



WINCHESTER
HOUSE
HEALTHCARE AND REHABILITATION

Family Night

September 30th, 2016

Agenda

- ▶ New WH progress
- ▶ Flu prevention
- ▶ POLST
- ▶ Volunteer program
- ▶ Celebrate success!- Highlights
- ▶ Upcoming events

New Winchester House progress

- ▶ Medicaid application
 - ▶ Completed as of March 1st
 - ▶ In TCLC name
- ▶ Medicare application approved
- ▶ TCLC change of ownership with IDPH
 - ▶ Completed
- ▶ CON timing & application
 - ▶ CON application was approved on 6/21/16

Flu Prevention- Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention



Practitioner Orders for
Life-Sustaining Treatment

**Illinois Department of Public Health (IDPH)
Uniform Practitioner Orders for
Life-Sustaining Treatment (POLST) Form**

Revised 10/19/15

POLST
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The IDPH Uniform POLST Form in Illinois

HIPAA PERMITS DISCLOSURE OF DNR/POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

State of Illinois
Illinois Department of Public Health

DO-NOT-RESUSCITATE (DNR)/PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name _____ Patient First Name _____ MI _____
Date of Birth (mm/dd/yyyy) _____ Gender ☐ M ☐ F
Address (street/city/state/ZIP code) _____

A **CARDIOPULMONARY RESUSCITATION (CPR)** If patient has no pulse and is not breathing.
Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNR ☐
(Selecting CPR means Full Treatment in Section B is selected)

B **MEDICAL INTERVENTIONS** If patient is found with a pulse and/or is breathing.
Full Treatment: Primary goal of sustaining life by medically indicated means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. Transfer to hospital and/or intensive care unit if indicated.
Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital, if indicated. Generally avoid the intensive care unit.
Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.
Optional Additional Orders _____

C **MEDICALLY ADMINISTERED NUTRITION** (If medically indicated) Offer food by mouth, if feasible and as desired.
☐ Long-term medically administered nutrition, including feeding tubes. Additional Instructions (e.g., length of trial period) _____
☐ Trial period of medically administered nutrition, including feeding tubes. _____
☐ No medically administered means of nutrition, including feeding tubes. _____

D **DOCUMENTATION OF DISCUSSION** (Check all appropriate boxes below)
☐ Patient ☐ Agent under health care power of attorney
☐ Parent of minor ☐ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative
Signature (required) _____ Name (print) _____ Date _____

Signature of Witness to Consent (Witness required for a valid form)
I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.
Signature (required) _____ Name (print) _____ Date _____

E **Signature of Attending Practitioner** (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)
My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.
Print Attending Practitioner Name (required) _____ Phone _____
Attending Practitioner Signature (required) _____ Date (required) _____

Form Revision Date January 2015 (Prior form versions are also valid.)

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED - COPY ON ANY COLOR OF PAPER IS ACCEPTABLE - 2015

HIPAA PERMITS DISCLOSURE OF DNR/POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

"THIS SIDE FOR INFORMATIONAL PURPOSES ONLY"

Patient Last Name _____ Patient First Name _____ MI _____

The Illinois Department of Public Health (IDPH) Do Not Resuscitate (DNR)/Practitioner Orders for Life Sustaining Treatment (POLST) is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHCD) is recommended for all capable adults, regardless of their health status. A POAHCD allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information
I also have the following advance directives (OPTIONAL):
☐ Health Care Power of Attorney ☐ Living Will Declaration ☐ Mental Health Treatment Preference Declaration

Contact Person Name _____ Contact Phone Number _____

Health Care Professional Information
Preparer Name _____ Phone Number _____
Preparer Title _____ Date Prepared _____

Completing the IDPH Do Not Resuscitate (DNR)/POLST Form
• The completion of a DNR/POLST form is always voluntary, cannot be mandated and may be changed at any time.
• A DNR/POLST should reflect current preferences of persons completing the DNR/POLST Form; encourage completion of a POAHCD.
• Verbal/phone orders are acceptable with follow-up signature by attending physician in accordance with facility/community policy.
• Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a Do Not Resuscitate (DNR)/POLST Form
This DNR/POLST form should be reviewed periodically and if:
• The patient is transferred from one care setting or care level to another,
• or there is a substantial change in the patient's health status,
• or the patient's treatment preferences change,
• or the patient's primary care professional changes.

Voiding or revoking a Do Not Resuscitate (DNR)/POLST Form
• A patient with capacity can void or revoke the form, and/or request alternative treatment.
• Changing, modifying or revising a DNR/POLST form requires completion of a new DNR/POLST form.
• Draw line through sections A through E and write "VOID" across page if any DNR/POLST form is replaced or becomes invalid. Beneath the written "VOID", write in the date of change and re-sign.
• If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order
1. Patient's guardian of person 5. Adult sibling
2. Patient's spouse or partner of a registered civil union 6. Adult grandchild
3. Adult child 7. A close friend of the patient
4. Parent 8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
<http://www.idph.state.il.us/publicbooks/advin.htm>

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

613-1001-15-464 Page 2

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED - COPY ON ANY COLOR OF PAPER IS ACCEPTABLE - 2015

The IDPH Uniform POLST Document

3 Primary Medical Order Sections

A. CPR for Full Arrest

- ▶ Yes, Attempt CPR
- ▶ No, Do Not Attempt CPR (DNR)

B. Orders for Pre-Arrest Emergency

- ▶ Full Treatment
- ▶ Selective Treatment
- ▶ Comfort Focused

C. Medically Administered Nutrition

- ▶ Acceptable
- ▶ Trial Period
- ▶ None

The IDPH Uniform POLST Form

Practitioner Orders for Life-Sustaining Treatment

| | |
|---|---|
| A | Cardio-Pulmonary Resuscitation (CPR) |
| B | Medical Interventions |
| C | Medically Administered Nutrition |
| D | Documentation of Discussion |
| E | Signature of Attending Practitioner |
| R | Reverse Side – Contains More Information and Instructions |

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Section “A”: Cardio-Pulmonary Resuscitation

Code Status – only when pulse AND breathing have stopped

HIPAA PERMITS DISCLOSURE OF DNR/POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

State of Illinois
Illinois Department of Public Health

**DO-NOT-RESUSCITATE (DNR)/PRACTITIONER ORDERS
FOR LIFE-SUSTAINING TREATMENT (POLST) FORM**

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name Patient First Name MI

Date of Birth (mm/dd/yy) Gender ☐ M ☐ F

Address (street/city/state/ZIPcode)

A **CARDIOPULMONARY RESUSCITATION (CPR)** If patient has no pulse and is not breathing.

☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNR

(Selecting CPR means Full Treatment in Section B is selected)

When not in cardiopulmonary arrest, follow orders B and C.

- There are multiple kinds of emergencies. This section only addresses a **full arrest** event (no pulse and not breathing), and answers “Do we do CPR or not?”
- **NOTE!** Patients can use this form to say YES to CPR, as well as to refuse CPR.

The IDPH Uniform POLST Form

Practitioner Orders for Life-Sustaining Treatment

A

Cardio-Pulmonary Resuscitation (CPR)

B

Medical Interventions

C

Medically Administered Nutrition

D

Documentation of Discussion

E

Signature of Attending Practitioner

R

Reverse Side – Contains More Information and Instructions

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Section “B”: Medical Interventions

Do Not Resuscitate does NOT mean Do Nothing

| | | |
|-----------------|--|-----------------|
| IDPH DNR/POL/ST | <div data-bbox="443 548 527 946">B Check (optional)</div> <div data-bbox="527 548 1640 946">MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing. ➤ Full Treatment: Primary goal of sustaining life by medically indicated means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. <i>Transfer to hospital and/or intensive care unit if indicated.</i> ➤ Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). <i>Transfer to hospital, if indicated. Generally avoid the intensive care unit.</i> ➤ Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i> Optional Additional Orders _____</div> | IDPH DNR/POL/ST |
|-----------------|--|-----------------|

- Three categories defining the intensity of treatment when the patient has requested DNR for full arrest, but is still breathing or has a pulse.
 - Full – all indicated treatments are acceptable
 - Selective – no aggressive treatments such as mechanical ventilation
 - Comfort-Focused – patient prefers symptom management and no transfer if possible

