CARE AND PREPARE: FINDING LOVING CARE AT THE END OF LIFE

https://wholeperson.care/

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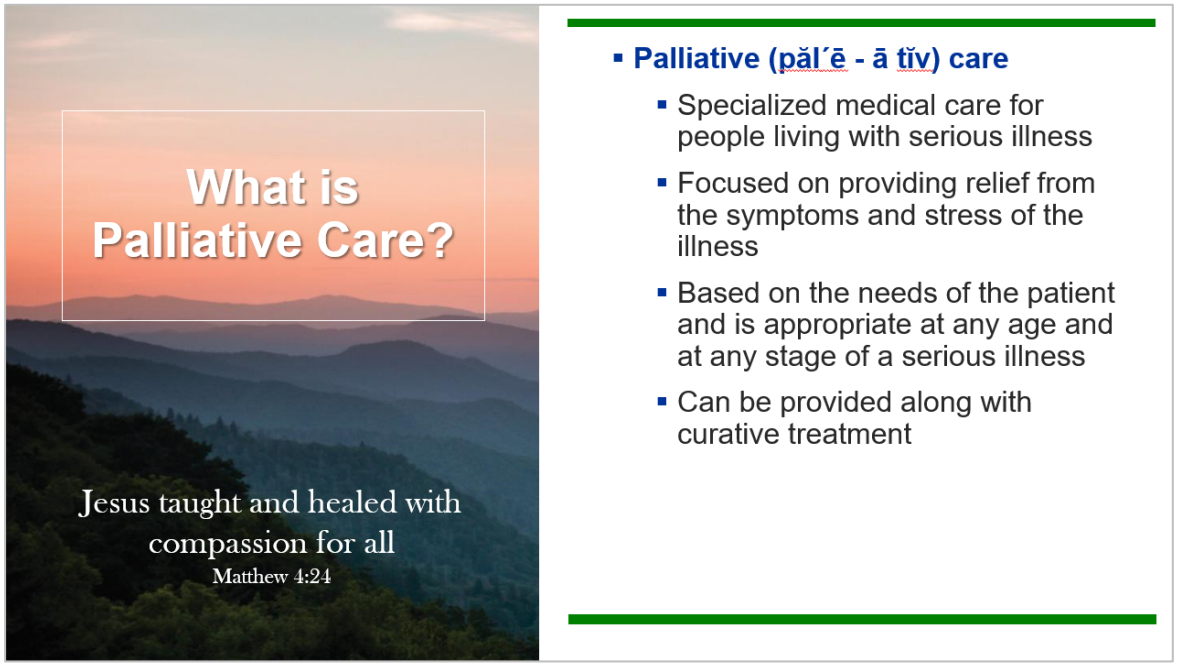
SESSION 1: PROMOTING HUMAN DIGNITY AT THE END OF LIFE

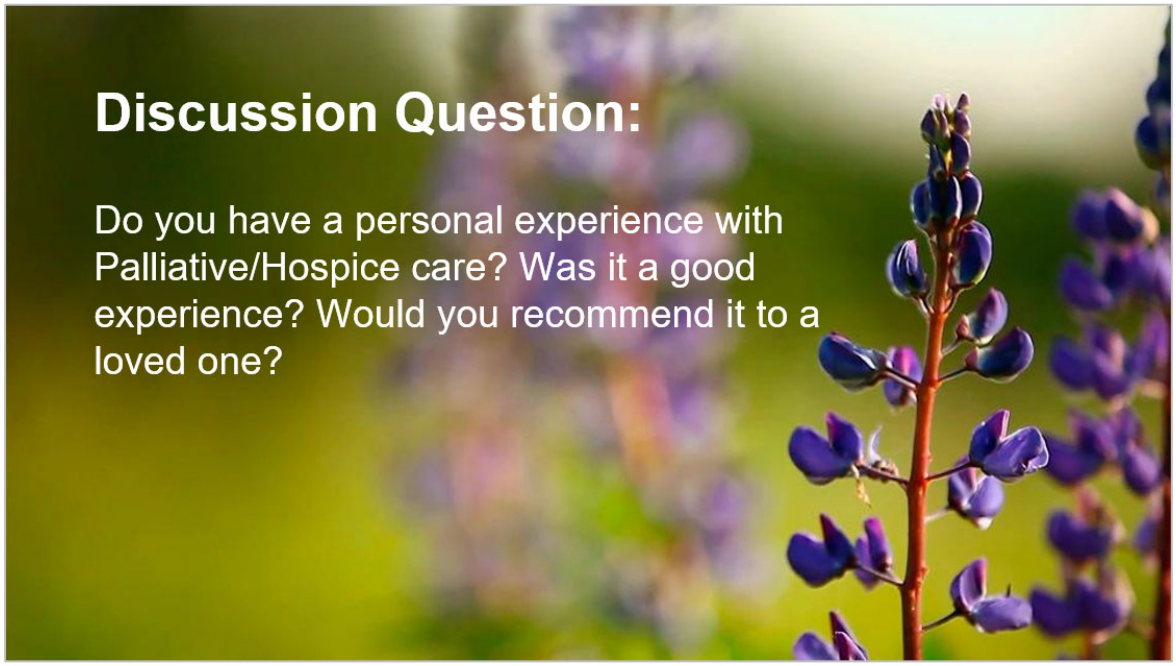


NOTES:

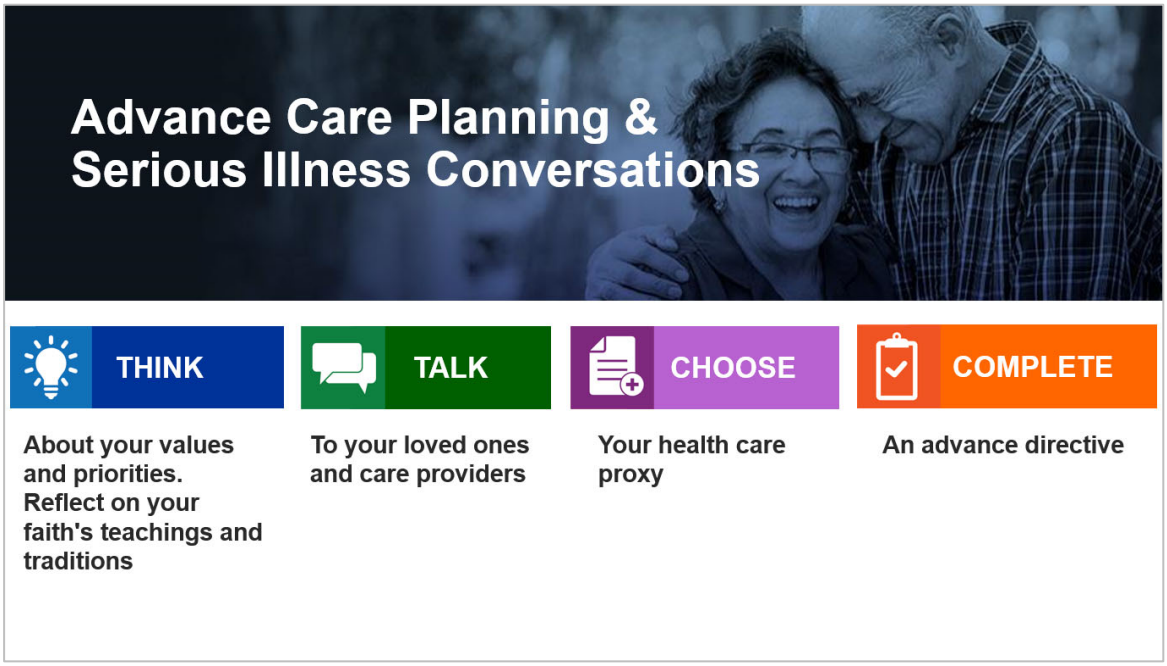
What is Hospice Care?

- Prognosis of 6 months or less
- Interdisciplinary team (IDT): physician, nurse, aide, social worker, chaplain and volunteer
- Focus is on comfort
- Medication for pain and symptom management
- Medical equipment and supplies to accommodate a patient for home care
- 4 levels of care: routine, respite, continuous care and inpatient
- Bereavement support for family for 13 months following the death
- Patient can discontinue hospice at any time

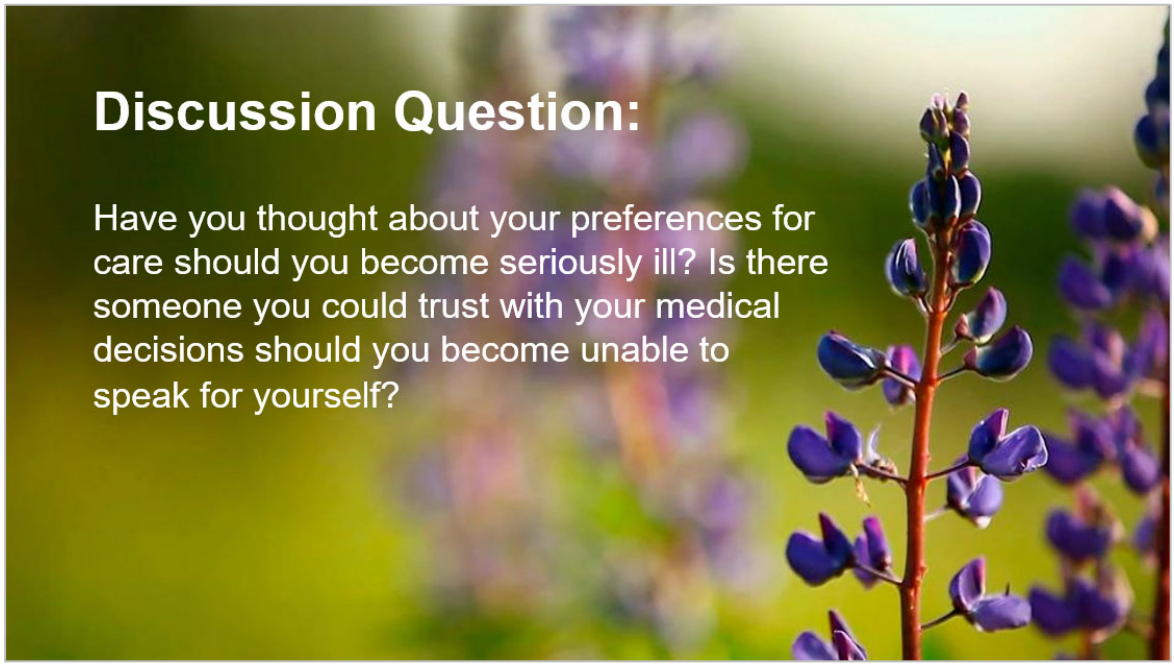
NOTES:


Discussion Question:
Do you have a personal experience with Palliative/Hospice care? Was it a good experience? Would you recommend it to a loved one?

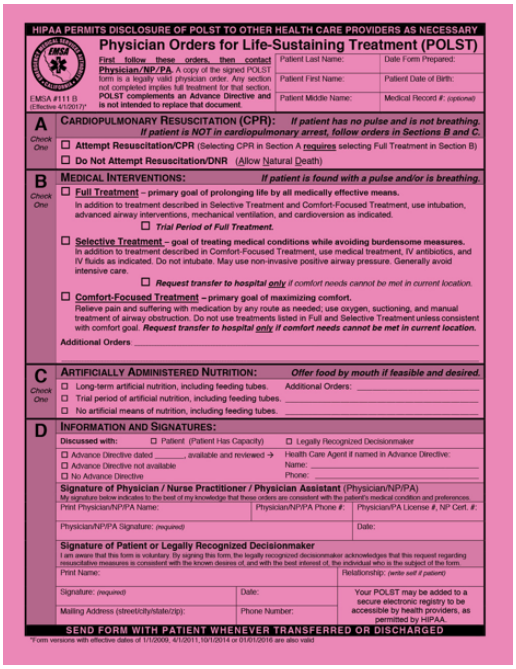
NOTES:


Advance Care Planning &
Serious Illness Conversations
THINK
About your values and priorities. Reflect on your faith's teachings and traditions
TALK
To your loved ones and care providers
CHOOSE
Your health care proxy
COMPLETE
An advance directive

NOTES:


Discussion Question:
Have you thought about your preferences for care should you become seriously ill? Is there someone you could trust with your medical decisions should you become unable to speak for yourself?

