POLST

Physician Orders for Life-Sustaining Treatment

Washington State Training Curriculum

For EMS Providers

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Contents
Acknowledgements ....................................................................................................................................... 1
Background / Scope ...................................................................................................................................... 4
  Introduction .............................................................................................................................................. 4
  Historical Perspective ............................................................................................................................. 4
Course Guide ................................................................................................................................................. 5
  Overview ................................................................................................................................................... 5
  Participant Requirements ......................................................................................................................... 5
  Course Length ........................................................................................................................................... 5
  Washington State Training Course Forms ............................................................................................... 5
  Educational Materials ............................................................................................................................... 5
  Instructor .................................................................................................................................................. 5
  Medical Direction ...................................................................................................................................... 5
Training Program Goals .................................................................................................................................... 6
  Cognitive Objectives ................................................................................................................................. 6
  Affective Objectives .................................................................................................................................. 6
  Psychomotor Objectives ............................................................................................................................ 6
The Washington State POLST Program for EMS Providers ........................................................................ 7
  Amendment to 1992 Natural Death Act ............................................................................................... 7
  Liability for the EMS Provider ............................................................................................................... 7
  Philosophy of the POLST program ........................................................................................................ 7
  What is the POLST form? ...................................................................................................................... 7
  What does the POLST form do? ............................................................................................................ 7
  Who qualifies to utilize the POLST form? ............................................................................................. 7
  Where is the POLST form used? ........................................................................................................... 8
  What is required for the POLST form to be valid? .............................................................................. 8
  How is the form transferred from one setting to another? .................................................................. 8
  POLST Form Contents – (See APPENDIX D: Sample POLST Form) .................................................. 8
  Who keeps the POLST and where will it be located? ....................................................................... 10
  Revocation of the POLST ..................................................................................................................... 10
  Special situation: .................................................................................................................................. 10
  Other valid resuscitation orders .......................................................................................................... 10
  Run report documentation ................................................................................................................... 10
Provide comfort care .......................................................................................................................... 11
How to manage grieving family members .......................................................................................... 11

APPENDIX A: Guidance Education for EMS Providers........................................................................... 12
Scene Size-Up/Initial Patient Assessment ............................................................................................. 12
Focused History and Detailed Physical Exam ......................................................................................... 12
Management ........................................................................................................................................ 12
When the patient has an existing, valid resuscitation order: .................................................................. 12
If resuscitative efforts have been started before learning of a valid DNR / DNAR order, stop these treatment measures: .................................................................................................................................. 13
Revoking the resuscitation order ........................................................................................................... 13
Documentation ..................................................................................................................................... 13
Comfort Care Measures ....................................................................................................................... 13
Special situation ................................................................................................................................... 13
Ongoing Assessment as appropriate ..................................................................................................... 14
Transport if necessary ........................................................................................................................... 14

APPENDIX B: “How Best To Tell the Worst News” .................................................................................. 15

APPENDIX C: Medical Terms Used For End of Life Care ....................................................................... 17

APPENDIX D: Sample POLST Form ........................................................................................................ 20
Background / Scope

Introduction

People have the right to make their own health care decisions. An advance directive document can help people communicate their treatment preferences when they would otherwise be unable to make such decisions. Unfortunately, the wishes expressed by an advance directive may in some cases not be honored because of the unavailability of completed forms or a provider's lack of understanding of how to translate the language of the document into treatment of specific medical conditions. Providers caring for people in various health care settings may in good faith initiate or withhold treatments that are potentially medically inappropriate or contrary to the desires of the person.

The "Physician Orders for Life-Sustaining Treatment" (POLST) is a document designed to help health care providers honor the treatment wishes of their patients. The POLST is designed to help medical personnel:

- Promote patient autonomy by documenting a person's treatment preferences and coordinating these with medical provider orders;
- Enhance the authorized transfer of patient records among facilities;
- Clarify treatment intentions and minimize confusion regarding a person's treatment preferences, and;
- Facilitate appropriate treatment by emergency medical services personnel.

The POLST document is a short summary of treatment preferences and medical provider orders for care that is easy to read in an emergency situation. The POLST is not intended to replace an advance directive document or other medical provider orders. It centralizes information, facilitates record keeping, and ensures transfer of appropriate information among health care providers and care settings.

