GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
Lillian Perez-Posadas, MN, RN Hospital Administrator/CEO	Hospital-wide	Interim Approved 2/18/2020	A-RI400	1 of 10
TITLE: PATIENT SELF-DETERMINATION (ADVANCE DIRECTIVES)				
LAST REVIEWED/REVISED: 02/2020				
ENDORSED:				

PURPOSE:

It is the purpose of Guam Memorial Hospital Authority (GMHA) to act affirmatively in preserving every patient's life.

It is the purpose of Guam Memorial Hospital Authority to act affirmatively with respect to every patient's right to make decisions regarding their choices of medical treatment. All patients have the right to accept or refuse any medical treatment. The Authority will respect the right of the patient to refuse medical treatment even if such refusal would soon result in death. All parents/guardians have the right to make advance directives for their children.

Every patient shall be advised of his/her right to make decisions regarding the medical treatment of their choice. Such decisions may be documented in the form of an Advance Directive such as a Durable Power of Attorney for Health Care, or a Living Will.

POLICY:

A. Every patient has the right, consistent with the Authority's corporate obligations and policies, to be informed on whether to accept or refuse medical treatment.

B. It is the right of every patient to formulate Advance Directives (Durable Power of Attorney for Health Care or a Living Will).

C. It is the intention of Guam Memorial Hospital Authority to honor and respect an Advance Directive in all inpatient and outpatient units.

D. The Authority's staff and personnel shall document in the patient's medical records whether or not the patient has executed an Advance Directive.

E. A copy of patient's Advance Directive document will be permanently incorporated in the patient's medical records.

F. The Authority shall **not** base the provision of medical care on whether or not the patient has executed an Advance Directive.

G. In those cases where an incompetent adult is without an Advance Directive, decisions regarding acceptance or refusal of medical treatment will be made by the following **legal representative**, if reasonably available, in order of priority:

1. the spouse of the patient;

2. an adult child of the patient chosen by his/her siblings to represent the family;

3. the parents of the patient;

4. an adult sibling of the patient; or, if there is more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;

5. the nearest other adult relative of the patient by blood or adoption who is reasonably available for consultation; or

6. Guam's Public Guardian, if no relative is available or if the attending physician has unresolved questions of a legal nature.

H. The patient reserves the right to change his/her Advance Directive or plan of care through discussions with the attending physician.

I. In those cases where a patient is incapacitated at the time of admission and is unable to receive information or indicate whether he or she has executed an Advance Directive, the Authority shall give Advance Directive information to the patient's family or surrogate. Once the patient is no longer incapacitated, the Hospital shall provide the same information to the patient.

J. In those cases where a patient is admitted first as an inpatient to an acute unit and then to the Skilled Nursing Unit (SNU) of GMHA, the Authority is required to provide the patient who is being transferred to SNU with information on Advance Directives.

K. GMHA shall not provide patients with Durable Power of Attorney for Healthcare forms as per GMHA legal counsel.

PROCEDURE:

I. REGISTRATION PROCEDURES

A. Upon each admission into GMHA, a Patient Registration staff will provide all patients or their legal representatives with an Advance Directive handout (*Attachment I*) describing the individual's right to make decisions regarding his/her medical treatment. The Advance Directives handout is part of the patient's rights and responsibilities, in addition, a brochure on Advance Directives will also be provided to the patient. The patient or representative will be asked to acknowledge receipt. The signature will be maintained in the medical record.

For outpatients: Patient Registration staff shall communicate the hospital's policy on Advance Directives to outpatients, upon request or when warranted by the care, treatment, and services provided. Assistance shall be provided in formulating advance directives upon request.

B. Patient Registration staff will inquire whether or not the patient has made Advance Directives in the past. If the patient or representative is unable to give information, Patient Registration staff shall complete and sign SECTION I of the Advance Directives Acknowledgement form (*Attachment II*).

C. If the patient or representative states that no Advance Directives has been made, the patient or representative and Patient Registration or Nurse must complete and sign SECTION II of the Advance Directives Acknowledgement form.

D. If the patient has an existing Advance Directive, Patient Registration staff will request for a copy of such document. SECTION III of the Advance Directive Acknowledgement form must be completed by the patient or representative and Patient Registration or Nurse. The attending physician will be notified of the existence of an Advance Directive by the Nurse.