NOTES:



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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B (Effective 4/1/2017)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name: | Date Form Prepared:
Patient First Name: | Patient Date of Birth:
Patient Middle Name: | Medical Record #: (optional)

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B Check One

MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with 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.***

Additional Orders: _____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
☐ Trial period of artificial nutrition, including feeding tubes. _____
☐ No artificial means of nutrition, including feeding tubes. _____

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:
☐ Advance Directive not available Name: _____
☐ No Advance Directive Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name: | Physician/NP/PA Phone #: | Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)* | Date:

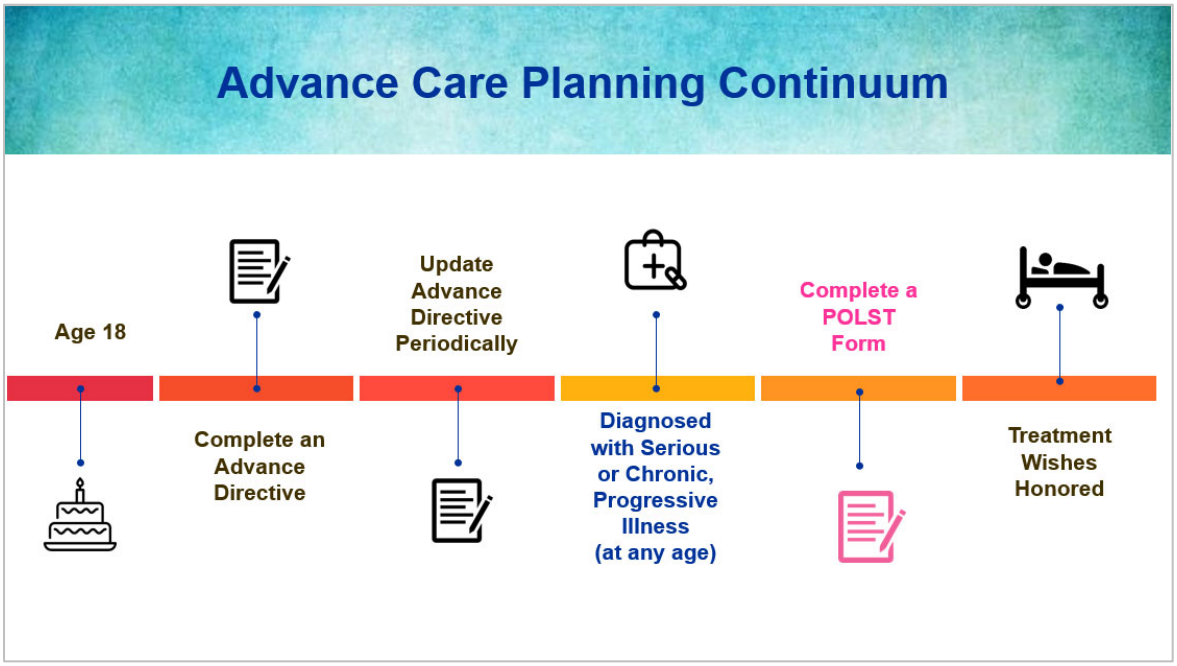
Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name: | Relationship: *(write self if patient)*
Signature: *(required)* | Date: | Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip): | Phone Number:

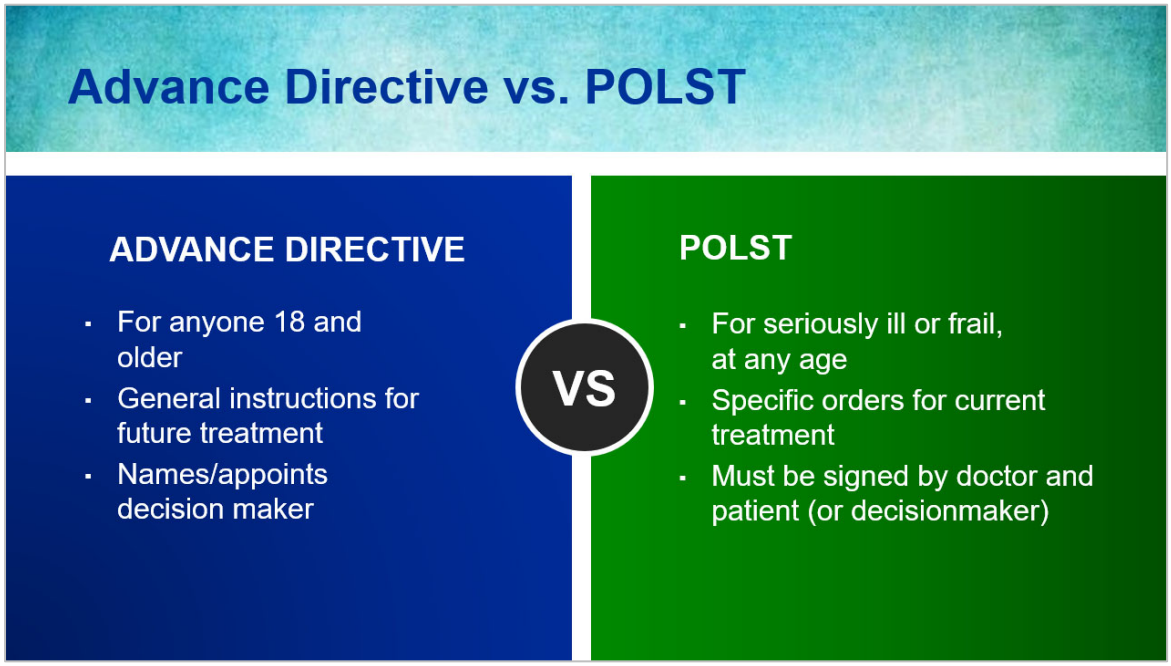
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

