Presents

POLST

Physician Orders for Life-Sustaining Treatment

Washington State Training Curriculum & Provider Protocols

Education, Training and Regional Support Section
P.O. Box 47853
Olympia, Washington 98504-7853
(800) 458-5281 (Ext 2) (360) 236-2840
http://www.doh.wa.gov/hsqa/emtp

Revised March 2003

Acknowledgments

Center for Ethics in Health Care, Oregon Health & Science University

William Bender, MD - Regional Ethics Network of Eastern Washington

Bruce Dentler, MD - Regional Ethics Network of Eastern Washington

John Osborn, MD - Regional Ethics Network of Eastern Washington

James Shaw, MD - Regional Ethics Network of Eastern Washington

Maria J. Silveira, MD – General Medicine, Bioethics Program, University of Michigan

TABLE OF CONTENTS

Page #

Preface iii

Introduction iii

Historical Perspective iii

Relationship To EMS Training iv

Medical Direction iv

Lesson Plan Components iv

Objectives iv

Preparation iv

Personnel iv

Recommended Minimum Time To Complete v

Presentation v

Application v

Instructor Lesson Plan 1

Appendix A: EMS Provider Protocols For Do Not Resuscitate (DNR) Orders 11

Appendix B: "How Best To Tell The Worst News" 17

Appendix C: Medical Terms Used For End Of Life Care 21

Appendix D: Sample POLST Form 27

Appendix E: Sample EMS-No CPR Form 31

Preface

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 due to 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 persons 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 primary care physicians and nurse practitioners, long-term care facilities, hospices, home health agencies, emergency medical services, and emergency physicians to:

- Promote patient autonomy by documenting a person's treatment preferences and coordinating these with physician orders;
- Enhance the authorized transfer of patient records between facilities;
- Clarify treatment intentions and minimize confusion regarding a person's treatment preferences;
- Reduce repetitive activities in complying with the Patient Self Determination Act, and;
- Facilitate appropriate treatment by emergency medical services personnel.

The voluntary use of the POLST document is intended to enhance the quality of a person's care and is expected to complement the advance directive if it has been completed. The POLST document is a short summary of treatment preferences and a physician's order for care that is easy to read in an emergency situation. The POLST is not intended to replace an advance directive document or other physician 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. While not an Advance Directive, the POLST form translates a patient’s wishes into actual physicians orders and is portable from one care setting to another.

Relationship to EMS Training

The information contained in this curriculum is to be provided to all EMS providers as an update during Continuing Medical Education (CME) or Ongoing Training and Evaluation (OTEP). In addition, this information replaces information provided in all curricula regarding EMS-No CPR.

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, specifically for every ambulance service/rescue squad. On-line and/or off-line medical direction must be in place to allow for EMS personnel to carry out and assist with the administration of patient's treatment decisions.

Lesson Plan Components

There is one module of instruction in the core content. This lesson has the following components:

Objectives

The objectives are divided into three categories: Cognitive, Affective and Psychomotor. To assist with the design and development of a specific lesson, each objective has a numerical value. This numerical value follows the same objective numbering system presented in the EMT-Basic National Standard Curriculum.

Preparation

Motivation – The lesson has a motivational statement that should be read by the instructor prior to teaching the lesson. It is not the intent for the instructor to necessarily read the motivational statement to the students, but more importantly to be familiar with its intent and to be able to prepare the students or explain why this is important to them.

Materials

Audio Visual (AV) Equipment - In recent years the design and development of high quality video has become available for the EMS community. They should be used as an integral part of the instruction in this program. The course administrator should assure that the necessary types of AV equipment are accessible to the class.

Personnel

Primary Instructor - Each lesson plan clearly defines the necessary qualifications of the primary instructor.

Recommended Minimum Time to Complete

Each lesson plan has recommended minimum time for completion. Due to the varying nature of adult learners, additional time may be required.

Presentation

Declarative (What) - This is the cognitive lesson plan. This is the information that the instructor provides. This may be accomplished by various methods, including lectures, small group discussion, and the use of audio-visual materials. Demonstrations, if the instructor desires, may be used as part of the instruction. The instructor must be well versed with the entire content of the lesson plan. These lesson plans are not to be read word for word. Lesson plans should be considered dynamic documents that provide guidelines for the appropriate flow of information. The instructor should feel free to write notes in the margins and make the lesson plan their own.

Application

Procedural (How) - This is the skills portion of the program. If the declarative (what) content was presented as a lecture, the instructor must perform demonstrations prior to having the participants perform the skills. If the instructor performed a demonstration as part of the declarative component, the participants may begin by practicing skills in the practical setting.

When this component of the lesson is being conducted the instructor/participant ratio should be no more than 1 to 6. For those having difficulty performing a skill or skills, remediation is required. It is well known that a demonstration must be followed by practice, which must be drilled to a level that assures mastery of the skill. It has been proven that demonstration followed as soon as possible with organized, supervised practice enhances mastery and successful applications.

Contextual (When, Where and Why) - This section is designed to help participants understand the application of their knowledge and skills as they relate to their performance as an EMS provider. This section relates back to the motivational statement and represents the reasoning as to why, where and when the EMS provider would need to use the knowledge or perform the skills. It is of utmost importance that the instructor be familiar with the intent of this section and relay that intent to the participants.

Program Participant Activities - individuals learn by various methods. The three types are: auditory, visual and kinesthetic. The intent of this section is to assure that the content of the curriculum is presented to meet the needs of the three different types of learning styles. These three areas should not necessarily be used separately from the lesson plan, but as an adjunct to it. If lessons are presented in this format, participants with separate or combined learning styles will learn.

Auditory (Hear) - This section allows the instructor to provide material in a verbal manner. Those participants that learn best by hearing will benefit from this method of instruction.

Visual (See) - This section allows the instructor to provide material in a visual manner. Visual learners will benefit from this method of instruction.

Kinesthetic (Do) - This section allows the instructor to provide material in a performance manner. Those individuals who learn best by hands-on performance will benefit from this method of instruction.

Instructor Activities - This section is to remind the instructors that they should supervise participants while they practice psychomotor skills. They should reinforce the participant's progress in the cognitive, affective and psychomotor domains. If a participant is having difficulty understanding the content or performing the skills, the instructor should remediate as needed.

Instructor Lesson Plan

POLST

OBJECTIVES

OBJECTIVES LEGEND

C=Cognitive P=Psychomotor A=Affective
1 = Knowledge level
2 = Application level
3 = Problem solving level

COGNITIVE OBJECTIVES

At the completion of this lesson, the EMS provider will be able to:

1. Describe the amendments to Washington's Natural Death Act (C-1)
2. Recognize the liability for EMS personnel regarding the POLST or other valid "do not resuscitate" orders. (C-1)
3. Describe the philosophy of the POLST Program. (C-1)
4. Describe what the POLST form is. (C-1)
5. Describe what the POLST form does. (C-1)
6. Describe who qualifies to have a POLST form. (C-1)
7. Describe where the POLST form is used. (C-1)
8. Describe what is required for the POLST form to be valid. (C-1)
9. Describe how is the form transferred from one setting to another. (C-1)
10. Recognize the POLST form and other valid do not resuscitate forms. (C-1)
11. Recognize the parts of the POLST form. (C-1)
12. Recognize when an individual has revoked the POLST or other valid "do not resuscitate" orders. (C-1)
13. Describe who keeps the POLST form and where the POLST form is kept. (C-1)
14. Recognize the POLST Form is replacing the EMS-No CPR form and EMS providers will still honor existing EMS-No CPR Forms
15. Describe the EMS provider protocols for managing a patient with a POLST form or other valid "do not resuscitate" order (See APPENDIX A: **EMS Provider Protocols for Do Not Resuscitate (DNR) Orders**). (C-1)
16. Describe how to document a POLST or other "do not resuscitate" orders on the patient run report. (C-1)
17. Describe how to provide comfort care measures to a dying patient. (C-1)

AFFECTIVE OBJECTIVES

At the completion of this lesson, the EMS provider will be able to:

18. Explain which patients qualify for the POLST program. (A-3)
19. Explain the steps you can use to communicate with grieving family members. (See APPENDIX B: "**How BEST To Tell The Worst News"**). (A-3)

PSYCHOMOTOR OBJECTIVES

At the completion of this lesson, the EMS provider will be able to:

20. Locate and identify the POLST form or other valid "do not resuscitate" orders. (P-1,2)

Preparation

Motivation:

Medical/legal and ethical issues are a vital element of the EMS Provider's daily life. The decision to treat or not 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 "do not resuscitate" orders are encountered.

MATERIALS

AV Equipment:

Utilize various audio-visual materials relating to POLST.

PERSONNEL

Primary Instructor:

One instructor knowledgeable in the Washington State POLST program.

Assistant Instructor

None required.

Recommended Minimum Time to Complete:

Approximately One hour

NOTE: **The DOH POLST educational material, guidelines and information may be obtained by contacting the Education, Training and Regional Support Section, P.O. Box 47853, Olympia, Washington 98504-7853 or by calling 1 (800) 458-5281, Ext. 2, or by downloading the files from the OEMTP web site at www.doh.wa.gov/hsqa/emtp**

Presentation

Declarative (What)

I. The Washington State POLST Program for EMS Providers

A. Amendment to 1992 Natural Death Act
   1. Health to adopt guidelines, protocols and a simple form. POLST is the final product.

B. Liability for the EMS Provider
   1. In 1992, the state legislature directed Department of Health to:
      a. Adopt guidelines for how EMS personnel should respond to written Do Not Resuscitate (DNR) Orders
      b. Prior to 1992, EMS personnel could not legally recognize prehospital DNR orders
   2. In 2000, RCW 43.70.480 was passed, which required the Department of The EMS provider protection from liability exists in RCW 18.71.210
   3. This law provides protection for all acts and omissions done in good faith.
   4. In honoring the POLST or EMS-No CPR orders, the EMS provider will be acting in accordance with MPD protocol and the physician's medical directive, and therefore acting in good faith.

C. Philosophy of the POLST program
   1. Individuals have the right to make their own health care decisions.
   2. These rights include:
      a. The ability of individuals to indicate their decisions about life sustaining treatment.
      b. A mechanism in which individuals could describe their desires for life sustaining treatment to health care providers.
      c. Health care providers who understand how to provide comfort care while honoring the individual's desires for life sustaining treatment.

D. What is the POLST Form?
   1. It is a bright lime green form that provides a short summary of treatment preferences and physician's order for care that is easy to read in an emergency situation.
   2. It is a "portable" physician order form that describes the patient's code directions, i.e., preferences for resuscitation, medical interventions, antibiotics, and artificially administered fluids and nutrition.
   3. It is "portable" because it is intended to go with the patient from one care setting to another using a single uniform document.

E. What does the POLST Form do?
   1. Completing a POLST form is voluntary on the part of an individual. The form is intended to:
      a. Allow an individual and their physician to discuss and develop plans to reflect the individual's end of life care wishes.
      b. Assist physicians, nurses, health care facilities and emergency personnel in honoring the individual's wishes for life-sustaining treatment.
      c. Direct appropriate treatment by EMS personnel.
   2. It replaces the current EMS-No CPR form that gives code directions to EMS providers when responding to a patient.

3. It translates an Advance Directive into a physician orders. **NOTE:** The POLST is **NOT** an Advance Directive and **DOES NOT** take the place of one.

F. Who qualifies to utilize the POLST Form?
   1. Any adult eighteen years of age or older with serious health conditions or who may expect to receive health care.

G. Where is the POLST Form Used?
   1. The completed POLST form is a physician order form that remains with an individual when transported between care settings, regardless of whether the setting is a person's home, a hospital, or a long-term care facility.

H. What is required for the POLST form to be valid?
   1. The POLST Form contains the individual's name; date of birth, date and the individual's or legal surrogate's signature.
   2. The POLST Form has been signed and dated by a physician and contains the physician's phone number.
   3. The individual is eighteen years of age or older.

I. How is the form transferred from one setting to another?
   1. The original bright lime green form must be transferred with the individual to be valid.
   2. Institutions may wish to keep a duplicated copy in the permanent medical record upon discharge or prior to Interfacility transports.

J. POLST Form Contents – (See APPENDIX D**: Sample POLST Form**)
   1. Patient/resident information – This area must be completed with the patient's/resident's name and date of birth.
   2. Physician Orders for Life Sustaining Treatment – Four different medical treatments or services.
      a. If the person requires treatment, the caregiver should first initiate any treatment orders recorded on the POLST, and then contact the attending physician.
      b. Any order section that is not completed indicates that full treatment should be provided for that section until clarification is obtained.
   3. Part A – Resuscitation: Patient has no pulse and is not breathing.
      a. If the patient wants CPR, the Resuscitate box is checked.
      b. If the patient does not want CPR, the Do Not Resuscitate box is checked. Resuscitation should not be attempted.
      c. Comfort measures will always be provided.
   4. Part B – Medical Interventions – Patient has pulse and/or is breathing.
      a. Healthcare providers will first administer the level of EMS services (appropriate to the level of certification) ordered and then contact the attending physician.
         (1 Comfort measures only – (See APPENDIX C: **Medical Terms Used For End of Life Care**)
         (2 Limited Interventions – Comfort measures and consider oxygen, suction, manual airway obstruction.
         (3 Advanced Interventions – All care above and consider oral/nasal airway, BVM/demand valve, monitor cardiac rhythm, medications, and IV fluids.
         (4 Full treatment/Resuscitation – All care above plus CPR, intubation and defibrillation.

(5 Other instructions.

