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|  |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID  Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Auto-fill  Auto-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  MARISTAT  RACE | Patient SSN  First Name  Last Name  Birth Date  Sex  Marital Status  Race | Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: can change  Auto-fill: no change  Auto-fill: no change |  |
|  |  | **Advance Directives** |  |  |
| 1 | admdt | Admission date | mm/dd/yyyy **Auto-filled: can be modified** | **Auto-filled; can be modified if abstractor determines that the date is incorrect.**   * Admission date is the date the patient was actually admitted to acute inpatient care,mental health (MH), community living center (CLC), nursing home (NH), or domiciliary (DOM) care. * For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation. * If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. * The admission date should not be abstracted from the earliest admission order unless there is substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.   **ONLY ALLOWABLE SOURCES:** Physician orders (priority data source), face sheet  **Exclude:** admit to observation, arrival date |

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| 2 | dcdt | Discharge date | mm/dd/yyyy  **Auto-filled: cannot be modified** | **Auto-filled; cannot be modified**  The computer auto-fills the discharge date from the ABI pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed. |
| 3 | decmak | On the day of or the day after admission, did a physician/APN/PA document the patient lacks (does not have) decision-making capacity?  1. Yes, there is physician/APN/PA documentation that the patient lacks decision-making capacity.  2. No, there is NO physician/APN/PA documentation regarding the patient’s decision-making capacity. | 1,2  If 1, go to end | **Decision-making capacity is the ability of patients to make their own health care decisions**. **The intent of this question is to determine if there is physician/APN/PA documentation that the patient lacks decision-making capacity. If the patient lacks capacity, they cannot complete an advance directive.**   * **Only review documentation found on the day of or the day after admission.** * Physician/APN/PA documentation that the patient is cognitively impaired, unable to answer questions, comatose, or lacks decision- making capacity is acceptable to answer “Yes”. * If there is no documentation regarding the patient’s decision-making capacity, answer “No”. * **If there is documentation the patient HAS decision-making capacity, answer “No**”.   **Exclude:** Any patient with documentation that he/she lacks decision-making capacity is excluded from the record review.  **Suggested data sources:** Consultation notes, Consent forms, H&P, Progress notes |
| 4 | discusad | On the day of or the day after admission, is there documentation that the patient was asked whether he/she would like information about and/or assistance with Advance Directives (ADs)?  1. Yes  2. No | 1,2  If 2, go to end | **VHA defines an AD as a written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that individual becomes unable to make those decisions. Examples of ADs include Durable Power of Attorney for Health Care (DPAHC), living will, and VA AD.**  **Upon inpatient admission, VHA requires that staff ask patients whether they would like information about and/or assistance with ADs.**   * **Only review documentation found on the day of or the day after admission.** * In order to answer “Yes”, documentation must clearly indicate the patient was asked if he/she would like information about and/or assistance with ADs. Examples of documentation acceptable to answer “Yes” include, but are not limited to:   “Patient wishes to update/create an AD: Y or N”  “Patient does not have an AD and does not want to create one at this time.”   * **If documentation only indicates the patient has an AD, that is NOT sufficient to answer “Yes”. Example: “Does patient have an AD: Y or N” does not indicate the patient was asked if he/she would like information about and/or assistance with ADs.** * If there is no documentation that indicates the patient was asked whether he/she wanted information about and/or assistance with ADs, answer “No”.   **Suggested data sources:** Consultation requests, H&P,Nursing admission assessment, Progress notes, other admission note (e.g., physician, Social Worker, Chaplain), or voluntary Advance Directive Notification and Screening Template |
| 5 | reqdisc | On the day of or the day after admission, did the patient request information about and/or assistance with ADs?  1. Yes  2. No | 1,2  If 2, go to end | **If patients request information about and/or assistance with ADs, VHA requires staff to provide information about and/or assistance with ADs. This question pertains to the note documenting the patient was asked whether he/she would like information about and/or assistance with ADs.**   * **Only review documentation found on the day of or the day after admission.** * In order to answer “Yes”, documentation must clearly indicate the patient asked for information about and/or assistance with ADs. Examples: “Patient wishes information on AD.”; “Reviewing AD with patient. He is willing to complete one at this time.” * If there is documentation the patient declined information about and /or assistance with ADs, answer “No”. Example: “Patient does have an AD or living will…is not interested in creating or updating AD/LW.”   **Suggested data sources:** Consultation requests, H&P,Nursing admission assessment, Progress notes, other admission note (e.g., physician, Social Worker, Chaplain) |
| 6 | docdisc | Is there physician/APN/PA/RN/Social Worker/Chaplain documentation in the medical record that information about and/or assistance with ADs was provided to the patient?  1. Yes  2. No | 1,2  If 2, go to end | **When patients request information about and/or assistance with ADs, VHA requires documentation that the discussion occurred.**   * **Documentation found any time during the admission is acceptable.** * In order to answer “Yes”, documentation must clearly indicate a physician/APN/PA/RN/Social Worker/Chaplain provided information about and/or assistance with ADs. * If no documentation is found that a physician/APN/PA/RN/Social Worker/Chaplain provided information about and/or assistance with ADs, answer “No”. |
| 7 | adnote | Was the discussion of ADs documented in either of the following note titles:   * “Advance Directive” * “Advance Directive Discussion”   **OR**  In an addendum to the “Advance Directive” note associated with the subject directive  1. Yes  2. No | 1,2 | **The discussion of ADs must be documented in either of the two VHA standardized note titles for AD discussions:**   * “Advance Directive” * “Advance Directive Discussion”   **OR**  In an addendum to the “Advance Directive” note associated with the subject directive   * **Documentation found any time during the admission is acceptable.**   **If a discussion is not documented in either of the two VHA standardized note titles for AD discussion, answer “No”.** |