Historical Perspective

The document was developed over a four-year period by a multi-disciplinary task force convened by the Center for Ethics in Health Care, Oregon Health & Science University, with representatives from numerous health care provider and institutional organizations. The Regional Ethics Network of Eastern Washington and the Department of Health first introduced the POLST form in Washington state as a pilot program in the Spokane area.

Patients, physicians, home care personnel, and families have been particularly satisfied with this form because it promotes clarity in the patient’s wishes in end of life care and interventions, and promotes compassionate care at this important time in a person’s life.

The POLST form translates a patient’s wishes into an actual medical provider order and is portable from one care setting to another.

The POLST document and training are reviewed and updated regularly.

In Washington, the following medical providers may sign the POLST form: physicians, an advanced registered nurse practitioner (ARNP), or a physician assistant – certified (PA-C).
Course Guide

Overview
Medical, legal and ethical issues are a vital element of the EMS provider’s daily life. The decision to treat or not to treat a patient requires knowledge of current state and local legislation, policy and protocol. Up-to-date knowledge of the Washington state POLST program is essential. Guidance will be given in this lesson to answer questions regarding POLST and to assist EMS providers to make the correct decision when POLST or other resuscitation orders are encountered.

Participant Requirements
The information contained in this curriculum is to be provided to all EMS providers in initial EMS training and as an update during continuing medical education (CME) or ongoing training and evaluation (OTEP).

Course Length
Recommended length minimum of one hour.

Washington State Training Course Forms
No application required for DOH – no credential to be issued by DOH. Documentation should be maintained by EMS provider.

Educational Materials
This curriculum is on the DOH website. It can also be requested by contacting DOH Emergency Care System at 360-236-2840 or by sending an email to HSQA.EMS@doh.wa.gov. Additional information regarding POLST can be found on the WSMA website.

Instructor
Training should be conducted by people knowledgeable in the Washington state POLST program, experienced in the delivery of EMS education, and in practical application of scene and patient management, such as senior EMS instructors or other people approved by the medical program director to teach continuing education. Content experts should be used to instruct as available by area.

Medical Direction
Medical direction of EMS personnel is an essential component in the acceptance and use of the POLST form. Physician involvement should be in place for all aspects of EMS. On-line and/or off-line medical direction must be in place to allow EMS personnel to carry out and assist with the administration of patients’ treatment decisions.
Training Program Goals
At the conclusion of the training program emergency medical services personnel will be able to:

Cognitive Objectives
1. Describe the 1992 amendment to Washington’s Natural Death Act
2. Recognize the liability for EMS personnel regarding the POLST or other valid resuscitation orders.
3. Describe the philosophy of the POLST program.
4. Describe what the POLST form is.
5. Describe what the POLST form does.
6. Describe who qualifies to have a POLST form.
7. Describe where the POLST form is used.
8. Describe what is required for the POLST form to be valid.
9. Describe how the POLST form is transferred from one setting to another.
10. Recognize the POLST form and other valid resuscitation orders.
11. Recognize the parts of the POLST form.
12. Recognize when a person has revoked the POLST or other valid resuscitation orders.
13. Describe who keeps the POLST form and where the POLST form is kept.
14. Describe the EMS provider education guidance for managing a patient with a POLST form or other valid resuscitation orders (See APPENDIX A: Guidance Education for EMS Providers)
15. Describe how to document a POLST or other valid resuscitation order on the patient run report.
16. Describe how to provide comfort care measures to a dying patient.

Affective Objectives
1. Explain which patients qualify for the POLST program.
2. Explain the steps you can use to communicate with grieving family members. (See APPENDIX B: “How Best To Tell the Worst News”).

Psychomotor Objectives
1. Locate and identify the POLST form or other valid resuscitation orders.
The Washington State POLST Program for EMS Providers

Amendment to 1992 Natural Death Act

A. March 1992, the state legislature directs Department of Health to:
   1. Adopt guidelines for how EMS personnel should respond to written do not resuscitate (DNR) orders
   2. Before 1992, EMS personnel could not legally recognize prehospital DNR orders

Liability for the EMS Provider

A. The EMS provider protection from liability exists in RCW 18.71.210
   B. This law provides protection for all acts and omissions done in good faith.
   C. In honoring the POLST, the EMS provider will be acting in accordance with medical program director (MPD) protocol and the patient’s medical provider order, and therefore acting in good faith.

