Facility: ____

Do Not Resuscitate Order & Advanced Directives

Policy:

All residents of **THIS FACILITY** must comply with the policy and procedure set forth here on in.

A resident has the right to have a party assigned to the decision making, if he / she is not of capacity to do so.

THIS FACILITY will provide care to all residents who meet statutory admission criteria and THIS FACILITY, can provide for their needs.

Procedure:

a. **THIS FACILITY** will provide residents with a copy of Form SCHS-4-2006-Health Care Advance Directives-The Patient's Right to Decide April 2006, regarding advance directives.

b. **THIS FACILITY** will provide this policy for residents to read.

c. **THIS FACILITY** does not provide residents with a DNRO. However, information about how a DNRO, if a resident or guardian decide, can be found at: http://www.doh.state.fl.us/demo/trauma/DNRO/Form1896.pdf or your health care provider.

d. Each resident of **THIS FACILITY** will have documentation in their record indicating whether or not he or she has executed a DNRO. If a DNRO has been executed, a copy of a resident's DNRO must be in the resident's file.

e. In the event a resident is receiving hospice services and experiences cardiopulmonary arrest, facility staff must immediately contact the hospice provider. The hospice procedures shall take precedence over those of the assisted living facility.

The Facility:

- **THIS FACILITY WILL NOT** administer chest compressions, insert an artificial airway, administer resuscitative drugs, defibrillate or cardiovert, provide respiratory assistance, initiate resuscitative IV, or initiate cardiac monitoring to any resident that has a DNRO.
- **THIS FACILITY** will administer chest compressions (CPR) to residents who do not have a DNRO.

Initials: ________Resident _______Administrator/ Designee

Do Not Resuscitate Order:
Resident Signature Acknowledgement Page

As a resident of THIS FACILITY I have read the facility's Do Not Resuscitate Policy and Procedure.

I have received a copy of Health Care Advance Directives – The Patient's Right to Decide

_______________________________________ _______________________________
Print Name (Resident or Guardian) Signature

____
Date

Dear Resident Please make an X next to your choice and sign.

_________ I have not executed a Do Not Resuscitate Order

_________ I have executed a fully completed Do Not Resuscitate Order and will provide a copy to THIS FACILITY.

_______________________________________ _______________________________
Print Name (Resident or Guardian) Signature

____
Date

Initials: _______Resident ______Administrator/ Designee