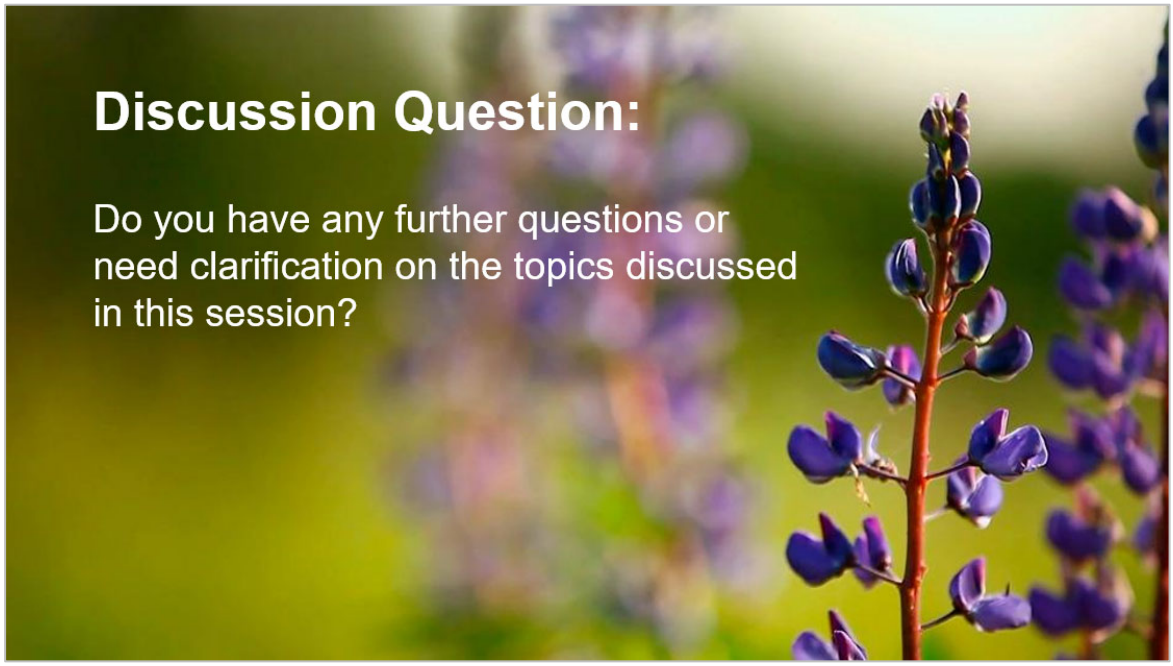
NOTES:


Advance Care Planning Continuum
Age 18
Complete an Advance Directive
Update Advance Directive Periodically
Diagnosed with Serious or Chronic, Progressive Illness (at any age)
Complete a POLST Form
Treatment Wishes Honored

NOTES:

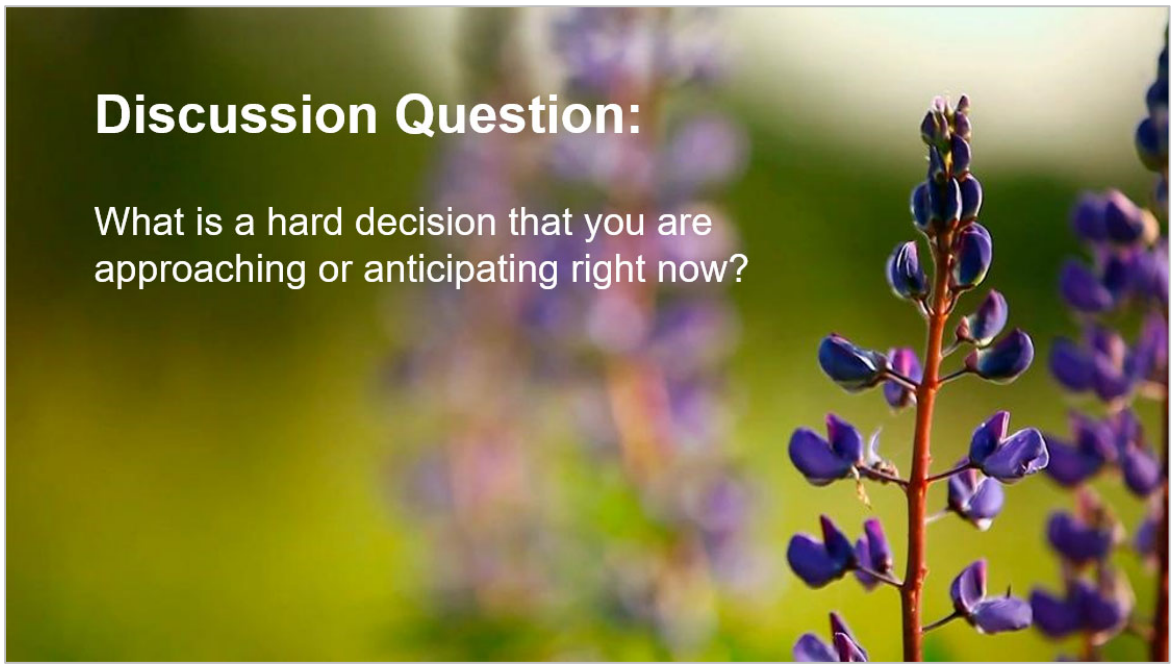

Advance Directive vs. POLST
ADVANCE DIRECTIVE
For anyone 18 and older
General instructions for future treatment
Names/appoints decision maker
VS
POLST
For seriously ill or frail, at any age
Specific orders for current treatment
Must be signed by doctor and patient (or decisionmaker)

NOTES:

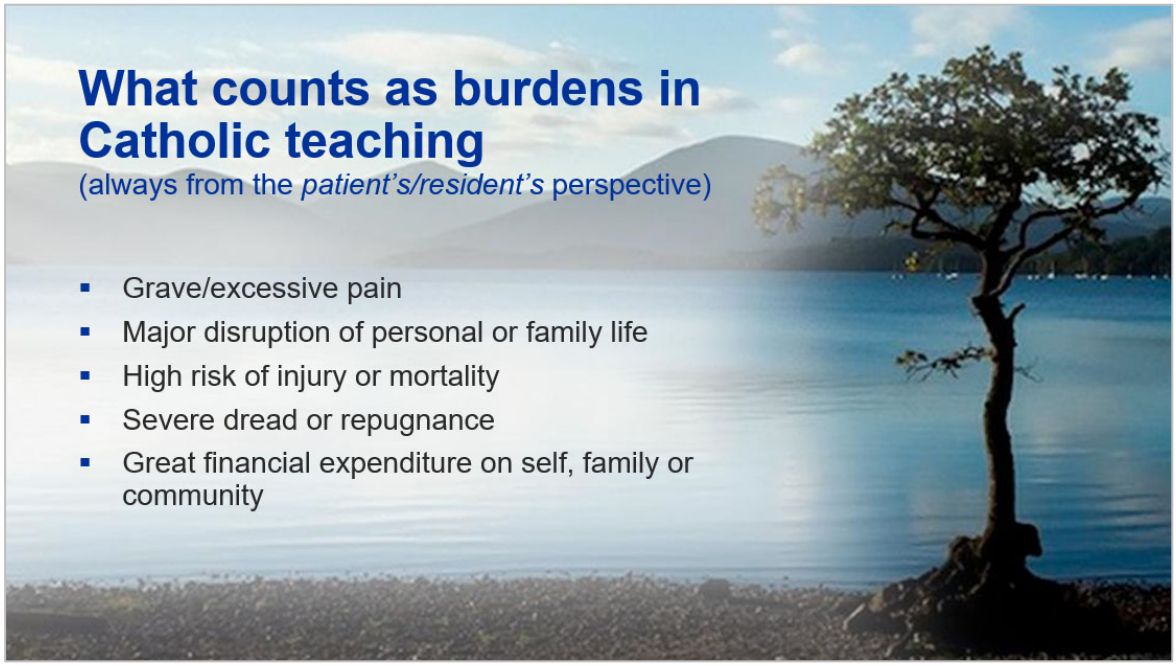

Discussion Question:
Do you have any further questions or need clarification on the topics discussed in this session?

NOTES:

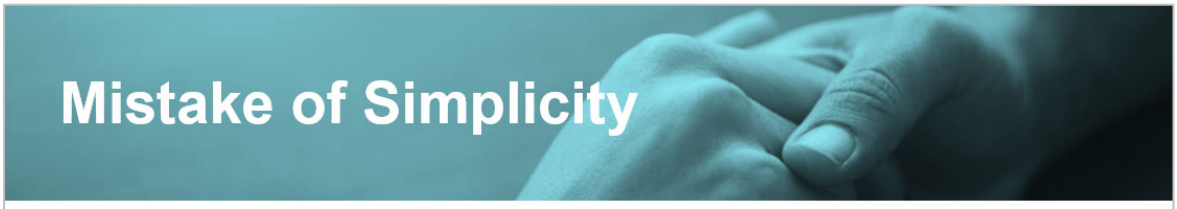
SESSION 2: CHURCH TEACHINGS ON END-OF-LIFE ISSUES



NOTES:


What counts as burdens in Catholic teaching
(always from the patient's/resident's perspective)
Grave/excessive pain
Major disruption of personal or family life
High risk of injury or mortality
Severe dread or repugnance
Great financial expenditure on self, family or community

NOTES:



Mistake of Simplicity

- Thinking that the technological simplicity of a medical treatment is the only factor that determines a specific treatment is ethically obligatory, i.e., thinking that the Church requires always using treatments that are medically (technically) simple, usual, ordinary, routine

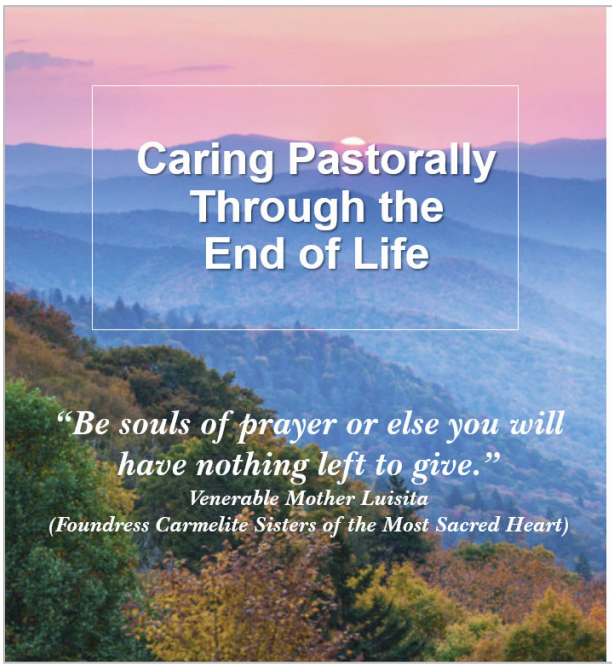
- Forgetting that the most important question is whether or not a specific treatment offers a reasonable hope of benefit *in the patient's judgment* **or** whether or not the treatment entails an excessive burden *in the patient's judgment*.

NOTES:


Discussion Question:
As we conclude this segment of the workshop, do you have any questions or concerns about Catholic teaching on end-of-life choices?

NOTES:

SESSION 3: PASTORAL CARE AT THE END OF LIFE



SPIRITUAL
How do they pray and relate to God?

PHYSICAL
What has been their health pattern prior to death?

EMOTIONAL
What brings them joy and comfort, What saddens and irritates them?