If the patient or representative does not have a copy available, this information will be noted on the Advance Directives Acknowledgement form and the patient or representative will be reminded to bring in a copy. The patient/representative will be asked to discuss their Advance Directives with the physician.

In the absence of an Advanced Directive document or physician's orders, all life support and resuscitative policies will be followed.

E. A copy of the patient's Advance Directive will become a permanent part of the medical record upon receipt by GMHA. Patient Registration staff shall input this information into the computer system which will alert staff, during patient's future visit to GMHA, that there is no further need to inquire about Advance Directives.

II. MAKING AN ADVANCE DIRECTIVE

A. The Patient Service Representative or unit charge nurse will immediately notify the attending physician of a patient's intention to make an Advance Directive.

B. Upon request, Patient Registration or Guest Relations staff will provide the patient or representative with a copy of a Living Will form (Declaration Regarding the Withholding and/or Withdrawal of Life Sustaining Treatment and Procedures) *(Attachment III)*.

C. It is the physician's obligation to inform the patient of his/her right to determine his/her own medical care. The Hospital recommends the patient and their legal counsel formulate an Advance Directive prior to hospitalization. The Hospital will assist the patient in formulating an Advance Directive, if needed. The physician may ask the nurse, Patient Registration, or Guest Relations staff to assist the patient in making an Advance Directive, but the agreement to proceed with the treatment must be between the patient and the attending physician.

D. The attending physician will document in the medical record discussions pertaining to Advance Directives.

III. RESPECTING ADVANCE DIRECTIVE

A. The desire of a patient will at all times supersede the effect of an Advance Directive.

B. GMHA, including its staff, will honor and respect a patient's Advance Directive.

C. In the case of conflict between the attending physician and the patient, family members or the legal representative, a request for consultation by the Ethics Committee may be considered. The provision of medical care **may be** transferred to any physician who is more sympathetic to the wishes of the patient, family members or legal representative.

D. In the case of a request for withholding and/or withdrawal of life-sustaining procedures, the DO NOT RESUSCITATE POLICY AND PROCEDURE MUST BE FOLLOWED.

IV. REVISING AN ADVANCE DIRECTIVE

If the patient wishes to revise his/her Advance Directive, patient and the nurse must complete and sign SECTION IV of the Advance Directive Acknowledgement Form.

V. REVOKING AN ADVANCE DIRECTIVE

If the patient wishes to revoke his/her Advance Directive, patient, nurse, or Guest Relations staff must complete and sign SECTION V of the Advance Directive Acknowledgement form. If the patient uses ambiguous verbal expression to revoke his/her Advance Directive in the presence of two adult witnesses, the names of the two witnesses (may be hospital employees) must be noted. The revocation becomes part of the patient's medical record and becomes effective upon its communication to the attending physician or other healthcare provider by the patient or a witness to the revocation.

REFERENCES:

Public Law 23-73 10 GCA Health and Safety Chapter 91 *The Natural Death Act of Guam*

Public Law 23-73 Section 91106 *Revocation of Declaration*

Policy A-RI500, *Do Not Resuscitate (DNR) Orders* of the Administrative Manual.

RESCISSIONS:

Policy A-RI400, *Patient Self-Determination (Advance Directives)* of the GMHA Administrative Manual made effective April 15, 2016.

ATTACHMENTS:

I. Advanced Directive Handout
II. Advance Directive Acknowledgement Form
III. Declaration Regarding the Withholding and/or Withdrawal of Life Sustaining Treatment and Procedures

ATTACHMENT I

GUAM MEMORIAL HOSPITAL AUTHORITY
850 GOV. CARLOS CAMACHO ROAD
TAMUNING, GUAM 96911

YOU RIGHT AS A PATIENT TO MAKE DECISIONS REGARDING YOUR MEDICAL TREATMENT

It is the philosophy of Guam Memorial Hospital Authority, unless otherwise restrained as provided below, to act affirmatively in preserving a patient's life including patients with terminal or irreversible illnesses. In the event a patient has been diagnosed as pregnant, and that diagnosis is known to her physician, the Living Will or Declaration Regarding the Withholding and/or Withdrawal of Life Sustaining Treatment or Procedures document shall have **no** force or effect during patient's pregnancy. In the case of conflict between the attending physician and the patient, family members or the legal representative, a request for consultation by the Ethics Committee may be considered. The provision of medical care **may be** transferred to any physician who is more sympathetic to the wishes of the patient, family members or legal representative.

