NGN NCLEX 2026 · LEGAL & ETHICAL · END-OF-LIFE CARE

Advance Directives

Legal & Ethical Rights | Patient Autonomy & Self-Determination | High-Priority NCLEX Topic

1. DEFINITION & OVERVIEW

- **Advance Directives (ADs)** are legal documents that express a person's healthcare wishes *before* they lose decision-making capacity
- Rooted in the **Patient Self-Determination Act (PSDA) of 1990** — all federally funded facilities must inform patients of their right to ADs upon admission
- ADs ensure the patient's **autonomy and right to refuse treatment** are honored even when they cannot speak for themselves
- Must be **created while the patient is competent** — cannot be created by a surrogate or after incapacity
- ADs are **state-specific** — requirements for witnesses, notarization, and valid forms vary by jurisdiction

2. TYPES OF ADVANCE DIRECTIVES

Living Will

Written document detailing specific wishes about life-sustaining treatment (CPR, ventilator, tube feeding). Becomes effective when patient is **terminal or permanently unconscious**.

Durable Power of Attorney for Healthcare (DPOA-HC)

Designates a **healthcare proxy/agent** to make ALL healthcare decisions when patient loses capacity. More flexible than a living will — covers non-end-of-life decisions too.

DNR / DNI Order

Do Not Resuscitate / Do Not Intubate — physician order (not just a directive). Must be renewed each admission. Does NOT mean "do not treat."

POLST / MOLST

Physician/Medical Orders for Life-Sustaining Treatment — actionable medical order signed by physician; typically for seriously ill patients. More detailed than a DNR.

3. LEGAL FRAMEWORK — KEY FACTS

1. **PSDA (1990)**
   — Requires all Medicare/Medicaid facilities to ask patients about ADs and provide written information about their rights.

2. **Competency vs. Capacity:**
   "Competency" is a legal term (court-determined). "Decision-making capacity" is assessed by the **physician** at the bedside.

3. **Witnessing Rules:**

4. PRIORITY NURSING INTERVENTIONS

DOC	**Document AD status** on every admission — ask every patient and place copy in the medical record. Flag in the chart prominently.
PRIORITY	**Honor the AD** — if the patient has a living will or DNR, the nurse must follow it. Failure to do so violates patient rights and is legally actionable.
ETHICS	**Do NOT pressure patients** to create or change ADs. The nurse provides information — never coerces or discourages a decision.
SAFETY	**Communicate conflicts** — if family/proxy wishes conflict with the AD, escalate to the physician, ethics committee, and social work team.
ASSESS	**Assess understanding** — ensure the patient and proxy truly understand the implications of the AD. Clarify misconceptions about DNR = comfort

Healthcare workers and family members generally *cannot* serve as witnesses to ADs (varies by state).

4 **Revocation:**
Patient can revoke an AD at ANY time, verbally or in writing, as long as they have decision-making capacity.

5 **Transfers:**
ADs must be communicated and transferred across care settings. The original document (or copy) must be placed in the chart.

only.

DOC **Report changes** — if patient verbally revokes or changes AD wishes, document immediately and notify the physician and care team.

ETHICS **Conscientious objection:** A nurse may object to participating in care they find morally objectionable but **must still arrange safe transfer of care** to another nurse.

5. NCLEX TEST TRAPS ⚠

These are the most commonly missed AD questions on NCLEX

❌ **TRAP: "DNR means do not treat."**
✅ **WRONG.** DNR means only CPR/resuscitation is withheld. The patient still receives all other treatments, comfort care, pain management, and medications.

❌ **TRAP: "The nurse should call a family meeting before following a DNR."**
✅ **WRONG.** A valid DNR with physician order must be followed. The nurse does NOT need family consent to honor it.

❌ **TRAP: "A living will covers all healthcare decisions."**
✅ Only covers **terminal illness/permanent unconsciousness**. DPOA-HC is broader and covers non-terminal decisions too.

❌ **TRAP: "A patient who is awake/talking cannot change their AD."**
✅ A patient with **decision-making capacity** can revoke an AD at ANY time verbally or in writing.

❌ **TRAP: "The nurse can help the patient complete their living will."**
✅ Nurses **cannot** serve as witnesses in most states. Refer the patient to social work, an attorney, or administration.

❌ **TRAP: "Family is automatically the healthcare proxy."**
✅ Family is NOT automatically the proxy unless legally designated. Without a DPOA-HC, state law determines the surrogate hierarchy (spouse → adult child → parent…).

6. SURROGATE DECISION-MAKING HIERARCHY

When no AD exists and patient lacks capacity — who decides?

Priority	Surrogate	Notes
1st	Legal Guardian	Court-appointed; highest authority
2nd	DPOA-HC Agent	Legally designated by patient
3rd	Spouse	Common law varies by state
4th	Adult Children	Majority agreement often required
5th	Parents	If patient is adult
6th	Siblings	Last family option
7th	Ethics Committee	No family available / conflict

⚖️ **Conflict Resolution:** Surrogate vs. patient's known wishes → **always follow the patient's documented wishes**. Escalate to ethics committee if conflict persists.

🏥 **Futile Care:** If family demands treatment the team deems futile, involve the ethics committee — not a nursing decision alone.

📞 **Interdisciplinary Team:** Chaplain, social worker, ethics committee, palliative care team are all appropriate referrals for AD conflicts.

7. PATIENT & FAMILY EDUCATION

8. MEMORY BOOSTERS & QUICK ASSOCIATIONS

- 📝 Create an AD **while healthy**, not during a crisis — discuss wishes with family and physician in advance
- 🔄 **Review and update** the AD after major health changes, life events (divorce, death of proxy), or change in personal values
- 📁 **Keep copies accessible** — give a copy to the physician, healthcare agent, attorney, and bring a copy to every hospital admission
- 🚫 **DNR does not mean abandonment** — comfort care, pain control, and dignity are still fully provided
- 🗣️ **Talk to your proxy** — ensure they understand your values, not just what's on paper; proxies must make decisions consistent with your wishes
- ↩️ **You can always change your mind** — verbally revoking an AD is valid at any time while you have decision-making capacity
- ⚖️ ADs are **state-specific** — if you travel or relocate, ensure your document meets the legal requirements of the new state
- 🙏 Consider **spiritual, religious, and cultural values** — involve a chaplain or spiritual care provider if these are factors in end-of-life decisions

🧠 MNEMONIC — "ADVANCE"

Ask every patient on admission
Document in the chart
Verify patient has capacity to create/revoke
Autonomous — never pressure
Notify MD of changes or conflicts
Communicate to all team members
Escalate conflicts to ethics committee

💡 **Living Will vs. DPOA-HC:** Think "Living Will = specific scenarios; DPOA = flexible agent." A DPOA-HC is generally **more comprehensive** because the proxy adapts to unforeseen situations.

🔑 **The #1 NCLEX priority:** When a patient with a valid DNR goes into cardiac arrest → **do NOT initiate CPR.** Honor the order.

⚡ **Quick trick — DNR ≠ "No Care":** A DNR patient still gets medications, IV fluids, nutrition, pain management, emotional support — everything except CPR/resuscitation.

🔄 **POLST vs. DNR:** POLST is signed by the *physician* and is an *actionable medical order.* A DNR order is similar. A living will is a *patient-created document* — not a medical order by itself.

🗒️ **NGN Clinical Judgment tip:** Questions may ask "what should the nurse do first" — the answer is usually **assess patient capacity, then follow the existing AD** before calling the MD or family.

● 9. NGN CLINICAL JUDGMENT FRAMEWORK (NCJMM) — ADVANCE DIRECTIVES APPLICATION NGN 2026

① RECOGNIZE CUES

- Patient says "I don't want to be on a machine"
- Family demands aggressive treatment despite existing living will
- Admission nurse forgot to document AD status
- Patient's capacity appears to be declining

② ANALYZE → ③ PRIORITIZE

- **Conflict:** AD vs. family request — AD takes priority if patient made it while competent
- **Capacity:** Is the patient currently able to make decisions? Reassess each encounter
- **Legal validity:** Is the AD properly executed for this state?

④ GENERATE → ⑤ TAKE ACTION → ⑥ EVALUATE

- Notify physician; place AD in chart; communicate to team
- Refer to social work / ethics committee if conflict
- Evaluate: Does family understand? Is proxy making decisions consistent with patient's stated values?
- Reassess patient's wishes at each care transition