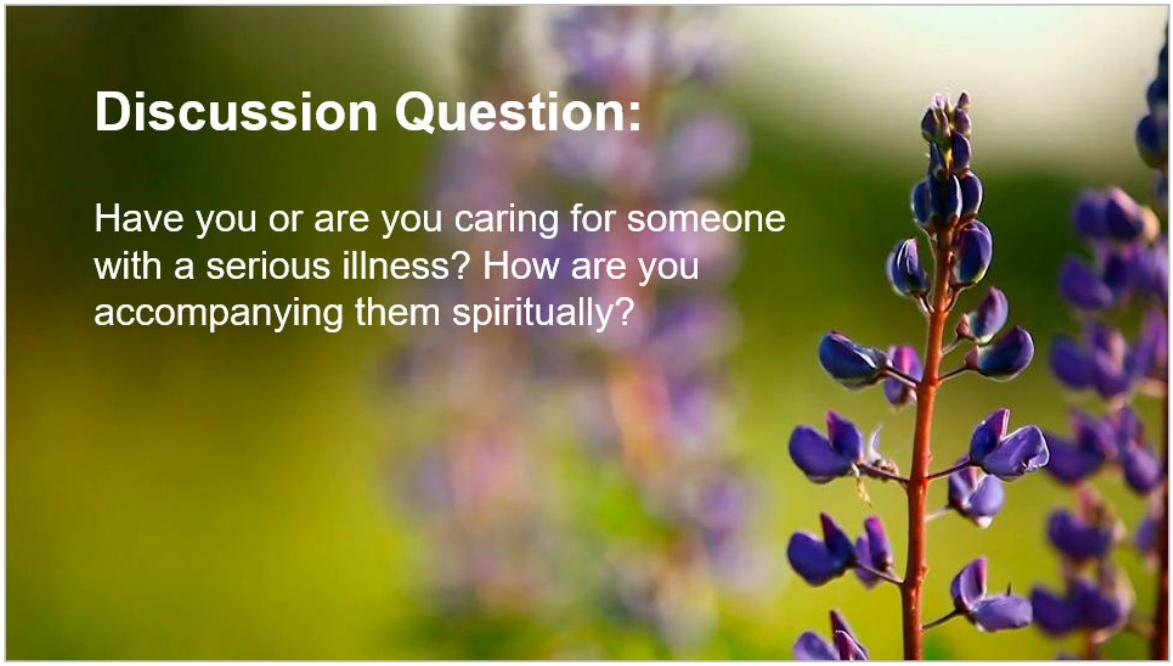
NOTES:

- Pain
- Agitation/anxiety
- Change in breathing patterns
- Irregular breathing
- Apnea - long periods of time between breaths
- Reduced fluid and food intake
- Decreased activity - sleep more
- Body temperature changes
- Blood pressure lowers
- Decreased blood flow to the hands and feet
- Disorientation - confused speech

NOTES:


Signs and Symptoms of Approaching Death:
How to Support Seriously Ill Parishioners and their Families
Emotional, Spiritual and Mental
Withdrawal
Detaching
Letting Go
Decreased Socialization
Only Wanting A Few People Present
Hallucinations
Fear of the unknown
Anger
Forgiveness
Depression
Sadness/anticipatory grief
Letting go

NOTES:


Discussion Question:
Have you or are you caring for someone with a serious illness? How are you accompanying them spiritually?

NOTES:

APPENDIX

Caring for the Whole Person

Advance Health Care Directive

(Under Authority of California Probate Code Sections 4670 through 4701)

Catholic Teaching Concerning End of Life Decisions

Death Is a Normal Part of the Human Condition. Death is neither to be feared and avoided at all costs, nor to be sought and directly procured.

Euthanasia Is Wrong. Euthanasia is not permitted. Euthanasia is defined as the intentional ending of human life by act or omission in order to relieve suffering.

Pain Relief. Modern pain control techniques do not ordinarily shorten life. However, the use of medicine to treat severe pain is acceptable even if, hypothetically, it were to shorten life. In any event, pain control is not the same as euthanasia, since death is not the objective of the treatment. Maintenance of lucidity is an important element in preparing for death, but severe pain should be alleviated to the extent possible.

Proportionality of Life-Sustaining Medical Treatment. Decisions to administer, refuse, or discontinue life-sustaining treatment should be based on the concept of proportionality. One does not have an obligation to pursue a life-sustaining treatment if its risks or burdens are disproportionate to its expected benefits. It will be possible to make a correct judgment "by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources." (*Declaration on Euthanasia*, section IV).

Nutrition and Hydration (Food and Water). The failure to provide a patient with nutrition and hydration – *for the purpose of ending the patient's life or accelerating the patient's death* – constitutes euthanasia and is always wrong, even when nourishment must be provided by artificial means. However, situations can arise where the provision of nutrition and hydration no longer provides substantial benefits and is actually burdensome to a dying patient. In such cases, the provision of food and water, by artificial means or otherwise, may no longer be appropriate, even if the dying process is *incidentally* hastened.

Organ Donation. Organ donation after death is a noble and meritorious act and is to be encouraged as an expression of solidarity (Catechism of the Catholic Church, n. 2296).

Consultation with Medical and Spiritual Advisors. It is not always easy for patients, family, or health care agents to apply the principles of proportionality to a particular situation. Consultation with medical advisors is almost always required in order to evaluate potential benefits, burdens, and risks. Consultation with competent spiritual advisors may help patients, family, or health care agents arrive at well-discerned decisions.

Pastoral Care Preferences. Penance, the Anointing of the Sick and the Eucharist as viaticum constitute at the end of Christian life the sacraments that prepare for the heavenly homeland and the completion of the earthly pilgrimage (Catechism of the Catholic Church, n. 1525). It is important to make personal preferences known about reception of these sacraments.

Speaking with Loved Ones. Though this written, signed documentation will be helpful, no Advance Health Care Directive can replace clear conversations about faith-guided principles and pastoral preferences with loved ones. The best option is to choose an agent who will make medical decisions in accord with personal directives based on Catholic teaching, discuss these together and receive the agent's agreement to act in accord with them.

More Detailed Guidance is Available. Most of the foregoing principles are drawn from the *Declaration on Euthanasia* which was promulgated in 1980 by the Vatican Congregation for the Doctrine of the Faith, and Catechism of the Catholic Church. Additional Church documents and guidance can be found on the website of the United States Conference of Catholic Bishops: www.usccb.org/issues-and-action/human-life-and-dignity.

