Article 4 – Health Care Directives

2.4.1 Advance Directive for Health Care

(a) Policy

(1) California Correctional Health Care Services (CCHCS) shall promote the utilization of advance directives to determine patients' health care preferences, including, but not limited to, treatment decisions regarding medications, surgeries, and life support treatments; however, patients are not required to complete an advance directive.

(2) The California Department of Corrections and Rehabilitation (CDCR) 7421, Advance Directive for Health Care, shall be utilized by staff whenever possible and especially when the patient is diagnosed with a serious medical condition or is admitted to a Correctional Treatment Center, Outpatient Housing Unit, Skilled Nursing Facility, hospice, or outside medical facility.

(b) Purpose

To ensure clinical staff are aware of patients' rights to make decisions about their health care and to appoint an agent or legally recognized decision-maker to make medical decisions for them if they are no longer able to make decisions for themselves.

(c) Responsibility

The Chief Executive Officer, or designee, is responsible for the implementation, monitoring, and evaluation of this policy and procedure.

(d) Procedure Overview

(1) CCHCS shall encourage all patients to complete an advance directive. Completion of a CDCR 7421 is the preferred method for patients to communicate their wishes; however, other documentation, if able to be validated, provided by patients or their agent, also known as legally recognized decision-maker, shall be honored.

(2) When clinically appropriate, Primary Care Providers (PCPs) shall discuss with patients their wishes for intensity of end-of-life care. The patients' specific wishes for end-of-life care shall be documented on the CDCR 7465, Physician Orders for Life Sustaining Treatment (POLST), which shall also serve as the preferred manner to document code status/Do Not Resuscitate (DNR) orders.

(3) A health care provider or institution may decline to comply with the preferences of the patient or the patient's agent or legally recognized decision-maker for reasons of conscience or if the requested health care would be medically ineffective or contrary to generally accepted health care standards. In such cases, the PCP shall discuss the case with institution and regional medical leadership and when appropriate present the case to the CCHCS Ethics Committee for review and consultation.

(e) Procedure

(1) Communication of Advance Directive Information to Patients

(A) The CDCR 7421 shall be available to patients through the following:

1. The "Patient Orientation to Health Care Services Handbook" includes information about advance directives.
2. The CDCR 7421 with the Patient Fact Sheet and Instructions is included in the informational packet given to patients in Reception Centers.
3. The Women's and Men's Advisory Councils are asked to educate patients about this procedure.

(B) Health care staff have professional obligations to discuss end-of-life decision-making and the goals of care with patients at clinically appropriate times. During these encounters, health care staff shall educate patients about their right to name an agent or legally recognized decision-maker and to specify their end-of-life preferences.

(C) PCPs shall document any discussion of advance directives with a patient in the health record. If a patient completes an advance directive, the PCP shall document the patient encounter, communicate the purpose of the advance directive, and discuss the decisions that the patient is making regarding his or her future health care. Health care providers shall determine and document effective communication when there is an exchange of health care information in accordance with the Health Care Department Operations Manual, Section 2.1.2, Effective Communication.

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

(2) Initiation of Written Advance Directives

(A) Patients shall be given an opportunity to complete and/or revise the CDCR 7421 during admission to a CDCR health care setting including Correctional Treatment Center, Outpatient Housing Unit, Skilled Nursing Facility, or hospice or an outside medical facility.

(B) Patients shall be given the opportunity to complete a CDCR 7421 when seen in a primary care clinic setting.

(C) Patients may request a CDCR 7421 at any time.

(3) Initiation of Non-Written Advance Directives

(A) Oral instructions may include amending any aspect of the CDCR 7421 or POLST. All health care providers shall document a patient's preferences in his or her health record and update the written CDCR 7421 and POLST as soon as possible.

(B) A patient may orally designate an agent or legally recognized decision-maker to make health care decisions only by personally informing the supervising health care staff (e.g., Supervising Registered Nurse, PCP, Chief Physician and Surgeon).

1. This appointment is only effective during the course of treatment, illness, stay in the health care facility, or for 60 calendar days, whichever period is shorter.
2. An oral designation of an agent or legally recognized decision-maker supersedes a previous written directive, including a designated agent or legally recognized decision-maker.

(4) Revocation or Amendment of a CDCR 7421

(A) Patients may amend or revoke any aspect of the CDCR 7421 or POLST at any time either orally or in writing.

1. If amendments are made, the patient shall complete a new CDCR 7421 as soon as practicable.
2. Oral amendments to the advance directive shall be noted on the CDCR 7421 and on a progress note by the health care staff member who was advised of the change by the patient.

(5) Evidence of a CDCR 7421

(A) Providers shall note in the Problem List that a CDCR 7421 and/or POLST has been completed.

(B) The original CDCR 7421 shall be scanned to the document type Advance Directive, and the scanned document can be located in Miscellaneous Patient Care grouper in the Notes tab.

(C) Evidence of a completed CDCR 7421 and/or POLST is noted in the Banner Bar of the electronic health record.

(D) If a patient completed an advance directive prior to entry into prison, the valid "outside" advance directive shall be forwarded to Health Information Management (HIM) to be scanned to the document type POLST or Advance Directive. The scanned document can be located in the Miscellaneous Patient Care grouper in the Notes tab and shall be honored until a new form is completed.

1. As soon as possible, a CDCR 7421 shall be completed by the patient and shall supersede the prior advance directive in the health record.
2. An advance directive that conflicts with an earlier advance directive revokes the earlier advance directive to the extent of the conflict.

(6) Determining Decision-Making Capacity

(A) Patients shall be determined to have decision-making capacity unless a determination has been made to the contrary.

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

(C) If there is any question regarding capacity to name an agent or legally recognized decision-maker or to express health care preferences, the PCP shall request a psychiatric consultation from a mental health professional or obtain the assistance of the Chief Medical Executive (CME) or designee. The PCP shall document when the patient has been determined to lack capacity for a given decision(s) and when the patient regains capacity for a given decision, if applicable, in the patient's health record.

(7) End-of-Life Discussions

(A) In the absence of patient 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 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 are subject to change as the clinical situation progresses.

(B) Important components of end-of-life discussions include the following:

1. 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;
4. The patient's (or agent's or legally recognized decision-maker's) current understanding of his or her health condition, treatment plan, and prognosis;
5. Values and treatment preferences, including the patient's 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.

(8) Guidance for Completing CDCR 7421, Advance Directive for Health Care

It is optional for a patient to complete a CDCR 7421 or POLST, and consenting to a DNR Order is not required for admission to hospice.

(A) **Part 1: Power of Attorney for Health Care**

1. The patient may choose to appoint someone to make medical decisions for him or her if he or she becomes unable to make those decisions. The form allows for three individuals to be designated:
   a. Primary Agent/Legally Recognized Decision-Maker - the patient's first choice.
   b. First Alternate Agent/Legally Recognized Decision-Maker - the patient'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 has previously revoked the designation of the Primary Agent.
   c. Second Alternate Agent/Legally Recognized Decision-Maker - the patient'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 has previously revoked the designations of the Primary and First Alternate Agents.
2. A patient may select any person (e.g., a family member including one who is also incarcerated, a friend in the community) as his or her agent or legally recognized decision-maker with the exception of:
   a. The supervising health care provider or employees of the CDCR.
   b. Operator/employee of a community or residential care facility.
3. Important factors in selecting an individual to be an agent or legally recognized decision-maker may include, but are not limited to, the following:
   a. The agent or legally recognized decision-maker should know the patient well and know the patient's values and wishes regarding end-of-life care.
   b. The agent or legally recognized decision-maker should be someone who is able to be reached by phone at any time and is preferably someone who maintains contact with the patient and, therefore, likely to be aware of health concerns.
   c. The agent or legally recognized decision-maker should provide an alternate phone number of someone who will know how to contact them in case phone numbers provided have changed.
   d. The agent or legally recognized decision-maker should be agreeable to serve in this role. The patient is encouraged to talk with those individuals he or she is considering designating as agents or legally recognized decision-makers.
   e. If the agent or legally recognized decision-maker is called upon as a medical decision-maker, he or she shall have access to confidential information about the patient's medical history. Access to confidential information shall not be available to the agent or legally recognized decision-maker until and unless the patient is unable to speak for himself or herself; however, a patient may provide the agent or legally recognized decision-maker with confidential health care information prior to that time if he or she completes a written authorization for release of medical information.
4. The agent's or legally recognized decision-maker's authority becomes effective when the patient loses medical decision-making capacity or is unable to communicate with health care providers.

