Current Issues of Concern

• Advance directives — when patients have them, education and resources when they don’t
• Oral designation of a surrogate decision maker
• Unrepresented patients — implication of recent court case
• Involving family caregivers — new law’s effect on admission, discharge planning policies
• Behavioral patient in the ED without a hold — what now?
Patient Capacity to Make Decisions

• Every **competent adult** has the fundamental right of self-determination over his or her body and property. Individuals who are unable to exercise this right, such as **minors or incompetent adults**, have the right to be **represented by another** who will protect their interests and preserve their basic rights.

*Consent Manual*, Chapter 1
Which Patients Are Competent to Make Decisions

1. **Adult** (18 years of age and older) who has capacity

2. **Minor** (under 18 years of age) who is given capacity under the law (*and* has capacity as that is generally understood):
   1. Emancipated
   2. Married
   3. Self-sufficient
   4. Active duty in the armed forces
   5. For certain services that the law authorizes minors to approve: like pregnancy, communicable diseases, assault

*Consent Manual*, Chapter 2
Minors: Check the Specific Exceptions for When They Have Legal Capacity
Determination of Capacity

• Generally patients are presumed to have capacity to make their own decisions

• A patient has capacity if the patient can:
  • Respond knowingly and intelligently to queries about the medical treatment
  • Participate in treatment decisions by means of rational thought, and
  • Understand the information necessary to give or refuse to give informed consent
Physician Determination and Documentation on Capacity

- Attending or admitting physician should determine “capacity”
- Incapacity finding (and any changes) should be documented by the physician in the patient’s record
- Physician should promptly notify patient, if possible, and the person(s) authorized to make health care decisions on behalf of the patient
Patients with Mental Illness

- Patients who are mentally ill are still presumed to have capacity to make medical care decisions and are not presumed to lack capacity because of the mental health condition
  - True even if a person is placed on a 5150 “hold” (involuntary mental health detention)
  - Plus 5150 holds cannot authorize medical care
- Mental health patient’s capacity (e.g., ability to understand and make decisions) needs to be assessed just like other patients
Lack of Capacity Can Be Temporary

- **Temporary**: unconscious, head injury, drugs or alcohol
- **Permanent**: late-stage Alzheimer’s disease

---

- If the lack of capacity might be temporary, the patient’s capacity to decide should be assessed close to the time of proposed treatment
Advance Directives

- Patients who have decision-making capacity have the right to formulate and execute advance health care directives

- Advance health care directives can be used to designate a surrogate decision-maker who will act for the patient when the patient lacks capacity to make decisions

- They also can be used to express the patient’s desires with regard to medical decisions

*Consent Manual*, Chapter 3
Forms of Advance Directives

- Advance Health Care Directive
- Power of Attorney for Health Care
- Also referred to as “living wills” and “Durable Power of Attorney for Healthcare”
- An individual health care instruction

Bottom Line: A written or verbal instruction that relates to the provision of health care when the individual is incapacitated.
Federal Regulation, 42 CFR § 489.102
Requirements for Providers

- Certain healthcare providers are obligated to maintain written policies and procedures concerning advance directives

- Applies to the following providers:
  - Hospitals
  - Critical access hospitals
  - Skilled nursing facilities
  - Nursing facilities
  - Home health agencies and providers of home health care (and for Medicaid purposes, providers of personal care services)
  - Hospices, and
  - Religious nonmedical health care institutions
Providers must provide written information concerning:

- The patient’s rights under state law to make decisions concerning such medical care, including accepting or refusing treatment
- The right to formulate advance directives
- The provider’s written policies on implementing these rights, including a clear and precise statement of limits if the provider will not implement an advance directive (in part) on the basis of conscience
Other Federal Requirements For Advance Directives

• Document in a prominent part of the individual's current medical record, whether or not the individual has executed an advance directive

• Not condition the provision of care or otherwise discriminate based on whether the individual has executed an advance directive

• Ensure compliance with requirements of state law regarding advance directives

• Inform patients that complaints concerning the advance directive requirements may be filed with the State survey and certification agency
More Federal Requirements: Staff and Community Education

• Educate staff concerning advance directive policies and procedures
• Provide community education about advance directives:
  o Community education can be provided directly or in concert with other providers and organizations
  o Different education materials may be used for community events versus in-hospital, but all must:
    • Define what constitutes an advance directive
    • Emphasize that an advance directive is designed to enhance an incapacitated individual's control over medical treatment
    • Describe applicable state law concerning advance directives
Process Steps 1 and 2: Inquiring about Advance Directives

- Step 1: Patients who have decision-making capacity (adults and minors with capacity) will be asked if they have completed an advance directive and if so, asked to provide a copy which will be placed in the patient’s chart.

