

ADVANCED DIRECTIVES

I. HEALTH CARE AGENTS/POWER OF ATTORNEY

- A. Illinois law allows persons to appoint an agent to make health care decisions for the patient in the event that the patient is unable to make his or her own medical decisions. The person chosen by the patient to make these decisions is called the "agent." An agent is appointed by the patient via a document called a "power of attorney for health care." The agent can order you to withdraw or withhold medical care of the patient.
- B. A health care agent has no authority if the patient himself or herself is alert and able to provide informed consent to treatment or transport. If the patient is alert and consents to treatment, continue to treat the patient, even if thereafter the patient is unable to communicate with you. In such situations, the health care agent has no authority over the treatment of the patient.
- C. If someone represents to you that they have power of attorney to make medical decisions for the patient, follow these procedures:
 - 1. Begin treatment of the patient.
 - 2. As soon as it is practical, ask the agent for the power of attorney form and examine the form to determine if the agent's name appears on the form as agent, and ask the agent to verify that his/her signature appears on the form. Review the form to see what medical authority has been given to the agent.
 - 3. Notify medical control as indicated of the confirmed presence of a health care agent and follow the instructions of the agent per the authority granted in the power of attorney form unless instructed otherwise by medical control.
 - 4. If you have doubt as to the identity of the agent, the extent of the authority of the agent, or if communications with medical control cannot be established, continue treatment of the patient and transport as soon as possible. Document concerns.

II. LIVING WILLS AND PATIENT SURROGATES

Illinois law allows terminally ill patients to instruct their health care providers, either directly with a living will, or indirectly through a patient surrogate, on their treatment in near death situations. However, the technical requirements of these laws make them unworkable and impractical for field use, where EMS personnel have limited time for analysis and decision making. Therefore, Region XI EMS System personnel shall not follow the instructions contained in a living will or given by any person purporting to be a surrogate for the patient unless instructed otherwise by medical control.

III. DO NOT RESUSCITATE (DNR)/IDPH PRACTITIONERS ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) FORM

For the purpose of this policy, Do Not Resuscitate (DNR)/POLST Orders are defined as medical orders by a physician or practitioner based on the patient's medical condition and

preferences. These orders provide guidance during life threatening emergencies and must be followed by all healthcare providers.

A. The sections of the POLST form are defined as follows:

1. Section “A” of the POLST form refers to Cardiopulmonary Resuscitation. This section notes if the patient wishes to have resuscitation/CPR attempted or if they prefer medical providers do not attempt resuscitation.
2. Section “B” of the POLST Form refers to medical interventions for patients who are NOT in respiratory or cardiac arrest. There are three options of treatment levels:
 - i. **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment (see #2 & #3 below), use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
 - ii. **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment (see #3 below), use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. **Do Not Intubate.** May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital, if indicated. Generally avoid the intensive care unit.
 - iii. **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of 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.**
 - iv. There is also a section for Optional Additional Orders.
3. Section “C” refers to the use of medically administered nutrition.
4. Section “D” refers to documentation of the discussion of the DNR/POLST document and signatures of the patient or legal representative’s consent and a witness.
5. Section “E” refers to the signature and date of the patient’s health care practitioner.

B. All system EMS personnel are permitted to withhold or withdraw medical care pursuant to a valid DNR/ POLST Order in cardiac arrest situations. Valid DNR/ POLST Orders can be followed by system EMS personnel in long term care facilities, with hospice and home-care patients, and with patients who arrest during interhospital transfers or transportation to or from home.

