POLICY: 570.21
TITLE: Do Not Resuscitate (DNR)
Physician Orders for Life Sustaining Treatment (POLST)
End of Life Options (Aid-In-Dying Drug)

EFFECTIVE: 07/01/2017
REVIEW: 07/2022
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Do Not Resuscitate (DNR)
Physician Orders for Life Sustaining Treatment (POLST)
End of Life Options (Aid-In-Dying Drug)

I. AUTHORITY

California Health and Safety Code, Division 1, Part 1.8, Section 442-443
California Health and Safety Code, Division 2.5, Section 1797.220 and 1798
California Probate Code, Division 4.7 (Health Care Decisions Law)

II. DEFINITIONS

A. **Advance Health Care Directive (AHCD)**: A written document that allows an individual to provide healthcare instructions and/or appoint an agent to make healthcare decisions when unable or prefer to have someone speak for them. AHCD is the legal format for healthcare proxy or durable power of attorney.

B. **Aid-in-Dying Drug**: A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.

C. **Basic Life Support (BLS) Measures:** The provision of treatment designed to maintain adequate circulation and ventilation for a patient in cardiac arrest without the use of drugs or special equipment. Examples include:

- Assisted Ventilation via a bag-valve-mask device
- Manual or automated chest compressions
- Automated External Defibrillator (AED)

D. **Comfort Measures:** Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.

E. **Do Not Resuscitate (DNR):** DNR is a request to withhold interventions intended to restore cardiac activity and respirations. For example:

- No chest compressions
- No defibrillation
- No endotracheal intubation
- No assisted ventilation

F. **End of Life Option Act:** California State law authorizes an adult, eighteen (18) years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his or her life in a humane and dignified manner.

G. **Ombudsman:** The Office of the Ombudsman works independently as an intermediary to provide individuals with a confidential avenue to address complaints and resolve issues at the lowest possible level. The Office proposes policy and procedural changes when systemic issues are identified.

H. **Patient Advocate:** Patient advocacy is an area of lay specialization in health care concerned with advocacy for patients, survivors, and care takers. The patient advocate may be an individual or an organization, often, though not always, concerned with one specific group of disorders.

I. **Physician Orders for Life Sustaining Treatment (POLST):** A signed, designated physician order form that addresses a patient's wishes about a specific set of medical issues related to end-of-life care. May be used for both adult and pediatric patients.

J. **Prehospital Emergency Medical Services (EMS) Personnel:** Persons who have been certified as qualified to provide prehospital emergency medical care pursuant to California Health and Safety Code, Division 2.5.

K. **Resuscitation: Intervention**(s) intended to restore cardiac activity and respirations, for example:

- Cardiopulmonary resuscitation (CPR)
- Defibrillation
- Drug therapy
- Other life saving measures

L. **Standardized Patient-Designated Directives:** Forms or medallion(s) that recognizes and accommodates patient's wish to limit prehospital treatment at home or the scene of an incident, in healthcare facilities or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form (Attachment 1)
- Physician Orders for Life-Sustaining Treatment (POLST) (Attachment 2)
- State EMS Authority-Approved DNR Medallion (V.C.2.b)

M. **Supportive Measures:** Medical intervention(s) used to provide and promote patient comfort, safety, and dignity. Supportive measures applicable for POLST and AHCD may include but are not limited to:

- Airway maneuvers, including removal of foreign body
- Suctioning
- Oxygen administration
- Hemorrhagic control
- Oral hydration
- Glucose administration
- Pain control

N. **Valid DNR Order for Patients in a Licensed Health Care Facility:**

- A written document in the medical record with the patient's name and this statement "Do Not Resuscitate", "No Code", or "No CPR" that is signed and dated by a physician; or

- A verbal order to withhold resuscitation given by the patient's physician who is physically present at the scene and immediately confirms the DNR order in writing in the patient's medical record; or
- POLST with DNR checked; or
- AHCD when the instructions state resuscitation should be withheld/discontinued.

O. **Valid DNR Order for Patients at a Location Other Than a Licensed Facility:**

- Fully executed California Emergency Medical Services Authority and the California Medical Association approved DNR form signed and dated by the patient's physician; or
- A Medic Alert bracelet inscribed "Do Not Resuscitate EMS"; or
- A Physician Orders for Life-Sustaining Treatment (POLST) form; or
- A written, signed order in the patient's medical record.

III. PURPOSE

To establish criteria for prehospital EMS personnel when they encounter patients with Do Not Resuscitate (DNR) orders or Physician Orders for Life-Sustaining Treatment (POLST) and other patient designated end-of-life directives.

IV. PRINCIPLES

A. The right of patients to refuse unwanted medical intervention is supported by California Statute.

B. Withhold or discontinue patient resuscitation if a valid AHCD or standardized patient-designated directive is provided.

C. If the patient's personal physician will sign the death certificate, invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient may be removed.

D. Patients are encouraged to utilize one of the standardized patient-designated directives to ensure that end-of-life wishes are easily recognizable. If the patient is in a private home, the DNR or POLST should be readily accessible or clearly posted.

E. Photocopies of all the patient-designated directives are acceptable.

F. A conscious patient who is oriented to person, place, time and purpose may revoke their patient-designated directive at any time.

V. POLICY

A. General Procedures for EMS Personnel:

1. Confirm the patient is the person named in the patient-designated directive

2. Initiate BLS measures immediately on patient in cardiopulmonary arrest pending verification of a valid patient-designated directive or the criteria for discontinuing measures outlined in Determination of Death in the Prehospital Setting Policy 570.20

3. Begin resuscitation immediately and contact the base hospital for further direction if family members/caretakers disagree or object to withholding resuscitation, or if EMS personnel have any reservations regarding the validity of the DNR directive

4. If the patient's condition deteriorates during transport, including Emergency 9-1-1 and Non-Emergency Inter-Facility Transfers (IFTs), and the patient has a valid DNR, transport the patient to the facility requested/designated by the physician or family member(s). If no facility is requested or designated then transport to the closest facility.

B. Documentation of a DNR incident shall include, but is not limited to, the following:

1. Check the "DNR" box on the electronic Patient Care Report (ePCR);

2. Describe the care given. Document the base hospital physician's name, if consulted, and the date of the DNR directive;

3. Note the removal of any invasive equipment;

4. Document DNR orders written in the medical record of a licensed facility, including, the date signed, physician name, and other appropriate information or provide a copy of the DNR with the ePCR;

5. When possible, provide a copy of the AHCD and/or other patient-designated directive with the ePCR.

C. Directive-Specific Procedures

1. AHCD

a. A valid AHCD must be:

i. Completed by a competent person age 18 or older
ii. Signed, dated, and include the patient's name
iii. Signed by two witnesses or a notary public
iv. Signed by a patient advocate or ombudsman if the patient is in a skilled nursing facility

b. If the situation allows, prehospital EMS personnel should make a good faith effort to review the AHCD and/or consult with the patient advocate.

c. Base hospital contact is required for any AHCD instructions other than withholding resuscitation.

2. State EMS Authority approved DNR medallion(s)

a. A medallion or bracelet attached to the patient is considered the most accurate form of identification for anyone not in a licensed facility

b. Medallions are issued only after a copy of the DNR or POLST is received from an applicant. There are two (2) medallion providers approved in California:

i. Medic Alert Foundation

ii. Caring Advocates

c. If the medallion is engraved "DNR," treat in accordance with this policy

d. If the medallion is engraved "DNR/POLST" and the POLST is available, treat as indicated on the POLST.

e. If the medallion is engraved "DNR/POLST" and the POLST is **NOT AVAILABLE**, treat in accordance with the DNR until the valid POLST is produced.

3. Physician Orders for Life Sustaining Treatment (POLST)

a. The POLST must be signed and dated by the physician, and the patient or the legally recognized decision maker. No witness to the signature is necessary.

b. The POLST is designed to supplement, not replace an existing AHCD. If the POLST conflicts with the patient's other health care instructions or advance directive, then the most recent order or instruction governs.

c. Prehospital EMS personnel should see the written POLST unless the patient's physician is present and issues a DNR order.

d. There are different levels of care in Sections A and B of the POLST. Medical interventions should be initiated, consistent with the provider's scope of practice and POLST instructions.

e. Contact the base hospital for direction in the event of any unusual circumstance.

4. End of Life Option Act

A patient who has obtained an aid-in-dying drug has met extensive and stringent requirements as required by California law. The law offers protections and exemptions for healthcare providers but is not explicit about EMS response for End of Life Option Act patients. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered and aid-in-dying drug:

a. Within 48 hours prior to self-administering the aid-in-dying drug, the patient is required to complete a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner (Exhibit B)." However, there is no mandate for the patient to maintain the final attestation in close proximity of the patient. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

b. There are no standardized "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" forms but the law has required specific information that must be in the final attestation. If available, EMS personnel should make a good faith effort to review and verify that the final attestation contains the following information:

   i. The document is identified as a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner."
   ii. Patient's name, signature and dated

c. Provide comfort measures (airway positioning, suctioning) and/or BLS airway/ventilation measures

d. Withhold resuscitative measures if patient is in cardiopulmonary arrest.

e. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental state. In this instance, EMS personnel shall provide medical care as per standard protocols. EMS personnel are encouraged to consult with their base hospital whenever possible.

f. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act, inform the family that comfort measures will be provided and consider Base Hospital contact for further direction.

g. Obtain a copy of the final attestation and attach it with the EMS ePCR when possible.

Cross Reference Policies:
Policy 560.11 Documentation of Patient Contact
Policy 570.20 Determination of Death in Prehospital Setting
Policy 570.35 Refusal of EMS Service

Exhibit A
Physician Orders for Life-Sustaining Treatment (POLST)

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

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

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. 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 →
☐ 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:	**FOR REGISTRY USE ONLY**
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 or 10/1/2014 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

Exhibit B
Example of Final Attestation Form

FINAL ATTESTATION FORM

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER, I _____, am an adult of sound mind and a resident of the State of California.

I am suffering from _____, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potentially associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed one or more members of my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed: _____
Dated: _____
Time: _____

Exhibit C
End of Life Option Algorithm