State of Iowa Department of Corrections
Policy and Procedures

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Applicability: Institutions
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Iowa Code Reference: 144A, 144D.2
Chapter 6: Health Services
Sub Chapter: Acute/Specialty Services
Related DOC Policies: N/A
Administrative Code Reference: N/A
Subject: Advanced Directives for End of Life
Care PREA Standards: N/A
ACA Standards: 5-ACI-6A-07
Responsibility: Dr. Michael Riley
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Authority:

1. PURPOSE

The purpose of this policy is to document a patient's wishes in the event of a terminal illness.

2. POLICY

It is the policy of the Iowa Department of Corrections to provide care consistent with a patient's directives during a terminal illness, in accordance with **Iowa Code 144A**, "Life-sustaining Procedures Act," and Iowa Administrative Rules 144A, "Out of Hospital Do Not Resuscitate." And Iowa Code 144D.2, "Physician Orders for Scope of Treatment."

3. DEFINITIONS - As used in this document:

A. Terminal illness - An incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending licensed medical practitioner, result in death within a relatively short period of time, or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery.

B. Critical care - The term "critical care" is used in this policy to apply to all of the extraordinary efforts to extend the life of a terminally ill patient. Examples of critical care include resuscitative and monitoring measures for hypotension, ventilatory or cardiac failure, acute pulmonary edema, arrhythmias, metabolic intoxication, and other crises heralded by failing organ systems. Examples of

such resuscitative and monitoring measures are cardiopulmonary resuscitation, tracheointubation, life support with mechanical ventilation and other assisting devices, and invasive monitoring. This list is not intended to be complete. The term "critical care" does not include the ordinary supportive care and comfort measures which are to be provided to patients who elect to forego extraordinary care, and who are likely to die in a prison setting.

C. Competent adult - Competency is a legal term referring to a decision made by a judge. An adult in Iowa is a person who has reached age 18 or who has been married. An adult is competent if a court has not declared them incompetent, and if they are generally capable of understanding the consequences of alternatives; weighing the alternatives by the degree they promote their goals or desires; and, choosing and acting accordingly. There is a strong legal presumption of continued competence. The determination of competence is not necessarily the function of psychiatrists. It is usually a practical assessment, which should be made by the physician who obtains the consent or accepts the refusal for critical care. It is suggested that the basis for the determination of competence or incompetence be documented by a physician-authored progress note entered in the patient's health record. Consultation is advisable when it is difficult to assess competence.

D. Advance directive - Written instructions of the patient's wishes as to how future care should be delivered or declined, including decisions that must be made when the patient is not capable of expressing those wishes.

E. Palliative care-medical care and support services aimed at providing comfort including pain management. Treatment is focused on symptom control and quality of life issues rather than attempting to cure conditions.

F. Medical Durable Power of Attorney for Healthcare - A legal document authorizing an attorney-in-fact to make healthcare decisions for a person if the person is unable, in the judgment of the attending licensed medical practitioner, to make healthcare decisions.

G. Decision Making Capacity - Refers to a physicians' determination, based on clinical examination, that a patient is able to make medical decisions for themselves. That they understand their condition, can appreciate the consequences of treatment options including non-treatment, the ability to reason and communicate their decision in a meaningful manner.

H. IPOST - Iowa Physician orders for scope of treatment form. A document containing medical orders which may be relied upon across medical settings that consolidates and summarizes a patient's preference for life-sustaining

treatments and interventions and acts as a complement to and does not supersede any valid Advanced Directive.

4. PROCEDURE

A. It is the goal of the Health Services staff of the Iowa Department of Corrections to facilitate proper decision making by communicating the consequences of declining treatment; to urge appropriate care; and, as appropriate, to honor the wishes of the patient.

B. The patient should be encouraged to establish a *Living Will* (see HSF-620A) Patients who wish to consider signing a Living Will should be given literature on *Living Will Patient Information*, IDOC policy HSP-620 Attachment A. The Living Will specifies what the patient wants done in the event they are no longer capable of expressing their wishes. A patient may also request a Do Not Resuscitate (DNR) order be written, which would outline the patient's specific refusal of certain extraordinary measures that may prolong life. HSF-620A, *Living Will* shall be completed.

C. A patient who may already have a Medical Durable Power of Attorney for medical care established is encouraged to provide a copy to IDOC Health Services staff. If there is no Medical Durable Power of Attorney for medical care in place, the social worker or a member of the health care team shall provide information on *Durable Power of Attorney for Health Care* and HSF-620B shall be completed.

1. Decision Making:

A. It is especially important that a patient have sufficient information so as to avoid misunderstanding the alternate choices relative to available healthcare. The patient should be encouraged to carefully consider any decision to decline critical care.

