HEALTH CARE PLANNING

A book to help you better understand the personal choices and legal issues surrounding your health care decisions and advance directives.

PRAIRIE LAKES
Healthcare System

YOUR HEALTH : OUR MISSION

PLANNING YOUR FUTURE CARE

During your life there may come a time when you or a member of your family may be asked to make difficult decisions about your health care. You may make these future decisions easier on your loved ones by communicating your wishes now by talking with them openly and completing the proper legal documents.

This book will help you understand the legal options you have to make sure your care is carried out to your wishes. It is important that you and your loved ones learn about the available options of medical care and discuss the kinds of treatment you would feel comfortable with before the need for such care and treatment arises. We encourage you to begin this discussion early and be open with your health care providers about your wishes.

MAKING DECISIONS

When you are making decisions and completing your advance directives, think about the following situations:
- If you have a sudden illness
- If you have a severe accident
- If you become terminally ill

Consider what type of treatment you would want in each of these situations. Write your wishes clearly and remember to revise your documents if your wishes ever change. As you age, your decisions may change.

If you move to a new state, be aware state laws differ and you may need to update your advance directives.

ADVANCE DIRECTIVES

WHAT ARE ADVANCE DIRECTIVES?

Advance directives are forms that outline the care you would like to receive or not receive if you are unable to speak for yourself.

The three types of forms are Living Will, Durable Power of Attorney for Health Care and Comfort One. These forms do not have to be completed by an attorney, however they do need to be signed and/or notarized.

WHAT IS A LIVING WILL?

A Living Will directs what treatment to provide or withhold when you are terminally ill. It specifies a person's choices of life-sustaining treatment to be received should the need arise. Unlike a Durable Power of Attorney for health care, a Living Will normally does not allow for the appointment of an individual to make health care decisions.

WHAT IS A DURABLE POWER OF ATTORNEY?

A Durable Power of Attorney for health care document authorizes another person to make health care decisions for an individual who, temporarily or permanently, can no longer make or communicate such decisions.

The term "durable" means that the individual appointed is authorized to make health care decisions on behalf of the person who becomes incapacitated — for example, a person who is in a coma after a car accident.

Without a Durable Power of Attorney for health care, the family member or close friend making the health care decision for you may not be the individual you would select.

WHAT IS COMFORT ONE?

Comfort One is an advance directive available through the South Dakota Department of Health pertaining to the administration of cardiopulmonary resuscitation, which is a medical order based on informed consent directing emergency medical services personnel to not perform resuscitative measures in the event of a respiratory or cardiac arrest or malfunction. Individuals wishing to register for Comfort One should request the form from their health care provider.

WHAT IS POLST?

The Minnesota Department of Health recommends the National POLST (Physician Orders for Life Sustaining Treatment) Paradigm. POLST is a voluntary approach to end-of-life planning that emphasizes eliciting, documenting and honoring the treatment preferences of seriously ill or frail individuals using a portable medical order called a POLST Form. In the states that approve it, emergency personnel follow the POLST form medical orders. A POLST form is more detailed than DNR order. Read more at polst.org.

WHAT IS A COMBINED DIRECTIVES FORM?

A combined form includes components of the Living Will while also designating a decision maker in the event that you are unable to speak for yourself. Some states do not recognize combined forms. If you live part-time in another state you may still need both a Living Will and Durable Power of Attorney.

QUESTIONS ABOUT MY HEALTH CARE DECISIONS

WHO SHOULD BE APPOINTED TO MAKE MY HEALTH CARE DECISIONS?

When choosing a Durable Power of Attorney for health care think carefully about who is best to speak for you on health care matters. Many times individuals choose a spouse or adult child, but anyone may be appointed, including a friend. Evaluate whether the individual could be available when health care decisions need to be made.

Make sure you have an open and honest conversation with the individual you'd like to select. Informing other loved ones of your choice will also help them be prepared for your health care wishes.

FOR WHAT PERIOD OF TIME IS A DURABLE POWER OF ATTORNEY EFFECTIVE?

A Durable Power of Attorney for health care is effective until revoked or death occurs. At least every two years, the document should be reviewed to ensure that the individual appointed and the health care decisions expressed are still appropriate. Remember the document only goes into effect during a period of incapacitation, in which you are unable to make such decisions for yourself.

