

UMHHC Policy 03-07-010

Advance Directives

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I. POLICY STATEMENT, PURPOSE AND SCOPE

Introduction

Law in the State of Michigan recognizes two forms of Advance Directives. One is the Durable Power of Attorney for Healthcare (DPOA-HC), recognized in the inpatient and ambulatory care settings within UMHHC. The other is a Do-Not-Resuscitate (DNR) declaration, which is intended for non-hospital settings. These documents state a patient's intentions, ought to be carefully considered in the patients' care, and ought to be followed unless they conflict with the best interests of the patient as per Michigan Law. (Note: Hospitals and those settings that fall within the scope of a hospital's license such as hospital outpatient departments are not required to follow but may elect to abide by the instructions in a DNR declaration (MCL 333.1052(c)). Freestanding surgical facilities wholly owned and operated by the UMHHC also are not required to honor the DNR declaration but may elect to implement the DNR declaration).

If either of these legal documents lacks certain elements (such as a witness or signature) they may be legally invalid; however, the information in them may be useful as evidence of a patient's intent or wishes regarding treatment choices.

A DNR declaration for non-hospital settings is different from a Do Not Attempt Resuscitate (DNAR) Order described in [UMHHC Policy 62-10-003 Patient Care Orders](#). DNAR orders are written for hospital inpatients.

"Living wills" and documented interactions with healthcare providers should be treated as explicit statements of a patient's intent regarding their future care so long as they were made at a time when the patient possessed decision-making capacity. These documents should guide the actions of the patient's healthcare providers and, where applicable, their Patient Advocate as named in a DPOA HC. In the case where a more recent living will or documented interaction contradicts an older advance directive or documented interaction, the more recent living will or documented interaction should be considered.

Policy Statement

It shall be the policy of the University of Michigan Hospitals & Health Centers (UMHHC) to recognize that a patient has the right to participate in health care decisions, including the use of Advance Directives, and that a patient is entitled to refuse treatment to the extent provided by law and to be informed of the consequences of that refusal. All adult inpatients with decision-making capacity will be asked if they have an Advance Directive. Adults with decision-making capacity in Ambulatory Care settings, when warranted by care, treatment, and services provided will be asked if they have an Advance Directive. If they do not, they will be provided information about Advance Directives. Where appropriate, discussion should occur with the patient or responsible family members, advocates, parents or guardians about planning around end-of-life care. The results of such discussion should be

documented in the progress notes or relevant section in the electronic health record. This documented discussion or a living will should be seen as explicit statements of a patient's intent regarding their future care and should be used to guide future care decisions by the patient's providers and by their DPOA-HC.

While the State of Michigan does not explicitly have a statute regarding documented interactions as advance directives or living wills, there are examples of legal cases elsewhere in the country where these documents were held as clear expressions of the patient's wishes (see "References and Resources" p1,2). These cases should be taken as evidence that living wills and documented conversations should be seen as indications of the patient's wishes.

Care planning and decision making will be congruent with the patient's Advance Directive unless there is reason to question the validity of the Advance Directive or whether the terms of the Advance Directive accurately reflect the patient's current wishes or are not consistent with UMHHC ethical guidelines or professional standards related to the provision of care. Any individual involved in the patient's care who believes the patient's wishes are not being addressed or who has concerns about futility of care may request an *Ethics Consult* (telephone 734-936-4000 and ask for the adult or pediatric Ethics Consultant on call).