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

5. Part C – Antibiotics (notify physician of new infection) **NOT APPLICABLE TO PREHOSPITAL EMS CARE**.
   a. No antibiotics except if needed for comfort.
   b. No invasive (IM/IV) antibiotics.
   c. Full Treatment.
   d. Other instructions.
6. Part D – Artificially Administered Fluids and Nutrition. Other fluids and nutrition must be offered if medically feasible. **NOT APPLICABLE TO PREHOSPITAL EMS CARE**.
   a. No feeding tube/IV fluids.
   b. No long term feeding tube/IV fluids.
   c. Full treatment.
   d. Other instructions.
   e. Always provide other measures to assure comfort.
7. Part E – The form provides an area where it is indicated with whom the treatment decisions have been discussed and an area to indicate the basis for the orders.
8. Signature block – Includes:
   a. Physician printed name, signature, phone number and date (signature required for form to be valid).
   b. Patient/Resident or Legal Surrogate for Health Care signature (required for form to be valid).
9. Changing the POLST Form – **(NOT APPLICABLE TO PREHOSPITAL EMS CARE.)**
   a. Part F – Patient/Resident Preferences as a Guide for this POLST Form.
      (1 The patient/resident has personal values that may be expressed orally, in writing (such as an advance directive) or by a surrogate.
      (2 Copies of advance directives or guardianship documents are encouraged as attachments to the POLST Form.
      (3 The POLST Form cannot be completed without a conversation between the physician and the patient/resident.
      (4 If the patient/resident's preferences or medical status changes, the POLST should be evaluated.
      (5 The person completing the POLST Form must print their name, sign and date the POLST Form.
   b. Part G – Review of this POLST Form – **(NOT APPLICABLE TO PREHOSPITAL EMS CARE.)**
      (1 This part records the review of POLST if a person's preferences or medical status change.
      (2 The orders should also be reviewed by the attending physician (or designee) immediately after the person is transferred from one care setting to another, periodically, or as determined by the care setting.
      (3 This review includes the date, the reviewer's name and the location of the review.

(4 The outcome of the review is also recorded by checking either the box indicating no change, or one of the two boxes indicating the old form has been voided and a new form completed or not completed.
(5 The reviewer may also wish to record why the form was voided.
(6 With any change, the form should be voided by drawing a diagonal line and/or the word VOID across the front of the form. The person voiding the form must then sign or initial the form.
(7 After voiding the form, a new form should be completed reflecting the new medical indications and treatment wishes of the person.
(8 If no new form is completed, full treatment and resuscitation may be provided.

II. The Washington State EMS-No CPR Form

A. The POLST Form, the preferred prehospital DNR order, is replacing the Washington State EMS-No CPR Form.
   1. EMS-NO CPR forms will be phased out of counties who have received an orientation on the POLST Form.
   2. EMS personnel will still honor the EMS-No CPR form as a prehospital DNR order.

B. Who Qualifies for the EMS-No CPR Form?
   1. Any adult eighteen years of age or older who informs his/her personal physician that he/she does not want CPR performed in the event of a cardiac arrest or respiratory arrest, and completes and signs the form.
      a. Form must be signed by the individual's primary care physician to be valid.
      b. Legal Surrogate may sign on behalf of a qualified patient

C. EMS-No CPR Form -, (See APPENDIX E: Sample EMS-N0 CPR Form)
   1. The EMS-No CPR Form is light green and consists of 3 parts
      a. Part 1- Individual completes this section indicating the desire to have CPR withheld in the event of cardiac or respiratory arrest
      b. Part 2 - Patient's legal surrogate completes this part of form in the event the patient is unable
      c. Part 3- Physician's EMS-No CPR Directive to EMS Personnel- Physician completes the final section directing EMS personnel to withhold CPR
   2. Either the EMS-No CPR Form or EMS-No CPR bracelet can be honored

D. EMS-No CPR Bracelet
   1. Bracelet is plastic and white in color with a red No CPR logo and a blue Washington Department of Health logo
   2. Can be worn on patient's wrist, ankle, or on a necklace or neck chain worn by the patient

III. Who keeps the POLST or EMS-No CPR Form and where will it be located?

A. In the home, the individual keeps the POLST or EMS-No CPR Form in a prominent location:
   1. Bedside Table
   2. Back of patient's bedroom door
   3. On the medicine cabinet
   4. On patient's refrigerator

B. When the individual is staying in a medical facility, the POLST or EMS-No CPR Form will be kept by the facility in the individual's medical chart along with other medical orders.

IV. Revocation of the POLST or EMS-No CPR Form

A. POLST or EMS-No CPR Forms may be Revoked by:
   1. The patient verbally revoking the order
   2. The patient destroying the form and/or bracelet
   3. The physician 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.

B. POLST Form changes are noted in Part G

V. Special situation:

A. A patient's wish to withhold to resuscitation should always be respected. Sometimes, however, the family may vigorously and persistently insist on CPR even if a valid POLST order or EMS-No CPR order (form or bracelet) 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 paramedics (for First Responders and EMTs).
   3. Advanced life support personnel should continue treatment and consult medical control.

VI. Other Valid DNR Orders

A. EMS personnel may recognize other physician-signed health care DNR orders, but if any doubt about validity, CPR should be started.

B. Sometimes health care facilities prefer to use their own health care DNR orders. When EMS providers see other DNR orders, they should do the following:
   1. Verify that the order has a physician 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 physician-signed DNR order.

