

EMS System Operation

Date: 07/01/2021

Do Not Resuscitate (DNR) and Advanced Directives

Policy #4120

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: M F
NP/PA's Supervising Physician		Preparer Name (if other than signing Physician/NP/PA)
Name:	Name/Title:	Phone #:
Additional Contact <input type="checkbox"/> None		
Name:	Relationship to Patient:	Phone #:
Directions for Health Care Provider		
Completing POLST		
<ul style="list-style-type: none"> • Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences. • POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts. • POLST must be completed by a health care provider based on patient preferences and medical indications. • A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known. • A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately. • To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law, and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy. • If a translated form is used with patient or decisionmaker, attach it to the original English POLST form. • Use of original form is strongly encouraged. Photocopies and FAXed signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on hard copy paper when possible. 		
Using POLST		
<ul style="list-style-type: none"> • Any incomplete section of POLST implies full treatment for that section. <p>Section A:</p> <ul style="list-style-type: none"> • If found pulseless and not breathing, use a defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation." <p>Section B:</p> <ul style="list-style-type: none"> • When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). • Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations. • IV antibiotics and hydration generally are not "Comfort-Focused Treatment." • Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment." • Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel. 		
Reviewing POLST		
It is recommended that POLST be reviewed periodically. Review is recommended when:		
<ul style="list-style-type: none"> • 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. 		
Modifying and Voiding POLST		
<ul style="list-style-type: none"> • A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line. • A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests. 		
<p>This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit www.caPOLST.org.</p>		
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED		