

# Audit for Advance Directive

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### Advance Directive Audit

Question	Yes	No	N/A	Comments
Was resident admitted with an advance directive?				
If no advance directive on admission, documentation indicates resident was provided with education and offered/received assistance on formulating an advance directive?				
Documentation indicates resident received written information on the facility policies for advance directives and the right to accept or refuse medical or surgical treatment?				
Resident incapacitated or unable to made decisions and advance directive information provided to resident representative?				
Documentation clearly identifies the Resident Representative in the designated area of record?				
Advance Directives are kept in designated area in the resident record?				
Resident's identified choices are documented in the resident plan of care?				
Documentation substantiates periodic evaluation for decision-making ability?				
If resident's decision-making ability improves so that resident is able to make own decisions, this information is assessed, documented and the resident choices updated?				

**Resident Identifier:** \_\_\_\_\_ **Evaluator:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Question	Yes	No	N/A	Comments
Documentation indicates evidence of Advance Care Planning?				
Physician orders are consistent with resident choices?				
If resident refusal is noted, documentation includes: <ul style="list-style-type: none"> <li>• reason for refusal</li> <li>• resident advised of consequences of refusal</li> <li>• education provided</li> <li>• relevant alternatives offered</li> </ul>				
If the resident is participating in research, documentation includes: <ul style="list-style-type: none"> <li>• Resident received written information regarding the right to refuse both before and during research</li> <li>• Written informed consent</li> <li>• Monitoring for adverse consequences</li> </ul>				

**Resident Identifier:** \_\_\_\_\_ **Evaluator:** \_\_\_\_\_ **Date:** \_\_\_\_\_