Philosophy of the POLST program

A. People have the right to make their own health care decisions.
   B. These rights include:
      1. The ability of people to indicate their decisions about life-sustaining treatment.
      2. A mechanism in which people could describe their desires for life-sustaining treatment to health care providers.
      3. Health care providers who understand how to provide comfort care while honoring the person’s desires for life-sustaining treatment.

What is the POLST form?

A. It is a bright lime-green form that provides a short summary of treatment preferences and medical provider’s order for care that is easy to read in an emergency situation.
   B. It is a “portable” order that describes the patient’s care directions, i.e., preferences for resuscitation, medical interventions, antibiotics, and artificially administered nutrition.
   C. It is “portable” because it is intended to go with the patient from one care setting to another using a single uniform document.

What does the POLST form do?

A. Completing a POLST form is voluntary on the part of a person. The form is intended to:
   1. Allow people and their medical providers to discuss and develop plans to reflect the person’s end of life care wishes.
   3. Direct appropriate treatment by EMS personnel.

Who qualifies to utilize the POLST form?

A. Anyone can qualify for a POLST, as long as it is signed by the person’s medical provider. It is most relevant to those who have a serious health condition or those who would like to place limitations on the emergency medical care they may receive.
Where is the POLST form used?
A. The completed POLST form is a medical provider order form that remains with a person when transported between care settings, regardless of whether the setting is a person’s home, a hospital, or a long-term care facility.

What is required for the POLST form to be valid?
A. The POLST form contains the individual’s name, date of birth, date and the person’s or legal surrogate’s signature.
B. The POLST form has been signed and dated by the medical provider.

How is the form transferred from one setting to another?
A. The original form, which is bright lime-green, is preferred but photocopies and faxes of signed POLSTs will be honored.
B. Institutions may wish to keep a duplicated copy in the permanent medical record upon discharge or before inter-facility transports.
C. HIPPA permits the disclosure of POLST to other health care providers as necessary.

POLST Form Contents – (See APPENDIX D: Sample POLST Form)
A. Patient information – This area must be completed with the patient’s name and date of birth.
B. Medical Conditions/Patient Goals section to give more detail and context for each patient.
   1. If the person requires treatment, the caregiver should first initiate any treatment orders recorded on the POLST, and then contact the attending medical provider.
   2. Any order section that is not completed indicates that full treatment should be provided for that section until clarification is obtained.
C. Section A – Resuscitation: Patient has no pulse and is not breathing.
   1. If the patient wants CPR, the Attempt Resuscitation box is checked.
   2. If the patient does not want CPR, the Do Not Resuscitate box is checked. Resuscitation should not be attempted.
   3. Comfort measures will always be provided.
D. Section B – Medical Interventions – Patient has pulse and/or is breathing.
   1. Healthcare providers will first administer the level of EMS services (appropriate to the level of certification) ordered and then contact the attending medical provider or online medical control.
      a. Full treatment - primary goal of prolonging life by all medically effective means. Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.
      b. SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures. Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care if possible.
      c. COMFORT-FOCUSED TREATMENT - primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed. Use oxygen, oral
suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no hospital transfer: *EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

2. Comfort care is always provided regardless of indicated level of EMS treatment.

E. Section C – Signatures
   1. The following are required to be valid:
      a. A medical provider (physician, ARNP, or PA-C) printed name, signature, and date.
      b. Patient or legal surrogate for health care signature and date.

F. Section D – Non-Emergency Transport Medical Treatment Preferences (*NOT APPLICABLE TO PREHOSPITAL EMS CARE*).
   1. Antibiotics
      a. Use antibiotics to prolong life.
      b. Do not use antibiotics except when needed for symptom management.
   2. Medically Assisted Nutrition
      a. No medically assisted nutrition by tube.
      b. Trial period of medically assisted nutrition by tube.
      c. Long-term medically assisted nutrition by tube.
   3. Additional Orders
   4. Signatures

G. Additional areas include:
   1. Directions for health care professionals
      a. Completing, using, and reviewing POLST
   2. Review of this POLST form
Who keeps the POLST and where will it be located?
A. In the home, the person keeps the POLST in a prominent location:
   1. Next to the front door
   2. On or in the refrigerator
   3. Look for a Vial of Life or other container.
B. When the person is staying in a medical facility, the POLST form will be kept by the facility in the person’s medical chart along with other medical orders.

