LONG-TERM CARE OMBUDSMAN WITNESSING OF AN

ADVANCE HEALTH CARE DIRECTIVE

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| --- | --- |
| **Intake Date:**       | **Completed Date:**       |
| **Activity Time:**    **HR**    **MIN** |

|  |
| --- |
| **Ombudsman Representative Name:**       |
| **Resident Name:**       |
| **Facility Name:**       |

**Individual requesting LTC Ombudsman to witness AHCD, if other than resident**

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| --- | --- |
| **Name:**       | **Phone:** (   )     -      |
| **Relationship to Resident:**       |

**Witnessing Status *(Check appropriate box)***

|  |  |  |
| --- | --- | --- |
| **[ ]** Not attempted | **[ ]** Completed | **[ ]** Attempted, Not Completed |
| Comments:      |

## Ombudsman Witness Statement

1. At the time of my witnessing visit with this resident, he or she demonstrated the ability to understand, and the intent to sign, the AHCD document voluntarily and without undue influence by others. *(Check the appropriate box below.)*

 [ ]  Yes

 [ ]  Yes, but the resident was unable to sign due to physical limitations. *(Explain below.)*

 [ ]  No *(Explain below.)*

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2. Comments *(Document special circumstances, such as existence of a POLST or other physician’s orders, multiple attempts to complete the witnessing of the AHCD, including dates and reasons witnessing was not completed, etc.)*

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|       |

3. This resident has signed the AHCD document or acknowledged the signature on the document as his or her own in my presence. [ ]  Yes [ ]  No

4. I signed the AHCD document and indicated that I was serving as a LTC Ombudsman witness.

 [ ]  Yes [ ]  No

***Answer Questions 5 and 6 if an AHCD Contains Other Powers of Attorney***

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| 5. I signed the *Long-Term Care Ombudsman Witness Addendum to an Advance Health Care Directive* (OSLTCO S102) to indicate that I only witnessed the portion of the document that pertains to the AHCD. [ ]  Yes [ ]  No |
| 6. This resident has initialed the AHCD addendum in my presence. [ ]  Yes [ ]  No |

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|  |  |  |  |
|  | **Ombudsman Representative Signature** |  | **Date** |
|  |       |  |
|  | **Printed Name of Ombudsman Representative Witnessing AHCD** |  |

INSTRUCTIONS

Witnessing Advance Health Care Directives (AHCD) in a Skilled Nursing Facility (SNF)

1. The role of the Long-Term Care (LTC) Ombudsman representative is to witness the resident’s signature on the AHCD. The Ombudsman representative ***does not*** complete the form for the resident, interpret the document at length for the resident, or assist the resident with decision-making regarding the AHCD.
2. Verify the identity of the resident by looking at the resident’s wristband, photo identification, or by asking the resident’s family member, friend, facility administrator, or facility staff to identify the resident.

1. Explain to the resident and others present that you are there to witness the resident’s signature on the AHCD and determine that the resident’s wishes are reflected, that you must speak privately with the resident, and that all information shared with you is confidential.
2. Briefly review the document to determine whether it includes financial powers or powers other than health care directives. Explain that as an Ombudsman witness, you can only witness the resident’s signature as it pertains to the health care directives. If the document contains powers other than health care, write “signature attached” in the signature line for Ombudsman witness, complete the OSLTCO S102, have the resident initial it, and make sure it is attached to the AHCD.

1. Work with the resident to locate an appropriate place where you can speak privately and speak with the resident to determine whether the resident understands the basic purpose of the AHCD.

 ***Standard questions for the resident are:*** Has the resident read and completed the AHCD or has it been read to him or her by someone else? What does the document do? Can the resident tell you the name of the person s/he has selected to be his or her agent? Does the document reflect the resident’s choices concerning medical care? Has the resident completed a similar document in the past? If the resident is proposing to change his or her designated agent, why does the resident want to make the change?

1. If it appears to you at the time of your visit that the resident does not have the ability to understand what he or she is signing, ***do not*** proceed with witnessing. Ask the resident if there is a better time to witness the AHCD, and if authorized by the resident, talk to the person who asked you to witness about whether there is a better time for the resident to acknowledge the AHCD.
2. If there is a question about whether the resident is signing the AHCD willingly and voluntarily, ***do* *not*** proceed to witness the AHCD.
3. Ask the resident to either sign the AHCD in your presence or, if already signed, to verbally acknowledge his or her signature on the document.
4. To be valid, an AHCD executed in a SNF must either be notarized or witnessed by a second witness in addition to the Ombudsman witness. The second witness cannot be the resident’s health care provider or a facility staff person. The Ombudsman role does not include recruiting a notary or a second witness.
5. The Ombudsman representative may ask the resident whether s/he has completed a POLST. If the answer is yes or if the resident is unsure, ask whether the resident would like to review the POLST with you to make sure its terms do not conflict with the terms of the AHCD. If changes need to be made, assist the resident to discuss with appropriate facility staff.