It is the philosophy of Guam Memorial Hospital Authority to act affirmatively about your right as a patient to make decisions regarding your choice of medical treatment. As a patient, you have the right to accept or refuse any medical treatment.

WHO CAN DECIDE WHAT KIND OF TREATMENT I WILL GET?

As long as you are a competent adult, it is only you who can decide what kind of treatment you can accept or refuse. Your attending physician will advise you of the benefits and risks of the treatment to be given and you will be given the opportunity to ask any questions. It is only you who can accept or refuse any kind of treatment even if it means refusing a treatment that will prolong your life.

If you are below the age of 18, your parent or legal representative will decide what treatment to accept or refuse.

IF I BECOME INCOMPETENT, WHO CAN DECIDE FOR ME?

If you become incompetent, meaning, you are not in a condition to make your own decisions regarding your treatment, decisions will have to be made by others. Whoever makes the decision for you **should make it in your best interest according to your expressed intention**. It is best if your decisions regarding the kind of treatment you want for yourself are known to your immediate family or friends. Some difficult decisions regarding your treatment are: would you like to be put on a mechanical ventilator to prolong life; or artificial nutrition (tube feeding/hydration); or would you refuse treatment

if you know that you had an irreversible or terminal illness and such refusal would ultimately lead to your death? These are some of the important decisions which might be necessary regarding your treatment. If your desires are not known, then your family or the courts would have to make this decision.

WHAT SHOULD I DO, SO MY WISHES ARE MADE KNOWN AND HONORED IN THE FUTURE?

While you are still competent, you can name someone who can make decisions for you should you become incompetent and unable to make a decision. To be sure the person you assigned to make such a decision has the right to do so, it is best that you put your intentions in writing through a **Durable Power of Attorney for Health Care**. The person named in the form is called a Legal Representative and will carry out decisions that are made known to him/her in your best interest. Aside from making known your decision regarding any medical treatment to your Legal Representative, you can also make these known to your physician and to your family either in written form or orally. It is important that your expressed intention be made known to your attending physician so it can be documented in your medical record.

WHO CAN BE MY LEGAL REPRESENTATIVE?

Anyone who is eighteen (18) years of age can be considered as a Legal Representative. You can choose from friends to immediate family members or any person you trust, who is willing to accept the responsibility of making decisions in the event you would become incompetent. To be sure that your wishes are carried out, you can also name an alternate representative just in case your primary Legal Representative is **not** available. **Your alternate Legal Representative will only act if your primary Legal Representative is not available**.

DO I HAVE TO GIVE INSTRUCTIONS TO MY LEGAL REPRESENTATIVE?

No, but it is best that you make a written decision in order to make it clear to everyone involved. If you want your Legal Representative to refuse any kind of treatment that is not in your best interest, it is best you write this out specifically in the Durable Power of Attorney for Healthcare form. Any other instructions can be verbally communicated to your Legal Representative. **REMEMBER, THAT YOUR LEGAL REPRESENTATIVE WILL ALWAYS ACT IN YOUR BEST INTEREST AND ON YOUR EXPRESSED INTENTION.**

CAN I JUST GIVE INSTRUCTIONS AND NOT NAME A LEGAL REPRESENTATIVE?

Yes, you can simply make your wishes known to your attending physician, your immediate family members and close friends. It is better for you to fill out a Living Will also known as a Declaration Regarding the Withholding and/or Withdrawal of Life-Sustaining Treatment and Procedures which is a written statement of your decisions and choices. Whatever you have made known to your immediate family members and to your close friends will also be taken into consideration, in the absence of Living Will or Durable Power of Attorney for Health Care Form.

DO I HAVE TO MAKE A DECISION NOW ABOUT MY FUTURE MEDICAL TREATMENT?

No. You do not have to fill out a Durable Power of Attorney for Health Care form or a Living Will and you do not have to tell anybody about your choices regarding medical treatment. Unless otherwise restrained, Guam Memorial Hospital Authority will act affirmatively to honor your wishes as long as you are competent. If you become incompetent, decisions will have to be made by your immediate family members in accordance with your expressed whishes and in your best interest. If a conflict arises, the courts may have to decide what is in your best interest.

IF I MAKE A DECISION NOW, CAN I CHANGE IT LATER ON?