Exceptions to following an Advance Directive

1. In accordance with Michigan law, in inpatient and Ambulatory Care settings, for pregnant women, 18 years of age/older, a Patient Advocate named in a DPOA-HC cannot make a medical decision to withhold or withdraw treatment for a pregnant woman that would result in the pregnant patient's death. While the DPOA-HC cannot make such a decision, the doctor should continue to act in the best interests of the patient.
2. A Patient Advocate named in a DPOA-HC CANNOT make mental health care decisions under Michigan law. For advance care planning for psychiatric episodes in which decision-making capacity is lost, patients should complete a separate Behavioral Health Advance Directive (see: Exhibits).
3. In inpatient and Ambulatory Care settings, patients having invasive procedures or treatments involving substantial risk of an adverse outcome will have their Advance Directive status established by the operative team and discussed with the physician (see [UMHHC Policy 62-10-001 Informed Consent for Invasive Procedures and Treatment Involving Substantial Risk of an Adverse Outcome](#)). Examples of invasive procedures with substantial risk for adverse outcomes include cardiac catheterization, implantation of a device, and major operative procedures. Unless there has been specific documented discussion between the physician and the patient (or the Patient Advocate or legal surrogate decision maker), any patient directive that limits intervention will not be in effect during operative procedures and during invasive diagnostic/therapeutic interventional procedures. This "required reconsideration" principle has been endorsed by the American College of Surgeons (see "References and Resources" p3,4).
4. In Ambulatory Care settings, Advance Directives that limit care are honored only if:
 - the patient is wearing a bracelet or carrying a DNR declaration; or
 - the Advance Directive is in the patient's medical record; or
 - a patient with decision-making capacity or valid surrogate has clearly communicated their desire to limit care in certain settings to the clinical team, and this has been documented in the medical record.

In both hospital inpatient and Ambulatory Care settings a Patient Advocate acting under a valid DPOA-HC will be recognized as the surrogate decision maker if the DPOA-HC is presented or on file at the time of care. A surrogate decision maker may only contradict a prior advanced directive or documented interaction if the surrogate is acting upon knowledge of a change in the patient's preferences or a major change in the patient's clinical status.

Nothing in this policy prevents a UMHC treating physician from signing a DNR declaration for a patient to use in non-hospital settings.

Persons who CANNOT enter into an Advance Directive include the following:

- A minor (person less than 18 years of age) may not appoint a Patient Advocate or execute a DNR declaration. They may however have documented interactions with healthcare providers that contain statements of their preferences for their care.
- Persons who lacked decision-making capacity at the time the DPOA-HC or DNR declaration was signed. Two witnesses are required for a valid DPOA-HC, and a physician and two witnesses sign a DNR declaration, in which they attest that the person signing appears to possess decision-making capacity and be under no duress, fraud, or undue influence. Possession of decision-making capacity and freedom from duress, fraud, or undue influence should also be considered when interpreting living wills and documented interactions.

Special Considerations for Guardians of Developmentally Disabled Adults:

A guardian of a developmentally disabled adult can designate a Patient Advocate in a DPOA-HC when the developmentally disabled adult ward lacks decision-making capacity. The guardian can sign a Do Not Resuscitate Order for a developmentally disabled adult ward when the ward lacks decision-making capacity if certain conditions are met. These include:

- Visiting and consulting with the ward if meaningful communication is possible no more than 14 days before executing the DNR order
 - Directly consulting with the ward's attending physician for specific medical indications for a DNR
- Both these steps should be repeated annually by the guardian as long as the DNR is in effect.

Policy Purpose/Scope

This policy has been developed to provide a standardized method of documenting the status of a patient's Advance Directive and identifies the procedure for providing written materials that explain Advance Directives and DNRs to patients; the method in which providers will be informed of the existence of an Advance Directive; the method for placing an Advance Directive in the current medical record; and the method for acquiring a copy of the Advance Directive from the patient. In addition, the policy will address the method for revoking an existing Advance Directive as well as the process for documentation of the patient's wishes in the absence of a written Advance Directive. The policy also addresses how living wills and documented interactions with the patient or other responsible parties around end-of-life care should be used. *UMHC does not discriminate against patients who do not have an Advance Directive and lack of an Advance Directive will not interfere with patient care.*

II. DEFINITIONS

Advance Directive (AD) - A legal document signed by an adult with decision-making capacity giving direction to health care providers about who can speak for them when they are deemed to be unable to speak for themselves and to express their choices for treatment in certain medical, surgical, and

behavioral health circumstances. Legal advance directives in Michigan are limited to Durable Powers of Attorney for Health Care (DPOA-HC) and Do-Not-Resuscitate (DNR) declarations; however, living wills and documented interactions should still be used to guide care in the absence of legal/applicable documents.