- Step 2: If the patient lacks capacity at the time of admission, the staff will ask the family or friends if they know whether the patient has completed an advance directive and if so, if they can provide a copy to be included in the patient’s chart.
Process Step 3: Providing Information on Creating

- Step 3: Upon request, the patient will be provided with information on how to formulate and execute an advance directive

- Suggested content for the “Advance Directive Package”
  - Brochures that provide simple overviews of patients’ rights to make decisions regarding medical care and advance directives like the State of California brochure entitled: “Your Right to Make Decisions about Healthcare”
  - A sample “Advance Health Care Directive” from the California Hospital Association Consent manual

- Patients who request more information should be directed to the hospital person (e.g., social services), who can provide information and resources

- Patients should be encouraged to communicate their wishes to their physicians
Process Step 4: Designating a Decision-Maker

- Patients should be informed that they also can designate a person to make decisions during the current episode of care.
- Any such designation must be communicated to and acknowledged by the patient’s attending physician.
- If the patient opts to designate a decision-maker, suggestion to have a form like the sample “Oral Designation of A Surrogate Decision-maker” that can be forwarded to the attending for acknowledgment.
Limits on Designated Decision Maker

- Designation is effective during the course of treatment or illness or during the stay in the health care institution when the designation is made.
- Must be promptly recorded in the medical record.
- Takes precedence over all other advance directives and surrogate decision makers.
- May be revoked by a patient who has decision-making capacity at any time by a signed writing or by the patient personally informing the supervising health care provider of the disqualification.
Process Step 5: Documentation

- The patient’s record must indicate if the patient has an advance directive.
- The patient’s physician(s), when necessary and indicated, will discuss the advance directive(s) with the patient or the patient’s surrogate decision maker and provide appropriate treatment orders that are consistent with the instructions in the advance directive.
- The physician’s discussion and orders shall be documented in the medical record.
Inpatient, Emergency, Observation and Same Day Surgery; Other

• For hospitals, §489.102(b)(1) requires that notice of the hospital’s advance directive policy be provided only when an individual is admitted as an inpatient.

• But since §482.13(a)(1) has a broader notice requirement, the Medicare survey standards require that hospitals also provide the advance directive notice to outpatients (or their representatives) who are in the emergency department, who are in an observation status, or who are undergoing same-day surgery.

• Hospital notices should be presented at the time of registration.

• Notices also required for SNF, home health, personal care and hospice, at the time of registration or on the first visits for home health and personal care services.
Outpatient and Ambulatory Care

- Suggested protocol for patients admitted to outpatient and ambulatory care settings, not including observation, emergency or outpatient surgery:
  - The existence of an advance directive will not be routinely assessed
  - However, if a patient proactively makes such a directive known, it shall be documented in the patient’s medical record
    - If it is a written directive, a copy shall be placed in the patient’s medical record
- Upon request, the patient will be provided with information on how to formulate and execute an advance directive by giving the patient the Advance Directive Packet
Validity of Advance Directives

- Generally providers can presume an advance directive is valid
- Review though to confirm it satisfies basic requirements:
  - Is in writing, dated, signed by the patient (or signed in the patient's name in the presence of the patient at his/her direction)
  - Either notarized or witnessed by two adults
  - The witnesses:
    - Are not the designated agent or surrogate, the patient's health care provider, any employee of the health care facility, an operator or employee of a community care facility or residential care facility for the elderly
    - At least one is not related by blood, marriage or adoption to the patient or a beneficiary of the patient's estate
    - Need not be told what the advance directive says; they just must watch the patient sign or see and hear the patient state that the signature is his or hers
Duration and Revocation

• Advance directives may remain in effect indefinitely unless the patient designates an expiration date, although if the patient is legally incompetent at the time a directive’s expiration date is reached, the directive will remain in effect.

• Patients who have decision-making capacity can revoke their advance directives by:
  
  o Executing a new, valid advance health care directive, or
  o By written notification given to either the health care agent or health care providers.

