CALIFORNIA COALITION
for COMPASSIONATE CARE

End-of-Life Decision-Making: The Survey

The following statements focus on end-of-life decision-making in skilled nursing facilities.

For each statement check TRUE or FALSE.

	Statement	TRUE	FALSE
1.	I feel well-prepared to facilitate end-of-life decisions with nursing facility residents and families.	☐	☐
2.	End-of-life care planning is only appropriate for those residents expected to die in the near future.	☐	☐
3.	If a person is oriented to person, place, and time, then s/he should always be considered to have full decision-making capacity.	☐	☐
4.	An adult with decision-making capacity can refuse treatment, even if that treatment is life-saving and even if the person is not terminally ill.	☐	☐
5.	For a dying resident, intravenous hydration should always be continued, even if other treatments have been stopped.	☐	☐
6.	If possible, it is best to avoid using morphine for dying residents because of the risks of addiction or respiratory depression.	☐	☐
7.	A person's ideas about death and dying and proper end-of-life care are influenced by his or her religious, cultural, and ethnic heritage.	☐	☐
8.	An advance directive becomes legally effective when the person loses decision-making capacity.	☐	☐
9.	Any resident admitted with an advance directive should have a DNR order written in his/her chart.	☐	☐
10.	A valid advance directive, such as Durable Power of Attorney for Health Care (DPAHC), is required to stop life support in a resident without decision-making capacity.	☐	☐
11.	The family of a resident without decision-making capacity can agree to stop life support treatments without going to court for a court-appointed guardianship.	☐	☐
12.	Legally and ethically, deciding to stop a life-sustaining measure such as tube feeding is considered the same as deciding not to start it.	☐	☐
13.	The Pre-Hospital Do Not Resuscitate form instructs emergency medical service (EMS) personnel to forego resuscitation attempts in settings such as a patient's home, nursing facility, and ambulance.	☐	☐
14.	A long-stay nursing facility resident who has a cardiac arrest has a very poor chance of benefiting from CPR.	☐	☐
15.	A person's chance of benefiting from admission to an intensive care unit can be determined by age alone.	☐	☐
16.	Sometimes it is appropriate for a resident with a DNR order to receive "aggressive" treatments.	☐	☐
17.	If a resident's overall goal of care is palliative, s/he should never be transferred to an acute care facility	☐	☐
18.	A well-informed registered nurse can help facilitate resident/family discussions about end-of-life care.	☐	☐

Date: ____________________

My role is (please circle the best response or write in other): ____________________________

DON   RN   LVN   CNA   Administrator   MD   MSW   Social services   Chaplain

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End-of-Life Decision-Making Survey: The Answers

1. _____ Facilitating end-of-life discussions requires knowledge and skills in bioethics, clinical care, and communication.
2. False Death is often unpredictable. Even young adults should name a surrogate by completing a Durable Power of Attorney for Health Care (DPAHC).
3. False Decision-making capacity includes the ability to comprehend the meaning of the decision required (including risks and benefits), to deliberate in accord with one's own values, and to reach and communicate a decision. Orientation, or lack thereof, can provide useful information regarding decision-making capacity but does not determine the issue.
4. True As long as the standards of informed consent are met, a competent adult may refuse treatment. The only exceptions occur in public health contexts such as prevention of tuberculosis.
5. False IV hydration is usually inappropriate for the dying because it can prolong and increase the discomfort of the dying process.
6. False There is no risk of addiction for the dying. Providers should offer adequate pain medication without undue concern for respiratory depression.
7. True For all of us, whether residents or providers, our attitudes about death and dying and end-of-life care are influenced by our religious, cultural, and ethnic heritage.
8. True An advance directive becomes legally effective only when the person loses decision-making capacity (unless the directive explicitly states otherwise). Residents should be directly involved in any and all decisions as long as they are able and willing.
9. False No assumptions about a resident's treatment preferences should be made simply because an advance directive exists. The content of the directive may limit care or call for aggressive care. Also, the directions of a resident with capacity take precedence over an advance directive regardless of its content, as noted in the previous question.
10. False Informal surrogates such as family members may consent to the withdrawal of life support for a patient lacking decision-making capacity. Such decisions should be based on the known preferences of the patient or on a best interest standard.
11. True There is no need for court involvement in most end-of-life decisions.
12. True Although there can be a felt psychological difference between withholding and withdrawing interventions such as tube feeding, there is no difference legally or ethically.
13. True The Prehospital DNR form or a MedicAlert DNR medallion must be presented to EMS personnel. These are the only mechanisms that allow EMS to forego resuscitation measures.
14. True Although one study showed that 9% of nursing facility residents receiving CPR survived the subsequent hospitalization, other studies have shown 0-5% survival beyond the hospitalization.
15. False Age is less predictive of outcome than is severity of illness.
16. True A DNR order means "do not attempt CPR or advanced cardiac life support (ACLS)" but does not preclude other aggressive treatments needed for acute illness or for palliation, including emergency hospitalization.
17. False Palliative care residents should be transferred to the hospital, with the consent of resident/surrogate, when symptoms or other conditions such as fractures cannot be managed in the nursing facility.
18. True Nurses and other members of the health care team can help facilitate end-of-life discussions. The physician must be involved as well, however, because the physician has the legal and professional responsibility for obtaining informed consent for treatment alternatives.