Advance Directives Screening Tool (ADST) - A form completed by UMHHC staff for the purpose of documenting that the policy standards related to Advance Directives have been met. All completed ADST's (as well as the Advance Directives) will be imaged into the electronic medical record. If the patient does not have a DPOA-HC, information must be provided.

Ambulatory Care - Ambulatory care encompasses healthcare services provided on an outpatient basis at a variety of locations including primary and specialty care clinics, ambulatory surgery centers, and other tertiary care units such as radiology and infusion centers.

Competent - Generally, a person is considered competent if he has sufficient understanding or capacity to make or communicate informed decisions. Adults are presumed to be competent. Mental illness and mental deficiency (including illness requiring involuntary commitment) do not necessarily result in a finding of incompetence. Only a judge can declare a person legally incapacitated but a physician can assess a patient and provide a clinical opinion as to whether a patient is impaired and not able to participate in medical decision making (see "Decision-Making Capacity" below). A Patient Advocate named in a DPOA-HC cannot begin to exercise his authority as a surrogate decision maker until two physicians or a physician and psychologist have determined that the patient is unable to participate in medical treatment decisions. See also [UMHHC Policy 62-10-001 Informed Consent for Invasive Procedures and Treatments Involving Substantial Risk of an Adverse Outcome](#).

Decision-Making Capacity - A clinical opinion rendered by a physician that a patient is impaired and unable to participate in medical decision making. This can be due to certain medication, injuries, illnesses, or other causes. Patients can lose decision-making capacity temporarily or permanently. A Patient Advocate named in a DPOA-HC cannot begin to exercise his authority as a surrogate decision maker until two physicians or a physician and psychologist have determined that the patient is unable to participate in medical treatment decisions (i.e., has lost decision-making capacity).

DNAR - Do Not Attempt Resuscitation is a physician order entered into the medical record for inpatients. See [UMHHC Policy 62-01-003 Patient Care Orders](#).

Do Not Resuscitate (DNR) Declaration for Non-hospital Settings - DNR declarations are written legal documents intended to be used in non-hospital settings. It allows a person to prohibit attempts to restore respiration and circulation, once both have stopped, in a non-hospital setting. This is different than an inpatient DNAR order, which can only be initiated by the primary care service after consultation with the attending physician according to UMHHC policy. In order to be legally valid, a DNR Declaration must have certain elements. In general, it must be in writing and:

- Signed and dated by the patient in the presence of two witnesses
- Signed and dated by the patient's attending physician
- Witnessed by two competent adults, at least one of whom is not the patient's spouse, parent, child, grandchild, or presumptive heir.

Documented Interaction - The results of a discussion with a patient with decision-making capacity and/or with responsible family members, a patient advocate, a parent, or a guardian. This discussion should be focused around goals of care and end-of-life planning, and be documented in the progress notes.

Durable Power of Attorney for Health Care (DPOA-HC) - Allows a person to name a "Patient Advocate" to make medical and/or mental health treatment decisions for that person, when it is documented that the person is unable to make those decisions for himself. The Patient Advocate may be given discretion to make treatment decisions or the person may provide specific instructions in the DPOA-HC that address that person's preferences.

Patients may have a DPOA-HC that names a Patient Advocate for medical care and another DPOA-HC that names a Patient Advocate for mental health treatment decisions, although typically only one document is executed. In order to be valid in Michigan, a DPOA-HC must have certain elements. In general, it must be in writing and be:

- Signed and dated by the patient voluntarily in the presence of two witnesses.
- Signed and dated by the person being appointed Patient Advocate.
- Witnessed by two competent adults who are not the patient's spouse, parent, child, grandchild, sibling, presumptive heir or known devisee (beneficiary) at the time of the witnessing; nor the patient's physician, Patient Advocate; nor an employee of a life or health insurance provider for the patient; nor an employee of a health facility that is treating the patient (**any UMHS employee, contract staff, or volunteer**); nor of a home for the aged where the patient resides; nor of a community mental health services program or hospital that is providing mental health services to the patient.
- Incorporated into the medical record; a DPOA-HC is not effective until it is entered into the patient's medical record.

A DPOA-HC is distinct from the surrogate of highest priority. The surrogate of highest priority, which is the surrogate in cases where the patient lacks decision-making capacity and there is no DPOA-HC on file, in Michigan is defined as "a member of the immediate family, the next of kin, or the guardian" by the Health Care Disclosure and Consent Act (see "References and Resources" p5).

Guardian - A person appointed by the probate court who has full legal rights and powers over the individual, their property, or both is called a plenary guardian or "full" guardian. There are also partial or limited guardians who have less than full power. A guardian may or may not be appointed to make medical decisions. **Letters of guardianship from the probate court must be read carefully to understand the authority that has been granted to the guardian to make treatment decisions for the individual.** Sometimes a person has a guardian but also has a DPOA-HC naming a Patient Advocate who will make treatment decisions instead of the guardian.

Imaging - The process of entering patient documentation into the electronic medical record.

Invasive Procedure - Most procedures involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspiration of abscesses or fluid collections, biopsy, cardiac or vascular catheterization, endoscopy, angioplasty, and implantation of a device. For the purposes of this policy, venipuncture, injections (unless consent is specifically required by the type of treatment being delivered through injections), insertion of medical devices into body cavities or orifices such as endotracheal tubes, Foley urinary catheters, and nasogastric and other orally placed feeding tubes and peripheral intravenous line placement, are not considered invasive procedures. See [UMHHC Policy 62-10-001 Informed Consent for Invasive Procedures and Treatments Involving Substantial Risk of an Adverse Outcome](#).

Living Will - A written document in which adults with decision-making capacity incorporate their wishes regarding care and treatment as a guide for their healthcare providers, family members, and/or their DPOA-HC.

Minor - An individual under the age of 18. A minor may be permitted to consent for his or her own treatment under limited circumstances for certain forms of healthcare (e.g., reproductive health and, in limited circumstances, mental health and or substance abuse). See [UMHHC Policy 03-07-018 Minors Consent and Access to Confidential Health Care Services](#). Michigan law states that an individual must be 18 years/older to enter into a DPOA-HC or a DNR declaration.

Patient Advocate - The person appointed by the patient in a DPOA-HC to be their surrogate decision maker when the patient is unable to make decisions for themselves. Patient Advocates must be 18 years or older and must sign a statement accepting responsibility to act on the patient's behalf. A Patient Advocate can be a family member, friend, or any other person the patient appoints. A Patient Advocate must act in accordance with the standards of care applicable to fiduciaries when acting for the patient and must act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

Patient Identification - Patient's name, date of birth, and registration number.

Primary Service - The team of primary care providers (attending physician, House Officer, Nurse Practitioner, or Physician Assistant) who are responsible for writing orders for a specific inpatient. For the purposes of this policy, at least one member of the Primary Service *should be notified* whenever an inpatient wants to discuss their wishes with their primary care provider(s) or expresses end-of-life wishes.

Substantial Risk - A risk that a reasonable individual would find important in determining his or her course of action. See [UMHHC Policy 62-10-001 Informed Consent for Invasive Procedures and Treatments Involving Substantial Risk of an Adverse Outcome](#).

Witnesses for a DPOA-HC - Witnesses must be adults who are not the patient's spouse, parent, child, grandchild, sibling, presumptive heir or known devisee (beneficiary) at the time of the witnessing, nor the patient's physician, Patient Advocate, nor an employee of a life or health insurance provider for the patient, nor an employee of a health facility that is treating the patient (*any UMHS employee, contract staff, or volunteer*), nor of a home for the aged where the patient resides, nor of a community mental health services program or hospital that is providing mental health services to the patient. Witnesses should not sign the DPOA-HC if they believe the patient does not possess decision-making capacity or is under duress, fraud, or undue influence based on the witness's observations and communications with the patient.

