CALIFORNIA PRISON HEALTH CARE SERVICES

VOLUME 1: GOVERNANCE AND ADMINISTRATION	Date Created: 7/15/09
CHAPTER 17B	Next Revision: 9/15/10
ADVANCE DIRECTIVE FOR HEALTH CARE	Attachments:Yes ☐ No ☒

I. Communication of Advance Directive Information to Patient-Inmates

A. The availability of the Advance Directive for Health Care (advance directive) form is communicated to patient-inmates through numerous methods.

1. The "Inmate-Patient Health Care Orientation Handbook" includes information about advance directives.
2. CDCR Form 7421 with the Inmate Fact Sheet/Instructions is included in the informational packet given to patient-inmates in Reception Centers.
3. The Women's and Men's Advisory Committees are notified of this policy and asked to educate patient-inmates about it.

B. Health care staff have professional obligations to discuss end-of-life decision making and the goals of care with patient-inmates at clinically appropriate times. During these conversations, health care staff should educate patient-inmates about their right to name a health care agent and to specify their end-of-life preferences.

C. Primary Care Providers (PCP) should document in the Unit Health Record (UHR) any discussion of advance directives with a patient-inmate. If a patient-inmate completes an advance directive it is important for the PCP to document that they have met with the patient-inmate, communicated the purpose of the advance directive, and discussed the decisions that the patient-inmate is making regarding his or her future health care. Health Care Providers must determine and verify effective communication as outlined below.

D. Advance directives and the goals of care (including POLST, progress notes, and DNR orders if applicable) should be reviewed as a patient-inmate's clinical situation changes.

II. Initiation of Written Advance Directives

A. Patient-inmates shall be given an opportunity to complete and/or revise the advance directive form during admission to a CDCR healthcare setting, including Correctional Treatment Center (CTC), Hospice, Outpatient Housing Unit (OHU), Skilled Nursing Facility (SNF) or General Acute Care Hospital (GACH).

B. Patient-inmates should be given the opportunity to complete an advance directive form when seen in a primary care clinic setting.

C. Patient-inmates may request an advance directive form at any time.

III. Initiation of Non-Written Advance Directives

A. All health care providers must document a patient-inmate's preferences in his/her unit health record (UHR). Oral instructions may include amending any aspects of either form.

B. A patient-inmate may orally designate a surrogate to make health care decisions only by personally informing the supervising health care staff (e.g., Supervising Registered Nurse, Attending Physician, Chief Physician and Surgeon). This appointment is only effective during the course of treatment, illness, stay in the health care facility, or for 60 days, whichever period is shorter. An oral designation of surrogate supersedes a previous written directive, including a designated agent.

IV. Revocation or Amendment of CDCR Form 7421

A. Patient-inmates may amend, or revoke any aspect of these forms at any time either verbally or in writing.

1. If changes are made the patient-inmate should complete a new CDCR Form 7421 as soon as practical and this should follow the same procedure as outlined above.
2. Oral updates to the advance directive shall be noted on the advance directive form and on a progress note by the health care staff member who was advised of the change by the patient-inmate.

V. Evidence of Advance Directive

A. Health Information Services (HIS) staff should apply a bright orange 1" X 3" label on the outside cover of the UHR, directly adjacent to the "Allergic to" area, noting that an inmate has an advance directive and/or Physician Order for Life Sustaining Treatment (POLST). The label (Advance Directive/POLST Alert Label) should state in bold letters. "Advance Directive in place" and "POLST in place" with checkboxes to mark either or both.

B. Providers should complete the bottom section of the Problem List page of the chart to indicate that an advance directive and/or POLST has been completed.

C. The original Form 7421 should be placed in the Medicolegal Section of the chart.

1. HIS staff should move CDCR Form 7421 'forward' any time a new volume of the chart is made (i.e. it is to be kept in the active UHR).
2. If HIS receives an updated advance directive the new CDCR Form 7421 should be placed in the UHR over the outdated forms. Any outdated CDCR Forms 7421 should remain in the UHR with a notation that a more recent CDCR Form 7421 has been submitted. This notation will include the date of the most recent CDCR Form 7421.
3. At institutions with a CTC, GACH, OHU, Hospice, or SNF:
   a. A copy of the advance directive and/or POLST will be made and placed inside the front cover of the inpatient record.
   b. An advance directive/POLST alert label will be placed on the front cover of the inpatient record.
   c. Upon discharge from the inpatient unit, the copy of the advance directive and/or POLST will be included in the inpatient record and forwarded to HIS for processing.

4. If a patient-inmate has completed an advance directive prior to their entry into prison, the valid "outside" advance directive should be forwarded to HIS to be placed in the Medicolegal Section of the UHR, and will be honored until a new form is completed (see #3 above). As soon as possible a CDCR Form 7421 should be completed by the patient-inmate and should supersede the prior advance directive in the UHR.
5. An advance directive that conflicts with an earlier advance directive revokes the earlier advance directive to the extent of the conflict.

VI. Determining Decision-making Capacity

A. Capacity means a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and in the case of proposed health care, includes the ability to understand its significant benefits, risks, and alternatives.

B. Capacity determinations are the responsibility of the physician. Capacity may vary and the patient-inmate may have capacity for some decisions and not for others. Capacity should be evaluated in relation to the task at hand, the patient's ability to understand the personal impact of his or her choices, and the ability to reason about those choices in light of his or her personal values.

C. If there is any question regarding capacity to name an agent or to express health care preferences, the provider should seek consultation from a mental health professional and the Chief Medical Officer. The provider shall document when the patient-inmate has been determined to lack capacity for a given decision(s) and when the patient-inmate regains capacity for a given decision, if applicable, in the patient-inmate's UHR.

D. Patients will be determined to have decision making capacity unless a determination has been made to the contrary.

VII. Completed Advance Directives for Health Care Forms

A. When a CDCR Form 7421 has been completed, the original should be forwarded to HIS to be placed in the Medicolegal Section of the UHR. HIS should forward a copy of the advance directive Form 7421 for the patient-inmate and a copy for each agent (no more than a total of four copies) to the patient-inmate. The patient-inmate should keep one copy and forward a copy to each of his/her agents.

B. It is the patient-inmate's responsibility to forward copies of the advance directive and to notify the agent(s) that he or she may be called upon to make future health care decisions for the patient-inmate. If the agent must be called upon to make health care decisions for the patient-inmate, the agent will be notified by CPHCS health care staff.

C. A copy should be faxed to the facility or sent with the patient-inmate on any trip to an outside hospital for emergency care or admission, or on transfer to other health facilities.

VIII. Guidance for Completing CDCR Form 7421, Advance Directive for Health Care

A. It is *optional* for a patient-inmate to complete these forms.

1. Completing an Advance Directive for Health Care or Physician Orders for Life Sustaining Treatment (POLST) or consenting to a Do Not Resuscitate (DNR) Order is not required for admission to hospice.

B. Sections of CDCR Form 7421

1. Part 1: Power of Attorney for Health Care
   a. The patient-inmate may choose to appoint someone to make medical decisions for him/her if he/she becomes unable to make those decisions. The form allows for three individuals to be designated:
      - Primary Agent - the patient-inmate's 'first choice'
      - First Alternate Agent - the patient-inmate's 'second choice'. The First Alternate Agent serves as agent if the Primary Agent is not willing, able or reasonably available to act, or if the patient-inmate has previously revoked the designation of the Primary Agent.
      - Second Alternate Agent - the patient-inmate's 'third choice'. The Second Alternate Agent serves as agent if the Primary and First Alternate Agents are not willing, able or reasonably available to act, or if the patient-inmate has previously revoked the designations of the Primary and First Alternate Agents.

   b. A patient-inmate may select any person as his/her agent except as provided in section c. For example a patient-inmate may select a:
      - Family member, including one who is also incarcerated
      - Friend in the community

   c. The patient may not select any of the following as his/her agent:
      - The supervising health care provider or employees of the California Department of Corrections and Rehabilitation (CDCR)
      - Operator/employee of community care or residential care facility

   d. Important factors in selecting an individual to be an agent may include but are not limited to the following:
      1) The agent should know the patient-inmate well and know the patient-inmate's values and wishes regarding end-of-life care.
      2) The agent should be reasonably available. The agent should be someone who is able to be reached by phone at any time and is preferably someone who maintains contact with the patient-inmate and, therefore, likely to be aware of health concerns.
         a) The agent should provide an alternate phone number of someone who will always know how to contact them in case they have moved and phone numbers provided have changed.
      3) The agent should be agreeable to serve in this role. The patient-inmate is encouraged to talk with those individuals he or she is considering designating as agents.

4) If the agent is called to step in as medical decision maker he or she will have access to confidential information about the patient-inmate's medical history. Access to confidential information will not be available to the agent until and unless the patient-inmate is unable to speak for himself or herself. However, a patient-inmate may provide the agent with confidential health care information prior to that time if he or she completes a written authorization for release of medical information.

e. The agent's authority becomes effective when the patient-inmate loses medical decision making capacity or is unable to communicate with medical providers.

1) There is a place for the patient-inmate to check if he or she wants his or her agent's authority to start right away. In general, even if the patient-inmate has checked this box the medical providers will continue to discuss the patient-inmate's health care decisions with him or her until such time he or she is unable to make those decisions, at which time the agent will be given the decision making authority.

f. The agent is not authorized to consent on behalf of the patient-inmate to any of the following:

- Abortion
- Sterilization
- Psychosurgery (as defined in Section 5325 of the Welfare and Institutions Code)
- Convulsive treatment (as defined in Section 5325 of the Welfare and Institutions Code).
- Commitment to or placement in a mental health treatment facility.

g. The agent is directed to make all health care decisions for the patient-inmate in accordance with any instructions he or she has left in the advance directive, or in any way made known to the agent. If the patient-inmate's wishes are not known, the agent is directed to make health care decisions in accordance with what the agent determines to be in the best interest of the patient-inmate. In determining the best interest of the patient-inmate the agent will consider the personal values of the patient-inmate.

2. Part 2: Instructions for Health Care

a. As the advance directive is referenced primarily when patient-inmates are unable to speak for themselves, the instructions written usually relate to preference for end-of-life care. The patient-inmate can specify instructions for health care in general if desired, but unless he or she is unable to speak for him or her self, these instructions would be communicated by the patient-inmate directly to the health care provider.

b. The health care provider reviewing the advance directive with the patient should seek to clarify specific instructions written by the patient-inmate and understand the reasons behind them. For example, a patient-inmate declining blood transfusion based on religious reasons may be making a much more

informed decision as compared to a patient-inmate declining blood transfusions because of fears of acquiring a blood borne disease.

3. Part 4: Verification of Understanding, Signature, Witnesses
   c. The "Verification of Effective Communication" box is to be completed by the health care provider. If the provider is not able to establish effective communication he or she should refer the patient-inmate to the Chief Medical Officer or the Chief of Mental Health for assistance.
   d. The patient-inmate's signature is required, along with the date the form was completed. If the patient-inmate is physically unable to sign the form, another adult may sign for him or her on their direction.
   e. The advance directive can be 'witnessed' in one of two ways:
      1) Two witnesses may sign document, or
      2) Notary Public may notarize document. As there is limited availability of notary services within the institutions, the California Prison Health Care Services (CPHCS) approves the use of two witnesses to facilitate more patient-inmates completing advance directives and being able to make their wishes known.
      3) Witnesses within a CDCR institution:
         - A CPHCS healthcare employee may serve as a witness to the patient-inmate's signature if he or she is not currently directly involved in the patient-inmate's medical care (Examples: a Licensed Vocational Nurse (LVN) working as a medication nurse in another unit, building or yard, a physical therapist who visits the unit but is not treating the patient-inmate who is completing the form)
         - A CDCR or CPHCS administrative employee such as an Office Assistant, Office Technician, Health Program Specialist, or Health Records Technician
         - A CDCR Custody Officer such as the Health Escort Officer
      4) Non-witnesses within a CDCR institution:
         - The patient-inmates current healthcare provider or other healthcare staff directly involved in the patient-inmate's care.
         - Anyone who is serving as an agent may not serve as a witness.
   f. In unusual circumstances, such as when two witnesses are not available and a notary is available, the patient-inmate's signature on the form can be notarized instead of having two witnesses.
   g. When a patient-inmate is in a CDCR or outside Skilled Nursing Facility (SNF), an additional witnesses (patient advocate or ombudsmen), besides the two witnesses or notary, must sign the advance directive to guard against the patient signing under duress.

IX. End-of-Life Discussions

A. In the absence of patient-inmate education and guidance, forms alone will not achieve clinical goals. Ideally, end-of-life decision making derives from informative

conversations that occur over time within supportive and trusting relationships between the patient-inmate and his or her health care professionals. Official forms are important by-products of such conversations, documenting understandings at a given point in time and subject to change as the clinical situation progresses.

B. Important components of end-of-life discussions include:

1. Discussions and documentation should include diagnoses and prognoses, including current and anticipated functional status;
2. Treatment options with their respective clinical benefits and burdens;
3. Current decision making capacity of the patient-inmate;
4. The patient-inmate's (or agent's) current understanding of his/her health condition, treatment plan, and prognosis;
5. Values and treatment preferences, including his/her beliefs about the chances for recovery;
6. Previous written/verbal statements of preferences or values;
7. Cultural factors and religious or personal beliefs relevant to preferences about end-of-life care; and
8. Pertinent information from family members or significant others.

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