POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER I-04	PAGE NUMBER 1 of 3
	RELATED NCCHC/ACA STANDARDS: P-I-04 (IMPORTANT)	
CHAPTER: 11 BUREAU OF CORRECTIONAL HEALTHCARE SERVICES	SUBJECT: END OF LIFE DECISION	
APPROVED BY THE COMMISSIONER:		
EFFECTIVE DATE: 11/19/07	REVISED: 4/13/09	
APPROVED FOR PUBLIC RELEASE		

I. AUTHORITY: Bureau of Correctional Healthcare Services

II. PURPOSE: To allow the terminally ill offender to participate in medical care decisions during the terminal stages.

III. APPLICABILITY: All Department of Correction employees and vendor staff, offenders, and any outside healthcare provider servicing DOC offenders.

IV. DEFINITIONS: See policy.

V. POLICY:

1. End-of-life medical care decision-making options are discussed with terminally ill offenders.

2. The Advanced Directives format approved by the state of Delaware is presented to and discussed with the offender.

3. A terminally ill offender may request to not have cardiopulmonary resuscitation performed when housed in the infirmary or other special medical housing area. This is known as a Do Not Resuscitate Order.

4. Documentation in the medical record includes:

   a. Extent of information that is shared with the offender to make an end of life decision.

   b. Consultation between the offender and members of the clergy or other non-healthcare staff has taken place if requested by the offender

   c. A mental health consultation has judged that the offender is competent to make an end-of-life decision.

5. The physician will write a "DO NOT RESUSCITATE" order when the offender has an executed Advanced Directive requesting no cardiopulmonary resuscitation.

6. The offender with a DO NOT RESUSCIATE order will be readily identifiable to the health care team.

7. Orders for "DO NOT RESUSCITATE" do not preclude other indicated medical and nursing care. Provisions of an executed Advanced Directive assist in guiding end of life medical care treatments.

8. Do Not Resuscitate orders and/or Advanced Directive when initially written or received is reviewed with the Regional Medical Director. Prior to withholding or withdrawing care based on an Advanced Directive, the Regional Medical Director and Medical Society of Delaware will review the patient's course of care and prognosis.

9. The offender may rescind "DO NOT RESUSCITATE" requests or any part or the entire Advanced Directive at any time.

10. "DO NOT RESUSCITATE" requests and the executed Advanced Directive are discussed with the terminal offender monthly and renewed or changed to reflect the desire of the offender.

11. Mental health staff and clergy will be requested to discuss the decision with the offender to evaluate the offender's understanding of the decision.

12. The Institutional Authority will be notified of any terminally ill offender who has requested a "no cardiopulmonary resuscitation" order or has executed an Advanced Directive.

13. If the offender approves, the family will be contacted.

14. The mentally incompetent patient is not able to make end-of life-decisions.

15. A copy of the offender's Advanced Directive is sent with the offender whenever receiving health care off site.

16. Request from an offender for a durable power of attorney for healthcare decisions is addressed on a case-by-case basis with the DOC legal department.

References:

National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2008, P-I-04

Advance Health Care Directive

of

_____

This form was developed by the Committee on Law and the Elderly of the Delaware Bar Association and approved for use by the Office of the Attorney General of the State of Delaware.

GENERAL INSTRUCTIONS

You should read this form carefully before filling it in. You should fill it in completely. If there are health care decisions you do not want to make, you should strike the wording of that decision rather than leave it blank. You may not change the qualifications for witnesses or agents, even if you cross out the wording. You should write legibly.

After you have filled out the form completely, you should sign the form before a notary public. Although signing before a notary public is not legally required, it is advisable. It is advisable because the notary, as well as your witnesses, can testify as to your competence when you sign the directive, if your competence becomes an issue. Notaries, who are registered with the State, are often easier to locate later than witnesses.

You should retain your original Advance Health care Directive, and give copies to your doctor, agent, spouse, family members, and close friends, if you desire. You should explain to each person who receives a copy of your health care directive what choices you made on the form, and why. This will help if, while you lack competence, there arises a need to make a health care decision that is not explicitly set forth on your advance health care directive form.

This form does not contain all of the types of health care decisions you are legally entitled to make. For example, the form does not give you the opportunity to nominate a guardian, in the event you become incompetent and need one. Also, the form does not give you the opportunity to designate a primary care physician, or another person, to certify that you lack the capacity to make your own decisions on health care. Finally, the form does not include a provision that accommodates a person's religious or moral beliefs. If you would like to exercise these options, you should talk to an attorney. If anything on the form conflicts with your religious beliefs, you should contact your clergy.