• Designation of an agent may be revoked only by a written, signed document or by the patient personally informing the supervising health care provider.
  
  o The supervising health care provider should be contacted if the patient informs a hospital employee he wants to revoke the designation of agent.
Requirements for Health Care Agents

• The health care agent cannot be:
  o The treating health care provider
  o An employee of the treating health care provider
  o An employee of the hospital
  o The operator or employee of a community care facility, or residential care facility for the elderly

• With two exceptions:
  o The individual is related by blood, marriage or adoption to the patient or
  o The individual is employed by the same health care provider as the patient

• The health care agent cannot delegate his or her duties to another party
Powers of the Health Care Agent
Powers of the Health Care Agent

- Generally, a health care agent has the same authority as a patient
  - Receive information regarding the proposed health care
  - Consent to or refuse the recommended medical care
  - Receive and review medical records
  - Consent to disclosure of medical records
  - Make a disposition under the Uniform Anatomical Gift Act
  - Authorize an autopsy and
  - Direct the disposition of remains
  - Approve or disapprove visitors
Emergency and Competency

• When an emergency arises (e.g., treatment is immediately necessary to prevent death, permanent disability or severe pain) and the patient is incapable of providing consent, the health care agent shall be contacted if time permits; otherwise, emergency treatment may be provided to address the emergency condition.
  
  o Efforts must be made to contact the health care agent to make any further decisions that may be needed.

• The health care agent is not authorized to make decisions as long as the patient is able to give informed consent.
Limits on Agent’s Authority

• The health care agent has all the principal's health care decision-making rights, with the following exceptions:
  o The health care agent cannot make any decision he or she wants but must instead act in accordance with the patient's known desire, or if those desires are not known, in the patient's best interests. Instructions that conflict with the patient’s known desires or best interests must be questioned.
  o Health care agents **cannot** authorize certain services including:
    • Commitment to a mental institution
    • Electroconvulsive therapy
    • Psychosurgery
    • Sterilization
    • Abortion
    • Any other limitation specified by the patient in the directive
Situations When Advance Directives Will Not Be Honored

• Other situations when an advance directive may not be honored:
  
  o Care has been requested that is contrary to the generally accepted standards of care or is medically ineffective or futile
    • Check the Hospital policy on Medically Ineffective Care
  
  o In limited situations, when orders to withhold resuscitation cannot be honored
    • Check the policy on Withdrawing and Withholding Care. Does it, for example, limit DNR orders in the operating room or during procedures requiring anesthesia?
  
  o The provider declines for reasons of conscience but in such cases, the patient or surrogate decision maker must be informed and the provider must help arrange for the transfer of the patient’s care to a provider who will accept the patient and comply with the patient’s instructions
Special Requirements for SNF Patients

• Written advance directives executed by SNF patients must be signed by a patient advocate or ombudsman who has been designated by the state Department of Aging

• The patient advocate or ombudsman:
  o Can be one or two witnesses or in addition to notarization
  o Must declare that he or she is serving as a witness as required by this law
  o May rely on the representations of the SNF administrators, SNF staff, or family members as convincing evidence of the patient’s identity if the representations provide a reasonable basis for determining the patient’s identity
Survey Procedures §482.13(b)(3)

- Review the hospital’s advance directive notice.
  - Does it advise inpatients or applicable outpatients, or their representatives, of the patient’s right to formulate an advance directive and to have hospital staff comply with the advance directive (in accordance with State law)?
  - Does it include a clear, precise and valid statement of limitation if the hospital cannot implement an advance directive on the basis of conscience?
• Review the records of a sample of patients for evidence of hospital compliance with advance directive notice requirements.
  o Does every inpatient or applicable outpatient record contain documentation that notice of the hospital’s advance directives policy was provided at the time of admission or registration?
  o Is there documentation of whether or not each patient has an advance directive?
  o For those patients who have reported an advance directive, has a copy of the patient’s advance directive been placed in the medical record?

• What mechanism does the hospital have in place to allow patients to formulate an advance directive or to update their current advance directive? Is there evidence that the hospital is promoting and protecting each patient’s right to formulate an advance directive?
Survey Procedures §482.13(b)(3) (cont.)

• Determine to what extent the hospital complies, as permitted under state law, with patient advance directives that delegate decisions about the patient’s care to a designated individual.

• Determine to what extent the hospital educates its staff regarding advance directives.

• Interview staff to determine their knowledge of the advance directives of the patients in their care.

• Determine to what extent the hospital provides education for the patient population (inpatient and outpatient) regarding one’s rights under state law to formulate advance directives.
Notifying Family of the Admission
Notifying Family of Patient’s Admission

- Each patient has the right to choose a family member or representative plus the patient’s physician who will be notified promptly of the hospital admission.

- Applies to inpatient admissions.

- Upon admission, competent patients must be asked whether the hospital should notify:
  - A family member or representative
  - The patient’s doctor (even if the admission is elective and the doctor should know about it)

- For patients who lack capacity, the hospital must make reasonable efforts to identify and promptly notify a family member or patient’s representative.

*Consent Manual*, page 1.23
Patient Admission Notice Requirements

- Notice must be given “promptly,” which means as soon as possible after the physician’s or other qualified practitioner’s order to admit the patient has been given.

