Policies/Procedures **RE: Advance Directives**	**Effective date: 10/18/2016** **Review date:** **Review date:**
Department: Administration/Nursing	**Approved by: GB**

PURPOSE
To familiarize staff members and patients and their family members with legal responsibilities and Facility policies in responding to patient emergencies and to provide needed information to other health care facilities in the event of an emergency patient transfer to a higher level of care.

POLICY
All staff members will be given an initial orientation and periodic training on the legal responsibilities of HSSC concerning advance directives.

All Medical Staff members and affiliates will be informed of HSSC's policy on advance directives.

All patients will be informed before the day of surgery that advance directives for "do not resuscitate" are not honored at HSSC. In every instance of an emergency or life-threatening situation, advanced cardiac life support procedures will be instituted and patients will be transferred to a higher level of care. Upon admission, the patient is again questioned as to whether or not he/she has an Advance Directive and at this time will be asked to sign the facility waiver of the directive for the duration of the encounter.

Patients who express an interest in formulating advance directives will be given information and referred to their primary physician.

PROCEDURE
1. Staff members attend orientation and training programs in HSSC to identify their roles in discussing advance directives and/or providing information to patients.

2. Notify Medical Staff members and medical affiliates of HSSC's policy on advance directives; place documentation of notification in the Medical Staff member or affiliate's file.

3. Interview patients during the preadmission process to ascertain pre-existence of advance directives and/or interest in formulating advance directives.

   > Request patients with existing advance directives to present all documentation concerning advance directives.

   > Refer patients who express an interest in formulating advance directives to their primary doctor.

4. Ask patients to sign a witnessed statement indicating their understanding of HSSC's policy on advance directives.

5. If the patient has advance directives, place it in an easily identifiable location in the patient's medical record and on the summary sheet, if available or indicate on the patient record if an advance directive has been executed.

6. In the event of a transfer to a higher level of care, include documentation of the patient's advance directives with the patient transfer.

AMBULATORY SURGERY CENTER PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not A Revocation Of Advance Directives
Or Medical Powers Of Attorney

All Patients have the right to participate in their own health care decisions and to make advance directives or to execute power of attorney that authorizes others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This surgery center respects and upholds those rights.

However, unlike in an acute care hospital setting, the surgery center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.

It is our policy, as a matter of conscience and as permitted by state law, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event or unexpected deterioration occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree with this policy, we are pleased to assist you to reschedule this procedure.

Please check the appropriate box in answer to these questions. Have you executed an advance health care directive, a living will, or a power of attorney that authorizes someone to make health care decisions for you?

- ❑ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney. Copy Obtained Y / N
- ❑ No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.
- ❑ I would like to have information on Advance Directives. ❑ Information Provided to Patient

IF YOU CHECKED THE FIRST BOX "YES" TO THE QUESTION ABOVE, PLEASE PROVIDE US WITH A COPY OF THAT DOCUMENT SO THAT IT MAY BE MADE A PART OF YOUR MEDICAL RECORD.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I indicated I would like additional information, I acknowledge receipt of that information.

BY: _____ DATE: _____
(Signature)

If consent to the procedure is provided by anyone other than the Patient, the person providing the consent or authorization must sign this form.

I acknowledge that I have read and understand its contents and agree to the policy as described.

BY: _____
(Signature)

_____
(Print Name)

Relationship to Patient
- ❑ Court Appointed Guardian
- ❑ Attorney in Fact
- ❑ Health Care Surrogate
- ❑ Other_____

Witness : _____ _____
(HSSC Employee) **Date**

PATIENT IDENTIFICATION:

Holly Springs Surgery Center, L.L.C.
600 Village Walk Drive
Holly Springs, NC 27540

PACIENTE DEL CENTRO DE LA CIRUGÍA AMBULATORIA CONSENTIMIENTO DE MEDIDAS DE REANIMACIÓN

No es una Revocación de las Instrucciones Anticipadas o de Poder Médicas

Todos los pacientes tienen derecho de participar en sus propias decisiones de atención médica y realizar instrucciones anticipadas o hacer cartas poder que autorizan a otros para tomar decisiones en nombre suyo basándose en los deseos explícitos del paciente cuando éste no tiene la capacidad para tomar decisiones o para comunicar sus decisiones. Este centro de cirugía respeta y mantiene estos derechos.

Sin Embargo, en un centro hospitalario de cuidado agundo, el centro de cirugía no realiza prodedimientos de "alto riesgo". La mayoría de los procedimientos que se realizan en este centro se consideran de riesgo minimo. Por supuesto, ninguna ciruía se considera sin riesgo. Usted hablará de los pormenores del porcedimiento con su médico que puede contestar las preguntas sobre los riesgos, recuperación esperada y cuidado que tendrá después de la cirugía.

Es nuestra política, pues la cuestión de trae de nuevo a conciencia y según la cosa permitida por la ley estatal, sin referirse al contenido de cualquier directiva o anticipó la instrucción de un substituto o de un abogado de la el deterioro ocurre durante su tratamiento en este recurso que iniciaremos medidas resucitadoras u otras estabilizadoras y que le transferiremos a un hospital agudo del cuidado para la evaluación adicional. En el tratamiento posterior del hospital de las medidas del tratamiento comenzadas ya será ordenado de acuerdo con sus deseos, directiva del avance o potencia de la atención sanitaria del abogado. Su acuerdo con esta política por su firma abajo no revoca ni directiva de la atención sanitaria o potencia de la atención sanitaria del abogado.

Si usted no está de acuerdo conesta política, con gusto lo ayudaremos a reporgramar el procedimiento.

Por favor, marque el cuadro apropiado de la respuesta a estas pregunats. ¿Harealizado usted instrucción anticipada de atención médico, un testamento vital, carta poder que autoriza a alguien a tomar decisiones por usted sobre su atención médica?

- ❑ Sí. tengo instrucción anticipada, testamento vital o carta poder de atención médica.
- ❑ No, no tengo instrucción anticipada, testamento vital o carta de atención médica.
- ❑ Me gustaría obtener información sobre instrucctiones anticipadas.

SI USTED MARCÓ EL PRIMER CUADRO "SÍ" A LA PREGUNTA ANTERIOR, POR FAVOR, PROPORCIÓNENOS U COPIA DE ESE DOCUMENTO PARA QUE PUEDA FORMAR PARTE DE SU EXPEDIENTE MÉDICO.

Al firmer este documento, reconozco que he leído y entiendo su contenido, y estoy de acuerdo con la política seqún descrita. Si ne indcada que me gustaría obtener informacíon adicional, reconozco que he recivo dicha informacción.

POR: _____
(firma del paciente)

Si el consentimiento del procedimiento se proporciona por alguien que no es el paciente, esta forma debe firmarse por la persona que proporcionoa el consentimiento o autorización

Reconozco que he leídoy entiendo su contenido, y estoy de acuerdo con la política sequin descrita.

POR: _____
(firma)

_____
(nombre con letra de molde)

Parentesco con el Paciente
- ❑ Tutor Designado Por El Juzgado
- ❑ Apoderado
- ❑ Apoderado De Asuntos Médicos
- ❑ Otro_____

PATIENT IDENTIFICATION:

Holly Springs Surgery Center, L.L.C.
600 Village Walk Drive
Holly Springs, NC 27540

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