(Example may be useful as guide in developing policies)

LONG-TERM-CARE: RESIDENT RIGHTS
THE ABC
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

DEPARTMENT: Resident Rights

SUBJECT: Advance Directives/ POLST/ Resuscitation Code Status **No.** 702

POLICY:

It is the policy of ABC to support the rights of residents in making decisions regarding their care and treatment.

Advance Directives are defined as written instructions to express a person's choice on treatments or to designate someone else to make healthcare decisions when the resident is unable. An Advance Directive can take the form of a living will or a Durable Power of Attorney for healthcare.

POLST is the Physician's Orders for Life-Sustaining Treatment. The POLST form is used by the physician to write orders that indicate what types of life-sustaining treatment the resident wants or does not want during their stay at the facility.

Resuscitation Code Status is the individual's preference regarding CPR and other life saving procedures.

Residents will be strongly encouraged to complete an Advance Directive at the time of admission to the ABC. The Advance Directive will be reviewed periodically.

It is the policy of ABC to honor previously completed Advance Directives within the parameters established by ABC philosophy.

Resident/family requests for discontinuation or refusal of treatment will be addressed on an individual basis and may be referred to the resident's physician, or the Ethics Committee for input. In the event that ABC is unable to comply with the resident/family's wishes, assistance in seeking alternative placement will be provided.

PROCEDURE:

1 On admission, the admissions coordinator and/or social worker will determine if the resident has an appropriately executed Advance Directive (Power of Attorney, Living Will, etc.) and request that a copy be brought into the facility for the facilities files.

2 On admission the Social Worker (or designee) will introduce the POLST. This form is used to indicate the extent of medical interventions that the resident wants during his/her stay at the facility. Unlike a Living Will, which describes the medical wishes for end of life, the POLST describes the

medical wishes for the current moment. The social worker will assist the resident and family in completing the POLST.

3 If the resident is not ready to complete the POLST specifically Section A (resuscitation) then the resident will be informed that until a decision is made the resident will be considered a FULL CODE. The resident will receive all resuscitative efforts.

4 The completed POLST should be "identified" for the physician's signature.

5 The completed POLST, Living Will, Durable Power of Attorney form will be kept in the medical chart under the Advance Directive tab.

6 At each care conference the interdisciplinary team will review the POLST and Advance Directive with the resident/family to ensure that the directive follows the resident's wishes in light of the information provided during the care conference. If there are any questions then educational materials (see attachment B) will be provided and the resident/family will be given an opportunity affirm the POLST or update the POLST to reflect their current wishes.

7 The updated POLST will be put in the medical chart and a progress note will be written in the interdisciplinary progress note reflecting the conversation and subsequent changes.

8 Any time the resident is sent to the hospital a copy of the POLST and Advance Directive will be sent with the resident.

10/05