

<b>This policy applies to:</b> <input checked="" type="checkbox"/> <i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> June 2010
<b>Name of Policy:</b> Advance Directives of Adult Patients	<p style="text-align: center;"><b>Page 1 of 10</b></p>
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## I. PURPOSE

Stanford Hospital and Clinics (SHC) supports the right of an adult patient (at least 18 years of age or an emancipated minor) who has capacity to participate in healthcare decision-making to the maximum extent of his or her ability. SHC complies with all state and federal regulations, accreditation requirements and court decisions regarding the right of an adult patient to make determinations about his or her medical treatment, and prohibits discrimination based on whether or not the patient has executed an advance directive for healthcare.

This policy and the implementing procedure describe recommended courses of action to comply with legal requirements. For questions consult Spiritual Care Service or the Risk Management office.

## II. POLICY

For purposes of this policy, an advance directive (AD) or Advance Health Care Directive (AHCD) means either an individual healthcare instruction or a power of attorney for healthcare.

The AHCD is the newest form of advance directive under the Health Care Decisions Law, effective July 1, 2000. It permits the patient to appoint an agent to make healthcare decisions when the patient is no longer able to make his/her own decisions. It also permits the patient to provide specific information concerning healthcare decisions, particularly decisions about end-of-life care. The patient may also designate another person to make health care decisions even if the patient is still capable of making his/her own decisions. The AHCD has replaced the Durable Power of Attorney for Health Care (DPAHC) as the legally recognized document for appointing a healthcare agent in California. The AHCD has also replaced the Natural Death Act Declaration as it allows a patient to do more than a traditional living will, which only states one's desire not to receive life-sustaining treatment **if** terminally ill or permanently unconscious. The AHCD allows a patient to state his/her wishes about refusing or accepting life-sustaining treatment in **any** situation.

All valid DPAHC and Natural Death Act Declarations remain valid. Thus, unless an existing DPAHC has expired, the patient **does not have to** complete a new Advance Health Care Directive. A DPAHC executed before 1992 by law has expired and should be replaced.

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Advance directives may be revoked by a patient at any time, in which case they are no longer in effect. The authority of an agent appointed under the DPAHC, and the instructions of a patient under the Natural Death Act, do not become operative until the patient is no longer competent to make his or her own healthcare decisions. The newer AHCD gives the patient the option of choosing to make the agent's authority effective immediately, even though the patient is still competent, or to become operative when the patient is no longer competent.

A living will or other type of advance directive from another state, even though it does not meet the statutory requirements of an AHCD, DPAHC or Declaration, is legally valid and enforceable in California if it satisfies the legal requirements of the state in which it was executed. If there are any questions about the legal validity of an advance directive, the legal office should be consulted.

### **III. PROCEDURES**

#### **A. Determining if a Patient has an Advance Directive**

1. Information regarding advance directives (AD) is obtained by the Admitting Representative whether the patient is admitted through Patient Admitting Services or bypasses Admitting and goes directly to the unit.
2. Admitting personnel will ask the patient or if the patient is incapacitated the family will be asked to record his/her information on advance directives on the "Core Data Advance Directive Information" form (15-1811) hereby called Advance Directive Information form.
3. Every patient, (or their representative), shall be given the brochure entitled "Your Right to Make Decisions about Your Medical Treatment" (form 04-503, or Spanish 04-503s) which describes:
  - a. The patient's rights under federal and California law to accept or refuse medical or surgical treatment (even if that treatment is life-sustaining), and to formulate an AD;
  - b. The hospital's policy regarding these rights; and

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- c. Information regarding the way such decisions and directives are implemented at Stanford Hospital and Clinics.
4. If the patient has a completed AD with him or her, Admitting will have the patient (or representative) verify that the AD is valid and check the appropriate box on the AD Information form (15-1811). Admitting will send a copy of the AD and the AD Information form with the patient to the patient care unit. The Unit Secretary will place both the AD and the Core Data form in the patient's medical record under the green divider labeled "Advance Directive".
5. If the patient has completed an AD but does not have a copy, instruct the patient (or representative) to check the box on the Advance Directive Information form (15-1811) which states "I have an advance directive but I need to get a copy brought in for the hospital. Until it is available I request that the following health care instructions apply:" and the patient will mark the box which applies. If the patient has additional questions they will be referred to Spiritual Care 650.723.5101 during the day, or after hours to the on-call Chaplain Pager # 1LOVE (15683).
6. If the patient wishes to complete a new form, then:
    - a. Give the patient the Advance Health Care Directive kit.
    - b. Contact Spiritual Care Service 650.723-5101 to help the patient complete the document. On evenings, nights and weekends, page the on-call Chaplain at #1LOVE (15683). This call is made by Admitting.
    - c. When Spiritual Care has obtained the "new" advance directive, they put one copy in the patient's paper chart, send one copy to Medical Records to be scanned into the patient's chart, give one copy to the agent (if available) and the original back to the patient.
    - d. The Unit Secretary informs the patient's nurse that an advance directive has been placed in the chart.