VII. EMS-Provider Protocols for Do Not Resuscitate Orders

A. Review APPENDIX A: EMS Provider Protocols for Do Not Resuscitate (DNR) Orders

VIII. Run Report Documentation of the EMS-No CPR order

A. All POLST or EMS-No CPR patients MUST be properly documented:
   1. Complete medical incident report form approved by your county MPD.
   2. State in writing in the upper left hand corner of the narrative summary: "Patient identified as POLST Form or EMS-No CPR form, bracelet or both."
   3. Record the name of the patient's physician, and state whether you contacted the physician.
   4. Record reason why EMS system was activated.
   5. Follow your local MPD protocols for patients who have expired. Actions may include contact of:
      a. Local coroner's office
      b. Local law enforcement agency
      c. Local chaplain service, or
      d. Funeral home

IX. 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. 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.

X. How to Manage Grieving Family Members

A. Review and Discuss APPENDIX B: "**How BEST To Tell The Worst News"**

Application

Procedural (How)
None identified for this lesson.

Contextual (When, Where, Why)
Medical/legal and ethical issues are present in every aspect of patient care. The decision to treat or not 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 orders are encountered.

STUDENT ACTIVITIES
Auditory (Hear)
- Participants should hear about actual POLST situations.

Visual (See)
- Participants should see actual copies of POLST and EMS-No CPR materials.

Kinesthetic (Do)
- Participants should practice role-play situations in which DNR orders are in effect.

INSTRUCTOR ACTIVITIES
Supervise participant's practice.
Reinforce participant's progress in cognitive, affective, and psychomotor domains.
Redirect participants having difficulty with content (complete remediation forms).

Evaluation

Written:
Develop evaluation instruments, e.g., quizzes, verbal reviews, and handouts, to determine if the students have met the cognitive and affective objectives of this lesson.

Practical:
Evaluate the actions of the participants during role-play, practice or other skill stations to determine their compliance with the cognitive and affective objectives and their mastery of the psychomotor objectives of this lesson.

Remediation

Identify participants who are having difficulty with this subject content. Complete remediation sheet from the instructor's course guide.

Enrichment

What is unique in the local area concerning this topic? Complete enrichment sheets from instructor's course guide and attach with lesson plan.

APPENDIX A: EMS Provider Protocols for Do Not Resuscitate (DNR) Orders

EMS PROVIDER PROTOCOLS FOR DO NOT RESUSCITATE (DNR) ORDERS

I. Scene Size-Up/Initial Patient Assessment

II. Focused History and Detailed Physical Exam

A. Determine the patient is in a Do Not Resuscitate status in one of the following ways:

1. The patient has an **original**, valid POLST Form at the bedside, on the medicine cabinet, on the back of the bedroom door, or on the refrigerator, OR
2. The patient has an EMS-No CPR bracelet that is intact and not defaced. The bracelet can be located on either wrist, either ankle, or on a necklace or neck chain, and worn by the patient, OR
3. The patient has an **original** EMS-No CPR Form at the bedside, on the medicine cabinet, on the back of the bedroom door, or on the refrigerator.
4. The patient has other DNR Orders: We encourage medical facilities to use the POLST Form.
   a. Sometimes health care facilities prefer to use their own health care DNR orders. When encountering other DNR orders, perform the following:
      (1) Verify that the order has a physician 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 DNR order.
5. In extended or intermediate care facilities, look for the DNR form in the patient's chart.

III. Management

A. Begin resuscitation when it is determined no valid DNR order exists.

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 suffered one or more of the following:
      (1) Decapitation
      (2) Evisceration of heart or brain
      (3) Incineration
      (4) Rigor Mortis
      (5) Decomposition

2. In your medical judgment, it is determined your patient has attempted suicide or is a victim of a homicide, begin resuscitation.

C. When the patient has an existing, valid DNR order:

1. POLST:
   a. Provide resuscitation based on patient's wishes identified on the form
   b. Provide medical interventions identified on the form
   c. Always provide comfort care
2. EMS-No CPR:
   a. Do Not begin resuscitation measures
   b. Provide comfort Care
   c. Contact patient's physician or on-line medical control if directed by local protocols or if questions or problems arise.
3. Other DNR orders:
   a. Follow specific orders contained in the DNR order based on the standard of care allowed by your level of certification/licensure and communications with on-line medical control.

D. If resuscitative efforts have been started before learning of a valid DNR order, STOP these treatment measures:

1. Basic CPR.
2. Intubation (leave the endotracheal tube in place, but stop any positive pressure ventilations).
3. Cardiac monitoring and defibrillation.
4. Administration of resuscitation medications.
5. Any positive pressure ventilation (through bag valve masks, pocket face masks, endotracheal tubes).

E. Revoking the DNR order. The following people can inform the EMS system that the DNR order has been revoked:

1. 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).
2. The physician expressing the patient's revocation of the directive.
3. The legal surrogate for the patient expressing the patient's revocation of the directive. (The surrogate cannot verbally revoke a patient executed directive).