C. A valid DNR/POLST Order will contain at least the following information:

1. Name of the patient;
 2. Name and signature of attending practitioner;
 3. Effective date;
 4. The words, "Do Not Resuscitate" or "DNR";
 5. Evidence of consent - either:
 - i. Signature of patient or
 - ii. Signature of legal guardian or
 - iii. Signature of durable power of attorney for health care agent or
 - iv. Signature of surrogate decision maker
- D. If the required evidence of consent does not appear on the DNR/POLST Order, the order is not valid for prehospital use.
- E. When presented with a DNR/POLST Order, follow these procedures:
1. Verify the order contains the criteria for a valid DNR/ POLST Order as listed above.
 2. Make a reasonable attempt to verify the identity of the patient (for example, identification by another person or an identifying bracelet) named in a valid DNR/POLST Order.
 3. Contact medical control as needed to discuss the situation and advise them of the presence of a DNR/POLST Order, along with the description of any specific treatments to be withheld that are set forth in the DNR/POLST Order. Always follow orders from medical control, even if they are contrary to the DNR/POLST order.
 4. If the order is valid and medical control does not order otherwise, follow the terms of the DNR/POLST order, and attach a copy of the DNR/POLST Order to the patient care report. If it is not possible to attach a copy of the DNR/POLST Order, record all information from the DNR/POLST order on the patient care report.
 5. If there is any doubt as to the validity of the DNR/POLST order, treat the patient and transport as soon as possible. Document any concerns in the patient care report.
- F. A DNR/POLST Order can be revoked if the order is physically destroyed or verbally rescinded by the physician who signed the order, the patient, or the person who gave written consent to the Order.

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Written: 2007 Taken from "Initiation of Termination of Resuscitative Measures" and "Do Not Resuscitate"

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State of Illinois
Illinois Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

| | | |
|-------------------------------------|--------------------|--|
| Patient Last Name | Patient First Name | MI |
| Date of Birth (mm/dd/yy) | | Gender <input type="checkbox"/> M <input type="checkbox"/> F |
| Address (street/city/state/ZIPcode) | | |

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

Check One **Attempt Resuscitation/CPR** **Do Not Attempt Resuscitation/DNR**
(Selecting CPR means Full Treatment in Section B is selected)

When not in cardiopulmonary arrest, follow orders B and C.

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

Check One (optional) **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of 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.**

Optional Additional Orders _____

C **MEDICALLY ADMINISTERED NUTRITION** (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One (optional) Long-term medically administered nutrition, including feeding tubes. **Additional Instructions (e.g., length of trial period)** _____

Trial period of medically administered nutrition, including feeding tubes. _____

No medically administered means of nutrition, including feeding tubes. _____

D **DOCUMENTATION OF DISCUSSION** (Check all appropriate boxes below)

Patient Agent under health care power of attorney

Parent of minor Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

| | | |
|----------------------|--------------|-------|
| Signature (required) | Name (print) | Date |
| _____ | _____ | _____ |

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

| | | |
|----------------------|--------------|-------|
| Signature (required) | Name (print) | Date |
| _____ | _____ | _____ |

E **Signature of Authorized Practitioner** (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

| | |
|---|-------------------|
| Print Authorized Practitioner Name (required) | Phone |
| _____ | () _____ - _____ |
| Authorized Practitioner Signature (required) | Date (required) |
| _____ | _____ |

****THIS SIDE FOR INFORMATIONAL PURPOSES ONLY****

| | | |
|-------------------|--------------------|----|
| Patient Last Name | Patient First Name | MI |
|-------------------|--------------------|----|

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

Health Care Power of Attorney
 Living Will Declaration
 Mental Health Treatment Preference Declaration

| | |
|---------------------|----------------------|
| Contact Person Name | Contact Phone Number |
|---------------------|----------------------|

Health Care Professional Information

| | |
|----------------|---------------|
| Preparer Name | Phone Number |
| Preparer Title | Date Prepared |

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

- This POLST form should be reviewed periodically and if:
- The patient is transferred from one care setting or care level to another, or
 - or there is a substantial change in the patient's health status, or
 - or the patient's treatment preferences change, or
 - or the patient's primary care professional changes.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

- | | |
|--|---|
| 1. Patient's guardian of person | 5. Adult sibling |
| 2. Patient's spouse or partner of a registered civil union | 6. Adult grandchild |
| 3. Adult child | 7. A close friend of the patient |
| 4. Parent | 8. The patient's guardian of the estate |

For more information, visit the IDPH Statement of Illinois law at <http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT