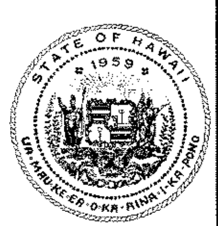

1.0 PURPOSE

To establish guidelines so that inmates approaching the end of life are permitted to execute advance directives.

2.0 REFERENCES AND DEFINITIONS

.1 References

a. Hawaii Revised Statutes; Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.

b. National Commission on Correctional Health Care, Standards for Health Services in Prisons and Jails, (2008).

.2 Definition

a. Advance Health Care Directive: A document designating the future health care wishes of the document signer should he or she become incapable of making their own health care decisions.

b. Power Of Attorney For Health Care Decisions (POA): An individual named as an agent to make health-care decisions for a designated person when they become incapable of making their own decisions

c. Do Not Resuscitate (DNR): A DNR is an order that is written by a physician to not perform resuscitative measures should the patient experience heart or respiratory failure. This order is usually written at the direction of the patient through the use of an Advance Health Care Directive, a direct patient request or the request of the Power of Attorney for Health Care Decisions.

3.0 POLICY

.1 All patients shall have access to an Advance Health Care Directive allow them to specify their health care wishes should they become incapacitated and unable to make their own health care decisions.

.2 All patients shall be permitted to designate a Power of Attorney for Health Care Decisions. Patients may appoint any one on the outside willing to serve in this capacity. Correctional employees and other inmates shall not be designated as the Power of Attorney for Health Care Decisions for an inmate patient.

.3 A Power of Attorney for Health Care Decisions shall not override any stipulations made by the patient in an Advance Directive should the patient become incapacitated. The primary care physician for unanticipated situations may consult the Power of Attorney.

.4 All patient decisions regarding future life sustaining treatments shall be voluntary, not coerced and based on medical information that is complete and easily understood by the patient.

4.0 PROCEDURES

.1 The primary care provider shall inform the terminally ill patient of their diagnosis, prognosis and care options associated with their disease or illness in plain language and in such a way that the patient understands the information.

.2 The primary care provider shall discuss advance care decision making with any terminal patient including the availability of an Advance Directive, Power of Attorney for Health Care Decisions, and DNR designation.

.3 There shall be documented evidence in the medical record that prior to executing the signing of any health care directive that the patient was provided sufficient and appropriate information to make a voluntary and informed decision. Language and cultural barriers to palliative care and hospice services must be addressed before a discussion about advance directives is undertaken.

.4 A psychiatrist or psychologist shall complete a mental health evaluation of the patient prior to the signing of a health care directive to assure the patient is competent to make end-of-life decisions.

.5 Competent patients wishing to make their health care wishes known in advance shall have the all of the options explained and they shall decide if they wish to create an Advance Health Care Directive, Form DOC 0458A and/or if they wish to designate a Power of Attorney for Health Care Decisions, Form DOC 0458B or if they wish to have a Do Not Resuscitate, Form DOC 0461.

.6 Patients desiring to designate a Power of Attorney for Health Care Decisions shall provide the name and phone number of the person selected to allow for contacting and verification their selected person's willingness to assume this position.

.7 The selection of a POA not currently familiar with the patient's health care desires shall be provided with adequate visit time for this health care information to be conveyed.

.8 In the event a patient is not competent; the primary provider shall consult with the patient's next-of-kin or designated POA for health care. If there is no next-of-kin or POA for health care, and the patient is in the infirmary, the primary care physician shall make the decision to resuscitate or to not resuscitate. If the patient is in a community hospital, normal hospital policies used in such situations shall apply.

.9 Health Care Sections with the patient's consent may use a hospice agency to assist the patient and the patient's family with end of life and treatment issues and concerns.

.10 Prior to executing the terms of an advance directive that stipulates the withholding or withdrawing of care, an independent review by a physician not directly involved in the patient's treatment shall occur. The reviewing physician shall evaluate the patient's course of care and prognosis, the mental health evaluation, the informed consent and any do not resuscitate order (DNR) to ensure clinical agreement regarding the planned course of care.

.11 A blue circle on the outside of the medical record cover will indicate a patient with a DNR order. The DNR order shall be documented in **red ink** on the Health Maintenance Summary form DOC 0478.