CAN THE INDIVIDUAL APPOINTED MAKE A DECISION CONTRARY TO MY EXPRESSED WISHES OR AGAINST MEDICAL PRACTICE?

The individual is encouraged to follow your expressed wishes stated in your advance directive and must consider the physician's recommendations. The decision by the appointed individual must be in accordance with accepted medical practice. This is why it is important to let your Durable Power of Attorney know your wishes.

SHOULD I ADD PERSONAL INSTRUCTIONS TO MY DURABLE POWER OF ATTORNEY?

One of the reasons for naming an appointed individual is to have someone who can respond as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. Talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

HOW DO I MAKE MY ADVANCE DIRECTIVES LEGAL?

If you complete a Living Will you must sign or have someone sign for you at your direction in the presence of two adult witnesses and have your document notarized.

While there are no legal requirements for witnessing your signature for a Durable Power of Attorney for health care, you should have it witnessed in the manner as your Living Will to be sure that your wishes are honored in the event someone challenges your document.

WHAT SHOULD I DO AFTER I SIGN MY DURABLE POWER OF ATTORNEY OR LIVING WILL?

No matter which document you have chosen, inform your physicians, your family and your faith leaders. You may also want to give copies to each of these individuals but be careful to keep a list. If you later decide to revoke your Durable Power of Attorney for health care or Living Will, you will want to get those copies back and give them updated copies. Advance directives will remain a part of your permanent medical record unless you choose to amend or revoke at anytime.

South Dakota does not maintain an Advance Directive Registry. However you may record a Durable Power of Attorney for health care at your county's register of deeds. Be aware if you do record your advance directive, you will also need to record any revocation you make.

HOW DO I KNOW THE FACILITY I ENTER WILL HONOR MY ADVANCE DIRECTIVES?

Federal law requires that hospitals, nursing homes, home health agencies and hospice programs provide their patients and residents with written information on their policies with respect to durable powers of attorney for health care and Living Wills. Most hospitals and nursing homes will provide this written information during the admissions process. You should carefully consider your decisions around advance directives prior to your admission to a hospital or nursing home.

WHEN SHOULD I COMPLETE MY ADVANCE DIRECTIVES?

The best time to make an advance directive is when you are healthy, of sound mind, and not worried about a health condition. As you age and your health changes, it is important to review, update, and communicate your wishes.

WHAT IF I DON'T HAVE ADVANCE DIRECTIVES?

If you do not have an advance directive and you become unable to make decisions about your health care, your physician or health care provider will ask your spouse or closest available relative for consent. This informal traditional practice has been enacted into law in some states so that health care providers have specific guidance on which relatives to contact and in what order to contact them.

If relatives are not available to give consent for treatment, such laws normally protect the physician or health care provider in the event treatment is provided. In most non-emergency cases, and all emergency cases, this facility and its medical staff will act with the intention of supporting life.

TERMS TO KNOW

ARTIFICIAL NUTRITION AND HYDRATION

Life can be sustained by nutrition and hydration given through medically assisted methods. Patients who cannot take food and water orally can be assisted in this regard.

These measures can become burdensome when nutrition and hydration cannot reasonably be expected to add to the length or quality of a patient's life or when they cause significant physical discomfort.

Artificial nutrition and hydration will not be withheld or withdrawn unless you specifically state that in your advance directive.

Life-sustaining treatment and artificial nutrition and hydration will not be withheld if you are pregnant, unless it is reasonably medically certain that such treatment will not permit the development and live birth of the unborn child, or will be physically harmful to you, or will prolong severe pain which cannot be alleviated by medication.

CPR

Cardiopulmonary Resuscitation, or CPR, is a medical procedure that can include chest compressions, drugs or electric shock in an attempt to restore a heartbeat. CPR is generally not successful in a terminally ill person.

"NO CODE" OR "DO NOT RESUSCITATE" (DNR)

Every person admitted to this facility will receive life-sustaining treatment, including CPR, unless a decision and an order not to revive from apparent death has been made. Many in South Dakota who choose this option look to Comfort One and receive a special bracelet to wear.

