

Mr. James is 84 years old with a diagnosis of Alzheimer's disease admitted on 1/29/10. He has no immediate family. Admission records include a Directive to Physicians and Family or Surrogates (Living Will) which does not specify Mr. James' preference for artificial nutrition and hydration, and a Medical Power of Attorney. He is admitted as a Full Code. He is incapable of making health care decisions as documented by his physician. He has recently experienced swallowing difficulty and weight loss. Initial nutritional assessment reveals his daily estimated energy requirements exceed his current estimated intake from meals and supplements.

(Advance Care Planning Process)

DATE	PROBLEM/NEED	GOALS	INTERVENTIONS	DISCIPLINE	RESOLUTION/R EVIEW DATE
12/10/10	Status of Advance Directives <input type="checkbox"/> Full Code <input type="checkbox"/> Living Will/Directive to Physician-Family-Surrogate <input type="checkbox"/> Medical Power of Attorney <input checked="" type="checkbox"/> Out of Hospital DNR 12/12/10 <input type="checkbox"/> No Decision at this time <input type="checkbox"/> Organ Donor <input type="checkbox"/> NO BLOOD PRODUCTS	Mr. James' Advance Directives will be honored and reviewed annually and on change of condition	<ol style="list-style-type: none"> 1. The care plan team will meet with the MPOA to discuss a "DNR" and the use of artificial nutrition and hydration to maintain weight and other end of life decisions 2. Staff will start CPR should cardiac arrest occur and/or breathing independently cease, call EMS and transport to hospital as ordered. 3. Staff will inform MPOA of the right to request assistance in making new advanced directives and/or the right to change previously formulated advanced directives at any time. 4. Staff will maintain all advance directives in a prominent location in the medical record 5. Staff will notify physician and MPOA of any changes in the resident's condition 6. 12/12/10 <i>Should cardiac arrest occur and/or breathing independently cease staff will allow a natural death</i> 7. 8. 	MD and all Nursing Social Services Nursing/ Social services/ medical records Nursing Nursing	12/12/10 <i>Completed</i> 12/12/10 On-going <i>See new approach</i> 12/12/10/on-going On-going On-going On-going

Care plan progress notes: 12/12/10 - Care plan team met with Ms. Smith, MPOA for Mr. James. Current medical condition with disease prognosis as well as disease progression and prognosis was viewed. DNR vs. Full code status was discussed. Tube feeding education was provided. The MPOA determined at this time a DNR order would be appropriate and signed DNR form. Ms Smith stated that Mr. James never discussed his personal feeling regarding tube feeding. Ms. Smith will take the information regarding feeding tube and discuss further with Mr. James' physician. R. Witherspoon, MSW.