PART I. INSTRUCTIONS FOR HEALTH CARE DECISIONS

If you are an adult who is mentally competent, you have the right to accept or refuse medical or surgical treatment, if such refusal is not contrary to existing public health laws. You may give advance instructions for medical or surgical treatment that you want or do not want. These instructions will become effective if you lose the capacity to accept or refuse medical or surgical treatment. You may limit your instructions to take effect only if you are in a specified medical condition. If you give an instruction that you do not want your life prolonged, that instruction will only take effect if you are in a "qualifying condition." A "qualifying condition" is either a terminal condition or permanent unconsciousness.

If you want to give instructions to accept or refuse medical or surgical treatment, you should fill in the spaces on the following page. You may cross out any wording you do not want.

A. END OF LIFE INSTRUCTIONS

1. Choice To Prolong Life

_____I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

OR

2. Choice Not To Prolong Life

I do not want my life to be prolonged if (please check all that apply)

_____ (i) I have a terminal condition (an incurable condition from which there is no reasonable medical expectation of recovery and which will cause my death, regardless of the use of life-sustaining treatment). In this case, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____

_____

_____ (ii) I become permanently unconscious (a medical condition that has existed at least four (4) weeks and has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma) and regarding the following, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____

_____

B. RELIEF FROM PAIN: Whether I choose A.1 or A.2, or neither, I direct that in all cases I be given all medically appropriate care necessary to make me comfortable and alleviate pain.

C. OTHER MEDICAL INSTRUCTION: If you wish to add to the instructions you have given above, you may do so here.

_____

_____

(use additional sheets if necessary)

PART II: POWER OF ATTORNEY FOR HEALTH CARE

Your agent may make any health care decision that you could have made while you had the capacity to make health care decisions. You may appoint an alternate agent to make health care decisions for you if your first agent is not willing, able and reasonably available to make decisions for you. Unless the persons you name as agent and alternate agent are related to you by blood, neither may own, operate or be employed by any residential long-term care institution where you are receiving care.

If you wish to appoint an agent to make health care decisions for you under these circumstances and conditions, you must fill out the section below. You may cross out any wording you do not want.

A. DESIGNATION OF AGENT: I designate _____ as my agent to make health care decisions for me. If he/she is not living, willing or able, or reasonably available, to make health care decisions for me, then I designate _____ _____ as my agent to make health care decisions for me.

_____
(name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

_____
(name of individual you choose as alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

B. AGENT'S AUTHORITY: I grant to my agent full authority to make decisions for me regarding my health care; provided that, in exercising this authority, my agent shall follow my desires as stated in this document or otherwise known to my agent. Accordingly, my agent is authorized as follows:

1. To consent to, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function;

2. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

3. To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;

4. To contract for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;

5. To hire and fire medical, social service, and other support personnel responsible for my care; and

6. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death.

C. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my attending physician determines I lack the capacity to make my own health care decisions.

D. AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part I of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, health care decisions by my agent shall conform as closely as possible to what I would have done or intended under the circumstances. If my agent is unable to determine what I would have done or intended under the circumstances, my agent will make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

PART III. ANATOMICAL GIFT DECLARATION (Optional)

I hereby make the following anatomical gift(s) to take effect upon my death. The marks in the appropriate squares and words filled into the blanks below indicate my desires:

I give [ ] my body; [ ] any needed organs or parts;
[ ] the following organs or parts _____

to [ ] the physician in attendance at my death; [ ] the hospital in which I die;
[ ] the following named physician, hospital, storage bank or other medical institution
_____

for the following purpose(s):
[ ] any purpose authorized by law; [ ] transplantation;
[ ] therapy; [ ] research;
[ ] medical education.

EFFECT OF COPY: A copy of this form has the same effect as the original.

I understand the purpose and effect of this document.

_____ (date)

_____ (sign your name)

_____ (print your name)

_____ (address)

_____ (city) (state) (zip code)

STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del.C. §§ 2502, 2503, in our presence, who in his/her presence, at his/her

request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

A. The Declarant is mentally competent.

B. That neither of us is prohibited by §2503 of Title 16 of the Delaware Code from being a witness. Neither of us:

1. Is related to the declarant by blood, marriage or adoption;
2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health care directive, is so entitled by operation of law then existing;
3. Has, at the time of the execution of the advance health care directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has a direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or an employee of a health care institution in which the declarant is a patient or resident; or
6. Is under eighteen years of age.

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____ _____, is at the time of the execution of the advance health care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

Witness	Witness
_____ (print name)	_____ (print name)
_____ (address)	_____ (address)
_____ (city, state, zip code)	_____ (city, state, zip code)
_____ (signature of witness) (date)	_____ (signature of witness) (date)

(Optional)

Sworn and subscribed to me this _____ day of _____.

My term expires: _____ _____ (Notary)

STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER I-04	PAGE NUMBER Review Addendum
SUBJECT: END OF LIFE DECISION		

I have reviewed this policy and it is being incorporated into BCHS Policy E-12, Continuity of Care.

Vincent F. Carr

Acting BCHS Bureau Chief
Vincent F. Carr, DO, FACP

6/22/22
Date