Revocation of the POLST
A. POLST form may be revoked by:
   1. The patient verbally revoking the order
   2. The patient destroying the form
   3. The medical providers by expressing the patient’s revocation of the order
   4. The legal surrogate
   5. By drawing a diagonal line or the word VOID across the front of the form.

Special situation:
A. A patient’s wish to withhold resuscitation should always be respected. Sometimes, however, the family may vigorously and persistently insist on CPR even if a valid POLST order is located. These verbal requests are not consistent with the patient’s directive. However, in such circumstances:
   1. Attempt to convince family to honor the patient's decision to withhold CPR. If family persists, then;
   2. Initiate resuscitation efforts until relieved by advanced level providers (advanced EMTs and/or paramedics [for EMRs and EMTs]).
   3. EMS personnel should continue treatment and consult medical control.

Other valid resuscitation orders
A. EMS personnel may recognize other medical provider signed health care resuscitation orders, but if any doubt about validity, CPR should be started.
B. Sometimes health care facilities prefer to use their own health care resuscitation orders. When EMS providers see other resuscitation orders, they should do the following:
   1. Verify that the order has a medical provider signature requesting "Do Not Resuscitate."
   2. Verify the presence of the patient's name on the order.
   3. Contact on-line medical control for further consultation. In most cases, on-line medical control will advise to withhold CPR following verification of a valid medical provider-signed DNR order.

Run report documentation
A. All patients must be properly documented:
   1. Complete medical incident report form.
   2. Identify patient as having a valid POLST.
   3. Follow your local MPD protocols for patients who have died.
Provide comfort care

A. Comfort care measures for the dying patient may include:
   1. Manually open the airway (do not provide positive pressure ventilation with a bag
      valve mask, pocket mask or endotracheal tube).
   2. Clear the airway (including stoma) of secretions with appropriate suction device.
   3. Provide oxygen per nasal cannula at 2-4 l/min.
   4. Positioning for comfort.
   5. Splinting.
   6. Controlling bleeding.
   7. Providing pain medications pertinent to the level of certification/licensure.
   8. Provide emotional support to the patient and family.

B. Contact patient's physician or on-line medical control if directed by local protocols or if
   questions or problems arise.

How to manage grieving family members

A. Review and Discuss APPENDIX B: “How Best To Tell the Worst News”
APPENDIX A: Guidance Education for EMS Providers

EMS providers should refer to local protocol for medical direction. This section is education material and provides an example of information that may be contained within a protocol.

Scene Size-Up/Initial Patient Assessment

Focused History and Detailed Physical Exam

A. Determine the patient is in resuscitation status in one of the following ways:
   1. The patient has a valid POLST next to the front door, on or in the refrigerator, or look for a Vial of Life.
   2. We encourage medical facilities to use the POLST form.
      a. Sometimes health care facilities prefer to use their own health care resuscitation orders. When encountering other resuscitation orders, perform the following:
         (1) Verify that the order has a medical provider signature requesting "Do Not Resuscitate."
         (2) Verify the presence of the patient's name on the order.
      b. Contact on-line medical control for further consultation. In most cases, on-line medical control will advise to withhold CPR following verification of a valid physician-signed resuscitation order.
   3. In extended or intermediate care facilities, look for the resuscitation form in the patient's chart.

Management

A. Begin resuscitation as indicated on the POLST
B. Do not initiate resuscitation measures when:
   1. The patient is determined to be obviously dead.
      a. The obviously dead are victims who, in addition to absence of respiration and cardiac activity, have experienced one or more of the following:
         (1) Decapitation
         (2) Evisceration of heart or brain
         (3) Incineration
         (4) Rigor mortis
         (5) Decomposition
         (6) Dependent lividity

If in your medical judgment you determine your patient has attempted suicide or is a victim of a homicide, begin resuscitation, follow local protocols, and contact medical control as needed.

When the patient has an existing, valid resuscitation order:

A. POLST:
   1. Provide resuscitation based on patient's wishes identified on the form
   2. Provide medical interventions identified on the form
   3. Always provide comfort care
B. Other resuscitation orders:
1. Follow specific orders contained in the resuscitation order based on the standard of care allowed by your level of certification/licensure and communications with on-line medical control.

If resuscitative efforts have been started before learning of a valid DNR / DNAR order, stop these treatment measures:
   A. Basic CPR.
   B. Intubation (leave the endotracheal tube in place, but stop any positive pressure ventilations).
   C. Cardiac monitoring and defibrillation.
   D. Administration of resuscitation medications.
   E. Any positive pressure ventilation (through bag valve masks, pocket facemasks, endotracheal tubes).

Revoking the resuscitation order.
The following people can inform the EMS system that the DNR order has been revoked:
   A. The patient (by destroying the order, drawing a diagonal line or the word VOID across the front of the form, or by verbally revoking the order).
   B. The physician expressing the patient’s revocation of the directive.
   C. The legal surrogate for the patient expressing in-person the patient’s revocation of the directive.

Documentation
   A. Complete medical incident report form.
   B. Identify patient as having a valid POLST.
   C. Follow your local MPD protocols for patients who have expired.

Comfort Care Measures
   A. Comfort care measures for the dying patient may include:
      1. Manually open the airway (do not provide positive pressure ventilation with a bag valve mask, pocket mask or endotracheal tube).
      2. Clear the airway (including stoma) of secretions with appropriate suction device.
      3. Provide oxygen per nasal cannula at 2-4 l/min.
      4. Positioning for comfort.
      5. Splinting.
      6. Controlling bleeding.
      7. Providing pain medications pertinent to the level of certification/licensure.
      8. Providing emotional support.
      9. Provide emotional support to the family.
   B. Contact patient’s physician or on-line medical control if directed by local protocols or if questions or problems arise.

Special situation:
   A. The patient’s wishes about resuscitation should always be respected. Sometimes, however, the family may vigorously and persistently insist on CPR even if a valid DNR/DNAR order is located.
These verbal requests are not consistent with the patient's directive. However, in such circumstances:

1. Attempt to convince family to honor the patient’s decision to withhold CPR/treatment. If family persists, then
2. Initiate resuscitation efforts until relieved by advanced level providers (advanced EMTs and/or paramedics (for EMRs and EMTs).
3. EMS personnel should continue treatment and consult medical control.

B. Remember: Once a death has occurred, the family and relatives become your patients.

Ongoing Assessment as appropriate
Transport if necessary
APPENDIX B: “How Best To Tell the Worst News”

"When you end a resuscitation, you gain a new set of patients: the grieving family."

It's not a pleasant job to tell someone that his or her relative has died from cardiac arrest. Although telling relatives about a death is an important issue in emergency care, it has not received much practical attention. Initial contact with the family has a strong effect on how its members respond to grief. Bad news conveyed in an inappropriate, incomplete or uncaring manner may have long-lasting psychological effects on a family. Here are some recommendations about how to convey bad news. These ideas were accepted by the 1992 National American Heart Association Conference. Portions of this document are directly from the October 28, 1992 JAMA publication of the Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care.

As a rescuer, one of the hardest switches in emergency medicine is to move from the inability to achieve ROSC to dealing with a family in shock from sudden grief. Rescuers go from technical aspects of directing a resuscitation (a "no time for feelings" situation), to the post-resuscitation situation where feelings, thoughts and empathy for loss begin a grief reaction. Feelings of failure, sadness and inadequacy make it difficult to initially support and counsel the patient's family.

Here are 18 tips:

1. One EMS provider on a team takes the lead. Decide quickly who might be most effective for these particular circumstances.
2. Get yourself ready. Recognize that you may be discouraged or overwhelmed. Take a deep breath and do what has to be done.
3. Gather information about the death. Obtain as much information as possible about the patient and the circumstances surrounding the death. Carefully go over the events as they happened:
   a. Medical history;
   b. The event itself;
   c. Relationship between patient and survivor.
4. Find a quiet location. When not in an enclosed building, be sure the location is a safe distance from hazards. Normal reactions to extreme grief can include involuntary physical responses such as walking or running about.
5. Get physically lower. If possible, sit down or have the family members sit down and kneel next to them.
6. Nonverbal actions speak louder than words. Make eye contact with the person closest to you. If there are several people, be sure to make eye contact with each of them during this conversation. Make eye contact, touch when appropriate and share.
7. Listen, and be still. Silent reactions are fine. Don't endlessly chatter. Answer questions.
8. When to touch: If someone reaches out to you first.
9. Briefly review the history and circumstances. Allow as much time as necessary for questions and discussion. Go over the events several times to make sure everything is understood and to facilitate further questions.
   Example A: "You have known that George had a long history of heart trouble and has had pain for several days."
Example B: "You know your baby-sitter found your son, John, not breathing in his crib."

10. Use the word "death" or "dead." Such simple terms are clear. Euphemisms are easily misunderstood. Avoid euphemisms such as "he's passed on," "she is no longer with us" or "he's left us." Instead use the words "death," "dying" or "dead."

11. Expect any reaction and allow time to express anguish. Normal reactions to a loved one's death range through a variety of physical, mental and behavioral responses. Silent reactions are fine. Allow time for the shock to be absorbed.

12. Convey sympathy for a grieving family, yet don't let it sound like an apology. Family members can resent too many comments about a very intimate experience you cannot share. Convey your feelings with a phrase such as "You have my (our) sincere sympathy" or "we are sorry for your loss."

13. Find someone to be with them during this time. Do they want you to call a neighbor, family member or clergyman?

14. "Would you like to say goodbye to --- (use the patient's first name) and see him/her now?" (For many, this establishes death). If equipment is still connected, let the family know.

15. Tell them the plan for disposition of the body. What is going to happen next? Know in advance what happens next and who will sign the death certificate. Physicians may impose burdens on staff members and family if they fail to understand policies about death certification and disposition of the body. Know the answers to these questions before meeting the family.

16. Ask if they have any questions. Answer them directly. Use simple sentences. People in crisis have trouble understanding complex messages.

17. Don't lie to them. This is especially important when a crime scene is involved or an autopsy will be performed. (Example: "We have to take your baby to the hospital for an autopsy to find out why he died. Perhaps we can learn something so this kind of thing won't happen again.").

18. Leave clear information about follow-up contacts for the family for when you have gone (social worker, counselor, chaplain). Enlist the aid of a social worker or the clergy if not already present. If time allows, offer to contact the patient's physician and remain available if there are further questions.

Summary

The community thinks of EMS personnel as superhuman rescuers who can work miracles in brief periods. Expectations about what EMTs and paramedics can do for the surviving relatives are frequently unrealistic. In the short period after resuscitation efforts, rescuers can do little more than set into motion a normal grief reaction. EMS providers must prepare for the next emergency. The most important task is to mobilize personal and community resources for those plunged into sorrow by the unexpected loss of a loved one.

References:

Excerpts in this portion are from: Emergency Cardiac Care Committee and Subcommittees, American Heart Association, Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, I: Introduction. JAMA. 1992, 268:2172-2183.

Acknowledgements:

Judy Reid Graves
APPENDIX C: Medical Terms Used For End of Life Care

**Advance Directives:** A communication from a patient to a physician. Advanced directives are instructions to a physician, which identify a person’s future medical treatment decisions in the event that he or she is incapable of such decisions.

**Antibiotics:** Antibiotics fight infections (such as pneumonia) that can develop when a person is seriously ill.

**Artificial Fluids and Nutrition:** When a person can no longer eat or drink by mouth, an IV or tube feeding can give fluids and liquid nutrients to them.

**Intravenous (IV) fluids:** A small plastic tube (catheter) is inserted directly into the vein and fluids are administered through the tube. Typically, IV fluids are given on a short-term basis.

**Tube feeding:** On a short-term basis, fluids and liquid nutrients can be given through a tube in the nose that goes into the stomach (nasogastric or "NG" tube). For long-term feeding, a tube can be inserted through a surgical procedure directly into the stomach (gastric or "G" tube) or the intestines (jejunal or "J" tube).

**Cardiac Arrest:** The heart no longer produces a detectable heartbeat (by manual palpation, blood pressure cuff or Doppler ultrasound). Occasional heartbeats, as measured by a palpable pulse at the carotid artery, are considered part of a cardiac arrest in the terminally ill. These weak "heartbeats" should not be supported with chest compressions, intravenous medications or fluids.

**CPR:** For the purposes of this document, "CPR" or "cardiopulmonary resuscitation" covers the full range of emergency cardiac interventions and is not limited to basic CPR.

The POLST does not authorize the withholding of other medical interventions, such as intravenous fluids, oxygen or any therapies necessary to provide comfort or to alleviate pain.

**Comfort measures:** Medical care undertaken with the primary goal of keeping a person comfortable rather than prolonging life. On the POLST form, a person who requests, "comfort measures only" would be transferred to the hospital only if it is needed for his or her comfort. Comfort measures include:

Oral and body hygiene, reasonable efforts to offer food and fluids orally, administering medications appropriate to the certification or licensure level of the health care provider, wound care, warmth, appropriate lighting, and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient. Transfer only if comfort measures fail.

**Dialysis:** A mechanical process used to clean the blood to remove waste and excess fluids when the kidneys fail.

**DNR/DNAR:** Do not resuscitate (DNR) and do not attempt resuscitation (DNAR) as per the “POLST” orders specify no ventilation support (other than manually opening the airway), no cardiac compressions, no endotracheal intubation, no advanced airway management, no cardiac monitoring, no defibrillation and no intravenous resuscitation medications.
**Durable Power of Attorney for Health Care**: A document signed by a person that appoints someone else to make health care decisions for the person in the event that the person loses the ability to make his or her own decisions.

**Emergency Medical Services (EMS) and Trauma Care System (WAC 246-976-010)**: An organized approach to providing personnel, facilities, and equipment for effective and coordinated medical treatment of patients with a medical emergency or injury requiring immediate medical or surgical intervention to prevent death or disability.

**EMS Personnel, Qualified**: Qualified personnel authorized to recognize prehospital resuscitation documents are certified by the Washington State Department of Health to provide emergency medical care or treatment. These caregivers include emergency medical responders (EMR), emergency medical technicians (EMT), advanced emergency medical technicians (AEMT), and paramedics.

**Health Care Representative**: If you are unable to make decisions for yourself, state law requires that a family member (for example, a spouse) be asked to serve as your representative and to make decisions for you. If you have completed a medical power of attorney, the person designated on that form would be your legal health care representative.

**Living Will**: Common term for a health care directive. This is a document that tells your health care provider that if you experience a health condition the document identifies, you want no artificial life support so you can die naturally. EMS providers who see these documents should contact medical control for direction.

**Medical Control (WAC 246-976-010)**: Medical program director authority to direct the medical care provided by all certified personnel in patient care in the prehospital EMS system.

**Medical Program Director (MPD) [RCW 18.73(4)]**: A person who: (a) is licensed to practice medicine and surgery pursuant to Chapter 18.71 RCW or osteopathy and surgery pursuant to Chapter 18.57 RCW; (b) is qualified and knowledgeable in the administration and management of emergency care and services; and (c) is so certified by the Department of Health for a county, group of counties, or cities with populations of more than 400,000 in coordination with the recommendations of the local medical community and local emergency medical services and trauma care council.

**Medical Provider**: A person licensed in Washington state as a physician (MD, DO) an advanced registered nurse practitioner (ARNP) [RCW 18.79.256] or a physician assistant – certified (PA-C) [18.71.090].

**POLST**: Physician orders for life-sustaining treatment. A medical order form that turns a person’s wishes for life-sustaining treatment into action. This form may be signed by a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant – certified (PA-C).

**Physician**: A physician, selected by or assigned to the patient, who has active responsibility for the treatment and care of the patient.

**Prehospital (RCW 70.168.015)**: Emergency medical care or transportation rendered to patients before hospital admission or during inter-facility transfer by licensed ambulance or aid service.
Prehospital Patient Care Protocols (WAC 246-976-010): Written procedures adopted by the medical program director that direct the out-of-hospital emergency care of emergency patients, including trauma care patients.

Respiratory Arrest: Breathing stops. Agonal respiratory gasps in the terminally ill are considered part of a respiratory arrest and should not be supported with any ventilatory support other than manually opening the airway.