5. There is an option on the CDCR 7421 for the patient to designate if he or she wants his or her agent's or legally recognized decision-maker's authority to begin immediately. In general, even if the patient has made this designation, the PCP shall continue to discuss the patient's health care decisions with him or her until such time he or she is unable to make those decisions. Thereafter, the agent or legally recognized decision-maker shall be given the decision-making authority.
6. The agent or legally recognized decision-maker is not authorized to consent on behalf of the patient to any of the following:
   a. Abortion.
   b. Sterilization.
   c. Psychosurgery (as defined in the Welfare and Institutions Code, section 5325).
   d. Convulsive treatment (as defined in the Welfare and Institutions Code, section 5325).
   e. Commitment to or placement in a mental health treatment facility.
7. The agent or legally recognized decision-maker is directed to make all health care decisions for the patient in accordance with any instructions he or she has indicated in the advance directive or in any way made known to the agent or legally recognized decision-maker. If the patient's wishes are not known, the agent or legally recognized decision-maker is directed to make health care decisions in accordance with what the agent or legally recognized decision-maker determines to be in the best interest of the patient. In determining the best interest of the patient, the agent or legally recognized decision-maker shall consider the personal values of the patient.

(B) **Part 2: Instructions for Health Care**

1. As the advance directive is referenced primarily when patients are unable to communicate their wishes, the written instructions generally relate to preference for end-of-life care. The patient can specify instructions for health care in general if desired, but unless he or she is unable to speak for himself/herself, these instructions should be communicated by the patient directly to the PCP.
2. The PCP reviewing the advance directive with the patient should seek to clarify specific instructions written by the patient and understand the reasons behind them (e.g., a patient declining blood transfusion based on religious reasons may be making a more informed decision compared to a patient declining blood transfusions due to fears of acquiring a bloodborne disease).

(C) **Part 3: Donation of Organs at Death**

1. A patient may choose to donate organs and/or other tissues. If a patient chooses to donate, he or she may specify any organ, tissue, or part or may specify only certain organs, tissues, or parts.
2. If a patient chooses to donate, he or she can decide if the donated organs, tissues, or parts may be used for transplant, therapy, research, and/or education.

(D) **Part 4: Verification of Understanding, Signature, Witnesses**

1. The Verification of Effective Communication box shall be completed by the PCP. If the PCP is unable to establish effective communication, he or she shall seek guidance from the CME or the Chief of Mental Health.
2. The patient's signature is required, along with the date the CDCR 7421 was completed. If the patient is physically unable to sign the CDCR 7421, another adult may sign for him or her on the patient's direction.
3. The advance directive can be witnessed in one of two ways:
   a. Two witnesses may sign the document; or
   b. A Notary Public may notarize the document. As there is limited availability of notary services within the institutions, CCHCS approves the use of two witnesses to facilitate patients completing advance directives.
4. Witnesses within a CDCR institution:
   a. A CCHCS health care employee may serve as a witness to the patient's signature if he or she is not currently directly involved in the patient's health care (e.g., a Licensed Vocational Nurse working as a medication nurse in another unit, building or yard or a physical therapist who visits the unit but is not treating the patient who is completing the form).
   b. A CDCR or CCHCS administrative employee including, but not limited to, an Office Assistant, Office Technician, Health Program Specialist, or Health Records Technician.
   c. A CDCR Custody Officer.

b. Anyone who is serving as an agent or legally recognized decision-maker.

6. When a patient is in a CDCR or outside Skilled Nursing Facility, an additional witness (patient advocate or ombudsman) in addition to the two witnesses or notary, must sign the CDCR 7421 to ensure the patient is not signing under duress.

(9) Completed CDCR 7421

(A) When a CDCR 7421 has been completed, the original shall be forwarded to HIM to be scanned to the document type Advance Directive. The scanned document can be located in the Miscellaneous Patient Care grouper in the Notes tab. HIM shall forward to the patient one copy of the CDCR 7421 for the patient and one copy for each agent or legally recognized decision-maker (no more than four copies).

(B) It is the patient's responsibility to forward copies of the advance directive to notify the agent(s) or legally recognized decision-maker(s) that he or she may be called upon to make future health care decisions for the patient. Health care staff shall notify the agent or legally recognized decision-maker if the agent or legally recognized decision-maker is needed to make health care decisions for the patient.

(C) A copy of the CDCR 7421 shall accompany the patient when transported to an outside hospital for emergency care or admission or transfer to other health care facilities.

References

- California Welfare and Institutions Code, Division 5, Part 1, Chapter 2, Article 7, Section 5325
- California Probate Code, Division 4.7, Part 1, Sections 4609, 4650, 4652, 4654, 4657, 4658, 4659, and 4660
- California Probate Code, Division 4.7, Part 2, Sections 4671, 4673, 4674, 4675, 4678, 4682, 4683, 4684, 4685, 4689, 4695, 4698, 4711, 4731, 4734, and 4735
- Health Care Department Operations Manual, Chapter 2, Article 1, Section 2.1.2, Effective Communication
- Health Care Department Operations Manual, Chapter 2, Article 4, Section 2.4.2, Physician Orders for Life Sustaining Treatment (POLST)

Revision History
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