B. A patient's directives concerning refusal of treatment may be honored unless the patient's competency is in question. Several exceptions to this general rule are recognized, including, but not limited to:

1) Serious mental illness or substance abuse - detailed procedures are specified in the law for imposing involuntary care in these cases. Mental health

services staff should be consulted concerning these procedures.

2) Threats to the public health - procedures are specified in the law for addressing these cases.

3) There is a third exception when the adult has dependents that could be harmed if care is not given. This third exception generally would not apply if the adult is terminally ill.

C. It is important that the licensed medical practitioner independently assess the appropriateness of carrying out the patient's wishes. If the patient and licensed medical practitioner concur, the agreed upon management should usually be pursued. It should be charted in the patient's record when the patient and licensed medical practitioner concur on a particular direction for care. Patient disagreement is an indication for careful re-examination and review by the patient and the licensed medical practitioner of their prior understanding of the situation; the patient's competence; and, whether one of the exceptions to the patient's decision making might apply. If this re-examination does not resolve the issue, arrangements should be made to obtain additional consultation from the IDOC Medical Director.

D. An Out-of-Hospital DNR (OOH-DNR) order, pursuant to Iowa Code 144A.7A (6), shall not apply when a patient is in need of emergency medical services due to a sudden accident or injury, which is outside the scope of the patient's identified terminal condition.

E. Incompetent adult patients who gave clear indications concerning their care before they became incompetent should (usually) be treated in accordance with their instructions to the same extent as if they were still competent. Thus, living wills or credible reports of oral instructions should be given significant weight in the decision-making process. Since the instructions cannot be discussed with the patient, the intent should be followed when different from the actual wording, if the circumstances are substantially different from those the patient anticipated when giving the instructions. If the

patient gave the instructions before the condition was known, and it is reasonably likely the patient will again be competent and able to communicate, the patient should be given an opportunity to recover communicative skills and express their present wishes rather than relying on the instructions.

F. In the absence of a Living Will/Durable Power of Attorney, and the patient becomes incompetent, management of the terminal illness will be provided on an individual basis as deemed appropriate by the licensed medical practitioner, often in conjunction with an appropriate next of kin (family member).

2. Documentation:

a. Thorough health record documentation by the attending licensed medical practitioner is required whenever a decision is made to withhold or withdraw critical care. The progress note shall indicate the scope of therapy covered, including interventions not to be initiated, (i.e. "Do Not Resuscitate"). A "DO NOT RESUSCITATE" requires a written order by the attending licensed medical practitioner. The documentation note is to include the decision-making process including:

    1. The patient's concurrence in the decision or the reasons the patient is unable to participate in the decision;

    2. Who was involved in the decision and whether they concurred or disagreed; and,

    3. Consultants (when used) and their advice.

b. The original Living Will or Medical Power of Attorney shall be retained by the patient. A copy shall be provided to Health Services and scanned into the EMR under the "Advanced Directives" tab. It is the patient's responsibility to provide a copy to family members and the designated attorney (if any). The problem list in the patient's Electronic Medical Record (EMR) must reflect a Living Will (ICD 10 Code Z0289) or DNR (ICD-10 Code Z66).

3. IPOST

a. Each institution may offer a patient the opportunity to participate in a program called IPOST. This is a paradigm approach to end-of-life planning based on conversations between patients, loved ones and health care professionals designed to ensure that seriously ill or frail patients can choose the type of treatments they want or do not want to participate in and that their wishes are documented. This option would be intended for frail, elderly or others whose death in the next twelve months would not be surprising.

b. Those staff who are designated to be the facilitators for the Advance Care Planning must complete a certification process and training course offered by the "Honoring Your Wishes Planning Initiative". The trained facilitator completes the form with the patient in consultation with the medical practitioner.

c. The form used would be the salmon colored form that is provided. This completed form needs to be signed by the attending practitioner. Each facility will develop procedures as to where the form is kept and how it is to be transported whenever the patient leaves the grounds to a medical facility or discharges from IDOC.

d. The completed IPOST packet will be scanned into the electronic medical record and stored in the file cabinet under the IPOST folder.

e. An IPOST form may be revoked at any time.

f. A medical practitioner must document in the electronic medical record detailing the results of the IPOST, the rational for the order, and the patient's wishes. A valid IPOST indicating DNR, pursuant to Iowa Code 144D, directs that resuscitative measures be withheld or ceased in all circumstances once verified by medical staff. The problem list in the patient's EMR must reflect IPOST ICD-10 Code Z1.

g. When a patient is transferred between DOC institutions or medical facilities, the salmon colored, completed IPOST form is sent on to the next facility. The original shall be sent with the patient if he discharges the IDOC.