

Advanced Directives

POLICY

Each resident has the right to formulate an advance directive, including the right to request, refuse and/or discontinue treatment. The facility will support and respect each individual resident's choice.

DEFINITIONS

Advance Care Planning (ACP)

Advance care planning is a process of documenting your health care service wishes for your health care team so that in the event you are no longer capable of making independent choices, your care preferences will be respected. Advance care planning is important for residents, families and health care providers as it assists in avoiding crisis-based decisions and avoids unwanted treatments.

Advance Directive (AD)

An advance directive (AD) is a legal document used to inform your health care provider and loved ones of your wishes regarding medical and mental health care. Advance directives will guide decisions regarding treatment(s) if you are not able to speak for yourself. An advance directive protects your right to make your own medically related decisions and can provide some comfort knowing that your wishes for future medical care will be respected.

“Physician Orders for Life-Sustaining Treatment (POLST) form

The POLST form was designed to improve patient care by creating a portable medical order form that records patients' treatment wishes. In the event emergency care is needed, the POLST form assists emergency personnel in determining what treatment options the patient has chosen, while considering the patient's current medical condition. ***A POLST paradigm form is not an advance directive but can be used as clear and convincing evidence of a patient's wishes.***¹

Durable Power of Attorney for Health Care

A Durable Power of Attorney for Health Care is a document used to designate who has the legal authority to make health care decisions for a patient in the event they are unable to make decisions for themselves.

Living Will

A Living Will is a written document detailing a person's wishes regarding medical treatment in the event they are no longer able to provide informed consent for such treatments as resuscitation, mechanical ventilation (breathing machine) and artificial nutrition (tube feeding). Living wills are not valid in all States.² However, the existence of a Living Will can serve as clear and convincing evidence of the resident's wishes pertaining to treatment.

¹ ***POLST is not used in all states. Please refer to State law, in which the facility is located, to determine applicability of this policy.***

² Please refer to State law, in which the facility is located, to determine if a Living Will is valid.

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This policy and procedure is not intended to replace the informed judgment of individual physicians, nurses or other clinicians nor is it intended as a statement of prevailing community standards or minimum standards of practice. It is a suggested method and technique for achieving optimal health care, not a minimum standard below which residents necessarily would be placed at risk.

PROCEDURE

1. Determine on admission if the resident has an advanced directive and, if not, determine whether the resident wishes to formulate an advance directive.
 - a. If the resident has an advance directive, maintain a copy in the medical record and communicate with staff.
 - b. A review of the advance directive will be conducted by resident and staff at least annually in an effort to assure that the wishes, as documented, continue to be an accurate representation of resident's wishes.
 - c. In the event there is no advance directive, the Social worker, or designee, will provide information in a manner easily understood by the resident or resident's representative about their right to refuse medical or surgical treatment and formulate an advance directive.
2. The IDT will assess the resident's decision-making capacity at least quarterly and with significant change in status. State law mandates the process for determining incapacity. The facility documentation will support compliance with State requirements.
3. The facility will identify and invoke the health care agent or representative if the resident is unable to make relevant health care decisions.
4. The resident's relevant health care issues and medical issues will be presented to the residents' representative as appropriate.
5. During the care planning process, the IDT will identify, clarify and review existing care instructions with the resident and/or legal representative and ask the resident if they wish to make any changes. This will also be done if a resident is identified as having a significant decline or improvement.
6. Any decision making regarding resident choices will be documented in the medical record, communicated to the IDT and staff responsible for the resident's care.
7. Residents will not be discharged or transferred if the advance directive identifies a refusal of treatment unless the criteria for transfer or discharge is met.
8. Should the resident refuse treatment of any kind, the facility will document in the medical record:
 - a. What was refused
 - b. The reason for the refusal
 - c. The explanation of the consequence of refusing the treatment
 - d. The alternatives offered
 - e. The continuation of other services.
 - f. The refusal of care in the residents' comprehensive care plan.
9. The facility uses the process provided by State law for managing situations in which the facility staff and/or the physician do not believe they can provide care in accordance with a residents advance directives or other wishes on the basis of conscience.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Review Dates: _____

F 578 Resident Rights: Request/Refuse/Discontinue Treatment; Formulate Advance Directives (November 2017)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

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