Witnesses for a DNR Declaration - Witnesses must be adults, at least one of whom is not the declarant's spouse, parent, child, grandchild, sibling, or presumptive heir.

III. POLICY STANDARDS

- A. Upon admission of every competent adult inpatient, and when warranted by the care, treatment, or service provided to any adult Ambulatory Services patient, there must be evidence in the medical record that the patient was offered the opportunity to provide a copy of, or revoke, an existing Advance Directive. This will be documented through the Advance Directive Screening Tool (ADST). The most recently dated copy of the DPOA-HC or DNR declaration will be considered the valid copy.

- B. If the patient does not currently have an Advance Directive, they will be given one of two publications: 1) "Advance Directives" trifold brochure ([Exhibit 1](#)) or 2) "Durable Powers of Attorney for Health Care" booklet, which includes forms to complete a DPOA-HC or a DNR declaration ([Exhibit 2](#)). The patient may choose to execute an Advance Directive using the booklets. The absence of an Advance Directive will not influence patient care. The patient will be encouraged to make his wishes known to his Primary Service providers who will document the patient's wishes in the medical record and write orders as appropriate. The patient may also talk to a member of the Department of Social Work for more information or assistance with completing the Advance Directive forms.
- C. When patients have a DPOA-HC or an Outpatient DNR declaration ([Exhibit 3](#)) previously entered into the medical record, staff will verify with the patient that the copy in the medical record is valid pursuant to the procedure detailed in Section V of this policy titled "Procedure Actions". If the patient's wishes have changed and the patient wants to execute a new DPOA-HC, staff will provide the patient with the opportunity to revoke the document according to Section III.E of this policy, titled "Revocation", and will offer the written materials to generate a new DPOA-HC. Similarly, in Ambulatory Care settings, if a patient chooses to revoke a DNR declaration, the patient and staff should follow the instructions for Revocation detailed in Section III.E. of this policy.

If the patient has a DPOA-HC that is not available at the time of the current inpatient admission or Ambulatory Services episode of care, the patient or his/her family will be asked to provide a copy as soon as possible for inclusion in the medical record.

- D. During an inpatient admission, the Primary Service should be notified whenever a patient expresses a desire to discuss end-of-life care (whether or not they have a DPOA-HC). Notification will be documented on the Advance Directives Screening Tool.
- E. Revocation: A DPOA-HC patient advocate designation is revoked in the following circumstances:
- When the patient dies except to the extent the law and the DPOA-HC permit the Patient Advocate to consent to anatomical gifts
 - When ordered by the probate court
 - When the Patient Advocate resigns or is removed by the court, unless the DPOA-HC names a successor advocate
 - When the patient executes a new DPOA-HC that specifically revokes the old DPOA-HC or revokes it by inconsistency. A patient can, however, revoke a DPOA-HC and choose not to execute a new one.
 - If a Patient Advocate designation is executed during a patient's marriage and names the patient's spouse as the Patient Advocate, the Patient Advocate designation is (1) suspended when there is a court action filed for separation, annulment, or divorce and (2) is revoked upon the entry of a judgment of separate maintenance, annulment, or divorce. If the patient has named a successor individual to serve as a Patient Advocate, that individual acts as the Patient Advocate.
 - The patient revokes the Patient Advocate designation. Unless the DPOA-HC contains a specific waiver for mental health, **even if the patient is unable to participate in medical treatment decisions**, a patient may revoke a Patient Advocate designation at any time and in any manner by which he or she is able to communicate an intent to revoke the Patient Advocate designation. If there is a dispute as to the intent of the patient to revoke the Patient Advocate designation, the probate court may make a determination as to the Patient Advocate designation.