5.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

6/30/09

Medical Director Date

5/27/09

Correctional Health Care Administrator Date

7/22/09

Deputy Director for Corrections Date

APPROVED:

Director

7/28/09

Date

____

Name SID DOB Facility

PART I. INSTRUCTIONS TO THE PATIENT

The following people must be present to complete an Advance Directive:

a. There must be two (2) independent witnesses. The witnesses cannot be relatives or Health Care employees or anyone else who will be involved in your health care.

OR

There must be a Notary Public to notarize the document.

b. If you do not agree with the choices below or wish to add other instructions, including body and organ donations, you may add pages. Any additional pages must be signed by you and witnessed by two independent people or notarized

c. Once the Advance Directive is signed, witnessed or notarized the original document is filed in your medical record and you will be given a copy.

d. An Advance Directive may be amended or revoked at any time. You must inform the medical provider that you wish to amend or revoke your Advance.

PART II. PATIENT'S STATEMENT OF PRINCIPLE

The following choices on prolonging life, artificial nutrition and hydration, and relief from pain apply only if:

a. I am close to death and life support would only postpone the moment of my death

OR

b. I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is not probable that I will ever become conscious

OR

e. I have brain damage or a brain disease that makes me permanently unable to make health care decisions and communicate those decisions

CHOICE TO PROLONG OR NOT TO PROLONG LIFE

_____ YES I want to have my life prolonged within the limits of generally accepted health care standards that apply to my condition.

_____ NO I do not want my life prolonged.

ARTIFICIAL NUTRITION AND HYDRATION BY TUBE INTO STOMACH OR VEIN

_____ YES I do want artificial nutrition and hydration.

_____ NO I do not want artificial nutrition and hydration.

RELIEF FROM PAIN

______ YES I want treatment to relieve my pain or discomfort.

______ NO I do not want treatment to relieve my pain or discomfort.

____

Patient Print Full Name Signature Date

____

Witness Print Full Name Signature Date

____

Witness Print Full Name Signature Date

NOTARY PUBLIC

State of Hawaii, __________County

On this ________ day of _________, in the year ________, before me appeared __________________ ________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribe to this instrument and acknowledge that he or she executed it.

____

Notary Public State of Hawaii Date

SEAL My Commission Expires: ________________

STATE OF HAWAII

DURABLE POWER OF ATTORNEY FOR HEALTH-CARE DECISIONS

Name SID DOB Facility

(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)

(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.)

(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.

(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.

(5) NOMINATION OF GUARDIAN: If a guardian 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 guardian, I nominate the alternate agents whom I have named, in the order designated.

STATE OF HAWAII

COMPASSIONATE CARE ONLY – DO NOT RESUSCITATE ORDER

Name: ____

Facility: ______________ DOB: ________________ SEX: [ ] Male [ ] Female

Name of hospice program (if applicable):____________________________

Name of Patient's Physician:____________________________________

Physician's Telephone: ________________________________

Declaration make this ________ day of __________ , 20____ , pursuant to Act 173,

Session Law of Hawaii I, ____ hereby
Type of Print Patient's Name
make the following declarations:

1. I am over the age of 18 years, of sound mind, and am acting voluntarily;

2. I have be advised, and I understand and believe, that I have a terminal illness and I am not expected to recover from it;

3. I am making this declaration on my own behalf. I have been advised that the result of signing this declaration is that no efforts will be made to restart my heart or breathing, if my heart or breathing stops; and

4. I therefore direct emergency medical personnel, first responders and/or health care provider, to give me CARE FOR COMFORT ONLY, including pain medication and other measures required for comfort, and to NOT push on my chest or give me electric shock to restart my heart or rescue breathing, or medicines to try and restart my breathing or my heart.

______________________________	______________________________
Signature of Patient	Signature of Witness

I hereby certify that my above-named patient has a terminal illness from which recovery is not expected and that the patient has been notified of the presence and prognosis of that illness.

I further certify that the patient is of sound mind and is capable of making an informed decision about providing, and withholding medical treatment. Furthermore, the patient has been notified of the outcome of his/her decision and understands the consequences of making such a decision.

____

Signature of Physician Date

White: Patient's Copy Yellow: Medical Record Pink: Vendor's Copy

DOC 0462 (3/09)