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7. If the patient has **not** completed an AD, the Admitting Representative will ask if he or she would like to do so.
    - a. If the patient wishes to complete an advance directive at this time, give the patient the Advance Health Care Directive kit and contact Spiritual Care 650.723-5101 or, if after hours, page the "on call" chaplain at #1LOVE (15683).
    - b. If no, document this on the Advance Directive Information form (15-1811) and place in chart.
    - c. Explain that in lieu of a written advance directive the patient may orally appoint a surrogate decision-maker and may also discuss his or her wishes with their doctor. This will be documented in the medical record, on the Advance Directive Information form (15-1811), and will remain effective for the current hospital stay only.
  8. Health Information Management Services (HIMS) will keep all AD and AD Information forms (15-1811) as part of the permanent medical record as part of the Core Data section that is accessible in the Electronic Medical Record (EMR).
  9. Admitting Representative will document all information related to AD on the Advance Directive Information form (15-1811).
    - a. If the patient is transferred to another unit, the admitting RN should review the patient's advance directive status as part of the transfer assessment.
  10. If a patient's family brings in an AD from home, a copy is placed in the patient's chart, the patient's nurse is informed, and the AD Information form (15-1811) is updated.
- B. Admissions Under Special Circumstances:
1. Incapacitated Patients

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- a. If at time of admission the patient lacks decision-making capability, or is unable to receive information or answer questions regarding AD, the Admitting Representative asks the family (or representative) if they are aware of an AD. The family (or representative) should complete the AD Information form (15-1811) if they are able. If the patient is unaccompanied, and a surrogate decision-maker has been identified by the attending physician, ask that person. If they say there is an AD they are to be asked to bring it in. The AD Information form (15-1811) is completed with this information.
- b. In these situations, the Admitting Representative may choose to contact the Social Worker or Spiritual Care Service to follow up with the family.
- c. When the patient becomes able to understand and respond, the AD information will be given directly to the patient.

C. Honoring the Patient's Health Care Decisions

1. It is understood that the patient has the right to make his or her own healthcare decisions. Stanford Hospital and Clinics will adhere to a patient's healthcare decisions. However, please also consult SHC policies on withdrawing or withholding Life Support, Informed Consent DNR/DNI for situations which may provide an exception. This policy holds whether those decisions are written in an AD, expressed verbally to a Stanford Hospital and Clinics healthcare provider or, if the patient is unable to speak for him or herself, provided by the patient's agent appointed under an AHCD or DPAHC. This information is included in planning the patient's care.

Some patients may identify what they wish their DNR status to be on their advance directive. If a patient is undergoing an invasive procedure or surgery, however, there will be a separate discussion about a patient's DNR status and whether it will apply during the procedure. See also Do Not Resuscitate(DNR)/Do Not Attempt Resuscitation (DNAR) policy and Informed Consent policies for more specific guidance.

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2. If the patient lacks capacity to give consent and when an advance directive does not exist, surrogates may make medical decisions on behalf of the patient. (See Informed Consent When Adult Patient Lacks Capacity policy.)
3. However, if there is reason to believe that the patient's agent/surrogate is not acting in accordance with the patient's wishes or best interests, the Risk Management/legal office should be contacted at 3-6824.

D. Changing or Revoking an Advance Directive (AD):

1. The patient having capacity has the right to change or revoke an AD at any time, either orally or in writing.
2. Patients should execute a new AD if the patient wants to name a new agent or make other changes. The designation of an agent may only be accomplished in writing or by personally informing the supervising healthcare provider. (California Probate Code, Section 4695(a))
3. If the patient desires to revoke an AD while being treated, the patient (or representative) should notify the patient's attending physician. The physician should document these discussions in the patient's medical record.

E. Education

1. Staff

Educational information about ADs and the Stanford Hospital and Clinics policy regarding ADs is provided to medical staff, nursing and allied health professional staff, Social Workers, Admitting Representatives, Patient Representatives and Spiritual Care staff.

2. Clinics

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Stanford Hospital and Clinics have advance directive brochures, “Your Right to Make Decisions About Your Medical Treatment” (form 04-503 and 04-503S in Spanish) available in waiting rooms for patients and their families. The primary care clinics have the Advance Health Care Directive kit available for patients who request a form to complete.

3. Community

In order to educate the community served by Stanford Hospital and Clinics, education is provided through information in the Stanford Hospital and Clinics Health Libraries located in the hospital, Advance Medicine Center, and at the Stanford Shopping Center, and community forums.