Yes. You can change your decision or give new written or oral instructions. You can change your Durable Power of Attorney for Health Care or cancel your Living Will anytime. However, it is best that you review your Durable Power of Attorney for Health Care Form or Living Will at least once a year to make sure that it is still applicable.

DEFINITION OF TERMS

Patient: A person who receives medical care, either as an out-patient or in-patient.

Advance Directives: A document which instructs the attending physician to either provide, withhold or withdraw life sustaining procedures in the event that you become incompetent to make a decision regarding your medical treatment.

Durable Power of Attorney for Health Care: A document which authorizes someone else to make health care decisions on your behalf if you lose the capacity to make such a decision.

Artificial Nutrition and Hydration: Artificially administered nutrition and hydration which can be given in many ways. "Enteral" procedures give nutritional formulas and water into the stomach and intestines by means of naso-gastric tube being placed through the nose and throat or by gastrostomy tubes surgically inserted directly through the skin into the stomach. "Parenteral" procedure gives nutritional formulas and water into the bloodstream via a needle or small tube into the vein. Artificial nutrition and hydration do not include delivery of food or water by cup, spoon, baby bottle or drinking straw.

Life-sustaining procedures are medical procedures or interventions that, when administered, serve only to prolong life or artificially postpone the moment of death.

Terminal condition means an incurable or irreversible condition that, with or without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a short time.

ATTACHMENT II

Guam Memorial Hospital Authority

All patients have the right to make a written Advance Directive telling their physician of medical treatment decisions to be carried out in the event they are unable to make or communicate treatment decisions.

Unable to Assess

SECTION 1: Patient Registration to complete.
[ ] Patient or representative is unable to give information at this time. Follow-up will be done.
[ ] Patient or representative was given Advance Directive brochure.

Date_____ Signature of Patient Registration Staff_____ Title_____

Does Not Have Advance Directive

SECTION II: Patient or Representative to complete.
[ ] I have been given written materials about my right to make decisions about my medical treatments.
[ ] I would like to speak to someone who can tell me more about an Advance Directive.
[ ] I choose not to have an Advance Directive but I understand that I can make one during my hospital stay or anytime in the future.

Date **Signature of Patient or Representative**

Representative's Name (Please Print) **Relationship to Patient**

Registration or Nurses to complete.
[ ] Patient or Representative was given Advance Direction brochure.
[ ] Guest Relations and/or Patient Registration has been notified to provide additional information.
[ ] Attending physician has been notified that the patient wants to complete an Advanced Directive.
[ ] Upon follow-up on _____, patient or representative was given additional information by_____.

Date_____ Signature of Staff_____ Title_____

Has An Advance Directive

SECTION III: Patient or Representative to complete.
[ ] I have an Advance Directive: ( ) Living Will ( ) Durable Power of Attorney for Heath Care.
[ ] I have brought in a copy and provided it to hospital staff to go into my medical record.
[ ] I have an Advance Directive but did not bring it with me.
[ ] I have an Advance Directive from a previous admission and reviewed it with a nurse and/or my doctor.
[ ] During my stay, I made an Advance Directive and gave a copy to hospital staff.

Date **Signature of Patient or Representative**

Representative's Name (Please Print) **Relationship to Patient**

Registration or Nurse to complete.
[ ] Patient or representative was given Advance Directive brochure.
[ ] Copy of Advance Directive from previous admission requested from Medical Records on _____ via _____.
[ ] Copy of Advance Directive presented at admission, reviewed, and forwarded to patient's medical record.
[ ] Patient did not bring in copy of Advance Directive.
[ ] Attending physician has been notified that the patient has an Advance Directive.

Date_____ Signature of Staff_____ Title_____

Comments/Follow-Up Notes:

ADVANCE DIRECTIVE ACKNOWLEDGEMENT FORM

Patient I.D. Label

Original Copy – Medical Record | 2nd Copy – Patient Registration | 3rd Copy – Patient/Representative