ARTIFICIAL VENTILATION/INTUBATION

Artificial ventilation is the mechanical technique of breathing for patients unable to breathe on their own. This requires a tube to be inserted through the nose or the mouth into the trachea (wind pipe). The patient will be unable to speak, eat or drink.

LIFE SUSTAINING CARE

Life-sustaining care maintains life when an organ or body system has ceased to function at a level adequate for survival. Life-sustaining technologies include antibiotics and other medications, IVs, machines or medical procedures that can keep a person alive.

ALLOW NATURAL DEATH (AND)

This decision provides care and comfort measures for a terminally ill patient in place of aggressive, life-prolonging measures.

PALLIATIVE MEDICINE

Palliative medicine focuses on providing patients with relief from symptoms, pain and stress — whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. It is appropriate at any age and at any stage in a serious or chronic illness and can be provided along with curative treatment.

HOSPICE

Hospice includes a team of specially trained professionals to focus on pain and symptom management, spiritual issues, financial and legal issues, and other needs. The emphasis is on caring, not curing. Care may be provided at home or in the hospital, nursing home or other settings.

TERMINAL ILLNESS

Terminal Illness is the end stage of a disease process, injury or illness that is incurable, irreversible and will result in death within a foreseeable, but uncertain, time period.

ADDITIONAL RESOURCES

FOR MORE INFORMATION, PLEASE VISIT THE FOLLOWING WEBSITES:

Aging with Dignity: www.agingwithdignity.org
Minnesota Board on Aging: www.mnaging.org
POLST (Physician Orders for Life Sustaining Treatment): www.polst.org
Comfort One: www.sdemta.org
South Dakota Department of Health: www.doh.sd.gov
Minnesota Department of Health: www.health.state.mn.us

Hospice and Palliative Care:
LifeCircle South Dakota: www.LifeCirclesd.org
American Hospice Foundation: www.americanhospice.org
South Dakota Hospice Organization: www.southdakotahospice.org
National Hospice and Palliative Care Organization: www.nhpco.org
Caring Connections: www.caringinfo.org
Minnesota Network of Hospice & Palliative Care: www.mnhpc.org

QUESTIONS:

Please call 605-882-7000 and ask for Prairie Lakes Social Services.

MY NOTES

LIVING WILL DECLARATION

This is an important legal document. A living will directs the medical treatment you are to receive in the event you are in a terminal condition and are unable to participate in your own medical decisions. This living will may state what kind of treatment you want or do not want to receive.

Prepare this living will carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This living will remains valid and in effect until and unless you revoke it. Review this living will periodically to make sure it continues to reflect your wishes. You may amend or revoke this living will at any time by notifying your physician and other health care providers. You should give copies of this living will to your family, your physician, and your health care facility. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected, and a notary public.

TO MY FAMILY, HEALTH CARE PROVIDER, AND ALL THOSE CONCERNED WITH MY CARE:

I, ________________________, direct you to follow my wishes for care if I am in a terminal condition, my death is imminent, and I am unable to communicate my decisions about my medical care.

With respect to any life-sustaining treatment, I direct the following:

(Initial only one of the following options. If you do not agree with either of the following options, space is provided below for you to write your own instructions.)

______ If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

______ Even if my death is imminent or I am permanently unconscious, I choose to prolong my life.

______ I choose neither of the above options. Here are my instructions should I become terminally ill and my death is imminent or I am permanently unconscious:

____

____

____

____

Artificial Nutrition and Hydration: food and water provided by means of a tube inserted into the stomach or intestine or needle into a vein.

With respect to artificial nutrition and hydration, I direct the following:

(Initial only one)

______ If my death is imminent or I am permanently unconscious, I do not want artificial nutrition and hydration. If it has been started, stop it.

______ Even if my death is imminent or I am permanently unconscious, I want artificial nutrition and hydration.

____ Date: ______________________________
(your signature)

____ ______________________________________
(type or print your signature) (your address)

The declarant voluntarily signed this document in my presence.

Witness ___________________________________

Address ___________________________________

Witness ___________________________________

Address ___________________________________

On this the ______ day of ______________, ______ (year), before me,

________________________________, the undersigned officer, personally appeared

________________________________, known to me or satisfactorily proven to be the person whose name is subscribed to the within instrument and acknowledged that he/she/they executed the same for the purposes therein contained.

_______________________________________ Notary Public

My commission expires: _____________________________.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

1. DESIGNATION OF HEALTH CARE AGENT
   I, ____, herby appoint:
   (principal)

   ____ (agent's name)

   ____ (address)

   ____ (address)

   Home telephone ______________________ Work telephone _______________________
   As my agent to make health and personal care decisions for me as authorized in this document.

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during any period of incapacity in which, in the opinion of my Agent and attending physician, I am unable to make or communicate a choice regarding a particular health care decision.

3. AGENTS POWERS

I grant to my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or otherwise known to my Agent. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my Agent believes to be in my best interests. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, unless specifically limited by Section 4, below, my Agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnosis procedures, medication and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutrition support and hydration, and cardiopulmonary resuscitation;

B. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

C. To authorize my admission to or discharge (even against medical advice) from any hospitals, nursing home, residential care, assisted living, or similar facility or service;

D. To contract on my behalf for any health care related service or facility on my behalf, without my Agent incurring personal financial liability for such contracts;

E. To hire and fire medical, social service, and other support personnel responsible for my care;

F. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death;

G. To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law;

H. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing nay documents related to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent or to seek actual or punitive damages for the failure to comply.

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

A. The powers granted above do not include the following powers or are subject to the following rules or limitations:

____

____

____

B. With respect to any Life Sustaining Treatment, I direct the following:

(Initial only one of the following paragraphs)

_____ REFERENCE TO LIVING WILL. I specifically direct my Agent to follow any health care declaration or "living will" executed by me.

_____ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my Agent believes the burdens of the treatment outweigh the expected benefits. I want my Agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life sustaining treatment.

_____ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment.

1. If I have a condition that is incurable or irreversible and, without the admission of life-sustaining treatment, expected to result in death within a relatively short period of time; or
2. If I am in a coma or persistent vegetative state which is reasonably concluded to be irreversible.

_____ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the very greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

_____ DIRECTIVE IN MY OWN WORDS

____

____

____

C. With respect to artificial nutrition and hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make it clear that …

(Initial ONLY one)

_____ If my death is imminent or that I am permanently unconscious, I do not want artificial nutrition and hydration. If it has been started, stop it.

_____ Even if my death is imminent or I am permanently unconscious, I want artificial nutrition and hydration.

5. SUCCESSORS

If any Agent named by me shall die, become legally disabled, resign, refuse to act, be unavailable, or (if any Agent is my spouse) be legally separated or divorced from me, I name the following (each to act alone and successively, in the order named) as successors to my Agent.

A. First Alternate Agent: ____
Address: ____
Telephone: ____

B. Second Alternate Agent: ______________________________________
Address: ____
Telephone: ____

6. PROTECTION OF THIRD PARTIES WHO RELY ON MY AGENT

No person who relies in good faith upon my representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

7. NOMINATION OF GUARDIAN

If a guardian of my person should for any reason be appointed, I nominate my Agent (or his or her successor) named above.

8. ADMINISTRATIVE PROVISIONS

A. I revoke any prior power of attorney for health care.
B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.
C. My Agent shall not be entitled to compensation for services performed under this power of attorney, be he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.
D. The powers delegated under this power of attorney are separable, so that the invalidity of one or more of powers shall not affect any others.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Durable Power of Attorney for Healthcare on this ________ Day of _______________, __________(year).

____ (Signature)

____ (Printed)

My current home address is:

____

____

STATE OF SOUTH DAKOTA

COUNTY OF ______________________________

On this the ________ day of _____________________, __________ (year), before me,

____, the undersigned officer, personally appeared

____, known to me or satisfactorily proven to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness where of I have here unto set my hand and official seal.

____
Notary Public

(SEAL)

My Commission expires:__________

PRAIRIE LAKES
Healthcare System

YOUR HEALTH : OUR MISSION

prairielakes.com • 605.882.7000
401 9th Ave. NW, Watertown, SD 57201

095_1.11.24_Rev.C