- If the revocation is not in writing, an individual who witnesses a revocation of a Patient Advocate designation shall describe in writing the circumstances of the revocation. The individual who witnesses the revocation must sign the writing and notify, if possible, the Patient Advocate of the revocation.
 - If the patient's physician, mental health professional, or health facility has notice of the patient's revocation of a Patient Advocate designation, the physician, mental health professional, or health facility shall note the revocation in the patient's records and bedside chart and shall notify the Patient Advocate.
 - A patient can only waive the right to revoke a DPOA-HC as it relates to mental health treatment by making the waiver part of the document containing the DPOA-HC designation. This revocation is only applicable for 30 consecutive days after initiation of mental health treatment, and does not affect the patient's rights under the Mental Health Code. A patient advocate may exercise the power to make mental health treatment decisions only if a physician and mental health practitioner both certify that the patient is unable to give informed consent to mental health treatment.
 - In the case of the death of the existing Patient Advocate, the designation of Patient Advocate passes to the successor individual named by the patient. If no successor was named, the patient can elect to choose a new Patient Advocate.
- In the event the patient wants to revoke a DPOA-HC that was previously made part of their UMHHC medical record, staff will take the following actions:
- Ask the patient to boldly write "revoked" across each page of the DPOG-HC and sign and date each page.
 - All pages of the revoked document will be imaged into the electronic medical record and placed under the Advance Directive tab in the inpatient paper medical record.

Revocation of a DNR Declaration

A DNR declaration may be revoked at any time and in any manner by which the patient is able to communicate an intent to revoke the declaration. If the revocation is not in writing, a person who observes the revocation must describe the circumstances of the revocation in a signed document. A Patient Advocate or attending physician or delegate of the attending physician who has actual notice of the revocation must destroy the declaration and remove the DNR identification bracelet if the patient is wearing it. The written notice of the circumstances and revocation must be documented in the medical record. (Note: A licensed health care professional may *delegate* tasks or functions otherwise requiring such license to a licensed or unlicensed individual who is qualified by education, training, or experience in the performance of selected acts. M.C.L.A. 333.16104(1). These acts, tasks, or functions must fall within the scope of practice of the delegating licensee's profession and be performed under the licensee's supervision. Delegation shall not occur if the task when delegated cannot meet acceptable and prevailing standards of practice. M.C.L.A. 333.16215(1)).

For questions concerning revocation or revision of an Advance Directive, staff are directed to contact the Health System Legal Office at 734-764-2178 during regular business hours (8:00 a.m. - 5:00 p.m.). After 5:00 p.m., call the Paging Operator at 734-936-6267 and ask for the attorney on call.

PROCEDURES/ACTIONS

Implementation of this policy will require the combined efforts of physicians, nurses, clerical staff, unit hosts, social workers, and Health Information Management staff. Random monitoring of the medical records will be done on an annual basis.

Responsible Area	Action
<p>Ambulatory Care Staff</p>	<p>When a patient requests information about a DPOA-HC or DNR declaration, staff will provide information about Durable Powers of Attorney for Health Care or Do Not Resuscitate declarations.</p> <p>A. In ambulatory care settings, if a patient is being prepared for an invasive procedure or treatment that has a substantial risk of adverse outcome, Ambulatory Care staff will ask the patient about their DPOA-HC status. If the patient has a DPOA-HC, Ambulatory Care staff will request that the patient provide a copy of the DPOA-HC to include in the medical record. If the patient does not have a DPOA-HC, the Ambulatory Care staff can also provide the patient with Advance Directive materials.</p> <p>B. When a patient brings a copy of a DPOA-HC or DNR declaration to an Ambulatory Care site for inclusion in his/her medical record, staff will affix patient identification to every page of the DPOA-HC or DNR declaration (front and back when double-sided), and image it into the electronic medical record.</p> <p>C. Upon request, staff will refer patients to the Department of Social Work or their physician for assistance in completing a DPOA-HC.</p> <p>D. Patients requesting a DNR declaration will be referred to the Department of Social Work or their physician.</p>
<p>Operating Room Staff (UH, CVC, Mott)</p>	<p>A. Initiate the Advance Directives Screening Tool, at the time of admission, and provide documentation as follows:</p> <ol style="list-style-type: none"> 1. Ask the patient if they have a DPOA-HC. 2. If the patient does not have a DPOA-HC, offer/give the patient information about Advance Directives. Document the patient's answers to questions regarding the DPOA-HC. 3. Attach a copy of the DPOA-HC to the Screening Tool when the patient provides it after affixing patient identification to every page (front and back when double-sided) of the DPOA-HC.