Revised An Advance Directive	**SECTION IV: Patient to complete.** **[ ] I have revised my Advance Directive.** **Date** _____ **Signature of Patient** _____ **Nurse to complete.** **[ ] Attending physician has been notified that the patient has revised an existing Advance Directive.** **[ ] Copy of revised Advance Directive reviewed with patient and placed in front of chart.** **Date**_____ **Signature of Nurse**_____ **Title**_____
Revoked An Advance Directive	**SECTION V: Patient to complete.** **[ ] I have revoked my Advance Directive.** **Date** _____ **Signature of Patient** _____ **Nurse to complete.** **[ ] Attending physician has been notified that the patient has revoked an existing Advance Directive.** **[ ] Advance Directive removed from the chart and given to the patient.** **Date**_____ **Signature of Nurse**_____ **Title**_____ ..... **Witness #1 (if applicable)** _____ **Witness #2 (if applicable)** _____

Steps in Completing the Advance Directive Acknowledgement Form

NOTE: Refer to Administrative Policy #A-RI400 on Patient Self-Determination (Advance Directive)

An Advanced Directive does not replace the need for a physician to order and document Code Status (resuscitation status). Please refer to Policy and Procedures: Administrative Policy # A-RI400.

1. **On admission, ALL patients will be given an Advance Directive brochure.**
2. **On Admission, ascertain whether or not the patient has an Advance Directive.**
3. **If the patient or representative is unable to give information, Registration staff to complete and sign SECTION I.**
   - **Communicate need to reassess when patient is able to provide information on the kardex, plan of care or other appropriate document.**
   - **When patient is able to give information, ascertain whether or not she/he has an Advance Directive.**
4. **If the patient does NOT have an Advance Directive, patient or representative and the nurse or registration staff must complete and sign SECTION II.**
5. **If the patient HAS an Advance Directive, patient or representative and the nurse or registration staff must complete SECTION III.**
6. **If the patient wishes to REVISE her/his Advance Directive, patient and the nurse must complete and sign SECTION IV.**
7. **If the patient wishes to REVOKE her/his Advance Directive, patient and the nurse must complete and sign SECTION V. If the patient uses unambiguous verbal expression to revoke her/his Advance Directive in the presence of two adult witnesses, the names of the two witnesses (may be hospital employees) must be noted.**

ADVANCE DIRECTIVE ACKNOWLEDGEMENT FORM	**Patient I.D. Label**

Original Copy – Medical Record | 2nd Copy – Patient Registration | 3rd Copy – Patient/Representative

ATTACHMENT III

DECLARATION REGARDING THE WITHHOLDING AND/OR WITHDRAWAL OF LIFE SUSTAINING TREATMENT AND PROCEDURES

I, (*Print Name*) _____ being of sound mind and at least eighteen (18) years of age, do hereby declare as follows:

If I should have an incurable and irreversible condition that has been diagnosed by two physicians and that will result in my death within a relatively short time without the administration of life-sustaining treatment or has produced an irreversible coma or persistent vegetative state, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician pursuant to the Natural Death Act of Guam, to withhold or withdraw such life-sustaining treatment that only prolongs the process of dying or supports irreversible coma or persistent vegetative state and is not necessary for my comfort, nutrition, hydration or to alleviate pain.

Being of sound mind, I have made the following decisions regarding my medical treatment:

( ) I do not want cardiopulmonary resuscitation (CPR)

( ) I do not want to be placed on a kidney machine (dialysis).

( ) I do not to be put on a breathing machine (mechanical ventilation).

( ) I do not want tube feeding for nutrition.

( ) I do not want (specify) _____

If I have been diagnosed as pregnant, and that diagnosis is known to my physician, this declaration shall have no force or effect during my pregnancy.

Signed this _____ day of _____, _____.

PRINT NAME: _____

SIGNATURE: _____

ADDRESS: _____

_____

The declarant voluntarily signed this declaration in my presence:

I believe that the person who made and signed this Advance Directive is of sound mind and that he/she signed and acknowledged this document in my presence and that he/she is not acting under pressure, duress or undue influence.

I am not entitled to any portion of the estate of the declarant upon his/her death under any will or codicil thereto of the declarant now existing or by operation of law.

I am not a healthcare provider or employee of a healthcare provider, the operator or employee of an operator of a community care facility, or the operator or employee of an operator of a residential care facility for the elderly.

WITNESSES

Print Name: _____ Print Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Declaration Regarding the Withholding and/or Withdrawal of Life-sustaining Treatment and Procedures

GMHA FORM# 0255 STOCK # 990255

APPROVED DATE: EC __/__, SCC __/__, MEC __/__, EMC __/__, HIMC __/__

PATIENT ID LABEL