Section “B”: Medical Interventions

| | | | |
|--|--------------------------|---|---|
| <div> <div>IDP</div> <div>Check One (optional)</div> <div>IDPH DNR/POL ST</div> </div> | B | MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing. | <div> <div>ST</div> <div>IDPH DNR/POL ST</div> </div> |
| | <input type="checkbox"/> | Full Treatment: Primary goal of sustaining life by medically indicated means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. Transfer to hospital and/or intensive care unit if indicated. | |
| | <input type="checkbox"/> | Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital, if indicated. Generally avoid the intensive care unit. | |
| | <input type="checkbox"/> | Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i> | |
| <input type="checkbox"/> | | Optional Additional Orders | |

- Use “**Additional Orders**” for other treatments that might come into question (such as dialysis, surgery, chemotherapy, blood products, etc.).
- An indication that a patient is willing to **accept** full treatment should not be interpreted as forcing health care providers to offer or **provide** treatment that will not provide a reasonable clinical benefit to the patient (would be “futile”).

Section “B”: Medical Interventions

Yes to CPR in Section A requires full treatment in Section B

If choosing “Attempt CPR” in Section A, Full Treatment is **required** in Section B.

Why?

If limited measures fail and the patient progresses to full arrest, the patient will be intubated anyway, thus defeating the purpose of marking Comfort or Selective.



Section “B”: Medical Interventions

Selection of Full Treatment in Section B does NOT require CPR in Section A

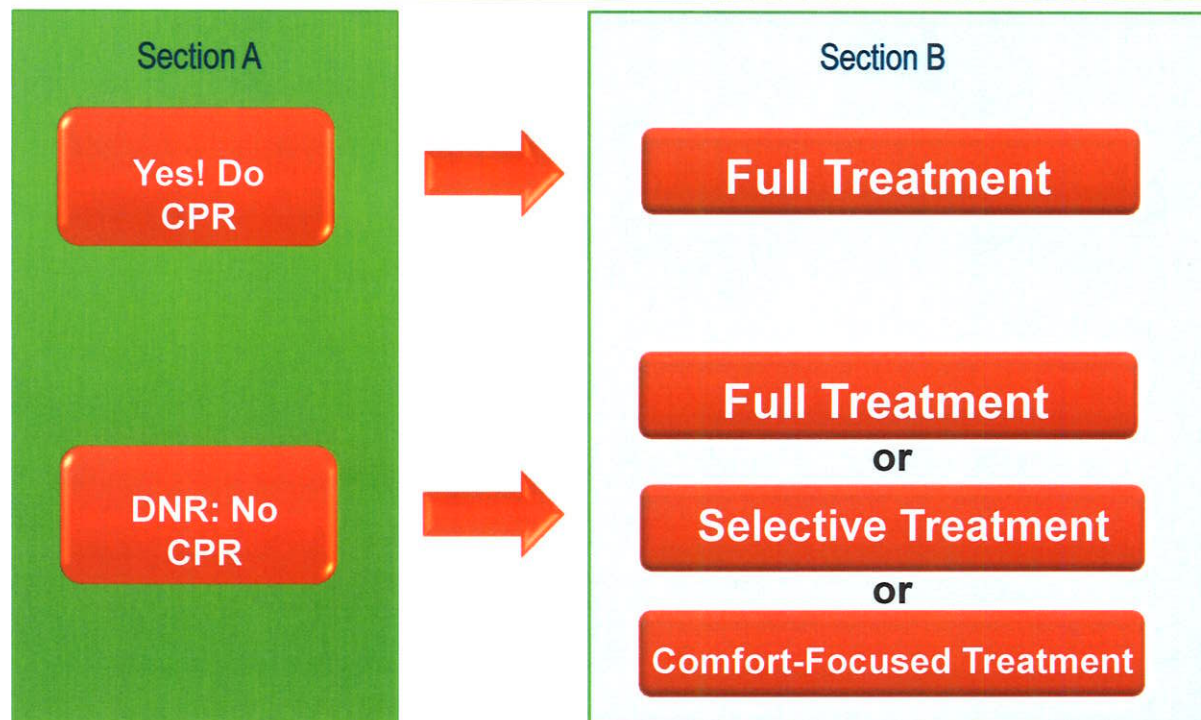
**Conversely, Selection of “Full Treatment” in Section B
does NOT require “Attempt CPR” in Section A.**

Why?

- Section B options are for Medical Emergencies aside from cardiac arrest.
- A person may wish to be intubated/mechanically ventilated in case of *Respiratory Distress*, but would not want that treatment in the context of *Cardiac Arrest* (success rates may be very different in those different contexts!).



Section “A” choices influence medical interventions in Section “B”



The IDPH Uniform POLST Form

Practitioner Orders for Life-Sustaining Treatment



| | |
|---|---|
| A | Cardio-Pulmonary Resuscitation (CPR) |
| B | Medical Interventions |
| C | Medically Administered Nutrition |
| D | Documentation of Discussion |
| E | Signature of Attending Practitioner |
| R | Reverse Side – Contains More Information and Instructions |

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Section “C”: Medically Administered Nutrition

| | | | | |
|-----------|--|---|----------------|--|
| DNR/POLST | C Check One (optional) | MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired. | IDPH DNR/POLST | |
| | | <input type="checkbox"/> Long-term medically administered nutrition, including feeding tubes. | | Additional Instructions (e.g., length of trial period) |
| | | <input type="checkbox"/> Trial period of medically administered nutrition, including feeding tubes. | | |
| | | <input type="checkbox"/> No medically administered means of nutrition, including feeding tubes. | | |



- Medically Administered Nutrition can include temporary NG tubes, TPN, or permanent placement feeding tubes such as PEG or J-tubes.
- A trial period may be appropriate before permanent placement, especially when the benefits of tube feeding are unknown, or when the patient is undergoing other types of treatment where nutritional support may be helpful.

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Practitioner Orders for Life-Sustaining Treatment

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|---|---|
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Section “D”: Documentation of Discussion

| | | | | |
|---|---|--|--------------|------|
| <div style="writing-mode: vertical-rl; transform: rotate(180deg);">IDPH</div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">DPH DNR/POLS</div> | D | DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below) | | |
| | | <input type="checkbox"/> Patient <input type="checkbox"/> Parent of minor | | |
| | | <input type="checkbox"/> Agent under health care power of attorney <input type="checkbox"/> Health care surrogate decision maker (See Page 2 for priority list) | | |
| | | Signature of Patient or Legal Representative | | |
| | | Signature (required) | Name (print) | Date |
| <div style="writing-mode: vertical-rl; transform: rotate(180deg);">IDPH DNR/POLST</div> | | Signature of Witness to Consent (Witness required for a valid form) | | |
| | | I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence. | | |
| | | Signature (required) | Name (print) | Date |

- The form can be signed by:
 - The **patient**
 - The agent with a **POAHC** (when the patient does not have decisional capacity)
 - The designated Healthcare **Surrogate**
 - when the patient does not have decisional capacity and has no POAHC or applicable Advance Directive
 - a parent of a minor child is a surrogate
 - a guardian is also a surrogate

The IDPH Uniform POLST Form

Practitioner Orders for Life-Sustaining Treatment

| | |
|---|---|
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| E | Signature of Attending Practitioner |
| R | Reverse Side – Contains More Information and Instructions |

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Section “E”: Signature of Practitioner

E Signature of Attending Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

| | |
|---|------------------------|
| Print Attending Practitioner Name <i>(required)</i> | Phone () - |
| Attending Practitioner Signature <i>(required)</i> | Date <i>(required)</i> |

Form Revision Date January 2015

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2015

- The form can be signed by the (a) attending physician, (b) a licensed resident who has completed at least one year of training, (c) a physician assistant, or (d) an advanced practice nurse.
- If more than one person shares primary responsibility for the treatment and care of the patient, any of those persons may sign the order.

The IDPH Uniform Form

Practitioner Orders for Life-Sustaining Treatment

| | |
|---|---|
| A | Cardio-Pulmonary Resuscitation (CPR) |
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| C | Medically Administered Nutrition |
| D | Documentation of Discussion |
| E | Signature of Attending Practitioner |
| R | Reverse Side – More Information and Instructions |

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Reverse Side: Guidelines and Instructions

Completion of the form is always voluntary.

| **THIS SIDE FOR INFORMATIONAL PURPOSES ONLY** | | |
|---|--------------------|----------------------|
| Patient Last Name | Patient First Name | MI |
| <p>→ The Illinois Department of Public Health (IDPH) Do Not Resuscitate (DNR)/Practitioner Orders for Life Sustaining Treatment (POLST) is <u>always voluntary</u>. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.</p> | | |
| Advance Directive Information | | |
| I also have the following advance directives (OPTIONAL) | | |
| <input type="checkbox"/> Health Care Power of Attorney <input type="checkbox"/> Living Will Declaration <input type="checkbox"/> Mental Health Treatment Preference Declaration | | |
| → <u>Contact Person Name</u> | | Contact Phone Number |
| Health Care Professional Information | | |
| → Preparer Name | | Phone Number |
| Preparer Title | | Date Prepared |

How can you help make a difference at Winchester House??



