POLICY TITLE: ADVANCE DIRECTIVES POLICY NUMBER: 31.1 (AF) CHAPTER 31: END OF LIFE AND DEATH		PAGE 1 OF 6
STATE of MAINE DEPARTMENT of CORRECTIONS Approved by Commissioner:		PROFESSIONAL STANDARDS: See Section VIII
EFFECTIVE DATE: August 15, 2003	LATEST REVISION: September 21, 2026	CHECK ONLY IF APA [ ]

I. AUTHORITY

The Commissioner of Corrections adopts this policy pursuant to the authority contained in 34-A M.R.S.A. Section 1403.

II. APPLICABILITY

All Departmental Adult Facilities

III. POLICY

The Department recognizes the right of an adult resident to state their wishes for future medical treatment of a terminal condition or while in a persistent vegetative state and to specify those interventions they consent to or refuse in the event they become incompetent or become incapacitated and unable to communicate their wishes.

IV. DEFINITIONS

1. Advance Directive – a witnessed, written legal document, voluntarily executed by a resident, which states the resident's wishes regarding the providing, withholding, or withdrawal of life-prolonging measures in the event the resident becomes incompetent to make such decisions or becomes incapacitated and unable to communicate their wishes.
2. Competent – a resident is competent if they have the ability to understand the significant benefits and risks of, and alternatives to, proposed health care and to make and communicate a reasoned health care decision.
3. Health care provider – for purposes of this policy, physician, physician assistant, or nurse practitioner.
4. Persistent vegetative state – a state in which the patient totally lacks higher cortical and cognitive function, but maintains vegetative brain stem processes, with no realistic possibility of recovery.
5. Terminal condition – a progressively deteriorating illness or disease or injury that is life-threatening and determined to be incurable. Death is anticipated from this condition or a complication thereof within six (6) months, regardless of the administration of life-prolonging treatment.

V. CONTENTS

VI. ATTACHMENTS

Attachment A: Advance Directive Information
Attachment B: Advance Directive form

VII. PROCEDURES

Procedure A: Advance Directive, General

1. During the orientation process, an adult resident shall be provided with the Advance Directive Information form (Attachment A) by designated intake staff.

2. In addition, the facility Chief Administrative Officer, or designee, shall ensure that all residents are provided with a copy of Attachment A as part of the resident handbook and have access to this policy.

3. Only the Advance Directive form approved by the Department (Attachment B) shall be accepted, and a resident shall not be allowed to make decisions regarding matters not included in that form (e.g., a resident is not allowed to appoint a health care power of attorney, make a choice as to their health care provider, make a choice of which hospital they will be transported to, etc.).

4. A resident shall not complete an Advance Directive form for another resident.

5. Staff shall not complete an Advance Directive form for a resident.

6. Staff shall not attempt to influence a resident with respect to any decision about an Advance Directive, but a facility health care provider may explain the form.

Procedure B: Completion and Review of an Advance Directive

1. A resident may request an Advance Directive form (Attachment B) from their case manager, who shall provide a copy of the form to the resident.

2. If needed, the case manager shall provide the resident with a foreign language interpreter.

3. If the resident does not have any questions and wishes to complete the Advance Directive form, they shall complete and sign the form in the presence of the case manager and another non-health care staff. If needed, the case manager shall arrange for the other staff to be present. Both the case manager and the other staff shall sign the form as witnesses.

4. It is the resident's responsibility to submit the completed, signed, and witnessed form to the facility medical staff, and staff shall not do that for the resident.

5. If the resident submits the completed, signed, and witnessed form to facility medical staff, it shall become part of the resident's electronic health care record (EHCR) upon receipt by medical staff.

6. If the resident has any questions, they shall request a meeting with a facility health care provider to discuss the form with the provider before the resident completes it.

7. Regardless of whether the resident submits an already completed, signed, and witnessed form to facility medical staff or the resident requests a meeting with a facility health care provider to discuss the form with the resident before they complete it, a facility health care provider shall meet with the resident to review the form at the next available meeting time.

8. At that time, the facility health care provider shall explain the form to the resident and answer any questions the resident may have so that the resident fully understands the benefits and risks of life-prolonging treatment.

9. If, as a result of that meeting, the resident decides to complete an Advance Directive or modify an already completed Advance Directive by completing a new one, they shall go back to their case manager and follow the process described above. If they decide to revoke an already completed Advance Directive, they shall put that in writing and submit it to the medical staff.

10. If the facility health care provider has a concern about the competency of the resident, the resident shall be referred to appropriate mental health care staff for a determination of whether or not the resident is competent to complete an Advance Directive.

11. If the resident is determined not to be competent to complete an Advance Directive, the facility health care provider shall meet with the resident to inform them that their Advance Directive is not valid. The Advance Directive shall be noted as invalid and archived.

12. An Advance Directive is not valid unless and until it is completed and signed by a resident who is competent, witnessed by the case manager and a non-health care staff, and included in the resident's EHCR.

