

PHYSICIAN'S ORDER FOR LIFE SUSTAINING TREATMENT (POLST) & DNR DIRECTIVES

PURPOSE

The purpose of this guideline is to define appropriate actions in the presence of a completed Physicians Order for Life Sustaining Treatment (POLST) and/or Do Not Resuscitate requests.

DEFINITIONS

- 1) **POLST** – Physician Orders for Life Sustaining Treatment form is a physician order written with the family and patient. It outlines what types of treatment should and should not be performed
- 2) **DNR** – “Do Not Resuscitate” means no CPR, no cardiotoxic drugs, no intubation and no defibrillation. The patient may specify which if any of these procedures they would like performed. This does not prevent the paramedic from treating pain, airway obstruction, or other illnesses or injury unrelated to the terminal condition.
- 3) **Comfort Measures Only** – Indicates a desire for only those interventions that enhance comfort. Use medication by any route, positioning, wound care, and oxygen, suction and manual treatment of airway obstruction (choking) as needed for comfort. **DO NOT** transfer to a hospital unless comfort needs cannot be met in the current location.
- 4) **Limited Additional Interventions** – Includes comfort measures and medical treatment and cardiac monitoring as indicated. This order is also used to indicate treatment for those with short term dehydration. Intubation, advanced airway interventions, mechanical ventilation is **NOT** used. An injured person should NOT be enrolled in the Trauma System, although transfer to a local hospital may be appropriate.
- 5) **Full Treatment** – Includes all care with no limitation of treatment. All support measures needed to maintain and extend life are utilized.

A patient may rescind either a DNR or POLST by verbal or written statement at any time.

RESPONSIBILITY

All EMS providers should make every effort to honor a patient's preferences for levels of treatment outlined on the POLST form. The Incident Commander and/or highest certified provider on scene are charged with the ultimate decision regarding POLST forms. If conflicts arise on scene regarding the appropriateness of resuscitation and/or clinical interventions, on-line medical control shall be contacted.

ACTIONS

The EMS Provider should consider the following when making DNR/POLST decisions:

- ❑ Section A - These orders apply only when the person has no pulse and is not breathing. This section **DOES NOT** apply to any other medical circumstances.

A Check One	CARDIOPULMONARY RESUSCITATION (CPR): <i>Patient has no pulse and is not breathing.</i>
	<input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR When not in cardiopulmonary arrest, follow orders in B and C.

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- ❑ Section B - These orders apply to emergency medical circumstances for a person who has a pulse and/or is breathing. This section provides orders for situations that are not covered in section A and were developed in accordance with EMS guidelines. Comfort care is always provided regardless of indicated level of EMS treatment.

B	MEDICAL INTERVENTIONS: <i>If patient has pulse and/or is breathing.</i>
Check One	<input type="checkbox"/> Comfort Measures Only (Allow Natural Death). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.</i> Treatment Plan: Maximize comfort through symptom management.
	<input type="checkbox"/> Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). <i>Transfer to hospital if indicated. Generally avoid the intensive care unit.</i> Treatment Plan: Provide basic medical treatments.
	<input type="checkbox"/> Full Treatment In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. <i>Transfer to hospital and/or intensive care unit if indicated.</i> Treatment Plan: Full treatment including life support measures in the intensive care unit.
	Additional Orders: _____

- ❑ Section C – These orders indicate the patient’s instructions regarding the use of artificially administered nutrition for a patient who cannot take fluids by mouth.

C	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible.</i>
Check One	<input type="checkbox"/> No artificial nutrition by tube. Additional Orders: _____
	<input type="checkbox"/> Defined trial period of artificial nutrition by tube. _____
	<input type="checkbox"/> Long-term artificial nutrition by tube. _____

- ❑ Section D – Upon completion of the orders, the physician/nurse practitioner/physician assistant checks the box(es) indicating with whom the orders were discussed. It is recommended that the patient or surrogate sign the form. **POLST forms MUST be signed to be valid.**

D	DOCUMENTATION OF DISCUSSION:	
	<input type="checkbox"/> Patient (Patient has capacity) <input type="checkbox"/> Health Care Representative or legally recognized surrogate	
	<input type="checkbox"/> Parent of minor <input type="checkbox"/> Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)	
	<input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other _____	
	Signature of Patient or Surrogate	
	Signature: <i>recommended</i>	Name (print): _____
	Relationship (write "self" if patient): _____	
	This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box <input type="checkbox"/>	

- ❑ Section E - The professional signing the form is acknowledging that the signature below indicates that the orders are consistent with the patient/surrogate preferences. The signer is recommended to include additional information supporting the basis for the orders.

E	SIGNATURE OF PHYSICIAN / NP/ PA		
	My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.		
	Print Signing Physician / NP / PA Name: <i>required</i>	Signer Phone Number: _____	Signer License Number: <i>(optional)</i> _____
	Physician / NP / PA Signature: <i>required</i>	Date: <i>required</i>	Office Use Only
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY			

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- ❑ Reverse Side - The June 2011 POLST form includes an educational section for the patient and/or surrogate. This section is intended to help patients know who the POLST form is intended to serve, the role the POLST form plays in advance care planning, and the relationship of the POLST and Advance Directive.

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT			
Information for patient named on this form		PATIENT'S NAME: _____	
<p>The POLST form is always voluntary and is usually for persons with advanced illness or frailty. POLST 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 Oregon Advance Directive is recommended for all capable adults, regardless of their health status. An Advance Directive allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself.</p>			
Contact Information			
Surrogate (optional):	Relationship:	Phone Number:	Address:
Health Care Professional Information			
Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:
PA's Supervising Physician:		Phone Number:	
Primary Care Professional:			

OTHER CONSIDERATIONS

- ❑ When presented with a Durable Power of Attorney for Health Care, the wishes of the person designated to make health care decisions for the patient shall be followed, but shall not override the wishes of a competent patient.
- ❑ The patient may always override a physician or previous DNR order.
- ❑ In situations where the wishes of the patient are unclear, the family may be consulted. Contact medical control for final decision.
- ❑ If unable to ascertain the patient's or family wishes, begin full resuscitation efforts, and contact medical control.
- ❑ Fully document the incident and the witnesses present.
- ❑ Contact medical control at any time for assistance in these situations.
- ❑ For any situation where efforts are terminated in the field, follow "Death in the Field" guideline.