

POLICY TITLE: Resident Advance Directives

DATE: November 2012

Purpose: To initiate a standard protocol to assure that all residents have been informed/educated about their rights to accept or decline treatments and, if they so choose, to formulate an advance directive to document such choices.

The facility will meet with the resident or resident's legal representative at the time of admission to determine if the resident has any written advance directives containing choices regarding care and treatment, documenting the existence of such choices on the form established for this purpose, and will request copies of such documents if not made available to the facility during the admission process. Written advance directive documents will be filed in the resident's clinical record and relevant data items in the record will be entered consistent with these advance care-planning choices (i.e. resuscitation status, surrogate decision-maker, etc.). If such documents are declared to exist but are not available, the resident or resident's legal representative will be requested to provide such copies to the facility within a designated period of time. Once obtained, copies of these documents will be incorporated and consistently maintained in the same section of the resident's clinical record readily retrievable by authorized facility staff.

For those residents or their legal representatives indicating that no written advance directives have been formulated, they will be provided written information concerning their rights to do so but will also be advised that facility policies do not condition the provision of care or discriminate against an individual based on a decision not to execute an advance directive. If after having been provided with this information on these rights, the resident, or resident's legal representative in instances in which this is valid as set forth in the laws of the State, wishes to formulate one or more directive(s), the facility will assist in the process.

The interdisciplinary care plan team will review the resident's advance directive status as documented in the resident's record at the time of the initial care plan conference and reconfirm that no changes in status are desired and will conduct such review and reconfirmation at the time of every scheduled care plan conference, including assessment of the resident's decision-making capacity, which, if altered, will require contact of and discussion with the health care agent or legal representative who will be authorized to act on the resident's behalf. If changes or revisions are required, the team will initiate the necessary processes to modify the status changes in the resident's record, including contact of the resident's attending physician so that appropriate orders to reflect these status changes are secured.

Facility staff will receive training at the time of hire regarding resident rights to formulate advance directives and the facility policy to assure the exercise of such rights and will be required to attend annual re-training programs. For resident staff not having access rights to the resident's clinical, a centralized file of resident care plans maintained on the nursing unit including a data item identifying all resident preferences regarding treatment options will be available to these staff members for reference to and consideration of in rendering care and services to the residents to whom they are assigned for duty.