F. Documentation

1. Complete the Medical Incident Report (MIR) form approved by your Medical Program Director.
2. State in writing in the upper left hand corner of the narrative summary:
   a. "Patient identified as DNR by POLST, EMS-No CPR, or Other directive."
3. Record the name of the patient's physician, and state whether you contacted the physician.
4. Record the reason why the EMS system was activated.
5. Comfort the family and bystanders when patients have expired
6. Follow your local Medical Program Director's protocols for patients who have expired. Actions may include contact of the local coroner's office, the local law enforcement agency, the local chaplain service, or funeral home. The MIR form must still be completed.

G. Comfort Care Measures - Providing comfort care is an important responsibility and service you provide to patients and their families at a crucial moment in their lives.

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

H. Special situation:

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

   a. Attempt to convince family to honor the patient's decision to withhold CPR/treatment. If family persists, then

   b. Initiate resuscitation efforts until relieved by paramedics (for First Responders and EMTs).

   c. Advanced life support personnel should continue treatment and consult medical control.

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

IV. Ongoing Assessment as appropriate

V. Transport if necessary

APPENDIX B: "How BEST To Tell The Worst News"

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 due to 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 they 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 and 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 turn from a failed resuscitation to 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 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 ranges 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 that you cannot share. Saying words like "I'm sorry" can be mistaken for guilt at not having been able to recall a patient to life. Convey your feelings with a phrase such as "You have my (our) sincere sympathy" rather than "I am (we are) sorry".

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 good-bye 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 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 of time. Expectations about what EMTs and Paramedics can do for the surviving relatives are frequently unrealistic. In the short period of time after resuscitation, 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

Medical Terms Used When Talking About End-of-Life Care

Advance Directives: A communication from a patient to their physician. Advance directives are instructions to a physician, which identify an individual'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 though 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 these protocols, "CPR" or "Cardiopulmonary Resuscitation" covers the full range of emergency cardiac interventions and is not limited to basic CPR. The “POLST” DNR and the "EMS-No CPR" 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.

> **The POLST and the EMS-No CPR orders do 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.

Durable Power of Attorney for Health Care: A document signed by a person which appoints someone else to make health care decisions for the person in the event that the person loses the ability to make their own decisions.

EMS-No CPR Bracelet: A durable identification bracelet with the letters "EMS-No CPR" along the lower window of the bracelet. EMS personnel should honor this bracelet. EMS personnel do not need to see the original signed directive. Once applied, the EMS-No CPR bracelet must be cut off to remove it and is not reusable.

EMS-No CPR Form: A special directive provided by the Department of Health. The directive is specifically designed to help patients, physicians and EMS personnel in No CPR situations. The directive encompasses ALL the documentation needed by the patient, the physician and the EMS personnel. The directive brings together the statement of the patient or surrogate that they want CPR withdrawn or withheld; the physician's directive to EMS personnel not to initiate CPR in the event of a cardiac arrest; and/or the surrogate's directive to EMS personnel to withhold CPR.

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 DNR documents are certified by the Washington State Department of Health to provide emergency medical care or treatment. These care givers include First Responders, EMTs, EMT-IV Technicians, EMT-Airway Technicians, EMT-IV/Airway Technicians, and EMT-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 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 over four hundred thousand in coordination with the recommendations of the local medical community and local Emergency Medical Services and Trauma Care Council.

POLST: Physician **O**rders for **L**ife-**S**ustaining **T**reatment. A medical order form that turns an individual's wishes for life-sustaining treatment into action.

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 prior to 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 (MPD) which direct the out-of-hospital emergency care of emergency patients, including trauma care patients.

Qualified Patient: Any person 18 years of age or older who informs his/her physician that he/she does not want CPR performed in the event that he/she suffers a cardiac or respiratory arrest and has signed an EMS-No CPR Directive. A legal surrogate may also sign on behalf of a qualified patient. To be valid, the directive must be signed by the person's physician.

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 DNR Directive may be made ineffective. The POLST or EMS-No CPR Directive 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 his/her surrogate decision maker if directive was executed by the surrogate; or

2) Verbal communication by a qualified patient or his/her surrogate decision maker expressing the patient's revocation of the EMS-No CPR Directive. The surrogate decision maker cannot 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/her own health care decisions. A surrogate decision maker must be one of the persons below, in the following order of priority:

1) Appointed guardian of the patient, if any;

2) Individual, 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 eighteen years of age;

5) Parents of the patient; and

6) Adult brothers and sisters of the patient.

