SECTION - MEDICAL/NURSING SERVICES
ADMINISTRATIVE DIRECTIVE NO. 564
(Replaces A.D. No. 564 dated 4/13/06)

Effective Date: March 8, 2007

SUBJECT: ADVANCE DIRECTIVES

I. PURPOSE

Guidelines for Advanced Directives.

II. AUTHORITY

California Code of Regulations, Title 22, Section 73524; Department of Mental Health, Special Order 108.01.

III. POLICY

A. It is the policy of Coalinga State Hospital to support an Individual's right to participate in decisions relating to health care. The hospital shall comply with Federal and State statutes regarding an Individual's right to formulate advance directives. The Individual's right to refuse psychiatric treatment may be specifically limited by Federal or State law.

B. Neither the hospital nor any of its employees shall condition the provision of care on whether or not the Individual has executed an advance directive. An advance directive may consist of one or more of the following documents:

1. Durable Power of Attorney for Health Care;

2. Natural Death Act Declaration; or

3. A Living Will.

C. The hospital shall not provide legal advice as to whether an Individual should execute an advance directive or how it may be worded. Only general information is to be provided.

IV. METHOD

A. Admissions:

1. Within 48 hours of admission, unit nursing staff shall provide each adult Individual with written information describing their rights under California statutes to accept or refuse medical treatment and formulate an Advance Directive "Your right to Make Decisions about Medical Treatment"). This includes transfers from other state hospitals.

2. Nursing staff will determine by asking the Individual if an advance directive exists (i.e., DPHAC, Natural Death Act Declaration or Living Will) and where it may be obtained if it does exist. The unit social worker will be notified by the nursing staff of the existence and location of any Advance Directives. The action taken shall be documented in the medical record.

3. If the Individual doesn't know if he has an advance directive or if he does not understand the question, then the admissions nursing staff shall document either situation in the medical record.

4. Any Individual requesting additional information about Advance Directives will be referred to the unit social worker. The course of discussion, the Individual's ability to understand, and what written information was provided to the Individual shall be documented on "Advance Directives". The form shall be signed and placed in the legal section of the medical record, along with a completed copy "Your Right to Make Decisions about Medical Treatment".

B. When Advance Directives Exist:

1. A copy of any existing Advance Directives shall be placed in the Individual's medical record in the Legal Section. A notation of the "Advance Directive" shall be added to the alert sections of the rand file, Individual's record, and team conference report.

2. When an Individual is transferred to another hospital or care facility, copies of any Advance Directives in the possession of the hospital shall accompany the Individual along with the discharge documents. In the event that the Individual is transferred to an acute care facility, a copy of the Advance Directive shall be immediately forwarded or faxed to that facility.

C. Role of the Unit Social Worker:

1. Review advance directives form and determine if an Advance Directive exists.

2. If an advance directive is said to exist, the social worker shall make reasonable attempts to obtain a copy for the Individual's medical record. These attempts shall be documented in the Individual's medical record. If a copy cannot be obtained, the social worker will offer the Individual an opportunity to complete a new advance directive.

3. The social worker shall serve as the primary contact person for Individuals, relatives or significant others who request additional information regarding advance directives.

4. Should the Individual request to complete an advance directive, the social worker shall ensure that the appropriate following steps are taken:

   a. Notify the Trust Office to coordinate witnesses or notary and scheduling appointments (see D-2 below) in the visiting room. A staff member will accompany the Individual(s) to the Visiting Room.

   b. If requested by the Individual, the social worker will arrange for appropriate and qualified witnesses, and arrange for family members as witnesses if appropriate. At least one of the witnesses shall be a person who is not one of the following:

      i. A relative of the Individual by blood, marriage or adoption; and/or

      ii. A person who would be entitled to any portion of the Individual's estate.

   c. The social worker shall assist the Individual by distributing copies to:

      i. Conservator;

      ii. Named health care agent/alternative agent, if appropriate;

      iii. Individual's medical record; and

      iv. Other persons as requested by the Individual.

5. Transfers from another unit or return from a community care setting, the receiving social worker will review the Individual's medical record to determine whether an Advance Directive exists. Upon admittance to the hospital, the Social Worker will also determine if the information regarding Advance Directives has been received. If not, the social worker will give the Individual a copy of the brochure, "Your Right to Make Decisions about Medical Treatment" and document.

D. Role of Hospital Staff:

1. Nursing staff, social service staff and medical staff shall work collaboratively to ensure compliance with the Patient Self-Determination Act.

2. Nursing staff shall provide care in accordance with the existing Advance Directives. Any staff member who is unable or unwilling to comply with the Advance Directive shall notify their immediate supervisor. The aforementioned staff member shall not be assigned to the direct care of the Individual once the Advance Directive is active.

3. The physician shall act in accordance with the Advance Directive. If the physician is unwilling to do so, he or she must take prompt and reasonable steps to transfer the Individual's care to another physician or health care provider who is willing to do so.

E. Individuals with No Prior Advance Directive and who Lack Capacity for Informed Consent:

1. Whenever the mental condition of an Individual precludes their making informed health care decisions, have no prior valid Advance Directive, and whose medical condition indicates that there is no reasonable possibility of the Individual regaining cognitive and sapient capacity; the following procedures will be followed:

   a. Contact the Medical Director to initiate a petition to the Superior Court for a guardianship for medical care (Probate Code Section 2353) and a finding of lack of capacity to give informed consent for medical care (Probate Code section 1880-90).

   b. The public guardian is empowered to make health care decisions for the Individual, including withdrawal of life support whenever medical consultation supports such a decision.

F. Education and Training:

1. All staff will receive training regarding Advance Directives as part of New Employee Orientation.

2. All physicians, nursing staff, and social workers will be oriented to their specific roles within one month of hire.

3. The discipline Service Chiefs will be responsible for the orientation, training, and annual updates according to the role in the procedure and need.

V. DEFINITION

A. Advance Directive:

A verbal statement or formal written document, completed before a person suffers an incapacitating illness or injury. A document in which a person can provide for decision-making about medical treatment if they become unable to make their own decisions. They may include living wills, durable powers of attorney, or similar documents or documentation conveying the Individual's preferences. Advance directives may be either:

1. Appoint an agent to make decisions; and/or

2. State choices about treatment.

B. Durable Power of Attorney for Health Care (DPAHC): (Type 1)

An advance directive may name someone else (referred to as an "agent" or "attorney-in-fact" or "surrogate decision-maker") to make health care decisions in the event the Individual becomes unable to make such decisions herself or himself. The DPAHC may also include specific instructions regarding which health care treatment(s) should be utilized in the event of incapacity. The DPAHC statute is found in the California Probate Code Section 4603 et seq.

1. A valid DPAHC is activated when the Individual receiving medical care becomes incapacitated and is no longer able to make decisions regarding the course of treatment. If no health care "agent" has been appointed or if the "agent" refuses the responsibility, it becomes an advisory document only.

2. The health care "agent" has the authority to give "informed consent" to a treatment or procedure excluding:

   a. Commitment in a mental health treatment facility;

   b. Convulsive treatment;

   c. Psychosurgery;

   d. Sterilization; or

   e. Abortion.

3. DPAHC is valid for an indefinite period of time, unless the time period is limited in the document.

4. Only the Individual may revoke a DPAHC, and may do so at any time by verbal or written notification to the appointed agent or a treating physician, provided the Individual has health care decision making capacity.

5. If a person has executed both a DPAHC and a Natural Death Act Declaration, the DPAHC prevails unless the person has expressly provided otherwise in the DPAHC itself.

C. Natural Death Act Declaration: (Type 2)

A document in which an Individual directs the attending physician to withhold or withdraw life-sustaining treatment in instances of terminal illness or permanent unconsciousness. A Declaration does not include provisions for the appointment of a surrogate decision-maker.

1. A valid Declaration is activated when the following conditions are met:

   a. Communicated to the attending physician;

   b. The Individual becomes terminally ill or permanently unconscious as diagnosed by two physicians; and

   c. The Individual is no longer able to make decisions.