4. Ask the patient to provide a copy of their DPOA-HC when they state they have one but a copy is not immediately available or has not previously been entered into the electronic medical record.

B. Review the Screening Tool for completeness. Sign and date the form in each section as appropriate.

C. Image the Screening Tool and DPOA-HC into the electronic medical record using the HIM Central Scanning vendor or through the media Manager under the ACP tab. Maintain the paper copies with all paperwork going to the OR/procedure area and/or to the inpatient unit.

**Inpatient Unit Clerk/Unit Host/Others
as assigned**

A. Place copies of the patient's DPOA-HC and Screening Tools under the Advanced Care Planning (APC) tab in MiChart.

B. Upon request:

1. For a newly submitted DPOA-HC, affix patient identification to every page (front and back when double-sided).

2. Image the DPOA-HC into the electronic medical record using the HIM Central Scanning vendor or through the Media Manager (clinic and units).

3. For previously admitted patients for whom a DPOA-HC exists, print a copy from the electronic medical record. If not already done, affix patient identification to every page (front and back when double-sided).

4. Give the printed copy of the DPOA-HC to the nurse to verify with the patient that this is their current/valid DPOA-HC.

5. Image a new DPOA-HC, if one has been provided, into the electronic medical record, as described above.

6. Image the Advance Directive Screening Tool into the electronic medical record under the ACP tab using one of the methods identified in B2 immediately above.

7. Notify the Department of Social Work if the patient requests additional information about a DPOA-HC or wishes to complete a DPOA-HC.

Inpatient Nurse

A. During nursing assessment, ask patient if they have a DPOA-HC and if a copy is provided, give it to the clerk to image into the electronic medical record. Notify the patient's Primary Service if the patient expresses a desire to discuss end-of-life care

and ask them to talk to the patient about their wishes. Notification will be documented on the Advance Directive Screening Tool.

- B. Complete the Advance Directive Screening Tool (ADST), Exhibit 3. Sign, date, and time the Screening Tool as appropriate. Give the completed Screening Tool to the clerk to image into the electronic medical record.
- C. If the most recent copy of the DPOA-HC is in the electronic medical record from a previous admission, the nurse will:
 - 1. Request the clerk to print a copy.
 - 2. Take the printed copy to the patient for review and *to verify that this copy is valid.*
 - 3. Request the clerk to place the corrected copy fo the DPOA-HC into the medical record under the APC tab when the patient verifies the copy is valid.
- D. If the copy from the electronic medical record **IS NOT VALID**, request that the patient revoke the DPOA-HC by writing "revoked" across each page of the DPOA-HC and to sign and date each page (See Section III.E.Revocation).
 - 1. Request the clerk to image the revoked copy into the electronic medical record.
 - 2. Ask the patient if they have a newly executed DPOA-HC, and if so, to provide a copy for inclusion in their medical record.
 - 3. If possible, notify the Patient Advocate if the patient revokes their Patient Advocate designation at any time and in any manner.
- E. Inform the patient they have the right to talk to their Primary Service and have their wishes written in their medical record.
- F. When a copy of the patient's current DPOA-HC is not available, the nurse will request the patient to have a copy brought to the hospital as soon as possible.
- G. When the patient **does not have** a DPOA-HC, the nurse will give the patient information about Advance Directives. If the patient does not want to receive the information, the nurse will document this on the Advance Directive Screening Tool.
- H. If the patient requests additional information or assistance with a DPOA-HC, the nurse will notify the Department of Social Work and document this on the Advance Directive Screening Tool.

Social Work

- A. When requested, Social Work will meet with the patient/family to address questions and concerns.
- B. Social Work will assess patient's appropriateness for completing DPOA-HC and consult with multidisciplinary team members if there are concerns (please see exceptions and the definition of decision-making capacity).
- C. Social Work will provide education, verbal and written, to patients and families about the process for designating a DPOA-HC.
- D. All specific questions about treatments and prognosis will be deferred to the medical team.
- E. If patient and family desire to complete a DPOA-HC during their inpatient admission and they are unable to independently find witnesses, the social worker may assist in finding witnesses (see definition of witness).
 - 1. If a DPOA-HC is completed on site, Social Work will refer to process delineated to the unit clerk/unit host.

Inpatient Primary Service (Attending Physician/house Officer/Nurse Practitioner/Physician Assistant)

- A. Review the DPOA-HC with the patient to clarify their intent or wishes when a DPOA-HC is placed in the medical record or is revoked. If a Patient Advocate has already been appointed pursuant to a DPOA-HC and it is documented in the medical record by two physicians or a physician and a psychologist that the patient is not competent to make medical decisions, review the DPOA-HC with the Patient Advocate.
- B. If time does not permit the patient to prepare a DPOA-HC, or if the DPOA-HC is not available at the time of the current admission, and if requested by the patient or a patient's legally appointed guardian who has the power to make medical decisions, the Primary Service will document the patient's wishes in the medical record and write appropriate orders. DNAR orders require consultation with the attending. Refer to [UMHHC Policy 62-10-003 Patient Care Orders](#).

IV. EXHIBITS

Exhibit 1: Advance Directives (trifold brochure/patient information)

Exhibit 2: Durable Powers of Attorney for Health Care booklet (patient information)

Exhibit 3: Outpatient Do Not Resuscitate Declaration

V. REFERENCES AND RESOURCES

1. In the case of *Camp v White* in Alabama, a competent patient orally refused to be placed on permanent artificial ventilation. The physicians complied; after the patient passed the patient's daughter sued the hospital for failing to obtain her mother's wishes in writing. The Alabama Supreme Court ruled that the physicians were not liable, and that written directives are not the *only* means of communicating patient preferences at the end of life.
2. In Delaware in 1994, an elderly patient had repeatedly stated to her physicians that she did not wish to have a feeding tube placed. This was also documented in a living will; however, under Delaware law, the living will only became binding in the event that she had a terminal illness diagnosed by 2 physicians. When she was incapacitated, the living will was not legally in effect; however, her son asked that a feeding tube not be placed, while the hospital disagreed. A court ruled in favor of the son, determining that the patient's wishes were clearly stated. No feeding tube was administered.
3. Cohen CB, Cohen PJ. "Required Reconsideration of Do-Not-Resuscitate Orders in the Operating Room and Certain Other Treatment Settings." *Law Med Health Care*. 1992 Winter;20(4):354-63.
4. [Statement of the American College of Surgeons on Advanced Directive by Patients: "Do Not Resuscitate" in the Operating Room. 1994 Sep; 79\(9\):2](#)
5. [Default Surrogate Consent Statutes, American Bar Association.](#)
6. Patient Self Determination Act of 1990.
7. Michigan Compiled Laws 700.5501-700.5520, Estates and Protected Individuals Code, Act 386 of 1998.
8. Michigan Compiled Laws 333.1051-333.1067, Michigan Do-Not-Resuscitate Procedure Act
9. The Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH)
10. [UMHHC Policy 62-10-003 Patient Care Orders](#)
11. [UMHHC Policy 03-07-018 Minors Consent and Access to Confidential Health Care Services](#)
12. [UMHHC Policy 62-10-001 Informed Consent for Invasive Procedures and Treatments Involving Substantial Risk of an Adverse Outcome](#)

VI. AUTHORS

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