- See Rhonda Guzman if you are interested in volunteering
- Orientation is held the 1st Wednesday of every month
- Examples of volunteer opportunities include
 - Sponsor an activity
 - Assist residents with gardening
 - Leading a special interest class
 - Individual resident visits

Highlights-Our 1st Annual Car Show was rocking & rolling!



Thumbs up to all iCare Club members!!



Upcoming events...



Please join us on:

*Thursday, October 27th @ 2:00pm in the
main dining room*

Festivities will include:

- ▶ Pumpkin picking & decorating
- ▶ Fall themed games
- ▶ Seasonal refreshments

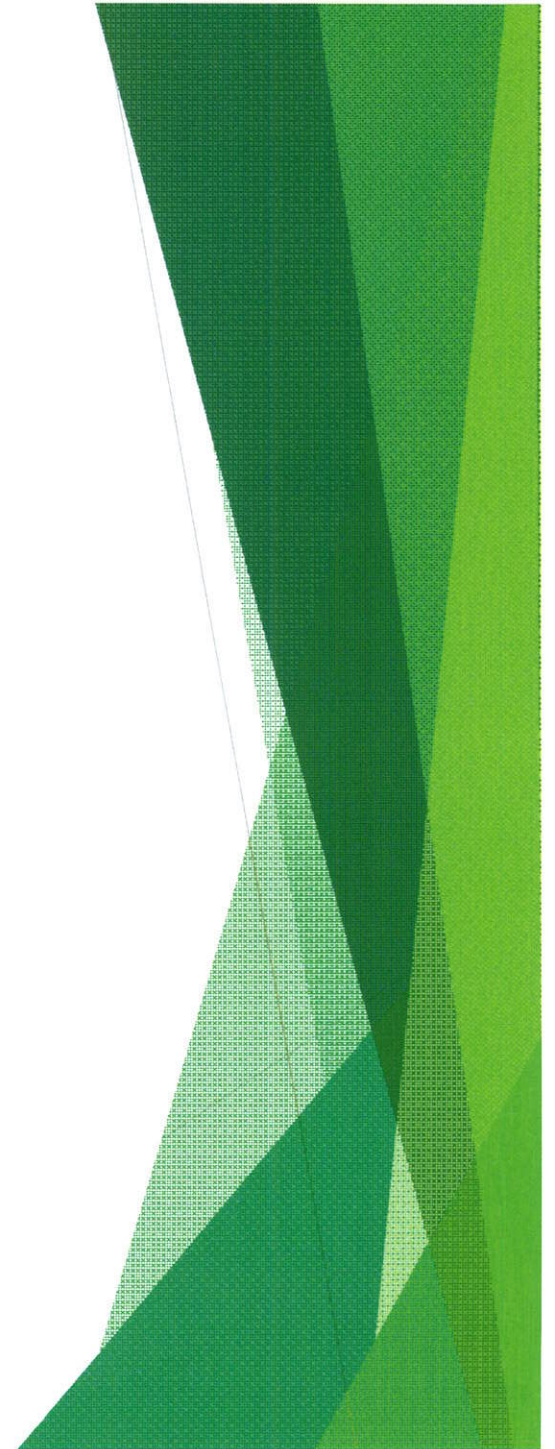
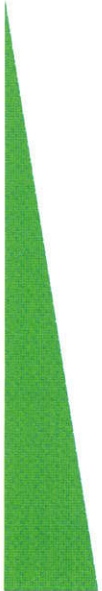
Next Family Meeting

Friday, November 18th @ 4:00pm

Topics:

New Winchester House update

Antibiotic usage in the elderly



Remember whether it be a
compliment, concern or bright idea
we're here to listen.