2. A terminal condition is defined as an incurable and irreversible condition that, without the administration of life-sustaining treatment, will within reasonable medical judgment, result in death within a relatively short time. A permanent unconscious condition is defined as an incurable and irreversible condition that, within reasonable medical judgment, causes the Individual to be in an irreversible coma or persistent vegetative state.

3. A Declaration is effective indefinitely.

4. An Individual may revoke a Declaration at any time and in any manner without regard to the Individual's mental or physical condition. A revocation is effective when it is communicated by the Individual to a staff member or other witness.

5. Capacity consists of the Individual's ability to understand the document and its ramifications at the time it is signed. It is the responsibility of the individual witnessing the signing of the document to attest to the identity of the Individual and his ability to understand what he is signing. Ability exists if the Individual:

   a. Knows his own name and names of others he interacts with regularly.

   b. Is able to explain the gist of the document and why he wants to sign it.

   c. Is able to hold an idea and concentrate well enough to understand communication from others and respond appropriately.

D. Living Will: (Type 3)

A Living Will is a general category that includes any advance directive that expresses treatment choices. The term usually refers to non-statutory directives that are considered advisory to Individuals' families and health care providers, but it also encompasses directives authorized by statute, such as a Natural Death Act Declaration.

1. Any Living Will executed in California that substantially complies with the Natural Death Act Declaration shall be given the same status as a Declaration.

2. A Living Will executed in another state in compliance with that state's law or does not comply with that state's law, but does substantially comply with Natural Death Act Declaration contents, shall be given the same status as a Declaration.

3. A Living Will completed in any other manner shall be considered as an advisory document of the treating physician.

W. T. VOSS
Executive Director

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a **power of attorney for health care**. Part 1 lets you name another Individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
(b) Select or discharge health care providers and institutions.
(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give **specific instructions** about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to **donate** your bodily organs and tissues following your death.

Part 4 of this form lets you **designate a physician** to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have,

to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1 - POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

_____
(name of individual you choose as agent)

_____
(address) (city) (state) (ZIP Code)

_____
(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my **first alternate agent:**

_____
(name of individual you choose as first alternate agent)

_____
(address) (city) (state) (ZIP Code)

_____
(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my **second alternate agent:**

_____
(name of individual you choose as second alternate agent)

_____
(address) (city) (state) (ZIP Code)

_____
(home phone) (work phone)

ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code Section 4701)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____
(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

If I mark this box ( ), my agent's authority to make health care decisions for me takes effect immediately.

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____
(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code Section 4701)

PART 2 - INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ (a) Choice Not To Prolong Life - I do not want my life to be prolonged if
(1) I have an incurable and irreversible condition that will result in my death within a relatively short time,
(2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or
(3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

☐ (b) Choice To Prolong Life - I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____
(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____
(Add additional sheets if needed.)

ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code Section 4701)

PART 3 - DONATION OF ORGANS AT DEATH (OPTIONAL)

(3.1) Upon my death (mark applicable box):

☐ (a) I give any needed organs, tissues, or parts, OR

☐ (b) I give the following organs, tissues, or parts only.

_____

(c) My gift is for the following purposes (strike any of the following you do not want):
(1) Transplant
(2) Therapy
(3) Research
(4) Education

PART 4 - PRIMARY PHYSICIAN - (OPTIONAL)

(4.1) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (ZIP Code)

_____
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (ZIP Code)

_____
(phone)

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(California Probate Code Section 4701)

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

_____

(sign your name) (date)

_____

(print your name)

_____

(address) (city) (state) (ZIP Code)

(5.3) STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of California
(1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence
(2) that the Individual signed or acknowledged this advance directive in my presence,
(3) that the Individual appears to be of sound mind and under no duress, fraud, or undue influence,
(4) that I am not a person appointed as agent by this advance directive, and
(5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness	**Second witness**
(print name)	(print name)
(address)	(address)
(city) (state)	(city) (state)
(signature of witness) (date)	(signature of witness) (date)

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____

(signature of witness) (signature of witness)

PART 6 - SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

_____

(date) (print your name) (sign your name)

_____

(address) (city) (state)