your medical provider after a discussion regarding your treatment wishes. This document would be used together with your Living Will or Power of Attorney for Health Care to guide healthcare providers in the event you are unable to express your own wishes.

**Here are a few questions to think about regarding Advance Care Planning:**

- What are your overall health goals?
- What is an acceptable quality of life?
- What are some daily activities in life that you cannot do without?
- What are your biggest fears and worries about your health?
- If you become more sick, what kind of healthcare treatments are you willing to endure to gain more time?

By planning ahead and discussing these important questions with your provider, you can give yourself peace of mind in knowing that your wishes regarding medical care will be carried out even if you cannot speak for yourself.

# Mary Lanning Healthcare Advanced Care Planning

**Patient Legal Name** *(Last, First, MI)*: _____ **DOB:** _____

## A. Cardiopulmonary Resuscitation (CPR) – if patient has no pulse and is not breathing:

*Check One:*

❑ **Attempt Resuscitation / CPR –** must check Full Treatment in Section B.

❑ **DO NOT Attempt Resuscitation / DNR –** if patient is not in cardiopulmonary arrest, follow orders in Section B.

## B. Medical Interventions – if patient has a pulse and/or is breathing:

*Check One:*

❑ **Full Treatment – primary goal of prolonging life by all medical effective means.** In addition to treatment described is: Selective Treatment and Comfort-Focused Treatment; use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Includes critical care. Transfer to hospital if indicated.

❑ ***Trial Period of Full Treatment***

❑ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics and IV fluids as indicated. Do not intubate or use mechanical ventilation. May use non-invasive positive airway pressure. If indicated, may include critical care and/or transfer to hospital.

❑ ***Request transfer to hospital <u>only</u> if comfort needs cannot be met in current location.***

❑ **Comfort–Focused Treatment – primary goal of maximizing comfort.** Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.

❑ Additional orders:

## C. Stopping Treatment

- Life-sustaining treatment is generally continued as long as the possibility exists of reversing the medical condition.
- Some patients may choose to stop receiving these treatments if it is failing, or it is likely that their medical condition after treatment would be unacceptable to them.

**<u>If, after medical treatment has been initiated, I am not able to make or communicate medical decisions</u>:**

*Check One:*

❑ I wish to CONTINUE on life support as long as it is medically indicated, including transfer to a facility on a breathing machine.

❑ I instruct my physicians and surrogates to STOP treatment for any of the reasons indicated: _____

_____

## D. Artificially Administered Nutrition – always offer food by mouth if feasible and desired:

*Check One:*

❑ Long-term artificial nutrition, including feeding tubes

❑ Trial period of artificial nutrition, including feeding tubes

❑ No artificial means of nutrition, including feeding tubes

❑ Additional Orders:

## E. Medical Decision Making:

**Directed By (check only one):** ❑ Patient ❑ Durable Power of Attorney for Health Care ❑ Spouse ❑ Majority of adult children ❑ Parents ❑ Majority rule for nearest relative ❑ Other: _____

**Rationale for these orders (check all that apply):** ❑ Advance Directives ❑ Patient's known preference ❑ Poor prognosis ❑ Limited treatment options ❑ Other: _____

**Discussed with:** ❑ Patient *(patient has copy)* ❑ Legally recognized decision maker

_____ _____

*Physician / APRN / PA Signature *(*My signature indicates, to the best of my knowledge, these orders are consistent with patient's medical condition and preferences.)* Date

_____

Physician / APRN / PA Printed Name

_____ _____

Signature of Patient / Legally Recognized Decision Maker Date

***<u>Send form with patient whenever transferred or discharged</u>.***

# Mary Lanning Healthcare Notice of Nondiscrimination

## Discrimination is against the law

Mary Lanning Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex (consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)). Mary Lanning Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Mary Lanning Healthcare provides at no cost:

- Aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate aids and services, or language assistance services, contact a House Supervisor at 402-984-0379, or speak to your provider.

If you believe that Mary Lanning Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Jennifer Gaede, Compliance Officer
715 N. St. Joseph Avenue, Hastings, NE 68901
402-460-5505, fax: 402-461-5321
jgaede@marylanning.org.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Jennifer Gaede, Compliance Officer, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.
This notice is available on Mary Lanning Healthcare's website: www.marylanning.org

- **ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 402-984-0379.
- **CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 402-984-0379.
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 402-984-0379.
- وظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 402-984-0379 (رقم)
- ဟသျဉ်ဟသး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘျဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လိၤ. ကိး 402-984-0379.
- **ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 402-984-0379.
- **XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 402-984-0379.
- **ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 402-984-0379.
- ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 402-984-0379.
- **PIŋ KENE:** Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 402-984-0379.
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 402-984-0379.
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 402-984-0379.
- ئاگادارى: ئەگەر بە زمانى كوردى قسە دەكەيت، خزمەتگوزاريەكانى يارمەتى زمان، بەخۆڕايى، بۆ تۆ بەردەستە. 402-984-0379
- **ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 402-984-0379.

Mary Lanning
HEALTHCARE

1-2026