Revocation: A procedure by which resuscitation order may be made ineffective. The POLST may be revoked at any time by any of the following methods:

1. Being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by a qualified patient, or by his or her surrogate decision maker if directive was executed by the surrogate; or
2. Verbal communication by a qualified patient or by his or her surrogate decision maker expressing the patient's revocation. The surrogate decision maker may not verbally revoke a patient executed directive. Such verbal revocation becomes effective upon its actual communication to the physician or EMS personnel.
3. By drawing a diagonal line or the word, “VOID” across the front of the directive.

Surrogate Decision Maker: A person authorized to provide informed consent with respect to an EMS-No CPR Directive on behalf of a patient who is not capable of making his or her own health care decisions. A surrogate decision maker must be one of the people below, in the following order of priority:

1. Appointed guardian of the patient, if any;
2. Person, if any, to whom the patient has given a durable power of attorney that encompasses authority to make health care decisions;
3. Patient's spouse;
4. Children of the patient who are at least 18 years of age;
5. Parents of the patient; and
6. Adult brothers and sisters of the patient.
APPENDIX D: Sample POLST Form

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial
Date of Birth - Last 4 #SSN (optional)

FIRST follow these orders, THEN contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide medical treatment based on a person’s current medical condition and goals. Any section not completed implies full treatment for that section. Completing a POLST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A  CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
☐ Attempt Resuscitation/CPR
☐ Do Not Attempt Resuscitation/DNAR (Allow Natural Death)
Choosing DNAR will include appropriate comfort measures.

When not in cardiopulmonary arrest, go to part B.

B  MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ FULL TREATMENT - primary goal of prolonging life by all medically effective means.
Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures.
Includes care described below. Use medical treatment. IV fluids and cardiac monitor as indicated. Do not intubate.
May use less invasive airway support (e.g. CPAP, BIPAP). Transfer to hospital if indicated. Avoid intensive care if possible.

☐ COMFORT-FOCUSED TREATMENT - primary goal of maximizing comfort.
Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no hospital transfer: EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional Orders: (e.g. dialysis, etc.) __________________________

C  SIGNATURES: The signatures below verify that these orders are consistent with the patient’s medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Print — Patient/ARNP/PA-C Name
Print — Patient or Legal Surrogate Name

Physician/ARNP/PA-C Signature (mandatory)
Patient or Legal Surrogate Signature (mandatory)

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 8/2017

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.

For more information on POLST visit www.wsma.org/polst.

WASHINGTON
WSMA
Washington State Medical Association
Physician Driven Patient Focused

See back of form for non-emergency preferences

Encourage all advance care planning documents to accompany POLST
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

**Patient and Additional Contact Information (if any)**

<table>
<thead>
<tr>
<th>Patient Name (last, first, middle)</th>
<th>Date of Birth</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Guardian, Surrogate or other Contact Person</th>
<th>Relationship</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**D Non-Emergency Medical Treatment Preferences**

**Antibiotics:**
- [ ] Use antibiotics for prolongation of life.
- [ ] Do not use antibiotics except when needed for symptom management.

**Medically Assisted Nutrition:**
- Always offer food and liquids by mouth if feasible.
- [ ] Trial period of medically assisted nutrition by tube.
  (Goal: ____________________________)
- [ ] No medically assisted nutrition by tube.
- [ ] Long-term medically assisted nutrition by tube.

**Additional Orders:** (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

- Physician/ARNP/PA-C Signature: 
- Date: 

- Patient or Legal Surrogate Signature: 
- Date: 

**Directions for Health Care Professionals**

**Completing POLST**
- Completing a POLST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their surrogate and medical provider based on the person's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

**Using POLST**
- Any incomplete section of POLST implies full treatment for that section.
- This POLST is valid in all care settings including hospitals until replaced by new physician's orders.
- The POLST is a set of medical orders. The most recent POLST replaces all previous orders.
- The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

**Reviewing POLST**
- This POLST should be reviewed periodically whenever:
  1. The person is transferred from one care setting or care level to another, or
  2. There is a substantial change in the person's health status, or
  3. The person's treatment preferences change.

To void this form, draw line through “Physician Orders” and write “VOID” in large letters. Any changes require a new POLST.

**Review of this POLST Form**

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Reviewer</th>
<th>Location of Review</th>
<th>Review Outcome</th>
</tr>
</thead>
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**SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

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