Part 1 – Power of Attorney for Health Care

1.1 Primary Appointment. I, _____, hereby designate the following individual as my agent to make health care decisions for me:

Print Name: _____ Relationship: _____

Home Phone: _____ Mailing Address: _____

Work Phone: _____ _____

Cell Phone: _____ E-Mail Address: _____

1.2 First Alternate Appointment. If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Print Name: _____ Relationship: _____

Home Phone: _____ Mailing Address: _____

Work Phone: _____ _____

Cell Phone: _____ E-Mail Address: _____

1.3 Second Alternate Appointment. If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Print Name: _____ Relationship: _____

Home Phone: _____ Mailing Address: _____

Work Phone: _____ _____

Cell Phone: _____ E-Mail Address: _____

1.4 Agent's Authority. My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw medical treatment, artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state in Part 2 below.

1.5 When Agent's Authority Becomes Effective. My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions, unless I mark the following box: If I mark this box ☐ authority to make health care decisions for me takes effect immediately.

1.6 Agent's Obligation. My agent shall make health care decisions for me in accordance with (i) this power of attorney for health care, (ii) any instructions I give in Part 2 of this form, and (iii) my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

1.7 Agent's Post-Death Authority. My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Parts 3 and 4 of this form:

_____

_____

_____ *[continue on page 8 if necessary]*

1.8 Designation of Conservator. If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not available to act as a conservator, I nominate the alternate agent I have named, in the order designated.

Part 2 – Instructions for Health Care

2.1 Health Care Decisions Should Be Consistent with Catholic Teaching. Any decision concerning my health care should be consistent with relevant teachings of the Roman Catholic Church. Those teachings are summarized on the first page of this Advance Health Care Directive.

End of Life Decisions. It is impossible to adequately anticipate all the considerations which must be weighed at the time when a decision concerning life-sustaining treatment is to be made. Therefore, if I have appointed an agent in Part 1 above, I have full confidence in the judgment of that person, and I request that my health care providers follow his or her instructions. However, to facilitate my agents' and health care providers' decisions, I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have initialed below:

_____ (*initial*) **(a) Choice Not to Prolong Life**
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, **or** (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, **or** (3) I have a life-threatening illness or injury and the likely risks and burdens of treatment would be disproportionate to its expected benefits. OR

_____ (initial) **(b) Choice to Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.2 Relief from Pain. Except as I state in the following spaces, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

_____

_____

2.3 Special Instructions (Optional). The following lines may be used to set forth any further directions, limitations, or statements concerning health care, treatment, services and procedures:

_____

_____

_____ [*continue on page 8 if necessary]*

Part 3 – Donation of Organs and Tissues at Death (Optional)

Upon my death I give my organs, tissues, parts. _____ (*initial to indicate yes*) By initiating this line, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

OR

I do not authorize the donation of any organs, tissues or parts. _____ (*initial*)

OR

I give the following organs, tissues, or parts only: _____

_____ _____ (*initial*)

My donation is for the following purposes (*strike aInny of the following you do not want*):

Transplant _____ (*initial*) Research _____ (*initial*) Therapy _____ (*initial*) Education _____ (*initial*)

If you want to restrict your donation of an organ, tissue, or part in some way, state your restriction on the following lines: _____

_____

If I leave Part 3 blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, use the line above).

Part 4 – Disposition of Remains (Optional)

4.1 Agent's Authority. I understand that my agent designated in this document has the authority to dispose of my remains unless I otherwise provide, in writing.

4.2 Instructions. My instructions for the disposition of my remains, including the funeral rites I prefer, are described in:

☐ (a) A written contract for funeral services with: _____
Name of Funeral Director, Mortuary and/or Cemetery

☐ (b) My will, which I keep: _____
Location of Will

☐ (c) Instructions as follows: _____

_____
Specific Instructions

Part 5a – Primary Physician (Optional)

I designate the following physician as my primary physician:

_____	_____
Name	*Phone*

_____	_____	_____	_____
Address	*City*	*State*	*Zip Code*

Part 5b – HIPAA Disclosure Authorization

5.1 Authorized Disclosures of Medical Information. I hereby grant to each of the individuals named as my primary and alternate health care agents in Part 1 of this document full power and authority to request, review and receive any information, verbal or written, regarding my physical or mental health, to the same extent that I myself would have such rights under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I further grant to each of said individuals the further right to consent to the disclosure of such information to third parties.

5.2 HIPAA Authorization Effective Immediately. The foregoing authorizations are effective immediately and, notwithstanding the provisions of Section 1.5 above, are not contingent on my own inability to make health care decisions.

Part 6 – Revocation of Prior Directives

6.1 Revocation of Prior Appointments of Health Care Agents. By execution of this document, I hereby revoke all prior Powers of Attorney for Health Care and any and all other appointments of health care agents under the laws of any jurisdiction within or without the United States of America.

6.2 Revocation of Prior Health Care Directives. By execution of this document, I hereby revoke all prior documents, wherever executed within or without the United States of America, which would be deemed to function as an Advance Health Care Directive under the laws of the State of California.

Part 7 – Signature and Witnesses

7.1 Effect of Copy. A copy of this form has the same effect as the original.

7.2 Signature and Date.

Date of Signature: _____, 20____ _____
(sign your name)

Place of Signature: _____

7.3 Statement of Witnesses. I declare under penalty of perjury under the laws of California (i) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (ii) that the individual signed or acknowledged this advance directive in my presence, (iii) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (iv) that I am not a person appointed as agent by this advance directive, and (v) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness: _____ Address: _____
(signature)

_____ _____ _____
(date) *(printed name)*

Second Witness: _____ Address: _____
(signature)

_____ _____ _____
(date) *(printed name)*

7.4 Additional Witness Statement. At least one of the above witnesses must also sign a declaration as follows:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____
(signature)

Part 8 – Acknowledgement Before Notary Public

8.1 Notary Public Acknowledgment as Alternative to Witness in Part 7. Acknowledgement before a Notary Public is not required if properly witnessed in Part 7 above. Acknowledgment before a Notary Public does not eliminate the need for the Statement of a Patient Advocate or Ombudsman, in Part 9 below, which is required for patients in skilled nursing facilities.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA)
)
COUNTY OF _____)

On _____, 20_____, before me, _____,
personally appeared _____ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under the PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

_____
Notary Public [Seal]

Part 9 – Special Witness Requirement (For Patients in Skilled Nursing Facilities)

9.1 Patient Advocate or Ombudsman. The following statement is required only for patients in a skilled nursing facility – a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement.