- Notice may be given orally in person, by telephone, by e-mail or other electronic means, or by other methods that achieve prompt notification:
  - It is not acceptable for the hospital to send a letter by regular mail.
Medical Record Documentation

- The hospital must document that the patient, unless incapacitated, was asked no later than the time of admission whether he or she wanted a family member/representative notified, the date, time and method of notification when the patient requested such, or whether the patient declined to have notice provided.

- If the patient was incapacitated at the time of admission, the medical record must indicate what steps were taken to identify and provide notice to a family member/representative and to the patient’s physician.
Survey Questions

• Determine if the hospital has policies that address notification of a patient’s family or representative and physician when the patient is admitted as an inpatient

• Ask the hospital who is responsible for providing the required notice. Interview person(s) responsible for providing the notice to determine how they identify the persons to be notified and the means of notification. What do they do in the case of an incapacitated person to identify a family member/representative and the patient’s physician?
• Review a sample of inpatient medical records.
  o Do the medical records provide evidence that the patient was asked about notifying a family member/representative and his/her physician?
  o Is there a record of when and how notice was provided?
  o Was notice provided promptly?
  o Is there a record of the patient declining to have notice provided to a family member/representative and his/her physician?
  o Is there documentation of whether the patient was incapacitated at the time of admission, and if so, what steps were taken to identify a family member/representative and the patient’s physician?
New Law on Caretakers

- SB 675, new law requires hospitals to involve Caretakers in discharge planning

- Susan covers
Decision-Makers for Incompetent Adults
Priority in the Search for Decision Makers

- Person designated to make decisions during the admission
- Healthcare agent designated in an advance directive
- Conservator
- Closest available relative (*Cobbs v. Grant*)
- Probate Code Section 3200 Petition
Selection of a Decision Maker – CHA Model Policy

See CHA Appendix 2-C – Model Policy – “Policy on Selection of Health Care Surrogates with the Assistance of Health Care Professionals”

• Health care provider can identify a surrogate who appears, after good faith inquiry, to be best able to function in this capacity
And if There is No One?
Options When There is NO ONE …

- Contact Public Guardian’s Office and seek conservatorship?
  - See *Consent Manual Chapter 2* for specifics on how to do this; details include who should file petition, notices, representation and the hearing process, and orders.

- Get Court order per Probate Code 3200?
  - Time consuming and costly
  - Requires someone (hospital?) to file the petition
  - Probate Code 4650: “In the absence of controversy, a court is normally not the proper forum in which to make health care decisions.”
How Big is the Problem?

- 2006 Study – 16% of patients in ICUs are unrepresented (about 1 in 6)

- Three groups predominate:
  - Homeless or mentally ill who have lost contact with family or friends
  - Patients alone by choice
  - Elderly who have outlived family and friends
Interdisciplinary Teams For Unrepresented Patients

- Health & Safety Code 1418.8 authorized use of IDT in Skilled Nursing Facility setting
  - Decisions made by that team could result in transfers to acute care hospitals
  - SNF teams might then be asked to authorize the care
- No comparable statute for acute care hospitals, but CHA suggested such teams could be considered

*Consent Manual*, page 2.5
CANHR v. Chapman

- June 2, 2015 Alameda County Superior Court order finding that aspects of law that allow nursing homes to rely on interdisciplinary teams to make decisions for unrepresented patients are unconstitutional

- Plaintiff was California Advocates for Nursing Home Reform (CANHR). Defendant the state

Consent Manual, page 2.7
CANHR v. Chapman Holding

• Court found that law permitting multidisciplinary teams to make decisions for skilled nursing patients:
  o Denies due process to patients
  o Lacks procedural safeguards re: decision regarding incompetency
  o Does not permit patients to be treated with psychotropic drugs
  o Does not permit physician or team to make end of life decisions
• Court held that SNFs had to use the Probate Code §3200 process instead
CANHR v. Chapman (cont.)

- The State (CDPH) is appealing, order stayed pending appeal
- SNFs may refuse unrepresented patients in the future, knowing the costs and burdens of seeking court orders for all future care
Recommendations

• CHA has recommended revising the policy on decision making for unrepresented patients to address concerns raised by the court

• See CHA App. 2-E “Considerations for Revising the Hospital’s Policy & Procedure Regarding Decision Making for Unrepresented Patients”

• Notice to the patient
  o Informs the patient about the incompetency finding and the opportunity to object
  o Should be given as early as possible so there is time to object; document if treatment cannot be delayed
  o Document notice was given (see sample form in Chapter 2)
Enhance the Team
Other Recommendations

• Include a person on the team who has the role of protecting the patient’s interests – a patient representative, ombudsman, patient advocate, bioethicist, community member, or other person

• When possible, involve a family member or friend of the patient who is unable or unwilling to take full responsibility on the team but would participate in the team review
Other Recommendations (cont.)

• If the patient will be administered antipsychotic drugs, consider obtaining the review of an independent physician

• Limit end-of-life decisions (such as withholding or withdrawing life-sustaining treatment, ordering hospice care) to patients who are terminally ill, comatose, or in a persistent vegetative state

• Confirm in the policy that the patient’s wishes will be taken into account when making health care decisions, to the extent those wishes are known
Caregivers
Caregiver’s Affidavit for Minors

- Family Code 6550-6552 allows a “Qualified Relative” who is raising a child “unofficially” (no legal guardianship) to complete a caregiver’s affidavit.
- Contents of affidavit (specified in statute) includes boxed “penalty of perjury warning”.
- Allows the caregiver to consent to medical, mental health, or dental care in the same manner that legal guardian could.

Consent Manual, Chapter 2
Minors Caregiver’s Affidavit

- Caregiver must try to notify parent/legal guardian of intent to get medical care and receive no objection if the parent/legal guardian is reached
- Affidavit, once signed, should be kept in minor’s chart
- Stays in effect until minor turns 18 or a parent returns. Forms prior to 2005 said they expire after one year, so a new form should be executed to replace any expired forms
- No liability for a health care provider who relies in good faith upon a caregiver affidavit
• If parent returns simply draw line through the caregiver affidavit form, note parent’s return and sign and date it (keep it in the chart)

• If situation changes, have new caregiver execute new form

• Caregiver can delegate authority to third party to consent for the minor’s care, too (e.g., if they are at work)
  - Use CHA Form 2-2
• Qualified relative includes spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix “grand” or “great,” or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

• Caregiver must notify health care provider if minor stops living with them.
Mental Health

- Patient with unstable mental health emergency (DTS, DTO, or GD) who wants to leave your ED can be detained
  - If placed on a 5150 hold
  - Or, provider can “lock the door” without fear of false imprisonment lawsuit by initiating a Health and Safety Code 1799.111 “hold”
Requirements of Health and Safety Code 1799.111

- Eliminates civil and criminal liability for detaining a person if:
  - The patient cannot be safely released because he or she, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled
  - “Gravely disabled” means an inability to provide for basic personal needs for food, clothing, or shelter
  - Repeated unsuccessful efforts have been made (and documented) to find appropriate mental health treatment

Consent Manual, page 12.29
Where and Who?

- Applies to licensed acute care hospitals that are not:
  - County-designated under Welfare and Institutions Code Section 5150
  - Licensed as an acute psychiatric hospital
- Who is qualified to make the determination?
  - Treating physician and surgeon
  - Clinical psychologist
Conditions for Immunity

- Attempts to find mental health placement must commence at the earliest possible time once it can be predicted when the patient will be medically stable for transfer
  - Calls cannot start after the patient is medically stable for transfer
- Allows detention only for 24 hours
If the patient will be detained more than 8 hours, two more conditions must be met:

- The transfer has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing
- The patient, as a result of a mental disorder, is still a danger to himself or herself, or others, or is gravely disabled
No Liability for Release After 24 Hours

- Conditions for immunity when a patient is released after having been detained for up to 24 hours:
  - Patient was not admitted under 5150 hold for psych evaluation and treatment
  - The release was authorized by a physician or clinical psychologist who determined, based on a face-to-face interview the patient does not present a danger to himself or herself or others and is not gravely disabled
- Still need to comply with seclusion, restraint and psychiatric medications laws
- Patients get credit for the time detained, up to 24 hours, if a 72-hour hold is later initiated
• Chapter 2 – Who May Give Consent

• CHA 2-A - Consent Requirements for Medical Treatment of Adults

• CHA 2-B - Consent Requirements for Medical Treatment of Minors

• CHA 2-C – Selection of Health Care Surrogates with the Assistance of Health Care Professionals - Sample Policy

• CHA 2-D – Health Care Decisions for Unrepresented Patients

• CHA 2-E – Considerations for Revising the Hospital’s Policy and Procedure Regarding Decision-Making for Unrepresented Patients
Questions?
Thank you

Suzanne F. van Hall, JD
Attorney at Law
van Hall Law Offices
(303) 670-6880
svhlaw@gmail.com

Linda Garrett, JD
Partner
Risk Management Services
(415) 924-4980
lindagarrett.risk@comcast.net