APPENDIX D: Sample POLST Form

Physician Orders for Life-Sustaining Treatment (POLST) This is a Physician Order Sheet. Based on patient/resident wishes and medical indications, it summarizes any Advance Directive. Any part not completed indicates full treatment for that part. When need for resuscitation occurs, **first** follow these orders, **then** contact physician. The purpose of Parts B, C, and D are to provide physician orders on end of life care as patients move through the various health care settings. Notify physician of any significant change in medical condition.	Last Name of Patient/Resident
	First Name/Middle Initial of Patient/Resident
	Patient/Resident Date of Birth

Physician Orders for Life-Sustaining Treatment

Part A check one box only	**Resuscitation.** Patient/resident has no pulse and is not breathing. For all other medical circumstances, refer to "Part B, Medical Interventions." ❑ **Resuscitate** ❑ **Do Not Resuscitate (DNR)**

Part B check one box only	**Medical Interventions.** Includes Emergency Medical Services. Patient/resident has pulse and/or is breathing. ❑ **Comfort Measures Only**. Oral and body hygiene, reasonable efforts to offer food and fluids orally. Medication, positioning, wound care, warmth, appropriate lighting and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient/resident. Transfer only if comfort measures fail. ❑ **Limited Interventions.** All care above and consider oxygen, suction, treatment of airway obstruction (manual only). ❑ **Advanced Interventions.** All care above and consider oral/nasal airway, bag-mask/demand valve, monitor cardiac rhythm, medication, IV fluids. ❑ **Full Treatment/Resuscitation.** All care above plus CPR, intubation and defibrillation. ❑ ***Other Instructions***:_____
Part C check one box only	**Antibiotics (notify physician of new infection)** ❑ No antibiotics except if needed for comfort ❑ No invasive (IM/IV) antibiotics ❑ Full Treatment ❑ ***Other Instructions***:_____
Part D check one box only	**Artificially Administered Fluids and Nutrition.** Oral fluids and nutrition must be offered if medically feasible. ❑ No feeding tube/IV fluids (provide other measures to assure comfort) ❑ No long term feeding tube/IV fluids (provide other measures to assure comfort) ❑ Full Treatment ❑ ***Other Instructions***:_____

Part E	**Discussed with:** ❑ Patient/Resident ❑ Agent of Durable Power of Attorney ❑ Court-appointed Guardian ❑ Spouse ❑ Other (Specify)_____	**The Basis for These Orders Is: (circle all that apply)** ❑ Patient's request ❑ Patient's known preference ❑ Patient's best interest ❑ Medical futility

Physician Name (print)	**Physician Signature** (mandatory)	**Phone**	**Date**
Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)		**Date**	

Revised 12/2/01

ORIGINAL FORM MUST ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE

Part F	**Patient/Resident Preferences as a Guide for this POLST Form.**		
	Significant thought has been given to life-sustaining treatment and patient preferences have been communicated to physician and/or health care provider(s). This document reflects patient treatment preferences. Further information regarding these preferences **may be** obtained from the following: ❑ Advance Directive *Attach copy* ❑ Court-Appointed Guardian *Attach copy of documentation* Name of Guardian_____ ❑ Agent for Durable Power of Attorney for Health Care *Attach copy* Name of Agent _____ **Please review these orders if there is a substantial change in my health status such as:** Close to death Improved Condition Advanced progressive illness Extraordinary suffering Permanent unconsciousness		
	Signature of Person Preparing Form	**Preparer Name (Print)**	**Date**

How to Change This Form

This POLST Form should be reviewed periodically and if:

- ✔ The patient/resident is transferred from one care setting or care level to another, or
- ✔ There is substantial change in patient/resident health status, or
- ✔ The patient/resident treatment preference change.

First, review "Patient/Resident Preferences as a guide for this POLST Form" **(Part F)**.
Second, record the review in "Review of this POLST Form." **(Part G)**.
Finally, if this form is to be voided, draw a line through the "Physician Orders" and/or **write the word "VOID"** in large letters, then sign or initial the form. After voiding the form, a new form may be completed.

If no new form is completed, full treatment and resuscitation may be provided.

SAMPLE

Part G	Review of this POLST Form			
	Review Date	**Reviewer**	**Location of Review**	**Review Outcome**
				❑ No Change ❑ Form Voided ❑ New form completed
				❑ No Change ❑ Form Voided ❑ New form completed
				❑ No Change ❑ Form Voided ❑ New form completed
				❑ No Change ❑ Form Voided ❑ New form completed
				❑ No Change ❑ Form Voided ❑ New form completed

Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)	Date

ORIGINAL FORM MUST ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

APPENDIX E: Sample EMS-N0 CPR Form

Emergency Medical Services

EMS - No CPR Directive

CPR

Part 1. EMS-No CPR Directive

I, _____, ask that emergency medical personnel not revive me if my heart stops beating or I stop breathing. I understand this request means nothing will be done to start me breathing or my heart beating again. I have been told by my doctor what is good and bad about this decision. I understand that I may change my mind about this request at any time by tearing up this directive and taking off the EMS-No CPR bracelet. I want all emergency medical personnel to be free from legal liability for honoring this directive.

_____ _____

Patient Signature Date

Part 2. Surrogate's EMS-No CPR Directive

(Use this section if individual is incapable of making health care decisions).

I, _____, have durable power of attorney for health care/guardianship/ substitute decision making authority for _____ to make health care decisions for him/her.

Relationship to patient: _____ (guardian; representative named in durable power of attorney for health care; spouse; adult child; parent; adult brother or sister.)

I believe this person would not want CPR in his/her condition, or if I do not know his/her belief, I believe that **attempting CPR would not be in this person's best interest**, so I ask that CPR not be tried. This person's physician has explained to me what will happen if he/she stops breathing or his/her heart stops and CPR is not tried: this person will die. I understand this.

_____ _____

Surrogate Signature Date

SAMPLE

Part 3. Physician's EMS-No CPR Directive to EMS Personnel

I, _____, am a physician actively caring for the patient named above, and hereby state that this directive is consistent with the patient/surrogate directive above. I have discussed the medical risks and benefits of this decision with the patient/surrogate. I direct all Emergency Medical Services personnel to withhold from the patient in the event of cardiac or respiratory arrest: cardiac compressions, endotracheal intubation, advanced airway management, defibrillation, intravenous resuscitation medications and CPR. (CPR includes any ventilation support **other than** manually opening airway.)

I further direct such personnel to provide other medical interventions such as intravenous fluids, oxygen, or other therapies necessary for comfort care or to alleviate pain, consistent with their operating protocols and their scope of practice.

_____ _____

Physician Signature Date

_____ _____

Address Phone

Green copy: To be kept by patient and immediately available to emergency personnel.
Yellow copy: To be kept in patient's permanent medical record.

DOH 530-042 (Revised 5/96)

Washington State Department of Health

Emergency Medical Services
No CPR Directive

Purpose

This EMS-No CPR Directive was developed by the Department of Health's Office of Emergency Medical and Trauma Prevention, and the EMS-No CPR Workgroup. This directive instructs EMS personnel to withhold resuscitation attempts in the event of a patient's cardiopulmonary arrest. Resuscitative measures to be withheld include any ventilation support (other than manually opening the airway), cardiac compressions, advanced airway management, defibrillation, intravenous resuscitation medications and CPR. This directive does **not** affect the provision of other emergency medical care by EMS personnel such as intravenous fluids, oxygen or other therapies deemed necessary to provide comfort care to alleviate pain.

Applicability

This directive applies to resuscitation attempts by EMS providers in **prehospital** settings -- i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility and in other locations outside acute care hospitals. The directive does **not** replace other written DNR orders that may be required pursuant to a long-term care facility's own policies and procedures governing CPR attempts by facility personnel. Patients should be advised that their prehospital EMS-No CPR instruction may not be honored in other states or jurisdictions, and may or may not be honored upon admission to a hospital.

Either an intact EMS-No CPR bracelet or the original EMS-No CPR directive must be present for the EMS-No CPR directive to be honored.

SAMPLE

Instructions

Patient completes EMS-No CPR Directive (Part 1); OR

2. Surrogate completes Surrogate's EMS-No CPR Directive;(Part 2)

Attending Physician signs the Directive to EMS Personnel (Part 3);

4. EMS-No CPR Bracelet and original signed EMS-No CPR Directive placed with the patient.

This EMS-No CPR Directive should be located at the patient's bedside (bedside table) or on the back of the door to patient's room or on the refrigerator. Patients should carry the original directive with them if traveling. If the patient is being transported by ambulance, the original directive should accompany the patient. However, the bracelet alone will be sufficient authorization to withhold CPR during ambulance transport if a cardiac arrest should occur.

The **green copy** of the directive should be retained by the patient. *The completed directive (or the EMS-No CPR bracelet) must be readily available to EMS personnel in order for the EMS No-CPR instructions to be honored.* Resuscitation attempts may be initiated until the directive (or bracelet) is presented and the identity of the patient is confirmed.

The **yellow copy** of the directive should be retained by the physician and made part of the patient's permanent medical record.

Revocation

If a decision is made to revoke the EMS-No CPR Directive, the patient's physician should be notified immediately and all copies of the directive should be destroyed. This EMS-No CPR directive or bracelet may be revoked at any time by any of the following methods:

By being **intentionally** canceled, defaced, obliterated, burned, torn, or otherwise destroyed by a qualified patient or his/her surrogate decision maker if the surrogate executed the directive; **or**

2. By verbal communication from a qualified patient or his/her surrogate decision maker expressing the patient's revocation of the EMS-No CPR directive. Such verbal revocation becomes effective upon its actual communication to the Attending Physician or EMS personnel.

Questions about implementation of the prehospital EMS-No CPR Directive should be directed to the Office of Emergency Medical and Trauma Prevention at (800) 458-5281 (extension 2).

Green copy: To be kept by patient and immediately available to emergency personnel.
Yellow copy: To be kept in patient's permanent medical record.

DOH 530-042 (Revised 5/96)

Washington State Department of Health