F. Complaints

1. If a patient has questions or concerns about advance directives, he/she may contact Spiritual Care Service at 650-723-5101
2. If a patient has complaints specifically about the hospital's provision of information about advance directives, he/she may contact:

Department of Health Services  
San Jose District Office  
100 Paseo de San Antonio, Suite 235  
San Jose, CA 95113  
(408) 277-1784

OR

Office of Quality Monitoring  
The Joint Commission  
One Renaissance Boulevard  
Oakbrook Terrace, IL 60181  
(800) 994-6610  
[complaint@jointcommission.org](mailto:complaint@jointcommission.org)

3. Medicare patients may also call 1-800-633-4227.

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#### IV. COMPLIANCE:

- A. All workforce members including employees, contracted staff, students, volunteers, credentialed medical staff, and individuals representing or engaging in the practice at SHC are responsible for ensuring that individuals comply with this policy;
- B. Violations of this policy will be reported to the Department Manager and any other appropriate Department as determined by the Department Manager or in accordance with hospital policy. Violations will be investigated to determine the nature, extent, and potential risk to the hospital. Workforce members who violate this policy will be subject to the appropriate disciplinary action up to and including termination.

#### V. RELATED DOCUMENTS

- A. Informed Consent When Adult Patients Lack Capacity
- B. Patient Rights and Responsibilities
- C. Do Not Resuscitate(DNR) Do Not Attempt Resuscitation (DNAR)
- D. POLST (Physician Order for Life Sustaining Treatment).
- E. Your Right to Make Decisions about Your Medical Treatment, 04-503 (English)
- F. Su Derecho a Tomar Decisiones Sobre el Tratamiento Médico (Your Right to Make Decisions about Your Medical Treatment), and 04-503S (Spanish)
- G. Advance Directive Information form, 15-1811

#### VI. DOCUMENT INFORMATION

- A. Legal Authority/References
  - 1. HCFA regulation "Patient Self-Determination Act (PSDA)" effective 12/1/91; Amended in Federal Register 33262, 6/17/95 and 33294, 6/27/95, effective 7/25/95.; Health Care Decisions Law, July 1, 2000; California Probate Code Sections 4600 - 4805
- B. Author/Original Date  
November 1991, C. Price, Director of Risk Management
- C. Gatekeeper of Original Document

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Administrative Manual Coordinators and Editors

- D. Distribution and Training Requirements
1. This policy resides in the Administrative Manual of Stanford Hospital and Clinics.
  2. New documents or any revised documents will be distributed to Administrative Manual holders. The department/unit/clinic manager will be responsible for communicating this information to the applicable staff.
- E. Review and Renewal Requirements
- This policy will be reviewed and/or revised every three years or as required by change of law or practice.
- F. Review and Revision History
- May 1993, N. McAllister, Manager, Community and Patient Relations; R. Partridge, Coordinator of Quality Assessment and Accreditation
- May 1994, N. McAllister, Manager, Community and Patient Relations; R. Partridge, Coordinator of Quality Assessment and Accreditation; M.Eaton, Legal Office
- December 1995, N. Manela, Community and Patient Relations
- May 1997, Advance Directive Task Force
- January 2001, N. Manela, Community and Patient Relations; W. Gridley, Risk Management; P. Simmons, Nursing Quality Assurance; T. Ervin-Grayson, Patient Admitting Services
- September 2003, F. Souza, Director of Patient Representation; C. Taylor, Patient Care Policies & Procedures Coordinator;
- October 2003, R.Reyes, Patient Admitting Services
- January 2007, T. Ervin-Grayson, Manager, Patient Admitting Services
- January 2007, T. Harrison, Director, Patient Representatives
- May 2007, C. Norek, Director, Risk Management
- Ocotber 2009, T. Reyna, Director Guest Services Operations
- March 2010, E. Ziemba, Administrative Director of Risk Management
- G. Approvals
- May 1993, M. Eaton, Legal Office
- October 1993 Medical Board
- February 1994 SUH Board of Directors
- November 1997, S. Nicholson, Legal Counsel
- November 1997, Medical Board

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December 1997, UCSF Stanford Health Care Services Board of Directors  
January 2001, L.L. Smith, Vice President and Director of Risk Management  
February 2001, SHC Medical Board  
February 2001, SHC Hospital Board  
January 2004, S. Shah, Risk Management Specialist  
March 2004, Quality Improvement and Patient Safety Committee  
April 2004, SHC Medical Board  
April 2004, SHC Board of Directors  
May 2007, Risk Management Office  
June 2007 Quality Improvement and Patient Safety Committee  
July 2007 SHC Medical Board  
July 2007 SHC Board of Directors  
May 2010, QPSEC  
June 2010, SHC Medical Executive Committee  
June 2010, SHC Board Credentials, Policies and Procedures Committee

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