13. If it is discovered that a resident already has an Advance Directive that was completed with an off-site medical provider, facility medical staff shall notify the resident's case manager, who shall meet with the resident as soon as practicable to inform them that the off-site Advance Directive is not valid and ask them if they wish to complete the Advance Directive form approved by the Department (Attachment B).

14. A facility health care provider shall discuss with any resident who has an Advance Directive whether the resident wishes to continue with the directive as is, modify it, or revoke it:
    a. at their annual exam;
    b. during their chronic care clinic, if applicable;

c. upon admission to a specialized health care unit, if applicable;

d. upon admission to an infirmary, if applicable; or

e. upon resident request.

Procedure C: Activation of an Advance Directive

1. An Advance Directive shall not be activated in the case of a terminal condition or persistent vegetative state brought about by a suicide attempt or other self-injurious behavior, and all treatment decisions shall be made as if the resident had not signed the Advance Directive.

2. The Advance Directive shall be activated when, in the opinion of the facility health care provider, the resident has a terminal condition or is in a persistent vegetative state, as documented in the resident's electronic health care record (EHCR), or, if applicable, an off-site medical provider determines the resident has a terminal condition or is in a persistent vegetative state.

3. The facility health care provider shall notify the facility Health Services Administrator (HSA), the facility Chief Administrative Officer, the Regional Medical Director, the Department's Health Care Services Manager, or their designees, immediately of the activation of an Advance Directive.

4. The above staff shall then determine if it is appropriate for the resident to be in a hospital or in a Department infirmary or other facility housing unit.

5. If the medical care of a resident who has an Advance Directive is turned over to emergency medical service (EMS) personnel or a hospital, facility medical staff shall inform them of the existence of the Advance Directive. A copy of the Advance Directive shall be given to them as soon as practicable, except in the case of a terminal condition or a persistent vegetative state brought about by a suicide attempt or other self-injurious behavior.

Procedure D: Modification of an Advance Directive

1. An adult resident may modify an Advance Directive at any time by completing another Advance Directive form.

2. The resident shall complete and sign the form in the presence of the case manager and another non-health care staff, who shall sign the form as witnesses.

3. If the resident submits the completed, signed, and witnessed form to facility medical staff, it shall become part of the resident's electronic health care record (EHCR) upon receipt by medical staff and shall replace the previous Advance Directive.

4. A facility health care provider shall meet with the resident to review the new form at the next available meeting time.

5. At that time, the facility health care provider shall explain the form to the resident and answer any questions the resident may have so that the resident fully understands the ramifications of the modification.

6. If the facility health care provider has a concern about the competency of the resident, the resident shall be referred to appropriate mental health care staff for a determination of whether or not the resident is competent to modify an Advance Directive.

7. If the resident is determined not to be competent to modify the Advance Directive, the facility health care provider shall meet with the resident to inform them that their modification is not valid, and the Advance Directive previously signed remains current. The modified Advance Directive shall be noted as invalid and archived.

8. A modified Advance Directive is not valid unless and until it is signed by a resident who is competent, witnessed by the case manager and another non-health care staff, and included in the resident's electronic health care record (EHCR). At that time, the previous Advance Directive shall be noted as invalid and archived.

Procedure E: Revocation of an Advance Directive

1. A resident may revoke an Advance Directive at any time by notifying facility medical staff in writing with the resident's signature or by notifying a facility health care provider orally.

2. A written revocation shall become part of the resident's EHCR upon receipt by medical staff. An oral revocation shall be noted in the EHCR by medical staff.

3. The revocation shall cancel the previous Advance Directive, and decisions about life-prolonging treatment shall be made as if the resident had never signed an Advance Directive.

4. A facility health care provider shall meet with the resident to review the revocation at the next available meeting time.

5. At that time, the facility health care provider shall answer any questions the resident may have so that the resident fully understands the ramifications of the revocation.

6. If the facility health care provider has a concern about the competency of the resident, the resident shall be referred to appropriate mental health care staff for a determination of whether or not the resident is competent to revoke an Advance Directive.

7. If the resident is determined not to be competent to revoke the Advance Directive, the facility health care provider shall meet with the resident to inform them that their revocation is not valid, and the Advance Directive previously signed remains current.

8. The revocation, if in writing, shall be noted as invalid and archived. The revocation, if oral, shall be noted as invalid.

9. A revocation is not valid unless and until it is made by a resident who is competent and noted in the resident's EHCR. At that time, the Advance Directive shall be noted as invalid and archived.

Procedure F: Documentation

1. Only an Advance Directive form approved by the Department (Attachment B) shall be accepted and placed into the resident's electronic health care record (EHCR).
2. The resident's EHCR shall reflect all meetings with a facility health care provider related to an Advance Directive.
3. The EHCR shall also reflect the date and time an Advance Directive became activated, if applicable.
4. The facility Health Services Administrator (HSA), or designee, shall inform all medical staff as to which facility residents have a current, valid Advance Directive.

VIII. PROFESSIONAL STANDARDS

None