Statement of Patient Advocate or Ombudsman

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Date: _____, 20_____ Address: _____

_____ _____
(signature)

_____
(printed name)

Space for Additional Limitations and/or Instructions

Copies

California law permits photocopies of this document to be ruled upon as though they were originals. It is recommended that you keep possession of your original and that you consider giving photocopies to, and discuss your specific desires with:

1) Your Agent and Alternate Agent
2) Your Primary Physician
3) Significant Members of Your Family, and
4) Any Other Person who is Likely to be Called in a Medical Emergency.

It is very important to keep a record of the persons who have received copies, in case you wish to revoke or modify this Directive.

Checklist for Advance Health Care Directive

To ensure that you have completed this form properly, you should be able to answer "Yes" to each of the following items:

☐ 1. I am a California resident who is at least 18 years old, of sound mind and acting of my own free will.

☐ 2. The individual I have selected to make health care decisions for me (my "Agent" or "Alternate Agent") is at least 18 years of age, at the time when such Agent will be making health care decisions on my behalf, is not and will not be:
- a supervising health care provider or an employee of the health care institution where I am then receiving care,
- an operator of a community care facility or residential care facility for the elderly where I am then receiving care,
- an employee of a health care facility, community care facility or residential care facility for the elderly where I am then receiving care, unless such employee is related to me by blood, marriage or adoption, or unless I am also employed by the same health care institution, community care facility or residential care facility for the elderly, and
- my conservator under the Lanterman-Petris-Short Act, unless additional legal requirements have been met.

☐ 3. I have spoken with the individuals I have selected to make health care decisions on my behalf, and these individuals have agreed to do so in the event I am unable to make such decisions for myself.

☐ 4. We have discussed the extent to which life-sustaining treatment (for example, ventilators/respirators, dialysis, chemotherapy, surgery, tube-feeding, CPR) should be implemented or maintained on my behalf.

☐ 5. The individuals I have selected understand how I would act on my behalf were I able to do so.

☐ 6. I have given a copy of this completed form to those who may need it in case an emergency requires a decision concerning my health care, including the individuals I have selected in this form, key family members and physicians.

☐ 7. I have had this form either notarized OR properly witnessed.
- ☐ (a) I have obtained the signatures of two adult witnesses who personally know me (or to whom I have proven my identity).
- ☐ (b) Neither witness is
  - an Agent whom I have designated to make health care decisions on my behalf,
  - one of my health care providers or any employee of one of my health care providers,
  - the operator or any employee of a community care facility (sometimes called a "board and care home"), nor
  - the operator or any employee of a residential care facility for the elderly.
- ☐ (c) At least one witness is not related to me by blood, marriage or adoption, and is not named in my will and, so far as I know is not entitled to any part of my estate when I die.

☐ 8. I understand that, if I want to change anything in this document, I must complete a new form. I should also tell everyone who received a copy of the old form that it is no longer valid and must ask that copies of the old form be returned to me so that I may destroy them.

☐ 9. I have signed and dated this form.

☐ 10. If I am in a skilled nursing facility, I have obtained the signature of a patient advocate or ombudsman.

☐ 11. If I am a Conservatee under Lanterman-Petris-Short Act, this form may not be applicable, and I should consult an attorney.

☐ 12. I am keeping a record of the persons who have received copies of this Advance Health Care Directive.

What is a POLST?

Key Facts About POLST for Individuals and Family Members

Physician Orders for Life Sustaining Treatment (POLST) is a medical order that helps give people with serious illness more control over their care during a medical emergency. POLST can help make sure you get the care you want, and also protect you from getting medical treatments you DO NOT want.

- **POLST is voluntary.** Nursing homes and assisted living facilities may include POLST in their admission papers, but can't require you to complete a POLST if you do not wish to.

- **POLST is for people who are seriously ill or have advanced frailty**. If you are healthy, an advance directive is for you.

- **A POLST does NOT replace an advance directive,** which is still the best way to appoint someone you trust to act as your medical decisionmaker. A POLST works together with your advance directive, providing more specific detail regarding medical wishes and goals of care during a serious illness or at the end of life.

- **The POLST form should be completed by your doctor or another trained medical provider** after you've had a good conversation about the form's medical terms and options. This conversation is very important and should cover your overall health, your personal values, goals for your care, and treatment wishes. It can be helpful to include your family in the talk so they know and understand your treatment wishes.

- **The POLST form is not valid until it is signed by both you (or your designated decisionmaker) *AND* your physician, nurse practitioner, or physician assistant.**

- **Once completed and signed, a copy goes in your medical record and you keep the original bright pink POLST**. Wherever you go for medical care, the signed pink form should go with you. At home, keep your POLST in an easy to find place, like on your refrigerator, in case of a medical emergency.

- **POLST does not expire, but it should be reviewed regularly to make sure your wishes haven't changed.** You do not need to fill out a new POLST if you move from one facility to another, or change doctors. You only have to complete a new POLST if your treatment wishes change.

- **POLST is a medical order, which means licensed medical providers are required to follow its instructions** regarding CPR and other emergency medical care. The POLST form is printed on bright pink paper so it is easy to recognize, but photocopies are also considered valid.

- **You can void your POLST form at any time, verbally or in writing.** If you have changes, it is best to complete a new POLST. To void a POLST form, draw a line through sections A through D, write "VOID" in large letters, then sign and date the line.

Please go to: http://www.capolst.org/ or call (916) 489-2222 for more information.

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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

First follow these orders, then contact Physician / NP / PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document**.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

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

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with 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.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes.

☐ Trial period of artificial nutrition, including feeding tubes.

☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

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 ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **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 signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- 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:

- 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

- 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.

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**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED