Frequently Asked Questions About POST and Appointment of a Surrogate

1. Should facilities develop a form to use when appointing a surrogate?

On May 3rd, 2005 the Board for Licensing Health Care Facilities approved a model form to use in the appointment of a surrogate. The law requires the physician to promptly record in the patient's clinical record and communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patients. When documenting his decision, the physician should also document how he arrived at his decision. Forms are available in English or Spanish at this web site.

2. How will a facility know if a surrogate named on a POST is patient appointed or physician appointed?

One should have a copy of the patient's Advance Care Plan or Health Care Power of Attorney form which would have the name of the appointed agent. If these forms have not been signed, then the physician would have had to appoint the surrogate. Also, one could ask the question at time of admission to clarify the name of the individual if the name or signature on the form is not familiar. The form "Appointment of Surrogate" is available for facilities to use if a surrogate is being appointed by the designated physician. This form along with the POST form should accompany the patient if transferred between facilities.

3. Can a physician appointed surrogate speak for the patient with regard to withholding artificial nutrition and hydration?

A physician-appointed surrogate may not make the decision to withhold artificial nutrition and hydration with only the surrogate decision. But, when the designated physician and a second independent physician certify in the patient's current clinical records that the continuation of artificial nutrition or hydration is merely prolonging the act of dying, and the patient is highly unlikely to regain capacity to make medical decisions, then artificial nutrition and hydration can be withheld.

4. Who should document in the medical record when the patient lacks capacity and the reason for appointment of a surrogate?

The appointment of a surrogate can only be done by a designated physician. The form "Appointment of Surrogate" covers all points that must be documented – documenting that patient lacks capacity and reasons for appointment.

5. Who should discuss and complete the POST form with patients?

Having a conversation with a patient about end-of-life issues is an important and necessary part of good medical care. The law allows anyone who is a health care provider to assist with the completion of a POST form. In many cases, physicians will initiate conversations with their patients to understand their wishes and goals of care. Depending on the situation and setting, other trained staff members – such as nurses, social workers, or chaplains – may also play a role

in starting the POST conversation. However, physicians are responsible for signing the POST form.

6. Does the POST form replace traditional Advance Directives?

The POST form complements an Advance Directive and is not intended to replace that document. An Advance Directive is still necessary to appoint a legal health care decision maker, and is recommended for all adults, regardless of their health status.

7. ***If someone has a POST form and an Advance Directive that conflict, which takes precedence?***

If there is a conflict between the documents, the more recent document would be followed.

8. Is the patient's signature required on the POST form?

The signature of a patient, parent of minor, or guardian/health care representative is recommended but not required by TN law. This section was developed to help the facility document involved parties in the discussion. The law states that a POST order must be signed by a physician for his/her patient with whom he/she has a bona fide physician-patient relationship, but only with the consent of the patient or consent of his agent, surrogate, or other authorized person..

9. Who is responsible to ensure the POST is provided on transfer from one care facility to another?

The health care facility initiating the transfer must provide the receiving facility a copy of the POST form according to law. Ambulance services should receive a copy of the POST form when they realize the patient has a DNR order. The ambulance service and receiving facility should honor the POST that has a physician signature if an emergency situation arises. **Copying the POST form is valid** and **several** copies should be available for **the** receiving facility, transporting entity as well as patients and families. Repeated behavior of not copying and completing the POST form is a violation of the law and should be reported to the Division of Health Care Facilities, Complaint Section. (Local number 615-741-7221 or toll free number 1-877-287-0010).

10. How does the order for Physician Scope of Treatment (POST) form ensure that the wishes of those terminally ill and incapacitated are followed?

The purpose of the (POST) form is to ensure that the wishes of a terminally ill individual are followed even if they are incapacitated. If the Advance Care Plan form (also known as Living Will) is not prepared while an individual has capacity, a physician must declare that he no longer has capacity and note it on his chart. If an agent or surrogate has not been appointed when an individual is determined to be incapacitated, a surrogate may be identified by his supervising health care provider to make decisions for him. Care must be taken to insure that the person appointed as surrogate is chosen from those who have exhibited care and concern for the patient, is familiar with his values, is willing to serve and is reasonably available. A person cannot be appointed as surrogate if he is subject to a protective order that does not allow contact.

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11. Who can sign the POST? Will a verbal order be acceptable?

The POST is designed to encourage physician/patient discussion about end-of-life care when an individual has been diagnosed with a terminal illness. However, sections A-E of the form may be completed by a nurse or social worker after a verbal physician order. The nurse or social worker can obtain the physician's signature later. Should the individual's condition suddenly worsen before the physician's signature is obtained, a physician could issue a verbal order based on the patient's wishes expressed on the POST.

12. Does the state envision a POST form being utilized differently in a home care or hospice setting than an acute hospital setting?

No. Rules and regulations for use of the POST are the same for all licensed facilities in the state.

13. Are there any situations in which a health care provider could honor a POST if the POST had not yet been signed by a physician, but had otherwise been completed by the patient and a nurse?

The POST should only be completed with the patient after a physician has issued a verbal order to do so. It would, therefore, be valid if completed and the physician's signature had not yet been obtained.

14. Can family members, present at the time a patient goes into cardiac arrest, override a POST signed by the patient and a physician that states Do Not Resuscitate?

Family members cannot override a POST signed by a patient and physician that states "Do Not Resuscitate."

15. How can a health care facility honor a POST that has been signed by a physician who has not been credentialed by that health care facility and continue to comply with JCAHO standards Medical Staff 2.20 and 3.20?

The POST takes into consideration the fact that the patient entering a hospital may have a physician that does not have privileges at that specific facility. The back of the POST form gives instructions for reviewing the form. It states that a POST should be reviewed if: "the patient is transferred from one care setting or care level to another."

Hospital admission is an ideal time to review the POST. If the patient is competent upon admission, the admitting physician could review the form with him. If the patient is not competent upon admission, the physician could review the POST with his agent, guardian, or surrogate. Those parties are legally obligated to follow the patient's wishes, if known, or to take action in his best interest if his wishes are not known.

16. Is there a time limit on the validity of a POST?

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No. Pursuant to Tennessee Code Annotated § 68-11-224 (3) (c) the POST, shall remain in effect until revoked.

17. How should the facility handle a conflict between the patient's instructions per a valid Advance Care Plan (living will) and the expressed wishes of the patient's agent for healthcare decisions if the patient is unable to communicate his wishes?

Since the Advance Care Plan (living will) is ~~a~~ documentation of a patient's end-of-life care preferences, it **must** be followed when there is a conflict between decisions of the patient's agent and a valid Advance Care Plan (living will).

The purpose of an Advance Care Plan (living will), as with any advanced directive, is to provide documented proof of the patient's end-of-life care wishes. Said documents are prepared with the expectation that they be followed. An individual appoints an agent to make health care decisions for him when he is no longer capable of making them himself. The agent is legally obligated to make decisions following the wishes of the patient, if they are known and in his best interest if they are not known.

Pursuant to statute, a **guardian** must comply with a patient's individual instructions and may not revoke a patient's advance directive without a court order. Additionally, an agent's health care decision takes precedence of that of a guardian without a court order. Tennessee Code Annotated § 68-11-1807.

If an agent or guardian wishes to give end-of-life instructions that are in conflict with a valid written advance directive signed by a patient, they will need to get a court order.

18. Can an agent for healthcare decisions override the patient's wishes outlined on a POST which has been signed by the patient and a physician?

No. As stated above, the agent has been appointed by the patient to make his healthcare decisions when he is no longer capable of doing so himself. He/She is legally obligated to follow the patient's wishes for end-of-life care, if known and to make decisions in his best interest otherwise. His decisions cannot override those on a POST signed by the patient and a physician as they are written documentation of the patient's wishes.

19. Can an agent for healthcare decisions override the patient's wishes outlined on a POST that has been signed by the patient, but not by a physician?

The POST is only completed upon verbal order of the patient's physician. It, therefore, becomes legally valid when it is signed by the patient. The POST is signed by the patient when he is capable of making healthcare decisions, and it constitutes written evidence of his preferences for end-of-life care. His agent is legally obligated to follow those preferences.

20. How should a healthcare facility handle a conflict between the patient's instructions via a valid Advance Care Plan (living will) and the instructions included on a valid POST?

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Pursuant to Tennessee Code Annotated § 68-11-1804 (d), "An advance directive that conflicts with an earlier advance directive revokes the earlier directive to the extent of the conflict."

This means that to determine whether to follow conflicting *i*nstructions on a valid Advance Care Plan (living will) and a valid POST, the treating physician will have to look at the date of execution of both documents. Instructions on the document executed last must be followed to the extent of the conflicting instructions.
If there is a conflict between the patient's valid Advance Care Plan (living will) and orders a physician puts on the POST, the conflict must be resolved by the facility's Ethics Committee **and facility administration**. This resolution must be documented in the medical record. If not documented, then this could be interpreted as not following the patient's wishes.

21. How should a healthcare facility handle a conflict between a valid Advance Care Plan (living will) and a valid POST that was completed by a surrogate and signed by a physician?

The surrogate is legally obligated to make healthcare decisions based on the known preferences of the patient. A valid Advance Care Plan (living will) is evidence of those preferences and should be followed by the surrogate when providing instruction to the physician when completing a POST.

22. Will a valid Advance Care Plan (living will) executed after the date of the signing of an otherwise valid POST revoke the POST?

Pursuant to the statutory mandate in Tennessee Code Annotated § 68-11-1804 a valid Advance Care Plan (living will) executed after a valid POST will revoke the POST only as to conflicting elements.

23. Do I need to redo the POST form that was completed at another facility when that patient/resident is admitted?

The POST form does not have to be redone but it should be reviewed with the patient/resident for any needed changes. The POST form is valid if signed by a physician. **If there are no changes in the plan of care reflected in the current POST, then it should NOT be redone or re-written on transfer. Repeating this difficult discussion puts unnecessary and undue stress on the patient/family in an already crisis filled time.** Directions for reviewing the POST are on the back of the POST form.

24. When should a patient's POST form be reviewed?

It is good clinical practice to review a patient's POST form when any of the following occur:
- The patient is transferred from one medical or residential setting to another;
- There is a significant change in the person's health status, or there is a new diagnosis;
- The patient's treatment preferences change.